South East Coast Ambulance Service NHS
NHS Trust

Business Plan 2008 – 2013

Annual Focus 2008 – 2009

Tables

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List of acronyms

A&E	Accident & Emergency
ACA	Ambulance Care Assistant
AfC	Agenda for Change
AHC	Annual Health Check
ALE	Auditor's Local Evaluation
AMPDS	Advanced Medical Priority Dispatch System
ARP	Ambulance Radio Programme
BASICS	British Association for Immediate Care
BLS	Basic Life Support
CAD	Computer Aided Dispatch
CCP	Critical Care Paramedic
CMS	Capacity Management System
CRL	Capital Resource Limit
DH	Department of Health
DoS	Directory of Services
ECA	Emergency Care Assistant
ECSW	Emergency Care Support Worker
EDC	Emergency Dispatch Centre
ePRF	Electronic Patient Report Form
ERC	European Resuscitation Council
FASC	Financial Audit Sub Committee
FFF	Fit for the Future
FT	Foundation Trust
HCC	Healthcare Commission
HEI	Higher Education Institute
HR	Human Resources
IGC	Integrated Governance Committee
IM&T	Information Management & Technology
IT	Information Technology
KSF	Knowledge and Skills Framework
MDT	Mobile Data Terminal
NED	Non Executive Director
NHS	National Health Service
NVQ	National Vocational Qualification
OD	Organisational Development
ODA	Operational Dispatch Area
PAS	Private Ambulance Service
PBL	Prudential Borrowing Limit
PbR	Payment by Results
PCT	Primary Care Trust

PEST	Political, Economic, Social & Technological
PP	Paramedic Practitioner
PPI	Patient and Public Involvement
PRF	Patient Report Form
PTS	Patient Transport Service
R&D	Research & Development
RAB	Resource Accounting and Budgeting
RMCGSC	Risk Management & Clinical Governance Sub Committee
ROSC	Return of Spontaneous Circulation
SECAmb	South East Coast Ambulance Service NHS Trust
SIMCAS	Surrey and Sussex Immediate Care Scheme
SLA	Service Level Agreement
SO	Standing Order
SRV	Single Response Vehicle
SSP	System Status Plan
STV	Support Tier Vehicle
SWOT	Strengths, Weaknesses, Opportunities & Threats
UHU	Unit Hour Utilisation
VAS	Voluntary Aid Societies
WTE	Whole Time Equivalent

1. EXECUTIVE SUMMARY

1.1. Introduction from the Chief Executive

The ambulance service is on a journey of transformation. We have changed from a service that historically has been predominantly focused on transporting patients to treatment, to a service that is now bringing treatment to the patient.

Demand continues to increase for our service – roughly by five per cent each year – and the spectrum of patient need that we are now seeing is broader than ever before. It ranges from the critically ill patients suffering from trauma, stroke and coronary heart disease, to patients at the other end of the spectrum who have primary care needs such as minor injuries and illnesses.

The ambulance service must change and adapt in order to meet the changing needs of *all* of our patients, and deliver continuous improvements in patient care. South East Coast Ambulance Service NHS Trust (SECAmb) is committed to driving that change in order to deliver the best possible care for patients.

Our vision is to be an innovative, clinically focused, high performing, team-based organisation that matches, and exceeds, international best practice. Since the formation of SECAmb in July 2006, much progress has been made towards achieving this vision. Some of the achievements have been:

- Development of specialist paramedic roles – the critical care paramedic and paramedic practitioner – providing the most appropriate care to patients;
- Roll out of innovative clinical practices and equipment – Protocol C and the Intraosseous device;
- 'Make Ready' – a high performing approach to vehicle cleaning and preparation, allowing clinicians more time to do what they're trained for – treating patients;
- Development of alternative care pathways – routing patients to the *right* care, not just the closest;
- Advances in technology - using technology to support the delivery of excellent patient care e.g. web based reporting of information, Directory of Services, Capacity Management System.

The future will bring with it more change further still as we continue to adapt and respond to the changing needs of our patients.

Delivering world class outcomes for patients is a goal we aspire to – and one that we will achieve in the future.

Paul Sutton
Chief Executive

1.2. Vision and Strategy

Our vision is made up of five key components:

Clinically focussed
Putting the patient at the heart of everything we do; being responsive to their changing needs.

Innovative
Spotting the technologies and techniques of the future and fast-tracking them into practice.

Team based
Identifying the factors that create a team environment which ensures patient safety.

High performing
Adopting processes and mechanisms that allow for the most efficient use of time and resources.

Matching and exceeding international excellence
Competing with the best; ensuring that we are implementing best practice models and improving upon them.

In addition, we uphold five principal values that are integral to our operation:

To be the best
Embrace challenge; be innovative; pursue excellence.

To value difference
Be inclusive; ensure engagement; value diversity.

To know our business
Be patient centred; ensure value for money; understand the wider environment.

To be professional
Leadership; teamwork; corporacy; be professional; be ethical; encourage disciplined people; promote disciplined thought and action.

To be open
Welcome challenge; be accountable; ensure objectivity; promote rational debate; uphold the truth; ensure transparency; be supportive; provide mutual respect.

1.3. Market assessment

We cover a geographical area of 3,600 square miles, providing accident and emergency services to the population of Kent, Surrey, Sussex and North East Hampshire. In addition, we provide non-emergency patient transport services in Kent and Sussex.

We serve a resident population of c. 4.5 million people, and this can increase further at certain times in the year.

We operate from a matrix of depot, station, response posts and locality operational locations. The locations change to reflect the nature of the changing pattern of demand, to meet local healthcare needs and also new business opportunities. In 2007 / 2008 we responded to approximately 500,000 emergency calls; this is approximately a call every minute.

Our Commercial Services Department (now known as Assure) provides training, paramedic cover and a private ambulance service to outside organisations.

1.4. Performance overview

In 2006 / 2007 we achieved a dual assessment of “Fair” for the Healthcare Commission’s Annual Health Check ratings for Quality of Services and Use of Resources.

Our aim is to improve on this for 2007 – 2008, by achieving a “Good” assessment for both components. The ratings for 2007 – 2008 are expected to be published in September/October 2008.

More detailed information and analysis of our performance is provided in section 2.5 of this document.

1.5. Summary of strengths, weaknesses, opportunities and threats (SWOT) analysis

We have undertaken, in conjunction with our stakeholders, a SWOT analysis to look at the Trust’s strengths and weaknesses, alongside the opportunities and threats to our Trust. This analysis is examined in section 5.2 of this document.

1.6. Principal risks and mitigation

We have considered the principal risks that we face in delivering the objectives set out in this plan. These risks are examined further in Chapter 7 of this document and consideration is given to how these will be monitored.

2. TRUST PROFILE

2.1. Overview

South East Coast Ambulance Service NHS Trust is an ambulance trust that responds to 999 calls from the public, urgent calls from health professionals and, in Kent and Sussex, provides non-emergency patient transport services (pre-booked patient journeys to and from healthcare facilities).

We provide these services to the South East Coast health economy, which includes Kent, Surrey and Sussex, and also to North East Hampshire.

We employ approximately 3,000 members of staff, with the operational workforce equating to roughly 85 percent of this figure. A more detailed analysis of our workforce is provided in Chapter 8 of this document.

2.2. Range of services

We provide a range of different services to ensure that we best meet the needs of local communities. Our patients range from the critically ill and injured, to those with minor healthcare needs who can be treated at home or in the community. Our highly trained staff use state of the art techniques, technology and equipment to ensure that when a member of the public calls 999, they receive a timely, professional response that is most appropriate for their clinical need.

All 999 calls that we receive are assessed as follows:

Category A
Life-threatening conditions where speed of response may be critical in saving life or improving outcome for the patient e.g. heart attack or serious bleeding

Category B
Conditions which need to be attended quickly, but which are not immediately life-threatening

Category C
Non life-threatening conditions that may be appropriate for referral to an alternative care pathway

The first point of contact for most patients is with one of the three Emergency Dispatch Centres (EDCs), where the dedicated staff receive almost 500,000 calls every year. We use the Advanced Medical Priority Dispatch System (AMPDS) to determine the condition of the patient and the most appropriate response for their clinical need. The EDCs also have Clinical Desks that are staffed by medically qualified staff, who use a special type of medical triaging software called PSIAM to manage Category C calls more effectively – again ensuring the most appropriate response for the patient's need.

The second point of contact for many patients is with our clinicians. We employ a range of clinical staff, and operate a variety of different vehicles; shown below:

Emergency Care Assistant
An Emergency Care Assistant (ECA) drives an ambulance under emergency conditions and supports the work of qualified ambulance technicians and paramedics.

Technician
Technicians respond to accident and emergency calls, as well as a range of planned and unplanned non-emergency cases. They support a paramedic during the assessment, diagnosis and treatment of patients, and during the journey to hospital.

Paramedic
Paramedics deal with medical emergencies, as well as complex non-emergency hospital admissions, discharges and transfers. They work as part of a rapid response unit, usually with support from an ambulance technician or emergency care assistant. Their primary goal is to meet peoples needs for immediate care or treatment.

Paramedic Practitioner (PP)
PPs are paramedics who are equipped with greater patient assessment and management skills and are able to diagnose and treat minor medical conditions, as well as referring patients on to other healthcare professionals.

Critical Care Paramedic (CCP)
CCPs are qualified paramedics who have undergone additional specialist training and education to work in a critical care environment (i.e. within the Critical Care Network (CCN) in the acute sector). Working alongside doctors, CCPs are able to treat patients suffering from major injury or trauma, providing intensive support and therapy, and ensuring that they are taken rapidly and safely to a hospital that is able to treat their complex conditions.

In addition to the groups of staff who are employed by the Trust, in differing situations we may also task either a community responder, or emergency medical support in certain situations. In the case of a serious or multi-casualty incident, the skills of a doctor may be required. We have the support of two emergency medical support organisations, Surrey and Sussex Immediate Care Scheme (SIMCAS) and the British Association for Immediate Care (BASICS). In addition, the Trust also has a number of community responder schemes in place, where members of the public (or off-duty members of staff or colleagues from another emergency service) are trained to deliver time-critical basic life support, before the arrival of a SECAmb clinician.

Support Tier Vehicle (STV)
These are double manned vehicles, usually staffed by a technician and ECA, whose predominant role is to convey pre-assessed patients to hospital. STV crews are all trained to provide basic life support if required.

Single Response Vehicle (SRV)
These are usually single-manned by either a paramedic practitioner, paramedic or technician and can be a car, 4x4 vehicle, motorbike or even a bicycle. They are used

primarily for making a rapid attendance at an incident and an initial assessment of patients and situations.

Emergency (A&E) ambulance
These are emergency ambulances with a crew of two who respond to the majority of 999 emergencies and GP urgent calls.

Helicopter air support
We benefit from air support from three helicopters which can be utilised to assist at an incident a patient is located across inaccessible terrain, or where a very fast evacuation to hospital is necessary. A dedicated desk situated in the EDC assesses incoming calls and determines the suitability of using one of the helicopters.

We also provide non-emergency patient transport services for the movement of patients to and from NHS facilities. This includes the transportation of ambulant, wheelchair bound and stretcher patients, plus infectious cases. The types of journeys undertaken include inpatient admissions, out-patients and day patients from the patient's place of residence, including nursing homes, to NHS facilities and non urgent transfers between hospitals and discharges from hospitals to home. We employ Ambulance Care Assistants (ACAs), who operate either single or double crewed vehicles to carry these patients.

In addition, we operate an ambulance car service using volunteers in their own vehicles who transport patients to and from hospital to attend an appointment or clinic.

We recognise the need for non-emergency ambulance provision, including the provision of clinical cover and resources for events; this is currently co-ordinated by our private ambulance service.

A non-emergency strategy is being developed, in consultation with patients, the public and other key stakeholders. This will be presented to the Trust Board for consideration in May 2008.

2.3. Activity

The following table shows our historic and predicted activity for A&E and PTS services. These are for the period 2006 – 2007, forecast activity for 2007 – 2008, and in the case of A&E, an estimation of activity for 2008 – 2009.

