



North East Ambulance Service
NHS Foundation Trust



Strategic Plan Document for 2013-14

**North East 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	31 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 (Chair)	Mr Ashley Winter
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Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Mr Simon Featherstone
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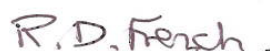
Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	Mr Roger French
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Signature



Strategic Context and Direction	<p>The North East Ambulance Service's (NEAS) vision sets out our intention:</p> <p><i>'To make a difference by integrating care and transport in pursuit of equity and excellence for our patients'</i></p> <p>The Trust's strategy over the next three years is to strengthen and improve our emergency response service, integrating our range of transport services and developing better urgent care pathways that provide us with alternatives to hospital admission. Our principle goals are:</p> <ul style="list-style-type: none"> • Achieve high standards of emergency and urgent care and responsiveness • Offer an excellent patient experience • Offer high quality, low cost services to commissioners <p>Our six strategic intentions:</p> <ol style="list-style-type: none"> 1. To lead in the provision of emergency care. We want to be the provider of choice for Emergency Care services and lead through innovation, research and performance. 2. To be a key partner in urgent care reform. We want to help deliver the changes that our patients and our commissioners are asking for using our expertise and infrastructure. 3. To transform our Patient Transport Services. We want to continue to be the provider of choice for PTS in the North East. 4. To be a first rate employer. We want our staff to be supported with appropriate reward and flexible working conditions and a safe productive working environment. 5. To have sound financial health. We want to maintain strong financial health that enables us to invest in new service developments, constantly taking the organisation forward. 6. To be a well governed and accountable service. We want to ensure that the safety and quality of our services to patients remains our highest priority. <p>The Trust is a strong performing ambulance service. Last year the Trust successfully exceeded its national Emergency care performance response targets, achieving 76.4% for responding to Category A incidents within 8 minutes, and 95.50% for responding to a request for patient transport to Category A incidents within 19 minutes. The Trust's underlying financial performance is also strong delivering a normalised financial surplus at the end of 2012/13 of £2.38million although the headline performance is a deficit of £2.98million largely due to a one off impairment of £5.24 million relating to the Trust's purchase of its headquarters building, Bernicia House.</p> <p>In the Trust's first full year as a foundation trust, within the regulatory framework the Trust has achieved a Governance Risk Rating of Green and Financial Risk Rating of 4.</p> <p>We are one of 11 ambulance trusts and currently one of five ambulance foundation trusts. We serve the population of the North East which is 2.66 million.</p> <p>The Trust's core areas of business include:</p> <ul style="list-style-type: none"> • Emergency Care (formerly referred to as A&E) • Patient Transport Services (PTS) • Contact Centre - 999 • North of England NHS 111 <p>The Trust recognises that it is operating in a changing environment, against the backdrop of NHS reforms, including Patient Choice, a new commissioning architecture, Monitor's assessment and compliance frameworks, the second Francis Inquiry in Mid-Staffordshire Hospitals, and the publication of the 'Everyone Counts: Planning for Patients 2013-14', which all set the scene for the NHS in the years ahead. To ensure alignment, particularly with our new clinical commissioners, of our longer term aspirations for our patients in the north east, we have set a new strategic corporate objective to commence in 2013-14.</p> <p>Objective 11: To commence work on a long term strategic plan for NEAS as a Foundation Trust</p> <p>We intend to revisit our vision and refresh our strategic direction which in turn will inform our long range ambitions. Our strong record of achievement of plans already delivered that were set out in our Integrated Business Plan 2010/11-2015/16 pave the way for us to put in place some equally ambitious and innovative plans for the next five to ten years.</p> <p>Competition Overview</p>
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The Trust has a number of key competitors with regards to the various service types we offer.

Emergency Care (999 – Telephony and Operational Staff)

There are a number of smaller private ambulance providers such as Emergency Medical Services (EMS), Ambuline, Lifeline, North of England Ambulance Service and Blue Star Medical Services. There are also larger providers, such as G4S Integrated Services and third sector providers such as St John Ambulance and the British Red Cross. This competition is not a threat to our core service provision as, for the foreseeable future – at least through 2013/14 – Emergency Care Service provision is listed as a mandated service which will be provided by the NHS and which will not be opened up to competition. Where these competitors are to be monitored is in ancillary service areas such as large events first aid support, organ transplant transport and where we as an ambulance trust utilise third party resources in times of high demand, such as winter pressures, to maintain our performance standards.

Strengths	Weaknesses
<ul style="list-style-type: none"> • Excellent clinical performance. • Excellent patient feedback – the Trust is extremely highly valued by our patients. • Core targets (R1 & R2) are being achieved at a Trust level. • NHS Brand. • Excellent reputation (overall). • Excellent training programmes and highly developed staff. • Established estates, fleet and staff. • High barriers to entry – 2 year training for paramedics, skilled staff, cost of equipment and vehicles, estates suitable for 24/7 operations. • Committed, dedicated workforce. 	<ul style="list-style-type: none"> • Agenda for Change generally means the Trust is higher than private competitors in terms of staffing costs. • Variation in performance, especially in rural areas. • Services are not currently marketed strongly enough. • Private competitors are able to loss-lead on contracts, Monitor constrains NHS foundation trusts from being able to loss-lead, and therefore private competitors have greater financial freedom. • Group 4 and similar organisations have a global reach and therefore the ability to off-set or subsidise financial investments in order to enter and dominate markets. • Support service capacity.

Patient Transport Services (Telephony and Operational Staff)

There are more significant competitive pressures within the PTS market, with some larger providers winning significant contracts from other regional ambulance services. Key players include Arriva, NSL Care Services, E-Zec, Group 4 and smaller services such as Lifeline and Emergency Medical Services. The Trust is not in direct threat to the core PTS contract for the period 2013/14. The reason for this is that there is a minimum 12 month notice period of putting the contract out to tender and with the change in commissioning arrangements from the Strategic Health Authority and Primary Care Trusts to the forming Clinical Commissioning Groups (CCGs) there is no imminent move to put significant contracts out to tender. The Trust is very much aware of the risk to PTS however with the recent experience of East Midlands Ambulance Service losing their entire PTS provision and North West Ambulance Service losing the contract for Greater Manchester PTS and South West Ambulance Service losing their PTS service to NSL. We are therefore in the process of a long term transformation programme to significantly improve the overall effectiveness of our PTS provision, work more closely with our Commissioners in a partnering methodology and achieve efficiency savings wherever possible.

