Unified Recovery Plan
10.1 Current State ................................................................. 25

11. NHS 111 Performance Improvement ........................................ 30
   11.1 Current State ............................................................. 30
   11.2 Priorities ................................................................. 30
   11.3 Trajectory ................................................................. 32

12. Clinical Outcomes .............................................................. 34
   12.1 Current State ............................................................. 34
   12.2 Priorities ................................................................. 34

13. Financial Sustainability ....................................................... 35
   13.1 Current State ............................................................. 35
   13.2 Cost Improvement Programmes ................................. 36

14. CCG Matrix ............................................................................. 37
FIGURES

Figure 1 – National R1 Performance ................................................................. 10
Figure 2 – National R2 Performance ................................................................. 10
Figure 3 – Change in 999 demand over time ..................................................... 11
Figure 4 – Percentage See and Convey for R2 patients ....................................... 12
Figure 5 – Job Cycle Time for Red 2 See and Treat ............................................. 13
Figure 6 – Hours lost at hospital ..................................................................... 14
Figure 7 – Hours Lost as a result of handover delays ......................................... 14
Figure 8 – Average time to call answer from call connect (unvalidated) ............. 26
Figure 9 – Job Cycle Time for See and Treat ...................................................... 27
Figure 10 – Job Cycle Time for See and Convey ............................................... 27
Figure 11 – Example Performance Dashboard .................................................. 28
1. FOREWORD

The recent period for South East Coast Ambulance Service (SECAmb) has been one of significant challenge and change. The organisation has been independently scrutinised and found to be failing in a number of areas critical to ensuring adequate governance, patient safety and leadership.

This document gives a clear, honest assessment of the Trust’s shortcomings and governance failures, what has been done to recover to date, and sets out the Trust’s ambition to improve further. It is the document we will use to hold ourselves to account throughout 2016/17.

The environment in which we work is becoming increasing challenging. The growing and increasingly complex needs of the people we serve, changes in the way we are funded, and changing commissioning intentions will all affect our plans for development of our services.

Alongside these challenging demands are the needs, expectations and aspirations of our patients and local people. We are absolutely committed to being open and transparent in all that we do and to listening and acting on what local people tell us they want from our services.

To do this we recognise the need to change the organisational culture and clearly define responsibilities and accountabilities, starting at the top, with a review of the board function and executive team portfolios. As importantly, however, we must communicate and support this change throughout the organisation, building on the work already undertaken to develop operational units and local accountability whilst not inhibiting the freedom of our managers and staff to act locally in the best interests of patients and the community.

It is vital to engage and empower our workforce, and to promote the use of quality improvement methodologies in order to translate the renewed direction of the Trust into action at a local level. This will require belief and ownership among our whole workforce, and this in turn will require focus on leadership and followership in order to facilitate sustainable improvement.

This document also recognises the importance of partnership working, of working across organisational and professional boundaries to develop services that revolve around patient need. We will work closely with all of our partners in delivering both this plan and supporting system change through the Sustainability and Transformation Plans.

We have ambitious and radical plans to ensure we deliver high quality, sustainable services. We will address governance concerns to ensure that these plans are well led, well communicated and appropriately scrutinised. In doing so we aim to provide a safe
framework which will empower our clinical staff and genuinely integrate care around the individual.

In publishing this document we are signalling our commitment and that of the Board to ensuring we are a well-led, well-governed and successful Foundation Trust that gives every member of staff the opportunity and support to give their very best for our patients.

Geraint Davies
Acting Chief Executive

Sir Peter Dixon
Interim Chair
2. **EXECUTIVE SUMMARY**

South East Coast Ambulance Service like all healthcare providers is working in a challenging context. Activity for 999 services is increasing, up 7.3% in May as compared to 2015 and 5.6% above contracted levels which means that growth being seen is not fully funded. The rate of growth is increasing faster than staff can be recruited or vehicles purchased even if full funding for this growth were available.

The Trust has received external criticism in relation to governance and more recently has had challenging initial feedback from the CQC with a full report expected later this year. This has resulted in several changes at Board level and further work is now required to realign the Trust’s governance and culture. Governance and culture are both core objectives of this Unified Recovery Plan.

The Trust, as a core part of the urgent care system, has also seen external challenge as other providers have experienced difficulty as a result of activity increase and funding challenges. In particular handover delays at hospital and delays and closure of services on which NHS 111 relies have increased the workload of the Trust at a time when we are already challenged.

The combination of activity, internal governance challenges and external pressures have led to poor performance against operational performance target in both 999 and NHS 111. This plan and the accompanying action tracker aim to address performance challenges however it must be acknowledge that external and internal factors play a role in addressing this.

This pressure on staff at all levels has increased challenges in retention of staff and it is necessary to work closely with staff at all levels to clarify roles and responsibilities, provide support and seek ways of minimising the pressure for staff. It is essential that staff are engaged in this and the wider recovery process to ensure that both staff and patient needs are addressed.