Table 2.1 – A&E activity

	2006 – 2007	2007 – 2008 (Forecast)	2008 – 2009 (Estimate)
Kent	165300	173120	
Surrey	125793	129009	
Sussex	188558	197895	
TOTAL	479,651	500,024	530,112

Figure 2.1 – Graph showing increasing A&E activity

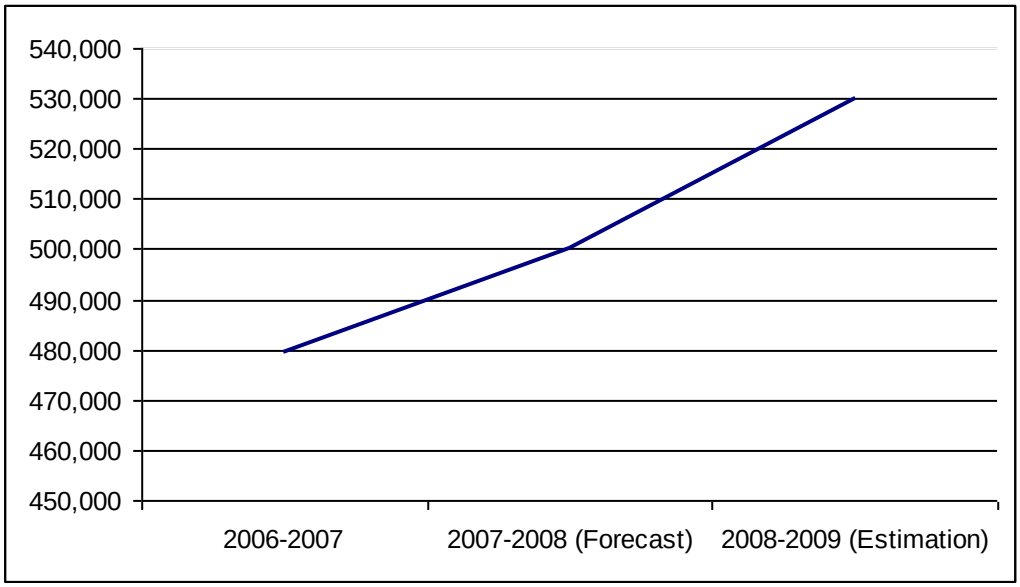


Table 2.2 – PTS activity

	2006 – 2007	2007 – 2008 (Forecast)
Kent	69372	69153
Surrey	989	1044
Sussex	388375	380259
TOTAL	458736	450456

2.4. Finance

SECAmb's budget for 2008 – 2009, as well as the Trust's medium-term five year financial plan, is set out in Section 6 of this document.

2.5. Target performance

As an NHS organisation we are assessed annually by the Healthcare Commission on our performance in the Annual Health Check. This is made up from two components; Quality of Services and Use of Resources. The Quality of Services includes our existing national targets, new national targets and core standards assessment, whilst the Use of Resources is based on the Auditor's Local Evaluation (ALE) assessment.

In 2006 – 2007 we achieved a rating of "Fair" for both the Quality of Services and Use of Resources components of the Healthcare Commission's Annual Health Check assessment.

In relation to the Use of Resources, we achieved a Level 2 score for all five components of the ALE assessment, leading to a score of “Fair” overall.

We aim to improve upon this rating in 2007 – 2008, and going forward into 2008 – 2009 and beyond, recognising the challenges that we face with the introduction of the new Call Connect performance target.

In relation to our performance against our existing national targets, the year to date performance (based at 19 March 2008) is shown in the following table:

Table 2.3 – Performance against national targets 2007 – 2008 (to date)

Target	Performance (as at 19 March)
75% of all Cat A patients must be reached within 8 minutes	77.17%
95% of all Cat A patients must be reached within 19 minutes	98.56%
95% of all Cat B patients must be reached within 19 minutes	95.50%

2.6. Commissioning arrangements

Arrangements are in place for the commissioning of our A&E services with the eight PCTs across the South East Coast region. These arrangements are led on a consortium basis via a lead commissioner. As part of this, there is a nominated Head of Ambulance Commissioning, who is employed by the PCTs to lead on issues relating to SECAmb on their behalf.

2.7. Overview of procurement arrangements

We are involved in the local procurement hub and also in national ambulance service procurement programmes. We intend to build on the work completed in 2007 – 08 and contribute to the procurement debate in a number of areas including vehicles, uniform and stores.

3. STRATEGIC GOALS

3.1. Trust vision

Our vision is made up of five key components, that outline what the Trust aspires to be:

Clinically focussed
Putting the patient at the heart of everything we do; being responsive to their changing needs.

Innovative
Spotting the technologies and techniques of the future and fast-tracking them into practice.

Team based
Identifying the factors that create a team environment which ensures patient safety.

High performing
Adopting processes and mechanisms that allow for the most efficient use of time and resources.

Matching and exceeding international excellence
Competing with the best; ensuring that we are implementing best practice models and improving upon them.

Significant work has been undertaken to consider how the Trust can achieve this vision and, in particular, how we can become a high performing ambulance trust. We have taken into account the concept of high performance in relation to ambulance trusts and have considered the four key indicators of high performance:

Response time reliability – getting to the patient quickly

Clinical effectiveness – making them better, or taking them to someone who can

Customer satisfaction – treating patients with dignity and respect

Economic efficiency – achieving all of this without costing the taxpayer more money

High performance will allow us to deliver continuous improvement in patient outcomes by converting every pound we receive into maximum improvement in patient care. The concept of high performance is intrinsically linked with the other four elements of the Trust's vision.

We are committed to designing a system that allows staff to perform to their maximum capability, to the benefit of patients, whilst being economically efficient; allowing funds to be ploughed into frontline patient care as opposed to being spent on things that do not add the greatest value to the patient.

3.2. Strategy

To ensure achievement of high performance, and ultimately our vision, we have identified a set of strategic objectives to guide the Trust's work programmes. To ensure these objectives are met we have developed strategic output measures, to be delivered on a three to five year timescale; stemming from these are annual output measures which will be agreed each year. The following table shows the inter-relationship between these components:

Table 3.1 – Vision, strategic objectives and output measures

Pillar	Strategic Objective	Strategic Output Measure	Annual Output Measure
Clinical Effectiveness	We will deliver excellence in leadership and development	To become a leading ambulance trust in R&D	Conduct a review of the Trust's R&D policies, procedures and programme to enable identification of R&D priorities and resources required
			Commence a programme of formal research
			Commence a SECAmb-wide programme of audit
		Become a teaching ambulance trust	Develop a pathway to become a teaching ambulance trust
			Develop a SECAmb career framework that reflects the high performance structure
			Review education and training skills required to deliver a professional workforce and develop a plan and programme
			Develop and implement a clinical supervision system
			Develop and implement a single scannable Patient Report Form
			Assess infrastructure required to support implementation of a learning environment and produce a plan

Pillar	Strategic Objective	Strategic Output Measure	Annual Output Measure
Clinical Effectiveness (continued)	We will deliver excellence in leadership and development (continued)	Development of clinical systems and pathways that meet the needs of the local population	Establish a process for reviewing local health needs across South East Coast through development of a Public Health programme
			Roll out Hub for Health, CMS and Directory of Services on a trust-wide basis
			Complete appraisal of CMS and Directory of Services
		Development and progression of new roles in line with the NHS Career Framework	Develop and implement a harmonised ECSW role
			Deliver 12 CCPs in accordance with the workforce plan
			Deliver 60 PPs in accordance with the workforce plan
	We will continuously improve access and outcomes to match international best practice	Achieve an "excellent" rating within the Healthcare Commission's Annual Health Check	Deliver full compliance with core standards, identifying and focussing on priority areas and achieve a good rating
			Achieve and exceed new national targets, focussing on priority areas
			Exceed existing national targets (A8, A19, B19)
			To achieve a level 4 in ALE

Pillar	Strategic Objective	Strategic Output Measure	Annual Output Measure
Clinical Effectiveness (continued)	We will continuously improve access and outcomes to match international best practice (continued)	Improve outcomes for key groups through innovative care and reducing health inequalities	Develop mechanisms for effective measurements of clinical outcomes (Trauma; CHD; Stroke)
			Demonstrate a 5% in year increase in ROSC rates (Cardiac)
			Increase number of patients using stroke pathways by 5%
			Develop and implement a system that will capture appropriate clinical information
		Continue to develop services within the Urgent and Emergency care environment that meet patient needs	Roll out the Directory of Services across SECAmb
			Reduce inappropriate conveyance to A&E by 5%

Pillar	Strategic Objective	Strategic Output Measure	Annual Output Measure
Customer Satisfaction	We will continuously improve satisfaction and experience for all stakeholders	Improve public health through community education and engagement	Develop and deliver a community education programme e.g. BLS skills
			Develop and implement a public information programme in relation to care provided
		Meet needs of stakeholders in accordance with the Single Equalities Scheme	Deliver the Single Equalities Scheme Action Plan
			Identify the marginalised diverse communities served by the Trust
			Develop and implement a programme of engagement to increase the patient and public involvement from marginalised communities
		Improved stakeholder experiences and satisfaction	To undertake the second annual stakeholder satisfaction surveys
			Identify a benchmark for satisfaction levels, and develop a plan to improve these
		Ensure engagement with patients, public, and patient representatives to inform and shape our services	Develop and implement a membership and involvement strategy
			Identify specific communities and groups to engage in service delivery and development
			To demonstrate increased engagement with specific communities and groups

Pillar	Strategic Objective	Strategic Output Measure	Annual Output Measure
Customer Satisfaction (continued)	We will be an organisation that people seek to join and are proud to work for	Provision of education, training and development targeted to meet the needs of patients, staff and the organisation	Review, revise and implement the contents of SECAmb education, training and development programmes
			Ensure new staff are properly inducted at corporate and local levels
			Ensure all staff receive statutory and mandatory training, appropriate to their role
		Development of career pathways for both clinical and non-clinical staff in line with the NHS Career Framework, service requirements and the Trust's vision	All staff to have entered into the appraisal process
			All staff have KSF outlines and Personal Development Plans
			Explore and implement increased use of NVQs
			Develop partnership contracts with Higher Education Institutes
		Achieve demonstrable leadership / management qualities to deliver the Trust's aims and objectives	Develop and implement a leadership / management development strategy
		Improve staff satisfaction to be in the upper quartile of ambulance trusts nationally	Demonstrate improvements to service delivery from staff feedback surveys
			Develop and implement a staff communications strategy
			Standardise SECAmb policies and implement review process
			Standardise Trust counselling service

Pillar	Strategic Objective	Strategic Output Measure	Annual Output Measure
Response Time Reliability	We will continuously improve on the Trust's performance standards and reduce variation	Deliver an integrated IM&T system	Implementation of a single CAD in line with key project milestones
			Implementation of a single MDT in line with key project milestones
			Implementation of ARP in line with key project milestones
			Implementation of ePRF in line with key project milestones
		Reduce variation in geographical and temporal service delivery	Implementation of a single CAD in line with key project milestones
			Implementation of a single MDT in line with key project milestones
			Increase no. of responder schemes in priority locations
			Introduce demand led rotas
			Standardisation of equipment in line with clinical requirements

Pillar	Strategic Objective	Strategic Output Measure	Annual Output Measure
Response Time Reliability (continued)	We will continuously improve on the Trust's performance standards and reduce variation (continued)	Exceed national and Trust-set performance targets	Implementation of a single CAD in line with key project milestones
			Implementation of a single MDT in line with key project milestones
			Increase no. of responder schemes in priority locations
			Introduce demand led rotas
			Standardisation of equipment in line with clinical requirements
			Continuous review of the operational system status plan (SSP) [When new CAD is live in each EDC, aim to refresh SSP on a quarterly basis]
		Deliver a front loaded service delivery model	Develop an action plan to deliver the front loaded service delivery model

Pillar	Strategic Objective	Strategic Output Measure	Annual Output Measure
Economic Efficiency	We will convert all available pounds / resources into maximum / optimum patient benefit	Achieve a year on year 3% efficiency saving that produces a quality unit hour of acceptable productivity and cost	Improve productivity of front line staff by demonstrating a 2.9% increase in UHU
			Increase the number of make ready depots
		Effective management of the Trust's assets	Delivery of a capital programme in line with 5 year capital plan
		To have a commissioning process that secures the required income to deliver the Trust's vision to be a high performing organisation	Run local Payment by Results shadow in line with Payment by Results Project Initiation Document milestones
			Agree local use of the national contract for shadow implementation during 2009 / 2010
			Implement a SECAmb education plan in relation to high performance for the local health economy
			Develop a PTS strategy
		Effectively manage fleet and estates in line with the high performance model	Produce a Fleet strategy and replacement programme
			Produce an Estates strategy
			Increase the number of make ready depots
			Procure new Trust vehicles, based upon the 5 year fleet replacement policy which reflects the front loaded service delivery model

Pillar	Strategic Objective	Strategic Output Measure	Annual Output Measure
Economic Efficiency (continued)	We will embrace our social and environmental responsibilities	Increased involvement with local community groups and education providers	Develop and implement an improvement plan delivering value for money, in consultation with local community and disadvantaged groups
		Reduced environmental impact of the Trust	Review compliance to environmental impact regulations and prioritise an implementation plan to address shortfalls and report on these

3.3. Aim for NHS Foundation Trust status

On 21 June 2007 the Department of Health announced that ambulance trusts will be eligible to apply for Foundation Trust (FT) status from 1 April 2009. We believe that this is a logical progression for SECAmb and fits with our aspiration of becoming a high performing ambulance trust.

We view the journey towards Foundation Trust status as core to the organisation, rather than a stand alone project. There is a significant amount of work required to prepare for the application process involving both cultural and structural change. We are confident that the approach outlined in this plan will place us in a strong position to achieve Foundation Trust status.

3.4. Stakeholder engagement

We are committed to engaging with and involving all stakeholders in shaping the strategic direction of our Trust. Stakeholders range from our staff and patients, to members of the public, other NHS organisations and emergency services, community and patient groups, as well as MPs and local authorities.