Strengths	Weaknesses
<ul style="list-style-type: none"> • Excellent patient feedback – the Trust is extremely highly valued by our patients. • Very strong reputation. • Excellent training programmes and highly developed staff. • Established estates, fleet and staff. • Years of experience of managing appropriate resources to match demand. • Committed, dedicated workforce. • Excellent data quality. • Auto-Planning software to maximise vehicle utilisation. 	<ul style="list-style-type: none"> • Agenda for Change generally means the Trust is higher than private competitors in terms of staffing costs. • Some areas of gaps in terms of management information, competitors may have more advanced software solutions. • Services are not currently marketed strongly enough. • Private competitors are able to loss-lead on contracts, Monitor constrains NHS Foundation Trusts from being able to loss-lead, and therefore private competitors have greater financial freedom.

Contact Centre (NHS 111)

There is significant competition in the contact centre market. NHS or healthcare specific providers include NHS-Direct, Out of Hours GP collectives and Care UK. Furthermore there are considerable non-healthcare specific providers such as Business Process Outsourcers (BPS) like Serco and Capita. These organisations are multi-national and multi-market providers with enormous financial and commercial strength and a depth of service provision which allows for considerable cross-subsidisation of services. The Trust is not in direct threat to our NHS 111 contract until March 2018 and therefore we have a considerable amount of time to completely embed the service over the whole region. Although this is a position of strength from which to compete, our plans will help us to ensure we protect the service from any long term threat. In the contact centre market, efficiency savings are generated directly from the volume of calls being handled by the service and therefore the larger providers, such as NHS-Direct, Care UK and the potential entry of Serco and Capita could pose a considerable threat in terms of driving down the cost per call and therefore the market value and price point at which the service will be competed.

Strengths	Weaknesses
<ul style="list-style-type: none"> • Well established operation, with experience back to October 2009. • Excellent patient feedback – the Trust is extremely highly valued by our patients. • Excellent training programmes and highly developed staff. • Established estates, contact centre and state-of-the-art technology. • Contact Centre Management specific software. • Workforce Planning Software. • Committed, dedicated workforce. 	<ul style="list-style-type: none"> • Agenda for Change generally means the Trust is higher than private competitors in terms of staffing costs. • Services are not currently marketed strongly enough. • Private competitors are able to loss-lead on contracts, Monitor constrains NHS Foundation Trusts from being able to loss-lead, and therefore private competitors have greater financial freedom. • NHS-Direct and Care UK have larger share of the NHS 111 market in the UK and therefore the ability to achieve lower price points due to efficiency savings.

Forecast health, demographic, and demand changes

The population of the North East is growing, but at less than half the England rate and it continues to have trends of higher than average health challenges caused through lifestyle choices, high levels of deprivation and an ageing population. There are disparities in life expectancy between sexes. Early death from cancer, heart disease and stroke has fallen across the North East, but still remain substantially higher than the rest of the UK.

The health challenges the North East faces are evident in the growing demand, particularly for our Emergency Care service and the pressures increasing in all emergency and urgent cares services. This pressure is compounded by the wider economic environment which has placed overall financial pressure on the Trust, its partners and all of us being required to do more for less.

In response we have developed a challenging Cost improvement programme (CIP). We do have a strong track record of financial performance and our CIP is robust, so is the delivery mechanism we have in place in the form of our Programme Management Office (PMO). Our planned areas of savings are also aligned to the areas where our Commissioners expect to see improved productivity and actual savings and we are already engaged in aspects of whole system improvements that will enable us to effectively manage the risk.

Impact Assessment of Market Share

For the period 2013/14 there is no forecast impact to market share for our services in the North East of England. Our core Emergency Care Services and PTS contract is secure for a minimum 12 month period. Our NHS 111 service has five operational years to run and will not be subject to competitive tender until March 2018.

Therefore 97% of our services and the associated income are safe from competition in the short term.

Changes in local commissioning intentions

The new commissioning environment, whereby we contract directly with 12 CCGs to provide our NHS services, is still in development locally. This has increased the challenge of developing and firming up our own longer term plans. Where possible we have ensured that the initiatives and strategies contained in this plan are in alignment with those commissioning intentions that are known and with those have transferred from our previous commissioners, many of whom, we will continue to work with in the new structures. To ensure that our relationship with the CCGs is as strong as it can be in the future, we have continued to commit to the following strategic corporate objective:

Objective 8: Further develop and implement a programme of engagement within the newly established commissioning architecture

Our Emergency Care Service remains strong within the North East health market and agreement has been reached on retention of the existing NHS standard one year contract for 2013-14. Provision of 999 ambulance services remains a mandatory NHS service which protects this revenue stream from potential tendering by CCGs through the mechanism of using 'any qualified provider'. Whilst this affords income protection, our commissioners continue to focus on developing locally applicable performance standards within the contract in addition to national requirements for R1/R2 (75% response within 8 minutes) and R19 (95% in 19 minutes). Increased 'Red' performance standards have been commissioned locally for more rural areas from 2013-14 with some funding increase. We are working closely with all CCGs, but in particular our three rural CCGs to jointly work on providing the desired level of service on a sustainable basis. This will involve working through new potential models of delivery.

The ability to sustain local and national performance standards is at risk from forecast increases in emergency activity arising out of changes to the NHS urgent care system in April 2013. Growth is anticipated in 2013-14 – whilst general growth of 1.3% would see us responding to 376,642 incidents in-year, the impact of the newly commissioned urgent care NHS 111, decommissioning of NHS Direct, changes to Out of Hours Providers and general significant improved access is likely to compound this further. Our ability to retain agreement from commissioners to fund activity at full local Payment by Results tariffs up to 376,642 incidents, and then apply a marginal rate beyond this enables us to put investment into additional flexible resources to sustain performance in the short-term and to plan for recurrent sustainable service investments in future years.