This plan sets out the governance and programme management mechanisms being used to approach the work plan for the next year. It also sets out some specific context for each of the eight objectives the Trust has set for 2016/17 to help address the challenges being faced.

Further detail of actions, progress against these actions, action owners and associated risks and issues will be tracked in a separate document which will be regularly updated to reflect progress and challenges and will be shared with the public board and stakeholders each month.
3. **INTRODUCTION**

2015/16 has been the most challenging year for SECAmb since its formation. The Trust has failed to deliver its operational performance and provide evidence of its clinical effectiveness; has seen changes in its leadership following the publication of external reports into the governance of the RED 3 re-triage project and the way in which public access defibrillators were recorded at the scene of incidents; and has received negative national press which has resulted in reputational damage and a decline in staff morale. Morale has also been impacted by increasing demand and challenges relating to patient flow in local health economies, not least the delays in patient handover at many hospitals.

The annual plan for 2016/17 is therefore based on a small number of clearly-defined priorities which will ensure the organisation is focused on improving the delivery of the core services it provides and which will result in the best possible outcomes for the population served.

It is recognised that considerable work is needed to rebuild governance structures, accountability and culture, and that for any other actions to be effectively delivered, audited and monitored, this review of systems and processes is required. Whilst we recognise that this will be frustrating for some stakeholders it is essential that changes are built upon a solid foundation, however we also recognise the need for change to happen at pace.

One of the key values of SECAmb is putting the patient at the centre of everything we do, and the rectification must focus on the patient and their interface with our workforce, as it is here where we demonstrate our capability and potential. Ownership, leadership and shared purpose will help us rebuild focus on the needs of our population.

Whilst 2016/17 will be a year of rectification, consolidation and rebuilding internally, SECAmb continues to work with the local and national health system to deliver its long-term strategy which aligns with the Five-Year Forward View. This includes participation in four Sustainability and Transformation Plans across the region.

3.1 **APPROACH**

This document sets out the context, both to inform stakeholders and to provide a clear single narrative from which the Trust can understand and respond to the challenges presented. It sets out the Unified Plan approach being taken, the governance for this and the key risks identified.

It highlights the key stakeholders and our high level plans for consulting and informing stakeholders with regard to our priorities. The document covers our priorities for the year and outlines our enabling strategic projects. It then sets out the current state, priorities, milestones, trajectory and success criteria for the Trust’s 2016/17 priorities.
4. CONTEXT

The Trust has recently been through a number of reviews in relation to governance and it is as result of these and the challenging performance position that the Unified Recovery Plan has been developed. The plan aims to bring together the requirements of a number of stakeholders and to ensure that delivery of the plan is clearly governed by the emerging governance structure of the unified board whilst providing sufficient assurance to regulators, commissioners and stakeholders.

Most importantly, patient safety and experience drives the objectives for 2016/17, strongly supported by ensuring the Trust has a culture which supports staff to provide excellent care and to raise concerns that are followed up and learned from to improve performance, safety and staff welfare.

4.1 GOVERNANCE CONTEXT

It is recognised by the Trust that following the Deloitte Report and action by NHS Improvement (NHSI) there is much work still to do with regard to governance, both structurally and to reassure stakeholders that effective actions and cultural change has occurred.

Feedback from the last NHSI Progress Review Meeting highlighted a number of outstanding actions which will be incorporated into the Governance and Culture workstreams, set out below. It also highlighted the need for the Trust to clearly articulate that it had accurately diagnosed the causes of poor performance. This document seeks to address this question.

It has been agreed with NHSI that the previously proposed Governance Review, required as part of the regulatory undertaking, will be deferred as another review of governance is unlikely to add value at this stage. This review will be conducted in the future to ensure that new governance processes being developed by the Trust as part of this plan have been embedded and are working effectively.

Specific governance concerns raised by commissioners and external reports will be addressed within the detailed recovery actions being developed, some of which relate to operational performance, some to clinical performance, and some to governance and culture.

4.2 RESOURCE CONTEXT

Core to delivering operational performance, ensuring high standards of patient care and supporting staff is having sufficient resources, primarily staff and vehicles, in the right place at the right time, with the right skills for both 999 and 111. Through a combination of financial, workforce and external competing demands this is an area of significant challenge which underpins the current Trust position.
4.2.1 OPERATING PLAN
The Operating Plan has been designed to deliver a surplus of £0.7M in line with the Control Surplus total that NHSI had put forward as part of the Sustainability and Transformation Fund (STF) process. Despite the fact that the STF funding element has been removed, clarified as not flowing to ambulance NHS trusts by NHSI, the intention is to continue to deliver a surplus of £0.7m for the financial year. (This is predicated on the system leadership in the local health economy also delivering improvement.)