Figure 3.1 (overleaf) provides a more detailed breakdown of our stakeholders, that have been categorised into five groups.

In late 2007 we held several “Shaping the Future of SECAmb” events, to which we invited staff, patients, members of the public and colleagues within the local health economy to discuss their views on the future of SECAmb. The outputs of these events have helped to shape the strategic direction of the Trust, and indeed this business plan, and have provided an invaluable insight into the varying views and perceptions held by different stakeholder groups.

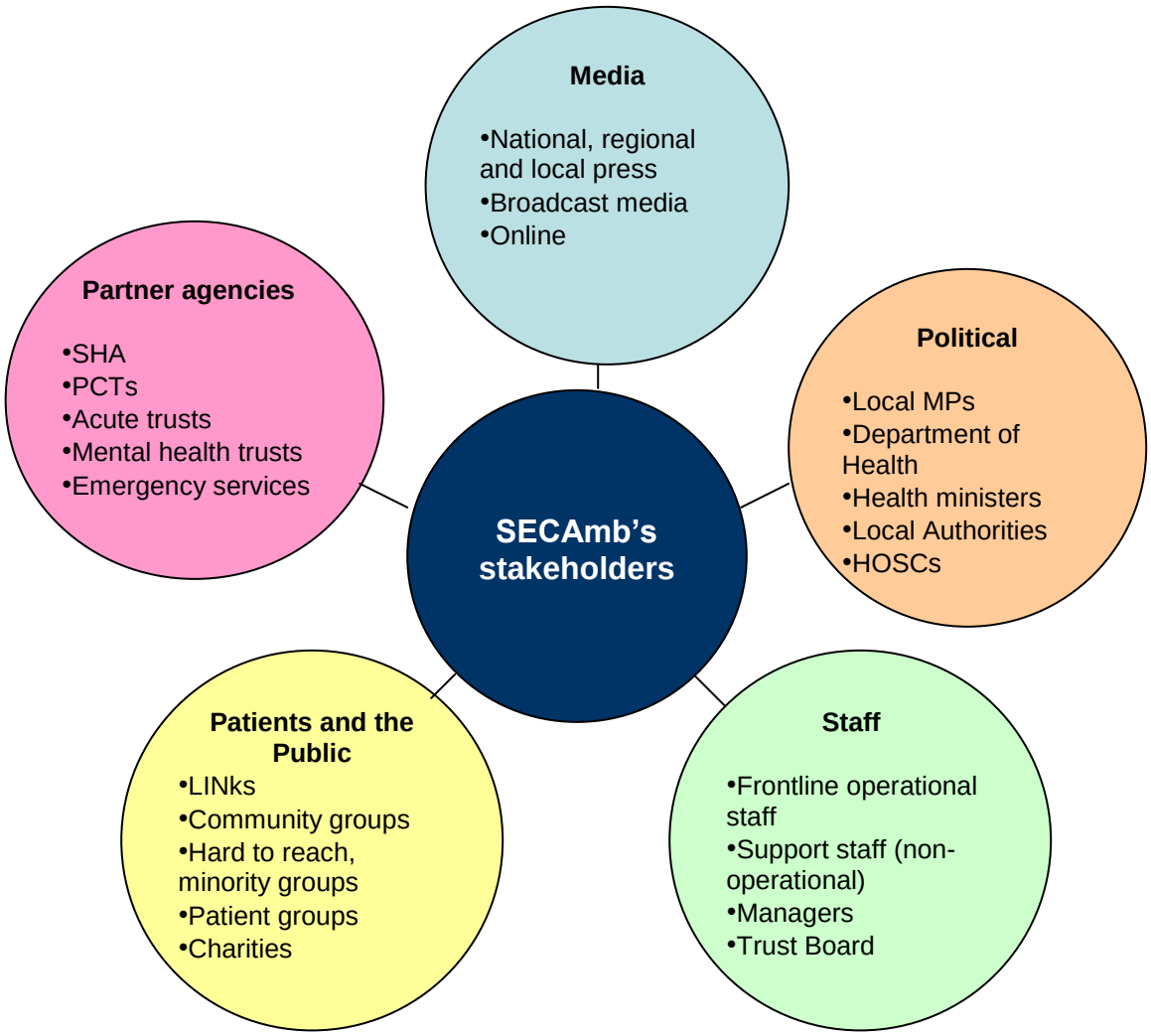
Building upon these initial engagement sessions, SECAmb is to undertake a survey of patients and the public across the South East Coast area looking at their satisfaction with the Trust and the services we are providing to patients. This survey will also look at their perceptions of the Trust and understanding of the range of services that we provide. Results from this survey will be published in the summer of 2008. The survey will be repeated annually so improvement in satisfaction levels can be tracked.

In 2008/09 we will also be taking a much more proactive role in improving the public health of the communities we serve. Knowing when to call for help, what to do in a medical emergency, as well as taking preventative action whenever possible, are all vital in contributing to the best possible outcomes for patients.

Many would say that these parts of the picture are out of the ambulance service’s control as they all happen before 999 is called. However, we believe we can influence behaviour pre-call and, more importantly, that we have a responsibility to do so as a Trust that is committed to continuously improving patient outcomes.

This will involve greater engagement with all sectors of the community, including marginalised and diverse groups, to raise awareness through education and information campaigns about the role that every member of the community can play in saving lives and improving outcomes.

Figure 3.1 – Our principal stakeholders



4. MARKET ASSESSMENT

4.1. Description of local health economy

We provide services to the South East Coast health economy, incorporating the counties of Kent, Surrey, Sussex and part of north east Hampshire. Within the South East Coast area there are eight primary care trusts (PCTs), 13 acute hospital trusts, two of which are foundation trusts, and four mental health and specialist trusts. In addition we provide services to a defined population within the north east of Hampshire PCT. Figure 4.1 shows the PCTs across the South East Coast region:

Figure 4.1 – PCTs in the South east coast region

The tables below indicate the acute and mental health trusts within the South East Coast area:

Table 4.1 – Acute Trusts in the south east coast region

Ashford and St Peter's Hospitals NHS Trust
Brighton and Sussex University Hospitals NHS Trust
Dartford and Gravesham NHS Trust
East Kent Hospitals NHS Trust
East Sussex Hospitals NHS Trust
Frimley Park NHS Foundation Trust
Maidstone and Tunbridge Wells NHS Trust

Medway NHS Trust
Royal Surrey County Hospital NHS Trust
Royal West Sussex NHS Trust
Surrey and Sussex Healthcare NHS Trust
The Queen Victoria Hospital NHS Foundation Trust
Worthing and Southlands Hospital NHS Trust

Table 4.2 – Mental health and specialist trusts in the south east coast region

Kent and Medway NHS and Social Care Partnership Trust
South Downs Health NHS Trust
Surrey and Borders NHS Trust
Sussex Partnership NHS Trust

4.2. Key factors driving demand

Demand continues to increase for our service. A 4.4 per cent increase in activity is anticipated for 2008 – 2009, and an annual increase of 4.98 per cent beyond this.

There are a number of factors driving this increase in demand including changes in the type of patients accessing our services, growth in local population and transformation of local NHS services.

Increased demand is predominantly driven by an increase in patients with primary care needs accessing healthcare via 999. The spectrum of patient need that we are now seeing is broader than ever before.

In addition, changes to population can also have an impact on demand. Significant economic development and growth is planned for the South East of England, in particular the economic development and regeneration of the Thames Gateway corridor, which will have implications for the population served by the Trust.

There is also evidence of an increase in migrant workers across this region, which is set to continue; this also has the potential to impact on the demand for our services.

SECAmb has robust plans in place to respond to changes to and increases in demand including but not limited to the development and implementation of new specialist clinical roles, continuous development of alternative care pathways to ensure patients receive the most appropriate care for their need, no matter how they access the NHS, and the development of a flexible deployment plan ensuring capacity best matches patient demand to ensure we’re reaching patients as quickly as possible..

4.3. Major changes in the external environment

We operate in an environment that is continually changing and developing. In particular, we are actively involved in the discussions taking place in the local health economy around Fit for the Future, which is looking at the configuration of acute services across the region.

One of the most significant changes that we face is the introduction of Call Connect; a new performance standard for all ambulance trusts that will take effect from 1 April 2008. This means that the measurement of our performance in relation to responding to 999 calls will be altered. As soon as the call is connected to our Trust's switch the clock will start. For many patients, reaching them as quickly as possible so treatment can commence is vital. Bringing the clock start forwards means our staff will be delivering care to patients even earlier. However, to achieve the best outcomes for patients we recognise that getting to patients quickly is only one part of the picture; what is equally important is sending the most appropriate response for the patient's need and delivering quality clinical care.

4.4. External environment analysis

As with any organisation, the external environment in which we operate has the potential to impact significantly on the Trust. A detailed PEST analysis of the operating environment will be undertaken to identify the key political, economic, social and technological factors that may impact upon us. As part of the ongoing Board development work in 2008 – 2009 a review of the key external factors that effect our operations is planned.

We recognise the need to identify the factors of competition that we face in all aspects of our business, and to determine how these can be addressed. We are currently the sole provider of A&E transport services in the region, however, we are open to competition in relation to our PTS services and are actively considering our approach for the future. A market assessment will be undertaken in due course to support our decision making in this area.

5. SERVICE DEVELOPMENT PLANS

5.1. Overview

In line with the Trust's vision and strategic objectives a number of key areas of development have been identified. We have considered our strengths, weaknesses, opportunities and threats, and used this information to inform the direction that the Trust takes.

This chapter considers an overview of some of our key areas of future development, as follows:

Clinical developments

Our role in the intermediate care agenda

Make Ready

Front loaded model

Integration of the CAD and MDT systems

National IT developments

Workforce

5.2. Our Trust's Strengths, Weaknesses, Opportunities and Threats

With involvement from our stakeholders at the "Shaping the Future of SECAmb" events held in 2007, we have identified the principal strengths and weaknesses of the Trust, and have also considered our opportunities and threats. Figure 5.1 sets out a summary of these.

Figure 5.1 – SWOT summary

Strengths	Weaknesses
Workforce (Professional, enthusiastic, committed, loyal, skilled) Dynamic leadership Staff development and training Clinical developments / clinical focus Innovative developments Partnership working / interaction with other services Good reputation and public image Performing against targets and raising standards Development of alternative care pathways 24/7 service Clear vision and direction Responsive Patient Transport Service Flexible and open to change	Ability to deal with mental health issues Funding – places restrictions on resources etc Communication internally within the organisation and externally to stakeholders Lack of common systems, equipment, policies, procedures Infrastructure across a large geographical area Care pathways are not all fit for purpose – need to be able to pass the caller on to the appropriate provider / response Competing priorities Workforce makeup – skill mix Lack of ownership of the Trust's vision Reporting and audit of clinician outcomes
Opportunities	**Threats**
Develop in line with Fit for the Future Foundation Trust status Raise the profile of / emphasis on PTS Take a lead role in the local health economy, with other emergency services and in liaison with local authorities Improve patient care through joint working with partners Develop best practice models based on information from legacy organisations Lead the field (in terms of innovation, technology, staff skills) Robust, longer term planning, involving all stakeholders Develop our workforce further Produce meaningful outcome data to help improve the effectiveness of care Communicate more effectively with the public Embrace, engage, enthuse and motivate staff	Unknown outcomes of Fit for the Future Call Connect Competition from the private sector Acting as a gateway to the NHS may cause a dilution of focus Complex agenda risks underachievement Need time to stabilise Increasing capacity Greater competition for funding Resistance of some partners to work with us Need to remain independent of politics and focussed on patient care Keeping up to date with technology and developments Change agenda too large for existing resources

5.3. Commentary on SWOT analysis

Information outlined in the SWOT analysis is summarised as follows:

Strengths
We recognise that our workforce is the critical factor in the delivery of patient care, and as such we are keen to ensure the appropriate development opportunities are provided.

Further information on this can be found in Chapter 8. In order to support our staff, we are also committed to continual development and improvement in relation to new systems of working and innovative technologies. We are keen to work closely with all our partners in the health and social care economy, to improve the individual patient experience. We are proud to have a good reputation amongst stakeholders and are working hard to maintain this.

Weaknesses
We recognise the need to work more closely with partners to ensure all patients receive the appropriate care and attention they deserve. Work is ongoing to improve communications both internally and externally, taking into account the complexity of the agenda that we face.

Opportunities
We are keen to seize opportunities that may bring further benefits to our patients. In particular, we are keen to build on our existing strengths, by further developing our workforce and identifying mechanisms to measure improvements in patient outcomes. As an aspirant Foundation Trust we are striving to engage fully with all stakeholders, and to ensure planning for the future is robust and evidence-based.