We are committed to increasing the number of patients we treat on scene and/or refer to alternative care pathways and will continue to work with Commissioners to improve patient access to appropriate alternatives to Emergency Departments, shifting care out of hospitals and closer to home through our strategies such as 'hear and treat' and 'see and treat'. Development and implementation of new initiatives to promote alternative care dispositions is a key theme within our CQUIN programme agreed with commissioners. Local CCGs stated intentions to improve response to GP urgent requests is being addressed by introducing a dedicated 'urgent' tier of resource, as part of our A&E Review and roll out is planned to commence during 2013-14.

We continue to develop relationships with each of the 12 CCGs to ensure our service developments align with their ambitions for patients. We will work with commissioners to develop services that meet their needs, engaging them and demonstrating the value of our services in a developing marketplace.

We remain fully committed to delivering a cost-effective, responsive PTS that meets patients' and commissioners needs and continues to offer invaluable resilience to our emergency services. We have shared our PTS strategy with commissioners and begin the first phase of its implementation during 2013-14 – allowing us to offer more flexible transport to patients, based around appointment times, at no extra cost to CCGs. We will support commissioners in promoting the adoption of appropriate eligibility criteria and are making joint

	<p>improvements to booking arrangements to reduce the number of aborted journeys undertaken. The standard one year NHS contract for 2013-14 has been agreed with commissioners. However, we recognise CCGs willingness to test the market for this service and have received notice of future tendering in one cluster area for PTS provision from 2014-15.</p> <p>Full regional roll-out of our NHS 111 service commenced in April 2013 and this five-year contract is a key component of our business strategy. It not only protects our contact centre service provision in an extremely competitive market, but also allows the organisation to maintain a whole system focus on the full urgent care pathway to the benefit of patients and commissioners. The service provided is the centrepiece of large scale changes that we expect to experience in urgent care and is the lever which will allow us to deliver on CCG intentions of reducing A&E attendances and ensuring appropriate patient care is delivered in the correct setting by the right healthcare professional. The contract will also drive the achievement of further health economy savings through innovative service development grown from emerging technologies and analysis of patterns of need and demand.</p> <p>The Trust is early in the process of realising a programme of income protection, expansion and potential diversification through engagement with both the private and public sector. Elements of this programme are in their infancy and due to their commercially sensitive nature are not detailed in this section. Three of our major scoping initiatives are detailed in Appendix 5.</p> <p><u>Collaboration, Integration and Patient Choice</u></p> <p>As a key player in urgent care we are seeking to work locally with all partners to enhance or develop new integrated pathways of care. We welcome the drive for a culture of cooperation and coordination between health, social care, public health, other local services and the third sector and have recently commissioned a piece of work on clinical care pathways to inform our own role in this agenda. As we are at the heart of emergency and urgent care we already work well across a number of organisational boundaries and have good partnership working in place. As this national initiative unfolds and lessons are learned from the pioneers we will look to see how we can further improve or transform our service provision with our partners to make seamless care provision standard in the North East.</p> <p><u>Competition Rules</u></p> <p>The Trust is compliant in terms of the legislation regarding competition and collaboration. We have regular consultation with our preferred solicitors and understand the competition law framework applied by Monitor, the Office of Fair Trading and the Competition Commission. The two principle areas to ensure we remain compliant are (i) the creation of anti-competitive agreements (ii) the abuse of a dominant position.</p> <p>The Trust ensures that our agreements are transparent, fair and open to scrutiny by Monitor and the Office of Fair Trading. We commit to abiding by the principles of fair practice and that our agreements are carried out in good faith for the benefit of our patients and without detriment to our competitors.</p> <p>The Trust has a dominant position in terms of our mandatory services, such as Emergency Care Services and our non-mandatory services, such as Patient Transport Services. We never impose unfair selling prices, apply dissimilar conditions to trading parties or obligate our partners to conditional contracts. We assure we operate in an objective, just and proper manner where our primary commitment is to offer high quality patient focused care services.</p>
<p>Approach taken to quality</p>	<p>An outline of existing quality concerns</p> <p>The latest Care Quality Committee inspection had no concerns or recommendations for the Trust.</p> <p>One area that has been deteriorating in service performance and is currently being addressed by the Trust is the provision of urgent transport. The definition of urgent transport is ‘a request from a health Care Professional to transport a patient within a specified timeframe’. At the end of 2011, we identified a decline in urgent performance and work and formal monitoring has been set up through the Trust’s clinical governance arrangements, reporting to the Trust’s Quality Committee and Trust Board. Plans are in place to introduce an immediate tier to support this aspect of our service and in the meantime a ring back procedure has been introduced in the contact centre to manage patients waiting and to monitor any deteriorating conditions that would require an emergency response. A Patient User Group has been established to review in detail any issues relating to urgent performance and quality issues. The group has been in place since February 2012 and meets on a monthly basis.</p> <p>There is growing concern within the Health economy of the effect of delays in transferring the care of a patient from an ambulance crew to hospital staff. These delays are unwelcome because there is the potential for harm to patients waiting for an ambulance response in the community and because they waste valuable NHS</p>

resources. Historically, these delays occur only in times of extreme pressure during the winter months as pressure builds in acute settings from increased levels of activity. However, over the last year we have continued to experience an increase in the number of delays affecting patients. Many initiatives have been trialled but have not delivered the reduction in waits required. In recognition of the increasing urgency to 'fix' this problem we took the lead in organising a summit with participants from across our local health community. There was a willingness to work together to address the issues and a number of actions have been implemented immediately including the appointment of two temporary posts to review the whole health economy systems and implement improvements. Although hosted by the Trust these members of staff will be working with all agencies. We have established a report that measures the handover time based on staff utilising information technology in every Emergency Department across the North East. We are working with the acute hospitals to ensure that the figures are accurate and that we take action to address concerns across the whole health economy. Other areas of focus to reduce turnaround delays include:

- Development of divert and deflection policy.
- Ensuring use of appropriate pathways.
- Handover and turnaround process development with individual acute trust providers.
- System development to underpin and support accurate handover recording and reporting.
- Identification of problematic areas, periods of time, etc. through data analysis.
- Rapid Process Improvement Workshop (RPIW) engagement with hospitals to support service improvement.