This challenging plan assumes any fines for 2016/17 are reinvested back into SECAmb, as part of the Unified Recovery Plan agreed with commissioners. A £0.7m surplus cannot be achieved whilst delivering a safe and sustainable service without this. In addition and due to the lack of clarity around the STF rules, since submission of the plans, it has become apparent that the acute hospitals that sign up and agree to the financial and operational control totals are not able to be fined if these are achieved. Unfortunately handover delays have not been uniformly included in the operational targets for acute Trusts and we are concerned that even with the best intentions, CCGs will be unable to enforce an improvement in this area, and in fact the situation could worsen. The Trust and CCGs continue to work together to improve the handover situation but with the incentives for acute trusts to hit their targets being linked to significant funding via the STF this will be very challenging.

4.2.2 IMPACT OF AMBULANCE QUALITY INDICATOR CHANGES
SECAmb had expected ambulance services to be outside of the fines regime for 2016/17 as NHSI had set a financial control total and because all ambulance services have been impacted by national changes to the Ambulance Quality Indicators. These changes alter the way in which performance is measured meaning that the same operational delivery now results in lower reported performance. We estimate that the impact is in the region of:

- 1.4% for Red 1
- 5.5% for Red 2
- 1.5% for Red 19

There has been no recognition of this national change in the expected performance in ambulance service contracts, or funding to provide the additional staff and vehicle hours which would be needed to close this gap for ambulance trusts outside of the Ambulance Response Programme (which is allowing some trusts to pilot less operationally-challenging response time targets for some call categories). SECAmb is not part of these revised targets and so the impact on performance is either reflected as such or requires additional funding to cover the cost of the extra resources required to hit the 75% targets – assuming the resources are available.

4.2.3 FINANCIAL SUSTAINABILITY
It is essential that the Trust is sustainable now and also in the long term. The plan is built to ensure that the working capital balance is above £10m throughout the year and
to ensure support for the Capital Investment Programme which is essential to maintain the Trust’s estate, fleet and IT. Further details on the estate plans for 2016/17 are included in the below sections on Enabling Strategic Projects.

In 2016/17 the fleet replacement strategy will involve refreshing double crewed ambulances and single response vehicles in order to remove the older vehicles, which cost more to maintain, from the fleet portfolio. To support the new fleet the Clinical Equipment Strategy is being refreshed to align with the vehicle replacement strategy.

In 2016/17 we plan to roll out the introduction of telematics software into 999 vehicle fleet. This will support the continued focus on driver safety and experience for patients whilst being transported. Job cycle time management is also seen as a valuable feature of the telematics software and supports the continued drive for the most efficient use of resources.

4.2.4 WORKFORCE
SECAmb’s workforce plans are the largest element of the Trust’s financial spend. Patient-facing staff, including those in the NHS 111 and 999 contact centres, account for more than 85% of the total workforce.

SECAmb, as with all ambulance services nationally, has a number of workforce challenges. The positive developments in paramedic education and development of the profession in response to key reports, such as The PEEP Report\(^1\), has necessitated paramedic education becoming entirely higher-education based, and the impact of supplying graduates is still being felt by trusts. The increasing recognition of the growing paramedic skill set has made them sought after across acute, urgent and primary care. In combination with ever-increasing demand this makes the recruitment of paramedics challenging for all trusts.

The Trust has developed international recruitment and in-house development through the introduction of the associate practitioner route to paramedic education, and development for existing paramedics to support retention. Despite these successes and the national view of SECAmb as innovative and supportive by graduates, recruitment is not able to fully meet operational demand.

SECAmb is expected, by the system, to absorb large losses of staff and vehicle time, both financially and operationally, as a result of hospital handover, covered in more depth below. SECAmb is also looked to as a system leader in times of crisis, playing a key part in day to day system management with extensive time spent at bed meetings, and negotiating hospital handover, as well as providing extensive support during industrial action and local incidents such as the Medway diverts in September 2015.

\(^1\) Paramedic Evidenced Based Education Project -
The Trust addresses these gaps through the use of sub-contracted capacity, private providers akin to agency staffing but with their own vehicles. Operating Plan sensitivities include a c10% shortfall (by financial year-end) in permanent staff resource versus operational modelling. As such the financial plans include a budget of £15m in the financial year 2016/17 for these independent sector resources. The Trust has contractual framework agreements with these providers and strong governance requirements in relation to vehicles, equipment and staff training. It is however recognised that no matter how strong this governance is, a transient workforce will always be more challenging to performance manage and ensure consistent use of changing external pathways and internal processes.

In addition to the challenge with clinical workforce, SECAmb has competing external demands on its management team. The Trust operates a relatively small management team in line with its turnover of £205m which is significantly less than most acute hospitals. Unlike an acute hospital the large geographic span of SECAmb means that it is required to engage with 22 CCGs, 12 System Resilience Groups and 4 Sustainability and Transformation Plans. Significant management time is required to meet these demands and expectations which are disproportionate to the size of the Trust and its management team when compared to other NHS providers.

The most significant risk associated with the workforce is the move to a new HQ/Emergency Operations Centre (EOC). Recruiting targets for EOC are already far higher than desired (due to very high levels of staff turnover), which provides some mitigation for losses due to relocation. There is provision within the Trust’s plans for associated redundancies but the detailed work on who this will impact is yet to be concluded.