Threats
In order to ensure that we continue to be a successful organisation, we need to understand the factors that potentially threaten our operations. The lack of certainty in the local health economy has a potentially significant impact on how we operate; however, our approach is to fully engage in all consultation processes and to consider how best SECAmb can develop to meet the changing demands of patients. We are aware of the challenges we face through the introduction of Call Connect, coupled with increasing demand, and significant time and effort has been dedicated to date, and is planned for the future, to address these.

5.4. Key strategic initiatives

Clinical developments

We are keen to provide clinical leadership, focus and direction, constantly seeking out opportunities to improve the safety and clinical quality of services to patients and service users, thereby facilitating improvements in both patient outcomes and the patient experience. We also strive to enhance the clinical capability and professionalism of our staff. These objectives will be attained with reference to the scientific evidence base and through the application of clinical quality improvement methods, research, development, application, and evaluation and through the promotion of sound clinical governance arrangements, learning and personal development.

We have made innovation, both clinical and non-clinical, an integral element of our core strategic objectives and have a proven record of improving the care patients receive and thereby promoting their recovery, the classic example being Protocol, a new method of resuscitating patients which is proving extremely successful.

Over the next five years we intend to become a leading advocate of innovative practice among ambulance and emergency medical services. We will seek to gain a reputation for clinical excellence in pre-hospital and mobile healthcare, while also contributing to the emergency preparedness agenda. The application of benchmarking and a commitment to engaging with partners both nationally and internationally will support these objectives.

Our role in the intermediate care agenda

We are keen to progress our role in relation to 'Hear and Treat' and 'See and Treat' processes within the forthcoming year. Key to the success of these are the development of our staff in the Emergency Dispatch Centres and the development of the clinical skills of our frontline staff to enable them to undertake clinical assessments and provide a wider range of treatments on scene. In addition, we also have a role in supporting the local health economy to manage demand appropriately, rolling out the Capacity Management System in conjunction with hospital colleagues to ensure the appropriate management of hospital capacity across the region.

We will also continue to work closely with PCTs to develop a Directory of Services which will enable information on community service provision to be available 24 hours a day, so that clinicians can refer patients to alternative pathways of care, which are available to them at that point in time and appropriate to the patient's need.

Make Ready

The Make Ready system is based on a quality-assured vehicles and preparation programme, designed to minimise cross infection and maximise patients safety. All of the vehicle preparation is undertaken by specially-trained, non-clinical staff, allowing ambulance clinicians to focus on the delivery of high quality patient care, a principle to which we are committed.

To facilitate Make Ready, large depot-style centres are created, as is currently being trialled at Chertsey, to centralise all the support services required – fleet, cleaning, maintenance – and support a greater critical mass of vehicles and staff.

Make Ready brings many benefits, both for patients and staff. As the vehicles are cleaned to a consistently high standard it significantly reduces the risk of cross-infection, which is key in terms of helping to improve patient safety.

By employing specially-trained teams of non-clinical staff to carry out the cleaning, this will also free up clinical staff to spend more time treating patients. In addition, Make Ready will allow for a more comprehensive maintenance programme for our vehicles, resulting in fewer breakdowns – which is better for both staff and patients. All vehicles will be re-stocked to the same agreed standards, minimising the risk of missing equipment or equipment not working when it is required for use.

Front Loaded Model

The needs of patients are changing, which means that the range of conditions that we are required to treat each day is becoming more and more diverse. These needs range from

the critically ill and injured who need specialist treatment and rapid transport to a specialist trauma centre, to those patients with primary care needs and minor ailments who can be more appropriately treated in their own home, or in the community.

Understanding that patient needs are more complex than ever, SECAmb has developed the “front loaded model” as one mechanism to adapt to this change in demand and ensure that patients receive the most appropriate care for their clinical need – not necessarily a trip to hospital. In essence, the front loaded model will see a change in the ratio between traditional double-manned ambulances and single response vehicles. Currently, the ratio of single response vehicles to double-manned ambulances is roughly 20 per cent to 80 per cent respectively. Over the next 12 to 18 months we aim to achieve a ratio of 30 per cent single response vehicles to 70 per cent double manned ambulances.

The single response vehicles will be manned by paramedics and paramedic practitioners to ensure that patients have the most highly skilled clinicians reaching them quickly to assess them and determine the most appropriate treatment for their clinical need; this may be conveyance to hospital in a traditional or air ambulance, or it may be treatment on scene, therefore not requiring an ambulance as no transport would be needed.

In support of this model, and in accordance with the principles of high performance, SECAmb is committed to establishing a rolling vehicle replacement programme to ensure the maximum efficiency of its vehicles. Based on standard vehicle platforms, carrying a standard load, the aim is to provide a 5 year replacement strategy for the front line fleet and to maximise interoperability throughout SECAmb. The strategy will reflect the balance required between ambulances and response vehicles in the front loaded model.

Integration of the Computer Aided Dispatch (CAD) Systems and Mobile Data Terminal (MDT) Systems

The A&E CAD system is crucial in enabling us to provide an effective service to our population, as it supports dispatchers in the deployment of the most appropriate care to patients; put simply, the more effective the CAD is in supporting dispatchers in their role, the more lives that can be saved. As a result, a key development for us to undertake in 2008 – 2009 is the procurement of a single CAD to cover the whole of the South East Coast region. This will enable the most efficient use of all of our resources.

Linked to the integration of the CAD systems is that of the MDT systems. These terminals, which are placed in every vehicle, track the location of vehicles, allowing them to be tasked appropriately by dispatchers in the EDC. They also allow dispatchers to send critical, clinically relevant data to the crew, prior to arrival at scene. Given the disparity of the current systems we have in place, due to their inheritance from the legacy organisations, there is an urgent need to align these and to gain the most added value from the technology to ensure maximum benefits to patients and staff.

National IT Developments

We are currently participating in a number of national projects that are aimed at improving the use of our information systems, namely the Ambulance Radio Programme (ARP) and Connecting for Health. Given the national scope of both of these projects, we are

endeavouring to ensure maximum engagement with all of our partners, whilst also upholding our values and principles.

ARP aims to modernise the radio systems used by UK ambulance services, to ensure interoperability with other emergency services, following findings from the London bombings.

Connecting for Health is working to produce systems that improve the experiences of patients at all stages of care. For ambulance services, the system that is likely to be offered is the Electronic Patient Report Form. This tool would eventually allow the ambulance record to become the seed for the hospital record, thereby allowing data on outcomes to be more readily available to the Trust. The system may also allow the clinicians to access some elements of the patient's medical record, therefore allowing the treatment to be tailored to the patient's individual needs.

Workforce

We are dedicated to ensuring that the members of our workforce are equipped with the skills they need in order to provide optimal levels of patient care. Detailed information about workforce developments is provided in Chapter 8.

6. FINANCIAL PLANS

6.1. Historical performance

This section describes our historical and current financial performance and outlines the budget for the 2008/09 financial year and then sets out the Trust's medium-term financial plan spanning a rolling five year term through to 2013.

The Trust and the predecessor legacy ambulance trusts have an excellent financial performance track record delivering sustained financial balance delivering all statutory duties. The following table shows the sustained financial balance and an improvement in the Reference Cost Index performance.

Table 6.1 – Financial balance and reference cost index performance

	2005/06 £'000	2006/07 £'000	2007/08 £'000
Surplus	832	3,050	677
Reference Cost	110 / 111 / 115	109	N / A
2005/06 figures show a consolidation of the Kent, Surrey and Sussex Ambulance Service performance for comparison, with disclosure of the 3 separate reference costs.			

The medium-term plan (at Appendix 1) shows our detailed service line and functional performance from 2007 – 2008 through to 2012 – 2013. For clarity, figures are shown in £'000 and positive figures show a budget increase whereas negative figures reflect a reduction – regardless of being a change to income or cost.

6.2. 2008 – 2009 Budget

We have worked with the Specialised Commissioning Group and have developed a recurrent baseline that will allow us to deliver national performance targets, including Call Connect, whilst achieving financial balance.

The A&E Service Level Agreement (SLA) for 2007 – 2008 totalled £116.8m recurrently and the 2008 – 2009 SLA was formerly agreed with our commissioners ahead of the February 2008 deadline and includes the following elements. This is shown in Table 6.2 overleaf).

Table 6.2 – Summary A&E Service Level Agreement 2008 – 2009

	£'m
2007/08 Baseline	116.8
Forecast under activity 2007/08 (50% marginal rate)	(0.4)
Pay and Prices Uplift @ 5.3% less 3% national efficiency target	2.7
Forecast 4.7% activity increase (@50% marginal rate)	2.8
Call Connect	6.3
Total	**128.2**

We recognise that limited funds are available within the local health economy to support service developments and negotiations are ongoing around investment in Fit for the Future in 2008/09 and beyond.

We are planning for 26 Patient Transport Service (PTS) SLAs in 2008 – 2009 with a total value of £10m. Negotiations are ongoing with PTS commissioners (PCTs and acute trusts) to negotiate contracts for 2008 – 2009. With the proposed value of each contract based on the 2007 – 2008 forecast outturn activity levels plus a 2.3 percent net uplift for inflation as per operating framework guidance.

Budgeted expenditure increases are as per the operating framework and commissioner agreements, reflecting 5.3 percent generic price increase, 3 percent efficiency saving and 4.7 percent A&E activity increase (incidents) at the marginal rate, which equates to a further 2.3 percent increase in A&E income.

Call Connect is fully funded from 2008 – 2009 to the levels agreed in the business case (£6.3 million).

We have made some infrastructure investment to aid delivery of the strategic high performance agenda, including expanding and centralising the clinical scheduling team to improve resource management and deployment. Increases to clinical capabilities include education, professional standards and governance, as well as posts to develop new pathways. Corporate affairs developments include new posts for infection control and equality and diversity agendas, as well as support for the development of alternative care pathways. The resourcing of the communications team has also been reviewed, reflecting the work planned in the five year communications strategy.

Corporate expenditure shows a reduction in 2008 – 2009 reflecting the allocation of growth funding to operational functions (Pay) and the removal of the 2007 – 2008 RAB, which was used to fund the preparation for Call Connect (Non Pay), which is now funded in full.

The South East Coast Strategic Health Authority has locally asked trusts to provide contingency reserve (1 percent of revenue) within their plan to ensure financial delivery.

This contingency will be available for use throughout the financial year and is reflected in corporate non pay expenditure.

Our activity funding for 2008 – 2009 represents 2.3 percent of A&E income and is used to provide the operational resource increases and the SHA contingency reserve, which will be used during this financial year. This funding growth will also be used to invest in our high performance agenda and, more specifically, the Make Ready expansion.

During 2007 – 2008, we have built on the existing work in Worthing and have developed a Make Ready site in Chertsey. The benefits arising from this are already apparent, with improved infection control and resource availability leading to more effective resource planning and less down time. When fully evaluated, we plan to expand this programme throughout the time of this medium term plan and, more specifically, by developing a further three Make Ready depots during 2008 – 2009.

These Make Ready developments free up clinical staff to focus on front line duties (creating more capacity) and are in line with the Trust's Estates Strategy.

6.3. Medium-term five year financial plan

As stated earlier, the medium term planning assumptions are based on the operating framework and 2008 – 2009 change levels, reflecting commissioner funding and expenditure increases of 5.3 percent generic price increase, 3 percent efficiency saving and 4.7 percent activity increase at the marginal rate, which equates to a further 2.3 percent increase in A&E income.

Price increases have been shown across all functions, but growth and efficiency is only shown against Operations and Technical Services (Make Ready).

The SHA required 1 percent contingency reserve has been included in each year of the plan and additional resource is set aside during 2009 - 2010 to facilitate our progression towards Foundation Trust status.

An additional planning contingency is shown against Operations throughout the 5 year plan to ensure financial viability and robustness of the model, given the early development of the Trusts high performance plans.

No back-office functional growth is shown, as we plan to fund this through functional efficiency savings, although the annual budget setting process will evaluate these needs and allocate resource accordingly.

We will continue the development of the high performance agenda, and the Trust's Make Ready expansion is reflected in this plan, in line with the Estates Strategy through 2010 – 2011. The Make Ready expansion is, of course, subject to benefits assessment and verification of the planned efficiencies and improvements being evidenced.

The planned efficiency savings will be derived from the high performance plans, including the Make Ready concept, which has a prudent saving of 1:2 reflected in this plan (for

every 1 WTE invested in Make Ready, it will free up the capacity of 2 WTE in front line operations).

6.4. Capital planning

The capital allocation system for NHS trusts changed in 2007 – 2008 to reflect the system currently utilised by Foundation Trusts. Trusts are no longer allocated a capital resource limit (CRL) which has previously determined the level of investment the Trust could make in its capital assets. Trusts now have to fund any capital expenditure from internally generated funds. That is, cash relating to depreciation spend (estimated £6m in 2008 – 2009) and any cash surpluses generated. Beyond internally generated funds, Trusts may borrow against their Prudential Borrowing Limit (PBL).

We have plans to spend £12 million capital during 2008 – 2009, including £6 million carried forward from unspent internally generated funds from 2007 – 2008. Thereafter the capital programme will revert to more normal levels without utilising the Trusts borrowing capacity (PBL). Appendix 3 shows the Trusts capital plans and the financing for 2008 – 2009 through to 2010 – 2011.