The key quality risks inherent in this plan

1. Maintaining quality of care if emergency activity continues to increase at current rate. Highest risk associated with back up transport, GP urgents as emergency resource is deployed to emergency activity and handover/turnaround delays.
2. Continuous change in the system and contributory factors such as, Clinical leadership and lack of alternative service may lead to ineffective delivery of correct/appropriate pathways.
3. Management of large volumes of new staff, and pressures on capacity may create risk to quality and safety.
4. Current trend identified for Serious Incidents related to the contact centre triage.
5. Commissioners unwilling to actively support contractual changes to PTS set out in our strategy, threatening our medium to longer term plans for this service.
6. Uncertainty over the level of activity, and consequent income assumptions and resource requirements, resulting from the North East wide introduction of NHS 111.
7. Delays to the Enterprise Information System (EIS) undermine confidence in the Informatics function.
8. Demand outstrips capacity impacting on ability to meet performance standards.
9. Lack of intelligence/knowledge of the CCG's agenda/priorities.
10. General lack of ownership of the Carbon target by the wider Trust as a whole impact on ability to meet carbon targets, to achieve carbon related cost improvements, and risks excluding the Trusts from tenders which require ISO 140001 compliance.
11. Workforce and trade union engagement does not sufficiently improve.
12. Insufficient capacity to ensure NEAS has the people and infrastructure to work on the Long Term Strategic Plan.

Work is underway to review the triage process of all calls within the Contact Centre, with the onset of NHS 111 and the high numbers of new call handlers coming into the Trust. The internal monitoring and review process has identified this as a potential area of high risk and is reviewing training and supervision arrangements.

All Trust risks are effectively managed via the Trust's Board Assurance Framework and Organisational Risk Register and the overarching processes detailed within the Risk Management Strategy.

Effective Board Performance

The composition of the Board of Directors was strongly enhanced as part of the preparations for our Foundation Trust status. It reviewed its capability and processes, composition and the effectiveness of its committees and also its own effectiveness, including information the Board receives and how it holds management to account. It identified a key annual corporate objective:

	<p>Objective 6: To continuously support internal and external customer information requirements through reliable and effective data collection and data quality systems in response to patient and staff feedback and experience</p> <p>The Trust has made good progress in this area over 2012/13 and will continue in 2013/14 to refine and develop, through technological solutions, the speed and validity of the information it receives and provides.</p> <p>In response to the Health and Social Care Act 2012, the revised roles of Board members; Executive and Non-Executive, and Governors will be specifically addressed through tailored development events and bespoke training programmes and our Governors will be supported in establishing effective engagement with the whole of their constituencies.</p> <p>Within our Service Line Management approach there are A&E Reviews, Management Reviews, Team Leader Reviews and PTS Reviews to ensure we change to a more focused management approach and to support our leadership element aspirations. New arrangements will be introduced in 2013/14 to ensure every employee has a performance review at least every 12 months, so that the competences of current and future leaders are motivated and developed within an overall organisational development strategy which has the quality of patient care at its centre.</p>
<p>Clinical Strategy</p>	<p>The Trusts Service Line Management Strategy</p> <p>There are three key dimensions identified to demonstrate quality identified as, Patient Safety, Patient Experience and the Clinical Effectiveness of care. Our Clinical Strategy focusses on these dimensions within this overall definition of quality. Each year these are reviewed to ensure alignment with Quality, Innovation, Productivity and Prevention (QIPP). This will ensure all opportunities are being maximised to achieve the strategic objectives of the local health economy and the NHS as a whole.</p> <p>The Trust's Clinical and Quality improvement focus is driven by our mission statement; Right Care, Right Place, Right Time. In planning for the next three years we have set in motion a number of annual corporate objectives. Those identified below relate directly to our clinical strategy and service line strategy to improve our quality of care and services:</p> <p>Objective 1: To continuously improve the quality of care provided ensuring it is patient focused, effective, safe and delivered with compassion</p> <p>The Trust employs two Quality Improvement Officers who audit clinical patient report forms and feedback to staff on their performance ensuring that the care that is given is patient focused that the treatment that they receive is both effective and safe and that it is delivered with compassion if there are any issues identified within these are dealt with. The Trust is developing a process to add the data into individual's personal development plans and to develop a report for staff portfolios. We continue to work with the e-PRF development and anticipate national plans for reporting solutions that will further enhance clinical review later in 2013/14.</p> <p>Objective 2: To deliver the right care pathway to improve the care offered to patients through maximising access to alternative services in the community</p> <p>As an ambulance service we have a pivotal role to play in the entire urgent and emergency care system. Traditionally, the ambulance service has been seen primarily as a call-handling and transportation service, encompassing some aspects of patient care. However increasingly, it is recognised as having a wider role, as a conduit to other NHS services and ensuring patients can access the right care, at the right place in the right time.</p> <p>As demand on unscheduled care services increases we will see increased development of Hear and Treat services (telephone based clinical advice and support), See and Treat (treatment on scene) and conveyance of patients to alternative care destinations. These alternative care pathways aim to reduce the pressure on emergency departments and in many cases provide more appropriate care and in an optimum time frame which is closer to home.</p> <p>In order to increase the use of alternative care pathways we have a number of initiatives planned, which collectively should result in an improvement in the use of alternative pathways:</p> <ul style="list-style-type: none"> • Appointment of a Clinical Development Manager to undertake a review of pathways and engage with alternative pathways commissioners and providers in area. Implement a clinical guidelines booklet to inform decision making related to alternative pathways; • Evaluate enhanced CARE educational delivery and deployment. The aim of CARE is to give Team Leaders enhanced skills in patient assessment and treatment, to facilitate use of care pathways and treatment on

scene of patients where appropriate;

- Increase the requests made to Contact Centre Logistics Desk for searches for alternative pathways on the Directory of Services; and
- Implementation of a Clinical Hub to support staff with increasingly complex issues such as prioritisation of competing clinical resource demands, safeguarding, mental capacity and consent as well as supporting decision making around alternative pathway utilisation.

Objective 3: To develop an integrated high quality contact centre service which is patient focused and at least exceeds all appropriate performance standards

Our contact centre is undergoing a significant transformation in order to improve its contribution to patients care through operating more efficiently, effectively, and economically with improved quality interactions, whilst attracting new business opportunities. Developments to support the objective include:

- Integrate planning and dispatch functions to ensure the right vehicle at any incident or medical requirement to get the patient to the right care at the right facility;
- Train call handlers with multiple skills to provide a flexible workforce, with the ability to respond to changes in demand;
- Investigate Homeworking with a view to expanding from the present small winter initiative to a team of call handlers working from home daily and; and
- Identify a Call Quality Analysis Tool that will recognise potential issues using voice analytics and support for better management of monitoring and coaching.