4.2.5 AGENCY CAP
SECAmb must meet an agency control total for 2016/17 of £4m, approximately 3.1% of the total pay bill. Whilst this cap supports financial sustainability it will provide a challenge in ensuring the Trust has sufficient short-term resource and expertise to deliver on some areas of the recovery plan.

SECAmb is already reviewing all agency spend prior to the cap coming into force for ambulance trusts on 1 July 2016. This will limit agency spend, excluding that for private ambulance providers on which the Trust has strong frameworks and competitive pricing already in place, to 55% above basic pay and a total of £4m for the year.

4.2.6 NATIONAL CHANGES
The positive net inflator to the Ambulance Tariff is more than offset by the impact of National Insurance Contribution legislation changes in respect of pension contributions, and an increase in the Clinical Negligence Scheme for Trusts costs, which for SECAmb is c.55%. This is a significant increase for all ambulance trusts when compared to the 33% inflation assumption set out by NHSI and is an unfunded cost pressure to SECAmb.
The financial plan has balanced these off against an increased level of efficiency savings.

There are outstanding national questions with regard to paramedic job evaluation and pay banding as promised by the Secretary of State in January 2015, on which unions are assessing the appetite for industrial action. There is also an outstanding question nationally on the future funding of Hazardous Area Response Teams (HART), particularly vehicle replacement.

The impact of changes via the Ambulance Response Programme and when this may be rolled out to further Trusts are unknown at this time but further roll out is expected within this financial year.

4.3 CONTRACTUAL CONTEXT

4.3.1 CAPACITY REVIEW
In 2014 a capacity review jointly funded by SECAmb and commissioners found that SECAmb had a funding shortfall of £5.71m which has not been addressed. Since this review, activity growth from commissioners has not kept pace with actual activity growth, placing a reliance on the 65% marginal rate.

Whilst SECAmb has made progress on some of the efficiency recommendations in the report, such as moving from a technician (Band 4) to an Emergency Care Support Worker (Band 3) workforce and reducing conveyances, the lack of funding has made other recommendations challenging to achieve. Many of the schemes were reliant upon replacement of private providers with employed staff, which requires guaranteed growth in income over a number of years.

4.3.2 CONTRACTED ACTIVITY
Commissioners across the three contracts offered SECAmb £174.6m in March 2016 based on a variety of outturn months. SECAmb issued three proposals as below:

- Outturn at M10 using commissioners growth assumptions - £175.3m
- Outturn at M12 using commissioners growth assumptions – £177.1m
- Outturn at M12 using the Trusts growth assumption - £179.7m

The final agreed contract position was £175.3m for which commissions expect to see the following performance:

- RED 1: 75% for Q4 of 2016/17.
- RED 2: 70% by the end of March 2017.
- RED 19: 95% by the end of March 2017.

The remaining gap between the commissioned levels and the national performance targets are due to the structural deficiencies within the local health economy, such as handover times and lack of alternative referral pathways as well as the gap presented by changes to AQIs. The cost of the additional resources to cover these gaps in order
to deliver the national performance targets is estimated to be at least £7 million. Commissioners are unable to fund this.

### 4.4 National Performance Context

Nationally all ambulance trusts have seen a challenging period for performance, as demonstrated below by the national R1 performance by week.

![Figure 1 – National R1 Performance](image1)

The introduction of the Ambulance Response Programme (ARP) now makes it difficult to directly compare all ambulance trusts, as those within the ARP have longer to respond to R2 calls. The graph, below, gives an indication of the national challenge with regard to R2 performance.

![Figure 2 – National R2 Performance](image2)
4.5 SYSTEM AND DEMAND CONTEXT

Activity has been increasing month on month, with significant spikes outside of control limits in December 2014 and March 2016 as shown below. These extreme peaks in demand are not able to be managed through existing escalation mechanisms and capacity.

Much of this demand is non-emergency, making it challenging to balance the needs of primary or urgent care patients with those who require emergency response.

Processes have not kept pace with technology in some circumstances. For example, nationally-determined questions when you call 999 are still designed to confirm a location before determining clinical need, despite the fact that we are able to automatically locate most callers. This can waste vital seconds in responding to a cardiac arrest.

The Trust has had significant success in reducing conveyance to hospital, which supports the national and local drive to care for more people appropriately out of hospital and supports commissioners by reducing care costs as shown in Figure 4.
This continued safe reduction in conveyance is driven by the development of staff, which requires investment and backfill of staff for education. Unfortunately whilst this conveyance reduction supports cost saving for the system, the current contractual mechanisms do not support return of any of these savings to SECamb, who incur additional costs as job cycle times for see and treat, which have increased substantially as shown in Figure 5. Whilst these are in part internal productivity challenges which are addressed in section 9, we know that referrals to other providers, particularly Out of Hours services, have become much more time-consuming over recent months.
Since July 2015 SECAmb has seen delays to hospital handover increase significantly, with almost 46,000 ambulance hours - in the region of 90,000 staff hours - lost in 2015/16. Figure 6 highlights that almost 7,000 hours of ambulance time was lost in March 2016 alone.