We have £29 million PBL (DH assessment 2006 – 2007), which remains unused throughout this plan as we invest from internally generated funds. Borrowing capability will be explored further when the both the Make Ready assessment and the estates review are complete.

6.5. Financial Strategy and risk

We are currently in a very strong cash position due to a delay in the 2007 – 2008 capital programme (with carried forward funds planned to be spent in the 2008 – 2009 budget) and the Agenda for Change back pay provision.

We have produced a five year cashflow plan, which demonstrates our strong liquidity position, even after the discharge of the above cash contingencies.

We will continue with our current financial strategy of planning for long term, sustained improvement and utilise existing resources on inward investment for service developments and improvements leading to model redesign (including spend to save initiatives), without the need to delay plans and agree initiative funding with commissioners.

The model is part of a system of robust financial monitoring to ensure sustainable long term financial viability, delivering on national priorities and targets, allowing the investment and developments to improve patient care and experience.

We will implement a monitoring mechanism to measure our efficiency and quality of the service provided. This will contribute to the delivery of our strategic objectives, including:

“We will convert all available pounds and resources into maximum patient benefit”

The most significant financial risk for the Trust continues to be the Agenda for Change pay banding of ambulance paramedic and technician staff groups. No effect of this decision has been reflected in this plan, which will lead to discussions with commissioners on how either the shortfall is funded or the surplus is utilised. Regardless of outcome, commissioners are fully aware of the circumstances to mitigate the risk arising.

6.6. Financial sensitivity

Financial sensitivity analysis has concentrated on our internal deliverables and specifically efficiency savings as generic expenditure pressures (price and activity levels) are subject to annual commissioner agreements for the service provided.

The extent of the efficiency savings (3 percent per annum) planned over the five year term will result in overall income levels reducing by some £20 million. We remain confident on our efficiency plans to deliver this level of cost improvement through the high performance agenda, however the Trust has factored into the plan contingencies (£16 million over the five year term) which mitigate the risk of non delivery.

These contingencies will be reviewed on an annual basis and re-invested appropriately in front line resource to deliver capacity and service improvements.
Patient Transport Services (PTS) is a separately identified service line shown in the medium-term plan Appendix 2. Any lost income is mitigated by rationalising the direct expenditure arising from the service.

As stated, the outcome and financial impact of the agenda for change appeal panel is not reflected in this plan, and will be resolved with commissioners upon conclusion.

6.7. Summary

The section shows how we plan to build on the robust historical financial performance to deliver improved levels of efficiency and service provision to optimise patient benefit. The 2008 – 2009 budget and medium term plan present a balanced financial position that demonstrates our sustainable financial viability, allowing for service improvement and demonstrable value for money.

7. RISKS

7.1. Principal risks

In setting our strategic objectives, we have also given due consideration to the risks that may be encountered in delivering these. These risks will form the basis of our Board Assurance Framework, which will be monitored by the Integrated Governance Committee. In addition to this, we also have a Trust Risk Register, where operational risks that may impact on the day to day delivery of our core business are recorded. This is regularly reviewed and monitored by the Risk Management and Clinical Governance Sub Committee.

7.2. Strategic risk areas

We reviewed the strategic objectives and have identified the principal risks that the Trust faces to the delivery of these. These are set out in Table 7.1.

7.3. Mitigation of principal risks

The principal risks will be managed through the development and monitoring of the Board Assurance Framework. Key controls and assurances to mitigate the risks will be identified and put in place. Gaps to these controls and assurances will also be identified and actions put in place to remedy these.

Table 7.1 – Principal risks

Pillar	Strategic Objective	Principal Risks
Clinical Effectiveness	We will deliver excellence in leadership and development We will continuously improve access and outcomes to match international best practice	Inability to deliver against the R&D agenda due to lack of resources, capacity, capability and infrastructure
		Inability to accommodate competing priorities of the workforce plan i.e. Call Connect, CCP / PP training, in terms of capacity internally and externally through HEIs
		Lack of robust information systems across the whole health economy to monitor and measure patient flows and outcomes and ability to benchmark internationally

Pillar	Strategic Objective	Principal Risks
Customer Satisfaction	We will continuously improve satisfaction and experience for all stakeholders	Lack of willingness from stakeholders to engage with the Trust
		Lack of stakeholder understanding regarding the Trust's vision and direction of travel
		Failure to manage patient and stakeholder expectations
	We will be an organisation that people seek to join and are proud to work for	There may be increased turnover of staff (beyond which the Trust can manage) due to the pace of change and culture shift
		Lack of understanding and commitment about where we are heading (in relation to the vision) and the implications of this
		Failure to deliver new roles and career framework
		Failure to be in the upper quartile of the staff survey results (ambulance service sector)

Pillar	Strategic Objective	Principal Risks
Response Time Reliability	We will continuously improve on the Trust's performance standards and reduce variation	Failure or significant delay to implement single CAD / MDT will result in non delivery of the development and implementation of UHU and the high performance agenda
		Failure to deliver Call Connect performance by month and annually will result in reputation management issues. The impact of continued escalation will also impact on the delivery of the wider corporate agenda

Pillar	Strategic Objective	Principal Risks
Economic Efficiency	We will convert all available pounds / resources into maximum / optimum patient benefit	Lack of developed performance management systems to permit the monitoring and review of the use of resources
		Lack of culture / ownership of the high performance process to enable us to effectively run the organisation
		Lack of stakeholder ownership of the new models of service delivery
	We will embrace our social and environmental responsibilities	Lack of resources, capacity and capability to deliver against the social and environmental agenda
		Lack of commitment to and understanding of the green agenda by staff in relation to their working environment
		National focus will impose objectives and targets on the Trust with regards to social and environmental responsibilities
		Failure to deliver on the Trust's social and environmental responsibilities will result in damage to the Trust's reputation

8. LEADERSHIP AND WORKFORCE

8.1. Overview

We are committed to delivering continuous improvements in the care and services we provide for our patients. In doing this, we recognise that our workforce are key to the delivery of our vision. Therefore, it is essential that we provide them with the necessary training, development and support to do so.

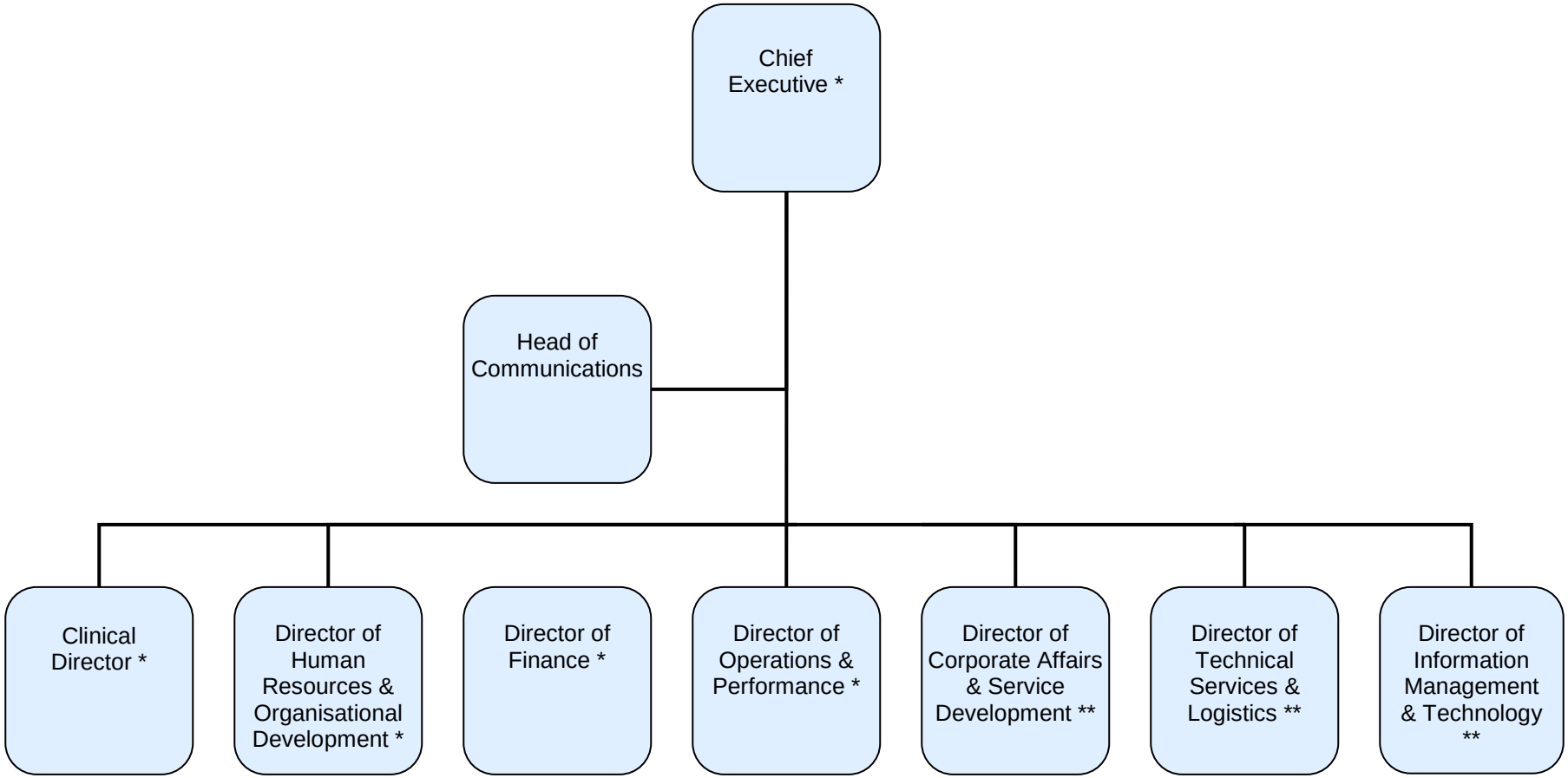
As a result, we have established a number of tools to achieve this, such as the Workforce Plan, and the Organisational Development (OD) Strategy, which aim to support us in delivering our vision, as well as meeting nationally and locally set priorities. In addition, we are also keen to ensure that we support staff by developing support mechanisms to improve their working lives.

8.2. Management arrangements

The Trust Board is responsible for the decision making of the organisation. The Executive Team, led by the Chief Executive, is split into directorates that support the Trust in delivering its core duties. Each directorate and operational dispatch area (ODA) receives support from an identified Human Resources Manager, and a Finance representative, who are able to provide specialist advice to the directorate teams. The Executive Team structure is shown in Figure 8.1.

From an operational perspective the Trust is divided into two divisions, East and West, and further into five Operational Dispatch Areas (ODAs), which are served by three Emergency Dispatch Centres. These divisions are based on patient flows. This information is shown in figure 8.2 on and in Table 8.1:

Figure 8.1 – Executive Team structure



* Voting Board member
** Non-voting Board member

Figure 8.2 – Operational Dispatch Areas

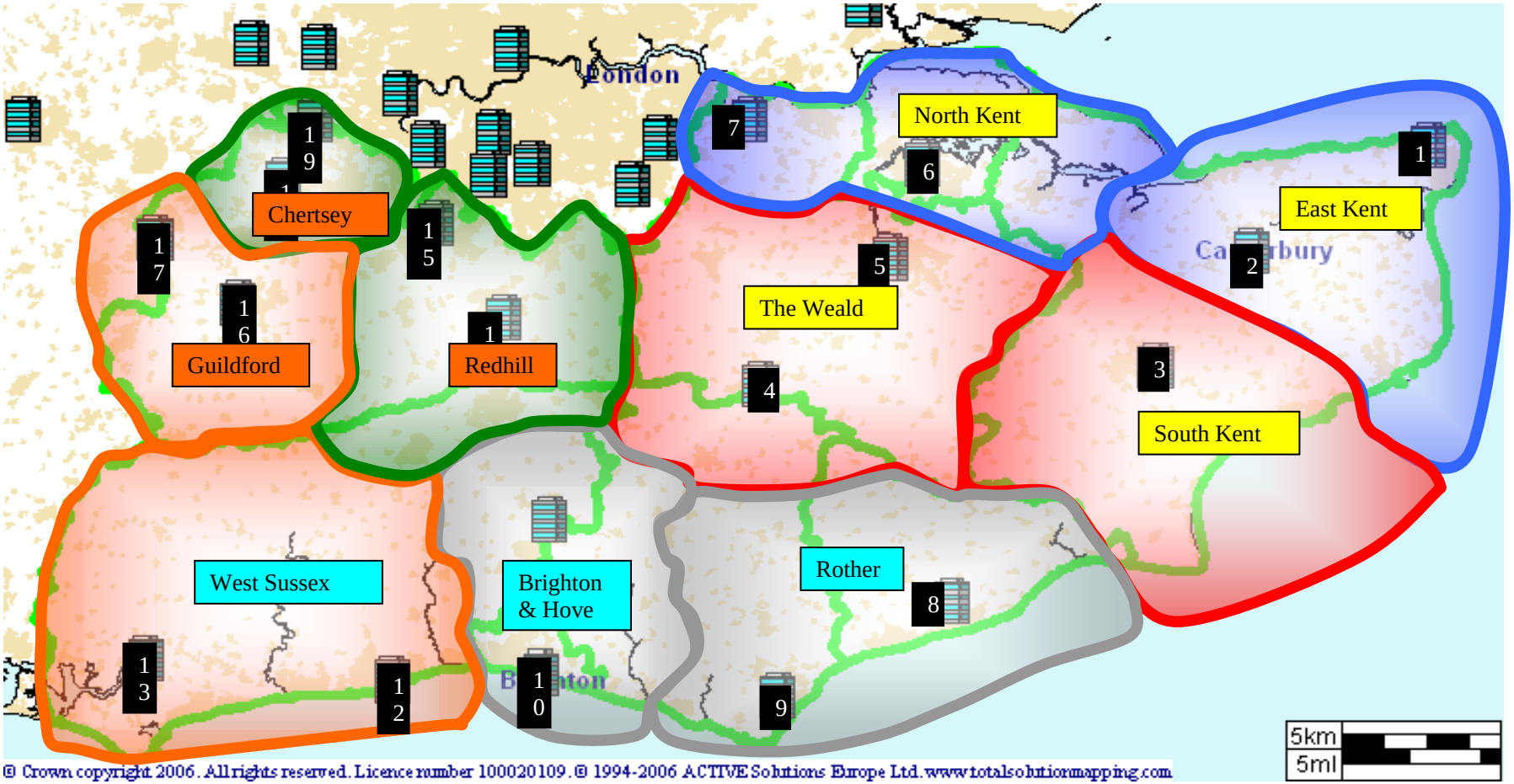


Table 8.1 – Operational Dispatch areas and Ambulance stations

SECA Divisions	SECA Operational Areas	No of Ambulance Stations	Ambulance Stations in Operational Area	EDC Dispatch Areas
East	North & East Kent	6	Herne Bay, Thanet, Dover, Deal, Canterbury, Faversham	East Kent
		6	Dartford, Medway, Sheppey, Sittingbourne, Strood, Thameside	North Kent
	The Weald & South Kent	3	Ashford, Folkestone, Lydd	South Kent
		6	Cranbrook, Crowborough, Maidstone, Sevenoaks, Tonbridge, Tunbridge Wells	The Weald
	Brighton & Hove and Rother	8	Battle, Bexhill, Eastbourne,Hastings, Hailsham, Heathfield, Rye, Uckfield	Rother
		6	Brighton, Burgess Hill, Haywards Heath, Hove, Lewes, Newhaven	Brighton & Hove
West	Guildford & West Sussex	7	Bognor Regis, Chichester, Littlehampton, Midhurst, Pulborough, Shoreham, Worthing	West Sussex
		8	Cranleigh, Godalming, Guildford, Farnborough, Haslemere, Knaphill, Tongham, Woking	Guildford
	Redhill & Chertsey	10	Caterham, Crawley, Dorking, East Grinstead, Epsom, Godstone, Horley, Horsham, Leatherhead, Redhill	Redhill
		4	Staines, Chertsey, Esher, Walton	Chertsey
		64	Note: Admin bases, Gatwick and Helicopter base not included in the above	

8.3. Board profile

The following are voting members of the Trust Board:

Name	Role	Appointment
Martin Kitchen	Chairman	July 2006
Paul Sutton	Chief Executive	July 2006
Janet Brierley	Director of Human Resources and Organisational Development	July 2006
Colin Farmer	Director of Finance	April 2007
Sue Harris	Director of Operations and Performance	September 2006
Andy Newton	Clinical Director	July 2006
Christine Barwell	Non-Executive Director	July 2006
John Jackson	Non-Executive Director	May 2007
Mike McSweeney	Non-Executive Director	May 2007
Nigel Penny	Non-Executive Director	July 2006
Vacancy	Non-Executive Director	Vacant

The following are non-voting members of the Trust Board:

Name	Role	Appointment
Geoff Catling	Director of Technical Services & Logistics	September 2007
Geraint Davies	Director of Corporate Affairs and Service Development	October 2006
Ian Arbuthnot	Director of Information Management and Technology	December 2006

8.4. Board development

During 2007 – 2008 a Trust Board Development plan has been implemented to support our preparation for Foundation Trust status. There have been a series of externally facilitated day-long sessions focusing on preparation of the Business Plan, Foundation

Trust competencies and also opportunities to hear from other existing Foundation Trusts. In addition to the facilitated sessions, there have also been a series of educational seminars for the Board covering areas such as strategic risk management, the NHS finance regime, bullying and harassment, whistle blowing and implications of new legislation, such as the Corporate Manslaughter Act.

Looking ahead to the next 12 months the Board development sessions will continue to focus on the Trust's preparation for Foundation Trust status, looking at issues such as Board competencies and undertaking the Audit Commissions Governance Toolkit assessment which comprises of a series of modules examining the Trust's governance arrangements and testing them for effectiveness in support of the Trust's application to become a Foundation Trust. Educational sessions will also continue and will encompass areas such as counter fraud and security management and equality and diversity.

8.5. Workforce profile and indicators

We employ a total of 2900 staff in 2584.25 Whole Time Equivalent (WTE) posts, with 79.62 percent of these being full time positions. We routinely monitor our workforce, to ensure turnover and sickness absence levels do not exceed an appropriate level. In addition we review the makeup of our workforce in relation to equal opportunities, considering the age, gender and ethnicity profile for both our operational and non-operational staff.

Following approval of the Managing Sickness Absence Policy, measures have been put in place to publicise and promote the new policy and to train managers in partnership with staff side representatives. Work is undertaken on an ongoing basis to minimise sickness absence and staff turnover and an HR Manager has been nominated to lead on a Trust-wide approach to addressing cases of high and / or intermittent sickness absence.

Table 8.2 – Workforce analysis, at 31 October 2007

	Sickness absence (%) for previous 12 months	Turnover (%) for previous 12 months
Operational	6.80	4.43
Non operational	3.05	17.77
Total	6.31	6.31

Table 8.3 – Workforce age profile (headcount), at 31 October 2007

Age	A&E	PTS	EDC	Support	Total	%
16-20	0	0	9	21	30	1.03
21-25	44	12	54	30	140	4.83
26-30	246	34	60	37	377	13.00
31-35	359	63	53	44	519	17.90
36-40	332	55	36	51	474	16.34
41-45	297	51	37	43	428	14.76
46-50	241	44	34	60	379	13.07
51-55	132	35	17	57	241	8.31
56-60	79	40	12	64	195	6.72
61-65	37	30	6	29	102	3.52
66-70	2	0	0	12	14	0.48
71-75	0	0	0	0	0	0.00
76+	0	0	0	1	1	0.03
TOTAL	1769	364	318	449	2900	100.00

The gender profile compares favourably with other ambulance trusts; we have a 60:40 ratio of male to female staff.

Table 8.4 – Workforce gender profile, at 31 October 2007

	Male		Female		Total	
	No.	%age	No.	%age	No.	%age
Operational	1461	59.61	990	40.39	2451	84.52
Support	217	48.33	232	51.67	449	15.48
TOTAL	1678	57.86	1222	42.14	2900	100.00

In considering the ethnicity of our workforce, the percentage of staff classified as non white British has increased from 12.86 percent to 13.50 percent compared to the same point in the previous year. We are keen to attract staff from diverse backgrounds that are representative of the population we serve, and seek to raise our profile as a potential employer.

Table 8.5 – Workforce ethnic profile (headcount), at 31 October 2007

Description	A&E	PTS	EDC	Support	Total	%
White British	1595	287	283	345	2509	86.52
White Irish	10	2	1	4	17	0.59
White, other background	10	2	4	6	22	0.76
White unspecified	19	0	0	2	21	0.72
Mixed White & Black Caribbean	2	0	0	0	2	0.07
Mixed White & Black African	1	0	0	0	1	0.03
Mixed White & Asian	5	0	0	2	7	0.24
Mixed, any other background	6	2	1	0	9	0.31
Asian or Asian Indian	0	0	1	4	5	0.17
Asian or Asian Pakistan	1	0	0	0	1	0.03
Asian or Asian Indian / Bangladesh	0	0	1	0	1	0.03
Asian or Asian British, any other Asian	0	0	0	2	2	0.07
Black other or Caribbean	2	2	0	2	6	0.21
Black other or African	2	1	1	1	5	0.17
Any other background	0	1	0	0	1	0.03
Not stated	116	68	26	81	291	10.03
TOTAL	1769	364	318	449	2900	100.00

We review the profile of our workforce on an ongoing basis, and this is reported to the Trust Board twice yearly. We benchmark against peers using the national staff survey, and use this to inform future planning regarding workforce developments. We ensure that the information on our workforce is made available on the Trust's website.

8.6. Agency and recruitment arrangements

We have a centralised recruitment department, based at Banstead, which oversees the recruitment and selection of staff, in accordance with Trust policy. The Trust uses agency staff for covering short-term vacancies in non-operational roles only. We have a number of "bank" staff, who are used to provide cover operationally, as appropriate, working to their appropriate skill level. In addition, there are agreements in place with a number of Voluntary Aid Societies that provide additional resources, as required by the needs of the Trust.

There is continuing momentum on recruitment for Call Connect and to meet ongoing activity increases. We are proactively seeking to recruit a workforce that is representative of the people we serve.

8.7. Workforce and organisational development

We recognise that one of the primary contributory factors to our success is our workforce, and as such, the ongoing development of our staff is key. We have a three year Organisational Development Strategy in place, that was approved by the Trust Board in October 2007, and outlines the comprehensive approach that the Trust is adopting to becoming a patient / user led organisation.

This strategy aims to develop the organisation into one that is empowering and inclusive, aligning behaviours, systems and procedures with a common set of values to deliver our vision. Work is ongoing to provide a framework for leadership and management development that sets the context for talent management and succession planning. We are dedicated to ensuring SECAmb is an effective and efficient organisation, delivering on performance targets, and constantly seeking to improve its services to the benefit of patients and the public. In addition, we recognise the importance of making SECAmb an organisation that staff at all levels feel proud to be a part of, are loyal to, and are committed to its success.

This strategy identifies and acknowledges the potential obstacles we face to organisational development, and puts forward suggestions as to how best these can be overcome.

Alongside the OD Strategy, we have a five year workforce plan that spans from 2007 – 2012. This again recognises the crucial role of our workforce in delivering appropriate and responsive care to our patients, and that the effectiveness of this workforce is key to enabling us to meet the needs of our local population. In particular, this plan takes heed of the modernisation and professionalisation agenda facing the Trust and considers the development of new ambulance roles, and the associated education needs of our staff.

We recognise that it is essential for our workforce to reflect the needs of Fit for the Future and the national ambulance modernisation agenda, and the development of new roles and new ways of working will support us in meeting patients' needs and in so doing, reduce unnecessary conveyance to A&E departments. The key changes are outlined as follows:

Development and introduction of Critical Care Paramedics (CCPs)

CCPs are qualified paramedics with additional training and education to work in a critical care environment and able to treat patients suffering from major injury or trauma who require intensive support and therapy. We have an education and training programme in place with Hertfordshire University that builds on the existing skills and qualifications of a paramedic through modules comprising:

- Patient assessment
- Concepts of critical care
- Advanced airway management
- Care and transport of the critically ill and injured
-

Development and introduction of Paramedic Practitioners (PPs)

PPs are paramedics who are equipped with greater assessment skills and are able to diagnose and treat minor medical conditions, as well as referring patients on to other healthcare practitioners, thus potentially reducing the need for a patient to attend an A&E department. A training programme has been developed by St George's Hospital, and consists of education modules and a series of practice placements.

Professionalisation of ambulance staff education

In order for us to fulfil our role within the modern health service, the future of the workforce development lies in Higher Education. As such, we are committed to providing staff with the opportunity to undertake a Foundation Degree in Paramedic Science, either as a direct entry student, or for existing Technician staff to convert to a Paramedic qualification.

Achievement of Call Connect and national ambulance performance standards

In order to support us in meeting the challenging demands of Call Connect, we are looking to increase the use of single responders (often referred to as a "front-loaded" model), to provide patients as rapidly as possible with an experienced clinician who can assess and identify the most appropriate course of action for the individual.

Development and introduction of a new model of Emergency Care Support Workers

The Trust is reviewing the skill mix of staff and considering how we can adopt the new national Emergency Care Support Worker role to support patient care.

8.8. Staff welfare developments

We have continued to make extensive progress in developing welfare and support mechanisms for staff. Over the next year, we are keen to ensure that cover arrangements are in place to provide welfare support on a 24 hour basis, 7 days a week, and 365 days a year.

Work is ongoing to ensure that a system is established to provide support for any staff who are injured or assaulted at work. We are also extending the network of Bullying and Harassment advisors, Listeners and Welfare Representatives to ensure that these services are available on a pan-SECAmb basis.