Objective 4: Delivering the PTS strategy to secure continuous quality improvement, long term financial viability and commercial competitiveness

In developing the long term strategy, there is an assumption that the Patient Transport Service (PTS) must be in a position to robustly defend its core contracts from April 2014 onwards. With the changes in commissioning arrangements, the need to consult upon and implement eligibility criteria and notice period of 12 months on the main contract this is seen as the earliest point that a tender could be instigated. To be successful the service will have to move to a new model of delivery that would enable it to improve the quality of its transport and reduce its cost base.

PTS will be central to the provision of an integrated transport solution for the North East of England, providing the service of choice to our customers. The service will deliver all planned, including same day activity, and urgent care transport in the North East and will be continually look to differentiate the business of the service line in line with customer needs.

The delivery of a high quality and cost effective patient transport solution will be supported by our most valuable asset, our staff. They will be well trained, motivated and engaged in the continual improvement of the service. We will have in place the appropriate resources, fleet and technology to ensure that our patients access the right service in the right place at the right time.

Objective 7: Maintain and improve the delivery of national emergency care performance standards

From the 1st April 2011, a series of performance indicators were introduced for all ambulance services in England. The new ambulance clinical quality indicators (AQIs) provide the public with the information to assess the quality of care being delivered. National benchmarking is undertaken and targets are set annually to demonstrate on-going improvement in our achievement of these. Our national response performance targets are:

- Achieve category R1 patient response time within 8 minutes 75% of the time;
- Achieve category R2 patient response time within 8 minutes 75% of the time; and
- Achieve category R19 patient transport time within 19 minutes 95% of the time.

To mitigate the risk of increased activity placing additional pressure on emergency response times, a flexible resource plan is to be effective mid 2013/14. Other plans described elsewhere in this plan significantly contribute to achievement of this objective.

Development of Strategy

The Quality Strategy was developed through engagement with all areas of the organisation, both support services and operational services. It was important that the strategic corporate objectives set the tone and pace for our future plans and that they were congruent with our mission (right care, right place, right time) and vision (to make a difference by integrating care and transport in pursuit of equity and excellence for our

	<p>patients) statements.</p> <p>In our strategy development it is important to us that we are considerate of both the local and national health economy and that we review relevant documents, commissioner intentions and changes in the healthcare landscape that are available to us. It is also important that we remain innovative and through our own planning we seek to influence innovation and service development, whilst leading and contributing to the fast pace of all reform in the local health economy.</p> <p>The workforce development strategy for the forthcoming years sets our plan to achieve:</p> <p>Objective 10: To ensure NEAS delivers the NEAS mission, vision and values by actively embedding a positive culture in order to retain, attract, support and develop a workforce which meets current and future service needs</p> <p>The workforce development clinical strategy seeks to play its part in supporting the transition from a corporate led service to a service line approach to delivering the Trust's Plan and sustaining future developments.</p> <p><u>An overview of the clinical workforce strategy</u></p> <p>The development of staff to support the clinical workforce is a whole systems approach which addresses the six key strategic intentions for the organisation.</p> <p>To lead in provision of emergency care</p> <ul style="list-style-type: none"> • Develop leadership/management capacity and capability for the future sustainability of the Trust. <p>To be a key partner in urgent care reform</p> <ul style="list-style-type: none"> • To design and deliver workforce development service to support the service line requirements. <p>To be a first rate employer</p> <ul style="list-style-type: none"> • To ensure all staff have access to learning and development opportunities and reach their full potential. <p>To have sound financial health</p> <ul style="list-style-type: none"> • To ensure workforce development service is delivered as efficiently as possible. <p>To be well governed and accountable</p> <ul style="list-style-type: none"> • To ensure workforce development has a robust accountability framework. <p><u>Key workforce pressures and plans to address them</u></p> <p>The Workforce & Organisational Development Directorate aims to provide a first class support service to the Trust in achieving its corporate objectives. Therefore, it is important that the Directorate is aware of workforce pressures and has plans in place by which to resolve them. Key work pressures, alongside solutions to address them are described below</p> <ul style="list-style-type: none"> • Nationally there are discussions about the strategic direction of paramedic education; changes to paramedic education may mean there are funding pressures or other unforeseen pressures around difficulty in recruitment. We are working with partners, on a national and regional level, to influence the strategic decisions and to ensure that the result of paramedic education is "fit for purpose". • The introduction of the new paramedic intermediate tier has seen an additional pressure placed on the Trust; this new programme has not been previously delivered. Alongside education and development, the workforce team will work closely with operations to ensure it is effectively embedded into operational practice. The new tier will be integrated into our career pathway. • The age profile of staff within the operations establishment (particularly PTS) has encouraged the Trust to look at the introduction of an apprenticeship scheme to improve access for all age groups. The success of the apprenticeship pilot will mean it can be developed in the future and become part of our career framework. • An operational bank is currently being recruited and trained to provide more resilience within the workforce. • A current workforce pressure is the requirement from the driving standards agency for staff to obtain the category C1 entitlement on their drivers licence to allow staff to undertake a role within operations that has elements of driving (current restricted to all who passed driving test prior to 1997). This is currently being offered as CPD opportunities for internal staff, and numerous meetings have been had with external organisations that look to support people into employment. • Access to continuous personal development (CPD) programs for the clinical workforce is an essential
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	<p>requirement of re-registration and therefore a need exists for all staff to have opportunity for high quality education programs and funding to support this. The clinical workforce development team have recently negotiated access into the CPD tier 1 portfolio at both Higher Education Institute providers and had a substantial amount of credits made available within both institutions for staff to access a range of academic programmes.</p> <ul style="list-style-type: none"> • There is a need to support student paramedics and newly qualified paramedics in the workforce. Research shows that when students and newly registered paramedics are clinically supported in practice the quality and safety of care provided to patients improves. The current provision of Enhanced CARE course, mentorship and preceptorship are essential for continued provision of a framework of education that will support the strategic intentions and assist the organisation in moving forward. Work is on-going to measure the effectiveness of training delivered through a structured return of investment program and the initial scope will look at the effectiveness of mentorship and enhanced CARE. <p><u>The impact of the workforce strategy on costs (short-term and long-term)</u></p> <p>Investment in education and development is essential to supporting the short and long term sustainability of the organisation. Well trained staff will add safety and value to the service provided. Therefore the organisational investment needs to be measured for evidence of return on investment/expectation.</p> <p>The investment in developing the service improvement methodology, evidence based practice and coaching (amongst others) will see a gradual shift in culture of the clinical workforce to ensure we are a lean and effective quality organisation.</p> <p>The implementation of a structured approach to corporate and local induction and also the essential annual training needs of the clinical workforce have seen the investment in additional posts within training to facilitate and deliver this new model. The essential training plan has been agreed for 2013-14 and the Trust will promote encourage 100% attendance.</p> <p><u>Findings of benchmarking or other assessment</u></p> <p>Within the clinical workforce development department there has been a substantive amount of benchmarking occurring within the last 12 months, with the department being assessed successfully to national standards by the below institutions:</p> <ul style="list-style-type: none"> • Driving Standards Agency (DSA) – for CPC driver training • Institute of Health Care & Development– for all ambulance driver training • NHS litigation authority– a mock assessment by Sunderland internal audit • Teesside university – an audit of provision for all clinical course that are co-delivered (student paramedic, CPD, enhanced CARE etc) • Matrix award <p>The workforce development focus for the coming year is to build upon the quality assurance provided by the assessment bodies above and to further explore</p>
	<p>Clinical Sustainability</p> <p>Working with the workforce planning team, we develop an annual and a five year clinical training plan as required by Monitor. This supports the on-going supply of the appropriate clinical skill mix in the Trust.</p> <p>Once clinical staff have completed their core training their clinical development will be through a robust performance appraisal and completion of individual development plans. The plan is to review the performance appraisal system so that it is more effective in linking individual and organisational needs to the annual training plan and costs.</p> <p>The clinical workforce and development team has a current clinical leadership framework established for all new recruits and this is also supported with the recent development of a clinical coaching diploma that is matched to the clinical leadership framework.</p> <p>The workforce development team are taking a lead role in the development of a clinical leadership framework and key roles are currently working alongside the college of paramedics about the future career framework of the paramedic workforce and this includes up to and including consultant level.</p> <p>Within the clinical workforce development team the community and volunteer first responder teams are trained to provide and additional volunteer workforce trained are able to assist with the provision of emergency care.</p> <p>Emergency services operate within the Health Care Professions Council framework of the College of</p>