This only accounts for clinical time and not management time spent attending acute trusts or on conference calls resolving issues. Conservatively, the clinical time alone accounts for in the region of £1.84m of unfunded expenditure.
The vast majority of these hours are lost between arrival and handover of the patient to the hospital, as set out in Figure 7. Please note that this data also includes hours lost at out-of-region-hospitals.

Figure 6 – Hours lost at hospital

Figure 7 – Hours Lost as a result of handover delays
4.6 **Risk Context**

SECamb, as with other ambulance services, operates in a high-risk context. The Trust is commissioned and therefore funded to a level which allows us to only reach three in four patients in cardiac arrest within eight minutes, but which ethically drives us to attempt to over-perform against the contractually funded expectation. Whilst it is contractually and therefore culturally accepted that one in four patients in cardiac arrest is unlikely to receive a timely response, it increases the challenge for staff to recognise and highlight incidents where a process issue may have adversely impacted on patient care and report this as being outside of the norm.

Decisions are made on a second by second basis in the control room with geographically dispersed resources and high levels of resource either waiting to handover at hospitals or engaged in what may be lower priority incidents. In a hospital context staff would leave the patient they were with to attend a cardiac arrest call without hesitation knowing that other staff could attend to the patient they had been with. More often than not we have a single resource with a patient and have not been in a position where we have been able to leave a patient to respond to a higher priority patient.

Commissioners recently requested that any patient waiting for handover for longer than 45 minutes should be declared as a Serious Incident. Whilst we accept that this delay in handover does represent a serious patient safety issue and should ideally be raised as a serious incident, there were over 16,000 such incidents in 2015/16.

This places the Trust in a context with a high risk tolerance. This does not mean that there are not governance or risk management challenges to address but makes it more important for the Trust to have strong systems and processes in place. It is also important, however, for external stakeholders to be honestly appraised of this risk context, which is significantly different from many other NHS settings, so that they can better understand the perspective of ambulance service staff and managers who will be used to seeing and managing much higher levels of risk on a daily basis than many external partners or stakeholders.
5. **UNIFIED PLAN APPROACH**

Following the challenging period described earlier, the Trust is focused on ensuring that it delivers its core services. This is the one truth that runs through the organisation and forms the basis of the Operating Plan Narrative submitted to the regulators and the recovery plan. The Trust has eight clearly-defined priorities and enabling strategic projects for 2016/17.

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<td>3a</td>
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<td>Clinical Outcomes</td>
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<td>Enabling Strategic Projects</td>
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<td></td>
<td>8</td>
<td>Electronic Patient Clinical Record (ePCR) Deployment</td>
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### 5.1 FORMAT OF THE PLAN

The Unified Recovery Plan sets out the high level summary for each of these areas and the overarching governance, as each of the eight priorities and enabling strategic projects is managed through a detailed local plan.

Development of the plan has followed the “Define, Measure, Analyse, Improve, Control” (DMAIC) approach, with most areas now in the measurement or analysis phase with a number of immediate improvement actions already underway. The ‘Current State’ sections below set out the current progress of the measurement and analysis, as well as the immediate improvements already underway for the priority areas.
5.2 **CONTINUOUS DEVELOPMENT**

Use of the iterative DMAIC approach means that planning is iterative with analysis used to determine the most appropriate next steps.

5.3 **CAPACITY TO DELIVER**

The Trust recognises that capacity is required to deliver this plan and has formed a project management office (PMO) to support delivery of the plan and the collation of reporting and assurance. The Trust will also be realigning current capacity or increasing capacity in the following areas immediately:

- Project management
- Service Improvement
- Data analysis
- Clinical Audit
- Additional internal audit

Further review of organisational development and quality and patient safety functions is also underway to ensure both have sufficient capacity and appropriate expertise.

5.4 **GOVERNANCE AND RISK MANAGEMENT OF UNIFIED RECOVERY PLAN**

As set out in section 7, the wider Trust governance and approach to risk management is under significant review. The governance and risk management of the Unified Recovery Plan and underlying project plans is therefore subject to change as the new structures and processes are agreed.

Section 6 sets out the key responsibilities and section 7 sets out the emerging governance structures within the Trust. Responsibility for delivery of each area will be led by a named Executive Director, as set out in the accompanying action tracker.

5.5 **MONITORING**

The Unified Recovery Plan and the underlying detailed plans will be monitored by the Executive on a monthly basis with assurance provided to the Board by both the Executive and through monitoring of progress by a quarterly internal audit. In addition, monthly updates will be provided to all key stakeholders through a progress report.

5.6 **LEARNING FROM BEST PRACTICE**

In additional to ensuring we capture and share internal examples of good practice, we will use national best practice and peer review, working closely with the Association of Ambulance Chief Executives (AACE), the College of Paramedics, Royal Colleges, academic partners and relevant expert national groups. Buddying arrangement have been agreed with South Central Ambulance Service and input from a number of other high performing NHS trusts is being sought.
6. **EXTERNAL STAKEHOLDERS**

It is recognised that the current Trust position means that there are a number of interested stakeholders: regulators, commissioners and other groups which need to be consulted and informed of progress against key areas of the plan. The below Responsible Accountable Consulted Informed (RACI) matrix sets out the current view of those who are accountable and responsible for the high level areas of the plan, along with those who need to be consulted and informed for each of the eight areas. This will be subject to comments and more detailed review for each of the eight constituent areas of work.