We are hoping to secure funding for an occupational health liaison nurse, who will take responsibility for the flu vaccination programme, preventative health, health promotion and random/targeted drug and alcohol testing. In addition, this individual will take responsibility for liaising with, monitoring and supporting those members of staff with long term or complex sickness. In terms of health promotion, in addition to the arrangements that we have in place to offer subsidised gym membership to all staff members, we are also hoping to provide exercise bikes and cross step machines on all stations for staff to use. Work is also ongoing to maximise the provision of healthy options in all staff restaurants.

8.9. Relationship with Unions

We are committed to involving our representatives from recognised trade unions and staff organisations in decision making throughout the organisation. The Staff Side Coordinator is a member of the HR and OD Group, as well as the Equality and Diversity Steering Group, and there is representation on many other committees and working groups. We are keen to ensure a formal process of consultation and negotiation, and this is achieved through the Joint Partnership Forum, which aims to provide effective partnership working.

This forum helps to align the distinct, but complementary, roles of both Trust management and Staff Side Representatives, and provides an environment in which policies and issues can be openly discussed and debated, ensuring both staff and management perspectives are reflected in the development of Trust policy.

8.10. Social responsibility and community involvement

In our work we ensure that we take into account our responsibilities to society and for community involvement, focussing on our role as a good employer and our role from a corporate citizenship perspective in relation to engaging communities and hearing views.

We recognise the part that we play in promoting the health of the nation. We are committed to embracing sustainable development and tackling health inequalities through our day-to-day activities, as well as through proactive educational and information campaigns.

We are committed to using our corporate powers and resources in ways that benefit rather than damage the social, economic and environmental conditions in which we operate. How we behave, as an employer, a purchaser of goods and services, a manager of transport, energy, waste and water, as a landholder and commissioner of building work and as an influential neighbour in many communities, can make a big difference to people's health and to the well being of society, the economy and the environment. We recognise and embrace this responsibility.

9. GOVERNANCE ARRANGEMENTS

9.1. Corporate governance and management

We have based our governance arrangements on the principles of integrated governance, with the Board taking responsibility for the key strategic and managerial issues facing the Trust. Authority is delegated to the Integrated Governance Committee, and from there to the Risk Management and Clinical Governance Sub Committee and the Financial Audit Sub Committee for relevant issues. The Terms of Reference of the Integrated Governance Committee are set out in line with guidance provided in the Integrated Governance Handbook. The Trust Board operates in line with the approved Standing Orders, which are reviewed annually.

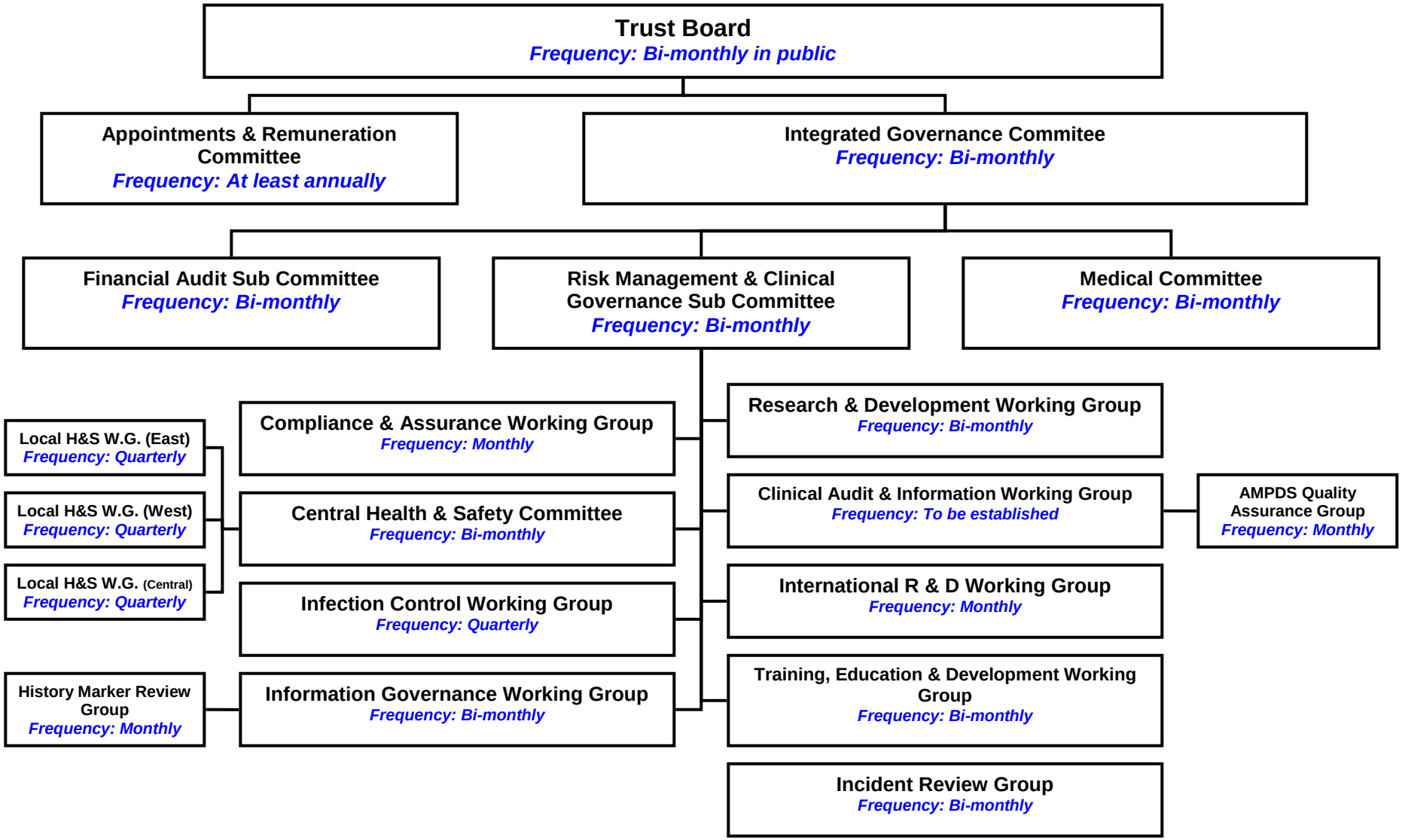
The Trust Board is chaired by the Chairman, and has 11 voting members. The Integrated Governance Committee, the Risk Management and Clinical Governance Sub Committee and the Financial Audit Sub Committee are all chaired by a Non Executive Director. Figure 9.1 shows our Trust Board and Committee structure.

In 2007 – 2008 we undertook a governance review, based on the Integrated Governance maturity matrix, from which we have set out a two year development programme of governance arrangements. Following on from this, the Board has committed to undergoing the Audit Commission governance toolkit in 2008 – 2009. We have been commended by both Internal and External Audit on our governance arrangements.

We have a Code of Professional Conduct established, whereby all staff are required to make declarations of interest, and also to declare any gifts or hospitality, whether or not accepted. In addition, we have a Secondary Working Policy, which states that all members of staff employed elsewhere must advise the Trust of this. Our Whistle Blowing Policy is highly publicised, and provides guidance on how staff can raise concerns.

We have adopted the Nolan Principles, the seven standards of public life, which the Trust acts in accordance with. In addition, we have recently adopted a set of principles governing etiquette at Board and Committee meetings.

Figure 9.1 – Trust Board and Committee structure



9.2. Risk management

Our system of internal control is designed to manage risk to a reasonable level and is based on an ongoing process designed to identify and prioritise the risks to the achievement of our objectives and to evaluate the likelihood and impact of these being realised.

Risk management is a corporate responsibility and therefore our Trust Board has ultimate responsibility to lead on this, ensuring that effective processes are in place. However, elements of responsibility also lie with employees of the Trust, and the organisational structure is designed to ensure that there is capacity to fulfil these responsibilities.

The Integrated Governance Strategy sets out the framework and systems for implementation of risk and governance processes.

Our Board Assurance Framework is the principal strategic tool for both the management and assurance of risks throughout the organisation, and is developed in accordance with guidance from the Department of Health. The Trust Board has overall responsibility for the management of risk, and this is delegated by the Board to individual Executive Directors.

In addition to the Board Assurance Framework, we have a Risk Register, which is a live document which records the risks that we face in the Trust, and assesses both the impact and likelihood of these, and grades the risks accordingly. This is reviewed by the Risk Management and Clinical Governance Sub Committee at every meeting. Risks can be identified by any member of staff, and following due procedure are assessed, and, if appropriate, will be included on the Risk Register and thereby monitored.

9.3. Audit arrangements

Our Internal Audit service is currently provided by Chantrey Vellacot DFK. An audit plan is developed annually, and approved by the Financial Audit Sub Committee. This is reviewed at the bi-monthly meetings, and altered where appropriate to reflect the Trust's needs. A representative from Internal Audit attends the Financial Audit Sub Committee and the Risk Management and Clinical Governance Sub Committee, as well as the Integrated Governance Committee and the Trust Board. Our External Audit service is provided by the Audit Commission. Again, a representative from the Audit Commission attends the Financial Audit Sub Committee and the Risk Management and Clinical Governance Sub Committee, Integrated Governance Committee and the Trust Board.

Appendix 1: Medium Term Financial Plan 2008 – 2009 to 2012 – 2013
Income & Expenditure (all figures in £'000)

	Forecast Wte	2007/08 Forecast Feb 08	Budget Wte	2007/08 Budget	Budget Wte	2008/09 Budget	Plan Wte	2009/10 Plan	Plan Wte	2010/11 Plan	Plan Wte	2011/12 Plan	Plan Wte	2012/13 Plan
Income														
A&E Contract Income		120,633		121,483		129,658		135,687		141,996		148,599		155,509
PTS Income		9,486		10,124		9,987		10,252		10,524		10,804		11,092
Other Non Emergency Services		1,930		1,692		1,770		1,812		1,855		1,899		1,944
Other Income		2,242		1,260		3,151		5,121		6,248		6,505		1,190
Total Income		**134,291**		**134,559**		**144,566**		**152,872**		**160,623**		**167,807**		**169,735**
Operating Expenditure														
Trust Board & Executive Directors		1,397	29.50	1,533	31.00	1,644	31.00	1,690	31.00	1,737	31.00	1,786	31.00	1,836
		304	0.00	559	0.00	811	0.00	827	0.00	844	0.00	861	0.00	878
Finance		886	28.50	1,025	28.50	1,056	28.50	1,086	28.50	1,116	28.50	1,147	28.50	1,179
		365	0.00	520	0.00	517	0.00	527	0.00	538	0.00	549	0.00	560
Human Resources		921	24.20	948	26.37	1,006	26.37	1,034	26.37	1,063	26.37	1,093	26.37	1,124
		752	0.00	594	0.00	594	0.00	606	0.00	618	0.00	630	0.00	643
Information Management & Technology		826	31.66	1,270	36.66	1,394	36.66	1,433	36.66	1,473	36.66	1,514	36.66	1,556
		3,098	0.00	2,591	0.00	2,655	0.00	2,708	0.00	2,762	0.00	2,817	0.00	2,873
Corporate Affairs & Service Development		1,043	28.40	978	36.90	1,329	36.90	1,366	36.90	1,404	36.90	1,443	36.90	1,483
		152	0.00	236	0.00	269	0.00	274	0.00	279	0.00	285	0.00	291
Clinical & Medical		2,823	72.00	2,872	91.60	3,441	91.60	3,537	91.60	3,636	91.60	3,738	91.60	3,843
		1,539	0.00	1,467	0.00	2,909	0.00	3,535	0.00	3,931	0.00	4,084	0.00	2,633
Technical Services & Logistics		2,732	86.21	2,661	98.41	2,507	98.41	2,577	98.41	2,649	98.41	2,723	98.41	2,799
		17,836	0.00	14,638	0.00	16,291	0.00	17,636	0.00	19,005	0.00	19,791	0.00	20,171
Emergency Operations		75,532	1,974.06	70,759	2,343.05	80,734	2,372.30	84,031	2,398.47	87,337	2,424.86	90,770	2,361.56	90,876
		1,859	0.00	1,490	0.00	1,726	0.00	1,761	0.00	1,796	0.00	1,832	0.00	1,869
Non Emergency Services		1,353	42.84	1,192	41.41	1,284	41.41	1,320	41.41	1,357	41.41	1,395	41.41	1,434
Non Emergency Services		264	0.00	373	0.00	299	0.00	305	0.00	311	0.00	317	0.00	323
PTS		7,728	364.10	8,580	350.10	8,471	350.10	8,708	350.10	8,952	350.10	9,203	350.10	9,461
PTS		1,513	0.00	1,419	0.00	1,391	0.00	1,419	0.00	1,447	0.00	1,476	0.00	1,506
Corporate Expenditure		125	226.50	3,107	0.00	203	0.00	209	0.00	215	0.00	221	0.00	227
		9,177	0.00	12,791	0.00	10,956	0.00	13,204	0.00	15,074	0.00	17,053	0.00	19,091
Pay	0.00	95,366	2,907.97	94,925	3,084.00	103,069	3,113.25	106,991	3,139.42	110,939	3,165.81	115,033	3,102.51	115,818
Non Pay	0.00	36,859	0.00	36,678	0.00	38,418	0.00	42,802	0.00	46,605	0.00	49,695	0.00	50,838
Total Operating Expenditure	**0.00**	**132,225**	**2,907.97**	**131,603**	**3,084.00**	**141,487**	**3,113.25**	**149,793**	**3,139.42**	**157,544**	**3,165.81**	**164,728**	**3,102.51**	**166,656**
Interest receivable		(1,082)		(192)		(192)		(192)		(192)		(192)		(192)
Unwinding discount		0		0		0		0		0		0		0
PDC		2,471		2,471		2,594		2,594		2,594		2,594		2,594
Total Expenditure		**133,614**		**133,882**		**143,889**		**152,195**		**159,946**		**167,130**		**169,058**
Total Surplus / (Deficit)		**677**		**677**		**677**		**677**		**677**		**677**		**677**
Commissioned Incidents		534,530		530,254		559,717		586,023		613,566		642,404		672,597
Ratios														
A&E Revenue per Incident		226		229		232		232		231		231		231