	<p>Paramedics, and as such do not lack critical mass, nor are staffed inappropriately.</p> <p><u>Innovations in care delivery developed at the trust or in conjunction with partner organisations</u></p> <p>The development of the enhanced CARE program in partnership with Teesside University is innovative in the delivery of unscheduled care within the NE region, and this is currently being built into the portfolio provision and therefore supported by all other regional NHS Trusts</p> <p>We are currently developing innovation in practice with an external provider over new eLearning provision and how we support the implementation of the strategy to educate staff in reducing inappropriate hospital admissions.</p> <p>The current NHS requirements for a clinical leadership framework have led to the Trust working with a local provider to develop and implement a clinical coaching for performance diploma and this is mapped directly to the national framework.</p> <p>There is on-going work with partnerships in Teesside around the development of Telemedicine and will inform our market appraisal of the opportunities to enter this market and support CCGs to rapidly take up advantageous technologies to help their patients maintain some independent living. We are the first ambulance Trust to develop a comprehensive and accredited preceptorship programme. This currently is only provided for newly qualified paramedics but it is hoped to expand to other clinical staff within the Trust.</p> <p>We have delivered the beginning of a talent management programme for 160 staff including team leaders. It is hoped to fully evaluate this and extend further to other staff in the Trust. As a result of the above the Trust has been invited to join a national talent management pilot in 2013.</p>
Productivity & Efficiency	<p>The Cost Improvement Programme</p> <p>The Cost Improvement Programme (CIP) is now entering its 3rd year of the Nicholson Challenge in 2013/14. The programme aims to deliver savings for the Trust in line with requirements laid down by the Department of Health for efficiency savings. It is part of the overall financial strategy contributing to the Trust's strategic intention 'To have sound financial health' and also its corporate objective:</p> <p>Objective 5: To preserve the strong financial position of NEAS and achieve the delivery of efficiency savings whilst protecting and continuously improving the quality of services provided'</p> <p>The Trust had a Cost Improvement Plan of £4.83million for 2012-13. The scope of the plan is broad, encompassing cost improvements across all of the Trust's functions and service lines as well as income generation opportunities.</p> <p>We achieved £5.5 million in total savings and revenue generation, which puts us in a strong position as we start work against next year's overall target of £4.74 million.</p> <p>The Trust has a strong track record of delivery against its cost improvement targets and tight budgetary control pre-dating the Nicholson challenge for the NHS and in some ways is a victim of its own success. For several years it has been the most cost effective Ambulance Service in England as evidenced by it having the lowest reference costs on an annual basis. This success is not recognised by commissioners, as the Trust has to meet the same efficiency targets as other less cost effective services, nor by pricing mechanisms. In this context there is a risk that, unless these facts are allowed for, should the current required level of CIP reductions continue indefinitely they will become simply unsustainable.</p> <p>Nonetheless the Trust will continue to seek to maximise efficiencies and retain its position at the head of the league table for financial efficiency whilst maintaining quality and performance standards.</p> <p>The way in which our cost improvement programme is managed, which was cited in 2011-12 by the National Audit Office as an exemplar of best practice, is via the Project Management Office and the mechanism it follows and the major schemes being progressed are outlined in the following sections.</p> <p>Project Management Office (PMO)</p> <p>One of the roles of the Programme Management Office (PMO) is to work with project sponsors and project leads to provide assurance that the quality of services provided by the Trust remain unaffected by any efficiency savings made by the Trust through the delivery of cost improvement projects. There are two aspects of quality in relation to projects that are taken into account. The first is defined as a way of managing the project deliverables and ensuring they are within an acceptable level of quality as defined by stakeholders. The second is to ensure that no project will impact on Clinical quality, Patient Safety and Patient and Carer experience.</p>

Compliance with National Quality Board

In August 2012, the National Quality Board provided guidance on future quality management in its report 'Quality in the new system – Maintaining and Improving Quality from April 2013'. As a result of the guidance, NEAS has further developed its processes for compliance to ensure no adverse impact on the quality of services and care as a result of the cost improvement programme.