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<thead>
<tr>
<th></th>
<th>NHS Improvement</th>
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* Delegated responsibility as appropriate for specific aspects of delivery
7. ENABLING STRATEGIC PROJECTS

In order to successfully deliver the Trust’s priorities, three strategic change projects will be delivered this year which will enable the embedding of cultural and performance changes.

7.1 ROLLOUT OF OPERATING UNITS

For some time the Trust has been replacing ambulance stations with a mix of Make Ready Centres and Ambulance Community Response Posts. This move has required an element of centralisation for staff. To support this, three further Make Ready Centres will be delivered in 2016/17; Gatwick, which opened recently, and Tangmere and Polegate, due to open this year.

Delivery of local performance requires strong local management with clearly-defined responsibility for delivery, clear lines of accountability and ownership of challenges by all staff. This requires both clear delegation and provision of appropriate support to management teams through realignment of local and central support functions.

In 2015/16 the Trust realigned the Band 8 structure and introduced a number of associate director posts to begin this transformation. The Trust is currently consulting on a review of Band 6 and Band 7 posts in operations as the next step in this process.

7.2 MOVE TO NEW EOC AND HQ

To support the provision of more consistent central support functions and to replace estate which is no longer fit for purpose the Trust will be moving to a new regional HQ and EOC in Crawley in early 2017. This will replace the three current offices and the Banstead and Lewes EOCs, with Coxheath EOC being retained until an alternative site can be found in Kent for the new EOC East.

This centralisation will provide greater collaboration for central support functions, as well as for EOC which will be run as a single service across two sites.

7.3 ELECTRONIC PATIENT CLINICAL RECORD (ePCR) DEPLOYMENT

Deployment of both staff issue iPads and ePCR remains a priority for 2016/17. This deployment will deliver a number of immediate benefits and put in place the foundations for a number of further developments in the future:

- Access to all policies, procedures and guidance to staff
- Online access to Trust systems, such as GRS for rosters and Datix for incident and safeguarding reporting, for remotely-based clinical staff
- Use of NHS Number aligned to ePCR
- Electronic sharing of and access to care records
- Collection of more detailed and accurate patient data to support audit and performance improvement
The Intelligence-Based Information System (IBIS), which is partially funded by the CCGs, continues to be developed as a way to manage patients with long-term conditions and frequent users of the 999 service. IBIS also promotes optimised outcomes for patients with advance care plans, and facilitates access to specialist advice and referrals for patients.
8. GOVERNANCE

It is clearly recognised by the board that changes in organisational leadership, governance and culture are required. Whilst that work has begun with a number of new senior appointments and a first board development day, there is a significant amount of work to do in this area.

8.1 TRUST LEADERSHIP

8.1.1 UNITARY BOARD
Following a board workshop in late April it has been agreed to restructure board committees to support the board to function in a more unitary way. With immediate effect the Executive are meeting monthly with the Senior Management Team and are having a monthly focus session on risk in addition to their weekly meetings.

<table>
<thead>
<tr>
<th>All directors acting collectively</th>
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</thead>
<tbody>
<tr>
<td>Establish and communicate the values and behaviours underpinning organisational culture.</td>
</tr>
<tr>
<td>Determine the organisation strategy from amongst options provided / recommended by the Executive.</td>
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<tr>
<td>Allocate resources using budgets.</td>
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<tr>
<td>Hold the Executive to account, exercising constructive challenge.</td>
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<table>
<thead>
<tr>
<th>Executives / Executive Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish the operational controls by which organisational objectives are met.</td>
</tr>
<tr>
<td>Hold management to account.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>NEDs / Non-executive led Assurance Committees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using a risk based approach, acquire and scrutinise assurances that the system of internal controls is well designed and operating effectively, thereby gaining confidence that objectives will be met.</td>
</tr>
</tbody>
</table>

These principles were adopted at the May Board. With immediate effect the Executive are meeting monthly with the Senior Management Team to improve communication and the focus on eight clear objectives. In addition, the Executive has started to meet monthly as a Risk Practice Group to establish greater control over the risk agenda.

8.1.2 EXECUTIVE PORTFOLIOS
A meeting of the Appointment and Remuneration Committee has endorsed a restructure of Executive Director Portfolios and development of new job descriptions. Further updates on structure and portfolios will be shared with stakeholders in due course. The changes in portfolio are expected to fully address the concerns raised in the Deloitte Report with regard to accountability and clarity of role, particularly for the clinical executives.