APPENDIX 1: Medium Term Financial Plan 2008 – 2009 to 2012 – 2013
Income & Expenditure (all figures in £'000)
In Year Changes

	Forecast Wte	2007/08 Forecast Feb 08		Budget Wte	2007/08 Budget	Budget Wte	2008/09 Budget		Plan Wte	2009/10 Plan		Plan Wte	2010/11 Plan		Plan Wte	2011/12 Plan		Plan Wte	2012/13 Plan	
Income																				
A&E Contract Income		(850)	(1%)				8,175	7%		6,029	5%		6,309	5%		6,603	5%		6,910	5%
PTS Income		(638)	(6%)				(137)	(1%)		265	3%		272	3%		280	3%		288	3%
Other Non Emergency Services		238	14%				78	5%		42	2%		43	2%		44	2%		45	2%
Other Income		982	78%				1,891	150%		1,970	63%		1,127	22%		257	4%		(5,315)	(82%)
Total Income		**(268)**	(0%)		**0**		**10,007**	7%		**8,306**	6%		**7,751**	5%		**7,184**	4%		**1,928**	1%
Operating Expenditure																				
Trust Board & Executive Directors		(136)	(9%)			1.50	111	7%	0.00	46	3%	0.00	47	3%	0.00	49	3%	0.00	50	3%
		(255)	(46%)			0.00	252	45%	0.00	16	2%	0.00	17	2%	0.00	17	2%	0.00	17	2%
Finance		(139)	(14%)			0.00	31	3%	0.00	30	3%	0.00	30	3%	0.00	31	3%	0.00	32	3%
		(155)	(30%)			0.00	(3)	(1%)	0.00	10	2%	0.00	11	2%	0.00	11	2%	0.00	11	2%
Human Resources		(27)	(3%)			2.17	58	6%	0.00	28	3%	0.00	29	3%	0.00	30	3%	0.00	31	3%
		158	27%			0.00	0	0%	0.00	12	2%	0.00	12	2%	0.00	12	2%	0.00	13	2%
Information Management & Technology		(444)	(35%)			5.00	124	10%	0.00	39	3%	0.00	40	3%	0.00	41	3%	0.00	42	3%
		507	20%			0.00	64	2%	0.00	53	2%	0.00	54	2%	0.00	55	2%	0.00	56	2%
Corporate Affairs & Service Development		65	7%			8.50	351	36%	0.00	37	3%	0.00	38	3%	0.00	39	3%	0.00	40	3%
		(84)	(36%)			0.00	33	14%	0.00	5	2%	0.00	5	2%	0.00	6	2%	0.00	6	2%
Clinical & Medical		(49)	(2%)			19.60	569	20%	0.00	96	3%	0.00	99	3%	0.00	102	3%	0.00	105	3%
		72	5%			0.00	1,442	98%	0.00	626	22%	0.00	396	11%	0.00	153	4%	0.00	(1,451)	(36%)
Technical Services & Logistics		71	3%			12.20	(154)	(6%)	0.00	70	3%	0.00	72	3%	0.00	74	3%	0.00	76	3%
		3,198	22%			0.00	1,653	11%	0.00	1,345	8%	0.00	1,369	8%	0.00	786	4%	0.00	380	2%
Emergency Operations		4,773	7%			368.99	9,975	14%	29.25	3,297	4%	26.17	3,306	4%	26.39	3,433	4%	(63.30)	106	0%
		369	25%			0.00	236	16%	0.00	35	2%	0.00	35	2%	0.00	36	2%	0.00	37	2%
Non Emergency Services		161	14%			(1.43)	92	8%	0.00	36	3%	0.00	37	3%	0.00	38	3%	0.00	39	3%
Non Emergency Services		(109)	(29%)			0.00	(74)	(20%)	0.00	6	2%	0.00	6	2%	0.00	6	2%	0.00	6	2%
PTS		(852)	(10%)			(14.00)	(109)	(1%)	0.00	237	3%	0.00	244	3%	0.00	251	3%	0.00	258	3%
PTS		94	7%			0.00	(28)	(2%)	0.00	28	2%	0.00	28	2%	0.00	29	2%	0.00	30	2%
Corporate Expenditure		(2,982)	(96%)			(226.50)	(2,904)	(93%)	0.00	6	3%	0.00	6	3%	0.00	6	3%	0.00	6	3%
		(3,614)	(28%)			0.00	(1,835)	(14%)	0.00	2,248	21%	0.00	1,870	14%	0.00	1,979	13%	0.00	2,038	12%
Pay	0.00	441	0%			176.03	8,144	9%	29.25	3,922	4%	26.17	3,948	4%	26.39	4,094	4%	(63.30)	785	1%
Non Pay	0.00	181	0%			0.00	1,740	5%	0.00	4,384	11%	0.00	3,803	9%	0.00	3,090	7%	0.00	1,143	2%
Total Operating Expenditure	**0.00**	**622**	0%	**0.00**	**0**	**176.03**	**9,884**	8%	**29.25**	**8,306**	6%	**26.17**	**7,751**	5%	**26.39**	**7,184**	5%	**(63.30)**	**1,928**	1%
Interest receivable		(890)	464%				0	0%		0	0%		0	0%		0	0%		0	0%
Unwinding discount		0					0	0%		0	0%		0	0%		0	0%		0	0%
PDC		0	0%				123	5%		0	0%		0	0%		0	0%		0	0%
Total Expenditure		**(268)**	(0%)		**0**		**10,007**	7%		**8,306**	6%		**7,751**	5%		**7,184**	4%		**1,928**	1%
Total Surplus / (Deficit)		**0**	0%		**0**		**0**	0%		**0**	0%		**0**	0%		**0**	0%		**0**	0%
Commissioned Incidents		4,276	0.8%				25,187	4.7%		26,306	4.7%		27,543	4.7%		28,838	4.7%		30,193	4.7%

Appendix 2: Medium Term Capital Plan 2008 – 2009 to 2010 – 2011

	2008-09	2009-10	2010-11
	£000	£000	£000
Capital Scheme Description			
Vehicle Procurement	10,600	4,771	5,380
IT	850	500	500
Equipment	100	1,350	100
Estates	250	679	1,720
Capital Resource Limit (CRL)	**11,800**	**7,300**	**7,700**
PLANNED FINANCING OF CRL (CASH)			
Depreciation	6,100	7,300	7,700
Movement in Capital creditors/debtors	5,700		
Sub-total - Internally Generated Capital Cash	11,800	7,300	7,700
Sub-total - External Capital Cash Requirement	0	0	0
Total Capital Cash Financing	**11,800**	**7,300**	**7,700**

Glossary of terms

Agenda for Change (AfC)	The current NHS grading and pay system for all NHS staff, with the exception of doctors, dentists and some senior managers.
Alternative care pathways	Referral to an alternative care pathway relates to the referral of a patient to another, more appropriate healthcare provider, rather than admission to A&E.
Ambulance Care Assistants (ACA)	See page 13
Ambulance Radio Programme (ARP)	A national programme that involves the roll out of a new ambulance radio system throughout the UK that will improve communications with other emergency services.
Annual Health Check (AHC)	Annual assessment of NHS organisations, aimed to promote improvements in healthcare.
Assurance Framework	A framework that provides a simple but comprehensive method for the effective and focussed management of the principal risks an organisation faces to achieving their objectives.
Call Connect	See page 30
Capacity Management System (CMS)	An online system that provides up to date information on the capacity of acute providers, enabling patients to be taken to a less busy hospital, if appropriate.
Category A calls	Calls that are classified as urgent and immediately life-threatening.
Category B calls	Calls that are classified as serious, but not immediately life-threatening.
Category C calls	Calls that are classified as neither serious nor immediately life threatening, and may be suitable for referral to an alternative care pathway.
Clinical Desk	A desk located within the Emergency Dispatch Centre, staffed by clinically trained staff who are able to provide advice to callers over the telephone.

Community responder	A member of the public (or off-duty member of staff or colleague from another emergency service) who attends emergency calls within an agreed radius of where they live or work and provides basic emergency care whilst waiting for an emergency response.
Computer Aided Dispatch (CAD) system	The electronic system in place within the Emergency Dispatch Centres to assist with the deployment of all emergency vehicles.
Connecting for Health	Government department responsible for the implementation of the National Program for IT (NPfIT) that is working to produce systems that improve the experiences of patients at all stages of care.
Critical Care Paramedic (CCP)	See page 12
Depot	A large site where vehicles are cleaned, repaired and restocked.
Directory of Services (DoS)	An online system that provides up to date information on care providers, to support the use of alternative care pathways.
Emergency Care Assistant (ECA)	See page 12
Emergency Care Support Worker (ECSW)	See page 56
Emergency Dispatch Centre (EDC)	See page 11
Emergency Medical Support	See page 12
Foundation Trust	A trust which is part of the NHS, but has a significant amount of managerial and financial freedom. The introduction of Foundation Trusts represents a profound change in the history of the NHS and the way in which services are managed and provided. For more information please visit http://www.nhsconfed.org/ftn/
Front loaded model	A term relating to increasing the ratio of single response vehicles to double manned ambulances.

Healthcare Commission (HCC)	An independent government body that carries out reviews of NHS organisations and publishes reports about the quality of health services throughout England and Wales.
Hear and Treat	A term relating to the method of assessing and treating a patient over the phone.
Intraosseous device	A battery driven drill that allows ambulance clinicians to inject fluids or drugs into patients through the shin bone when the convential intravenous (injecting into a vein) is too difficult. This particularly happens in resuscitation or trauma situations and is usually carried out when the patient is unconscious.
Joint Partnership Forum	A group made up of Trust managers and recognised trade union / staff organisation representatives who meet to discuss, debate and ensure involvement of both staff and management in the development of policies that affect the workforce.
Knowledge and Skills Framework (KSF)	A key part of the NHS Agenda for Change pay system that applies to all staff employed on Agenda for Change terms and conditions. It describes the knowledge and skills staff need to apply to work in order to deliver high quality services.
Make Ready	A quality assurance vehicle and equipment preparation programme designed to minimise cross-infection and maximise patient safety.
Mobile Data Terminal (MDT)	A terminal placed in each vehicle to allow the location of the vehicle to be tracked, allowing them to be deployed effectively. These also enable crews to receive critical clinical information prior to arrival on scene.
Nolan principles	A set of seven principles set out, which are intended to apply to all public service organisations. These are selflessness, integrity, objectivity, accountability, openness, honesty and leadership.
Paramedic	See page 12
Paramedic Practitioner (PP)	See page 12
Patient Transport Service (PTS)	See page 13

Payment by Results (PbR)	An activity-based costing and payment system being rolled out throughout the NHS.
Protocol C	A local variation to the European Resuscitation Council guidelines for the resuscitation of cardiac arrest patients.
Prudential Borrowing Limit (PBL)	The maximum of borrowing including financial leases (and working capital) a Trust can have outstanding at anytime as per the Prudential Borrowing Code.
Reference Cost Index	A publication that provides information on financial data within the NHS.
Risk Register	A log that records risks to the organisation that have been identified, assessed and rated. This provides a framework for the ongoing monitoring of these risks.
See and Treat	A term relating to the method of assessing and treating a patient face to face.
Service Level Agreement (SLA)	An agreement between two NHS organisations, one who provides the funding (the commissioner) and the other who provides the service. These specify exactly what service will be provided, for what sum of money, and for how long.
Single Equalities Scheme	A single scheme that covers all aspects of diversity, in order to meet legislative responsibilities.
Single Response Vehicle (SRV)	See page 12
Support Tier Vehicle (STV)	See page 12
Technician	See page 12
Unit Hour	A fully equipped and staffed ambulance available for service, or in-plan, for one hour.
Unit Hour Utilisation (UHU)	This provides a measure of the actual use of a resource (a vehicle) calculated as a percentage of the total use of that resource.