The Trust has an established process whereby a Quality Impact Assessment (QIA) pro-forma for managers/project leads is completed as part of its quality management. Once an initial assessment has been completed, the QIA is passed to the Director of Clinical Care and Patient Safety (Nurse Director) and the Medical Director for their assessment at which either the QIA is agreed or amendments requested.

Quality Committee

The Project Management Office (PMO) provides assurance of quality monitoring through quarterly reporting to the Quality Committee. The Quality Committee has a wide scope in providing assurance to the Trust Board on all aspects of quality which are detailed in its Terms of Reference. However it is specifically concerned with clinical effectiveness, patient experience and patient safety; and monitoring compliance against the essential standards of quality and safety set out in the registration requirements of the Care Quality Commission.

The reporting submitted to the Quality Committee by the PMO looks to provide assurance that the agreed processes for each project have been followed. It provides regular information on those projects where potential impacts have been identified and reporting on the key monitoring measures that are in place. Any indicators that trigger concern are highlighted to the Committee along with any mitigating actions.

Although reporting to the Quality Committee is quarterly, the PMO compiles the monitoring report on a monthly basis to ensure that if any early warning indicators are triggered, this is recognized at the earliest opportunity for actions to be taken. These actions would be escalated to the project manager and project sponsor as appropriate and also raised as a concern at the monthly Improvement Steering Group (ISG) meeting which oversees the CIP.

CIP profile

A list of our key CIP schemes including risk ratings for individual schemes is presented in Appendix 2

An outline of transformational service redesign CIP schemes is described below:

Scheme	Scheme Description	How change will be achieved
Capacity & Demand	To match demand within Emergency Care through effective use of resources. To ensure demand is matched by the right type of resource required across all call types to better support resource availability and productivity.	Project has identified several work-streams to take a staged approach to implementation. The project is looking at contact centre initiatives to increase hear and treat utilisation and to review and optimise geographical vehicle locations. It will build on these through a longer term delivery of an operational workforce management process which will represent a shift in approach to resource management.
PTS Strategy	To deliver change across PTS to ensure a quality, patient focused service which will be resilient in an ever changing healthcare environment.	Five key work streams are focusing of fundamental elements of the PTS service line. Each is looking at how PTS can transform the way it delivers its service including how it approaches new business opportunities to ensure it remains commercially viable. For example, PTS will be looking at developing and implementing its own taxi service, extending the use of volunteers, working with community transport providers and delivering a new approach to planning day to day operations.

	Workforce Management (Contact Centre)	Introduction of a workforce management system to provide a flexible and responsive workforce that can adapt to surges in demand	This project is already underway with a phased approach to delivery. A workforce management tool is being implemented to support production of activity demand forecasts and new rotas for staff. A new management structure has recently been implemented and a reorganisation is underway of key functions within the contact centre to deliver structural changes to support efficient ways of working
	Sickness Absence Reduction	To support delivery of a maximum 5% sickness absence rate across the Trust. To support a continual reduction of sickness absence below 5%.	Management structure and processes are key to delivery. Emergency Care and PTS are both delivering management changes which will support this project. Access to services such as physiotherapy will provide increased access for staff supporting their return to work. More structured sickness monitoring through a sickness absence management system will enable staff requiring support to be quickly identified to avoid problems escalating.
<p>CIP enablers</p> <p>Extent of clinical leadership and engagement in identifying and delivering CIPs:</p> <p>There is clinical involvement in all the operational facing CIPs as a matter of course. These are identified in many cases by operational management and all are agreed through the management teams. Most operational projects are managed by clinicians with PMO project managers only in place on the complex deliveries where this can't be combined with a day role. Many CIPs in areas such as Fleet, Estates and procurement also have high levels of clinical involvement as the impact of any change is in operations and these now report under the relevant service line. Operations management are provided monthly with visibility to the whole cost improvement programme and regular meetings take place with the PMO to ensure engagement levels are high. A 'Big Idea' initiative is in place to enable any member of staff in the organisation to contribute to the CIP and most of the ideas generated are from operational staff.</p> <p>The Requirement for enabling investment in infrastructure:</p> <p>Any project that identifies the need for investment has a defined process to go through. Project resources (both internal and external) are secured through the project mandate process initially via the Improvement Steering Group and if agreed in principle, then a business case process is undertaken. Where investment in a new system, funding for external requirements or departmental infrastructure is identified, the project owner will also produce a business case. The purpose of the business case is to identify the required spend, the justification for spend, the expected return on investment and associated benefits. All business cases are submitted to the Revenue Investment Group and if applicable, the Capital Monitoring Group for approval. This is an established process that many CIP projects have already undertaken.</p> <p>This is done on an individual basis based on each project however where there are dependencies between projects or the programme, a joint business case can be submitted.</p>			
<p>Quality Impact of CIPs</p> <p>The Trust has an agreed Standard Operating Procedure (SOP) for Quality Management. This document details provides the standard process for quality in all projects and at programme level. It provides guidance on the key roles in projects and their responsibilities in relation to all quality aspects of their projects. It gives definitions of quality management and how quality profiles for each project should be categorised including their level of risk to the organisation. The SOP also provides the process steps for project managers from identifying to evaluating quality within their projects.</p> <p>This procedure should be followed by all projects and also at programme level to ensure quality is correctly measured and any impact captured and reported.</p> <p>Quality Processes</p> <p>There is a step process for projects to follow when considering any quality impacts:</p>			