Following the appointment of an interim chair there have already been a number of changes to post holders and the Executive Team is currently as follows:
8.1.3 **Senior Management Team**
To support new structures and accountabilities a formal monthly senior management team will meet to focus on delivery. In addition the wider management team will meet for regular briefings on a monthly basis initially then quarterly.

8.1.4 **Risk Management**
The approach to Risk Management will be led by the Executive, through a monthly Risk Practice Group. This group will develop new ways of working and will allow disseminate of best practice through all directorates, working groups and programme boards.

8.1.5 **Working Group Stock Take**
Following realignment of board committee remits, in line with CQC domains and Well-Led guidance in June the Trust working groups will be realigned during July.

8.1.6 **Project and Initiatives Governance**
The new PMO will lead on the review and management of projects and initiatives, ensuring a single point of focus within the Trust and alignment between initiatives and both internal and external strategy. The PMO will lead the process seeking input from technical, clinical and quality improvement specialists and sign off from the Executive. The PMO processes will be designed to provide support to delivery of local quality improvement initiatives.

8.1.7 **Policies and Procedures**
The Trust recognises that it has a number of out of date policies and procedures and is taking action to both rectify this and put in place appropriate control systems to prevent recurrence of this issue in the future.

8.1.8 **Complaints, Litigation, Incidents and Safeguarding**
A unified approach to triangulating and learning from complaints, litigation, incidents and safeguarding is being developed. Reporting of these has been combined for the first time and alignment of structures, systems and processes is planned to further align these areas.
8.1.9 **Areas of Specific Commissioner Assurance**
Following on-going review of initiatives and governance arrangements commissioners have sought further assurance on the following areas, which will be incorporated into the deliverables for the governance workstream:

- Private Amb Providers
- Back Up Times
- Public Access Defibs
- Auto on Scene
- Running Calls

8.2 **Integrating CQC Feedback**
SECAmb recently underwent its first CQC visit under the new inspection regime following the previous inspection in 2013. Initial feedback has been incorporated into the action tracker and further details will be added as feedback is received.
9. Culture

To support changes in governance, cultural change is also necessary. It is important that the organisational culture is open, transparent and just. For a just culture to develop clear accountability and responsibilities must be in place along with clear policies and procedures supported by directorate, team and personal objectives.

A large number of actions are included in the action tracker, two of which are mentioned below as examples.

9.1 Safety Culture Audits

The medical director will be leading a series of patient safety culture audits, seeking to clarify with staff and volunteers at each operational unit level and in NHS 111 the current culture and actual or perceived blockages to patient safety and raising concerns with regard to patient safety, incidents and safeguarding. This will support identification of local good practice and perceived and actual blocks which can be built into the revision of processes in the governance workstream.

Linked to promoting a reporting culture, the Trust will continue to develop the Clinical Risk Panel which will provide a forum for triangulation and invite staff to make reports in order to enhance the other Trust systems, such as DATIX. This is particularly vital where no incident has occurred but a potential is seen. These opportunities to report help underpin the need to give staff more ownership and power to resolve issues they see as important to the safety of their patients.

9.2 Operational Unit Restructure

The ongoing operational unit restructure will provide further clarity and support to devolved management of operational performance, overseen by the new Interim Director of Operations. This work crosses the operational performance and roll out of operational units projects but is an important underpinning factor in developing clear accountability and culture.
10. 999 PERFORMANCE IMPROVEMENT

The Trust has developed a series of immediate actions, being deployed over the next few weeks as well as a longer term plan supported by externally commissioned analysis and support in implementing improvement methods.

The immediate action plan will address areas around the following pressure points that are adversely impacting on the Trusts’ ability to deliver the Recovery Plan:

1. Activity:- 999 activity was 7.3% higher than May 2015, which is 5.6% higher than the agreed contracted level for the month. This signals a risk to performance in the year as the commissioner expectation was for a much lower growth.
2. Hospital Turnaround: - increased in May to almost 5,000 hours lost, and remains above the agreed levels required to deliver the performance trajectory by well over 1000 hours.
3. Recruitment: - trajectory for the Trust has continued in May to be behind the Trusts trajectory and is only at 40% against plan.
4. Call Answer: - In May the Trust received 10% more 999 calls than expected. This, coupled with 15% EMA vacancies, resulted in a call answer performance that was less than 75% in 5 seconds
5. Abstraction: - combined with the current vacancy levels is impacting on the number of staff available to plan into frontline shifts. Abstraction for training was high in the early part of the year to ensure 80% compliance for key skills by the end of July.

To address the above and in addition to the immediate operations action plan, the Trust has commissioned Lightfoot to further develop SECAmb's understanding of the key factors influencing its 999 activity and performance. A report is expected early July which will support the recovery plan.

The Trust is continuing to work with Acute providers regarding hospital turn-around delays. The Trust also continues to raise awareness of the issue, and its priority, through a variety of stakeholders and mediums including engagement with system resilience groups, at the Urgent & Emergency Care Networks, Healthwatch regional forums and with Local Authority Health Scrutiny Committees

10.1 CURRENT STATE

At present call answer time is significantly above average through a combination of staff shortages and the impact of response delays meaning that staff are on the phone longer. Despite recruitment to manage the challenges seen from June 2015 onwards showing some improvement from September this improvement reversed between January and March, with April again showing signs of improvement.
Job cycle time has been increasing for both conveyed and non-conveyed incidents since January 2013. Despite a slower rate of growth during most of 2015, figures Figure 9 and Figure 10 show a significant increase again through winter 2015/16.