	<ol style="list-style-type: none"> 1. During the identification and scoping phase of a project, those that fall within the CIP must complete a Quality Impact Assessment (QIA). The QIA aims to give a focus on three key elements of quality – clinical quality, patient safety and patient/carer experience. All project managers must complete a QIA for their project stating any potential impact on the aforementioned areas and providing justification for their decisions. This should be completed once the details of the project are formally agreed as changes to scope may lead to different quality impacts and a requirement to undertake further assessments. 2. If during the assessment process a project identifies a potential negative impact on any of the 3 key areas, appropriate quality measures need to be provided as part of the submitted document. These need to be measurable with an existing baseline as they will be used by the PMO, project managers and the Quality Committee as early warning indicators of any change in quality of services. 3. Once a QIA has been completed by the project and approved by the project team, it is provided to the PMO. The PMO will carry out a review of the assessment and agree any required adjustments with the project team. The QIA will be formally logged as having been received and submitted for approval 4. The PMO will submit a completed QIA to both the Director of Clinical Care and Patient Safety (Nurse Director) and the Medical Director for approval. If approved, a signed copy of the form is provided back to the PMO. Any agreed quality measures are incorporated in the PMO report for monitoring. If the QIA is not approved, comments are provided back to the PMO for amendments to be made by the project until an approved version is agreed. 5. The PMO update all documentation to reflect completion of the quality processes and compile reports on a monthly basis. Any risks that emerge through quality measures indicating an impact are escalated to the project manager/sponsor as these become evident. These would also be reported to the ISG and the Quality Committee. 6. On projects where either significant change is underway or where potential risks attached to quality have been identified, a deep dive will be carried out at some point during the financial year. A timetable for deep dives is agreed between the PMO and Quality Committee and the project will undertake a review to provide assurance that the change process is being correctly managed in relation to protecting quality. These are reported to the Quality Committee and if any required actions are identified, these are reported back to the project for completion. 7. Once a project is formally closed, future monitoring is managed through ‘business as usual’ activities and is the responsibility of the Service Line. Part of the closure process includes a full handover of all quality measures linked to the delivery.
Financial & Investment Strategy	<p>Despite a headline deficit in 2012-13 the Trust’s normalised position remains strong and we are committed to retaining our strong financial position whilst maintaining quality and performance. The Trust is looking to achieve a financial risk rating of 3 for its financial surplus generating annual normalised surpluses in the range throughout the period of £1.37 million to £1.59 million, whilst generating an overall risk rating of 4.</p> <p>Running costs continue to be tightly controlled and opportunities to generate additional income explored, though the Trust recognises that in the current financial climate finances are generally tight in the NHS environment.</p> <p>Our CIP has identified target savings totalling £14.107 million over the three year planning period, inclusive of £0.711 million achieved by surpluses from revenue generation schemes.</p> <p>As commissioning has moved to become the responsibility of CCGs supported by the North of England Commissioning Support Unit (NECs) we are finding there are challenges in educating new commissioners about the activities of Ambulance Trusts; the currencies, the dynamic deployment and charging mechanisms and the development of PbR for ambulance trusts. Many of our financial efficiencies will be borne out of our work with partners to seek alternative dispositions for those patients who do not need to go to hospital and the benefits of the synergy between NHS 111 and 999 services in the North East, with both being operated by the Trust, it has meant that NHS 111 was introduced without the major difficulties evident in other parts of the country.</p> <p>The Trust is under pressure to improve performance in rural areas and is seeking to improve the resource levels in those areas to improve performance though it is commissioned for only 71% performance in Northumberland and North Durham CCG’s with agreement on the performance levels for Durham Dales, Easington and Sedgfield CCG yet to be agreed.</p> <p>The Trust has been prudent in its assumptions regarding Emergency Care income and we have assumed no additional income over the planning period arising from any move to a national PbR tariff. However, any move to a national tariff could be expected to bring an increase in income circa £12.0 million based on current comparisons made using the national reference costs.</p>

Our financial plan is based on the following assumptions for the next three years.		
2013/14	<ul style="list-style-type: none">Contracted Emergency Care (A&E) activity at 365,000 – unchanged from 2012-13Agreement to fund any over-activity at 100% of local PbR rates up to 376,642, with activity above this attracting a marginal rate of 50% of tariff per incidentForecast over-activity of 6.8% on our A&E contract will generate an additional £3.37mFull roll-out of NHS 111 across the North East, attracting income of £8.538m, with a penalty assumption of -£0.153mTariff deflator of -1.3% assumed for all NHS contracts, excluding Emergency Planning (EP) and HART service contracts where a 2.7% uplift has been agreedCQUIN funding of 2.5% as per NHS planning guidance, offset by a provision of -£0.5m for non-achievementAchievement of £4.3m in cost improvements and £0.446m in revenue generationPay inflation of 1.41% and non-pay of 2.83%	
2014/15	<ul style="list-style-type: none">No change in contracted A&E activity – remains at 365,000 incidentsForecast A&E contract over-performance income of £3.6 million (5.5% above contract in value terms, 8.1% in activity terms)NHS 111 contract income of £8.276 million net of penalties of £0.151 millionTariff deflator assumed at –1.3%, excluding EP and HART at 2.7% growthProvision for CQUIN position as per 2013-14, i.e. at 2.5% of contact value and 20% provision for unachieved income.Achievement of £4.706m in cost improvements and £0.326m in revenue generationPay inflation of 1.41% and non-pay at 2.20%	
2015/16	<ul style="list-style-type: none">No change in contracted A&E activity – remains at 365,000 incidentsForecast A&E contract over-performance income of £3.648m (5.2% above contract in value terms, 7.8% in activity terms)NHS 111 contract income of £8.168 million net of allowance for penalty of £0.149 million.Tariff deflator assumed at –1.3%, excluding EP and HART at 2.7% growthProvision for CQUIN position as per 2013-14, i.e. at 2.5% of contact value and 20% provision for unachieved incomeAchievement of £4.390m in cost improvements, less -£0.061m from revenue generation schemes in 2015-16Pay inflation of 1.34% and non-pay at 2.25%	
<p>The main risks associated with our planned surplus over the three year period are:</p> <ul style="list-style-type: none">A&E activity falls below forecastTendering of PTS services over the planning period with risk of loss of some/all of contracts, shrinking income base, overheads that cannot be releasedUnderachievement of Cost Improvement PlanApplication of penalties related to handover delaysNon-achievement of CQUIN – applicable in 2013-14 and 2014-15. Financial plan allow a 20% contingency for income shortfall from this source due to non-achievement of schemes.Withholding of CQUIN funding at year end impacts on ability to fund additional rural resources committed in year (as per agreement with commissioners, where scheme cost is less than income, excess will be utilised to improve rural performance)National tariff set below current local tariff (or a continuation of a lack of national tariff). This situation effectively penalises NEAS for being a cost efficient provider and limits the ability to invest in new services to enhance the patient experience		