It is recognised that a combination of internal and external action is required. For example a recent review of policies highlights that for non-conveyed patients 2 full sets of patient observations are required with 15 minutes between each set of observations. For some patients a second set of observations adds little clinical value and may be unnecessarily increasing job cycle time for see and treat. A review of policies and procedures and a risk based approach to reviewing these is therefore required.
3.16a. Cycle time (clear at scene) : (By Month(Jan))

Data Updated: 2016-05-03 09:30:24

Figure 9 – Job Cycle Time for See and Treat

3.16b. Cycle time (clear at hospital) : (By Month(Jan))

Data Updated: 2016-05-03 09:30:24

Figure 10 – Job Cycle Time for See and Convey
Figure 11 – Example Performance Dashboard
The Trust is using data provided by Lightfoot to provide further detailed analysis of problems by CCG, hospital and operating unit to determine the specific areas of focus for internal efficiency improvements as well as to highlight areas for which support will be needed from commissioners. Figure 11 shows an example of one of the many performance dashboards which gives immediate analysis of where in the call cycle delays are occurring.

10.1.1 IMPACT OF HANDOVER DELAYS

Hospital handover and the hours lost as a result of handover delays are one such area and the analysis from Lightfoot has highlighted that after R1 calls, for which we would expect a prolonged handover for clinical and staff welfare reasons, the longest handovers are for HCP calls.

It is known that processes in many localities for HCP calls are poor with inconsistent referral from HCPs to consultants and inconsistent acceptance of referrals in admission units with ambulance crews often moving patient back and forth between clinical areas before the patient is accepted by the hospital.

In addition to the commitment of commissioners to limit hours lost to handover to 3,450 hours per month, already breached by over 1,000 hours in April and May, this is an area in which tangible action could be taken. This is an area in which commissioners and NHS England as commissioners of primary care could support development of a standard for urgent patient referrals from primary care – handover of care being one of the highest risk care processes – to both improve patient safety and support reduction of lost ambulance hours.
11. NHS 111 PERFORMANCE IMPROVEMENT

11.1 CURRENT STATE
A comprehensive action plan was put in place in Q3 to address KMSS 111’s deterioration in its operational SLA performance. This was submitted to and accepted by Commissioners in August 2015 and has subsequently been tracked via regular meetings and conference calls.

There were many benefits and learnings from this action plan and there was tangible improvement with some good practices now embedded within the service. However it is acknowledged that for a variety of reasons this progress was too slow and the service has not attained a level of operational resilience to fully overcome the recent surge in call demand that has been seen nationally, which has adversely impacted so many NHS 111 providers including KMSS 111.

11.2 PRIORITIES
The plan is comprised of five areas of focus; recruitment, retention, operational (tactical) issues, strategy and external engagement/communication.

RECRUITMENT: A step change is required in recruiting not only enough trainee HA’s to meet service requirements but also of the appropriate quality. Subsequently a drive to recruit above substantive requirements is necessary to provide enough service resilience. Because of the nature of the national measures within NHS 111 services (i.e. calls answered within 60 seconds), a small deficit in actual required Health Advisor rota requirements can result in a significant “drop-off” in actual SLA performance. Because of the different way that the two organisations recruit potential HA’s, the plan indicates a differentiation in terms of measurement of progress. There is also a key document supporting both recruitment and retention which is populated on both a site-specific and overall service basis. Although the service is predicting that the available HA’s will exceed the capacity requirement by July, there is a three month lag time to enable HA’s to become fully proficient and this is reflected in the SLA performance indicated.

RETENTION: Although there has been a significant amount of recruitment over the past nine months, this has been negated by the issue of staff turnover. Having liaised with several other NHS 111 providers of a similar size, the current HA attrition rate in KMSS 111 is not a significant outlier. However the challenge of operating a service under pressure (especially at weekends) has resulted in a continual cycle of recruitment/attrition which needs to stop. The actions that are presented in the plan address some the factors creating this problem and although they will not totally stop the challenge of high staff turnover (always an issue in call centre environments), an improvement will have benefits that are manifest across all measures including operational performance. Some of the actions are relatively “quick wins” whereas as some others will take no longer to implement and longer still to experience the benefits.
However by focusing on the issue of retention, the service should be able to improve the service culture and importantly the well-being of our colleagues.

**Operational (Tactical) Issues:** Recruiting enough HA’s and retaining them effectively will not address the challenge of delivering an effective level of performance. These staff need to be performing at the required standard and also populate rotas that truly meet the needs of service users. To this end actions are in place to improve individual HA performance and this accounts for a recent spike in staff leaving the business for a variety of performance and attendance related reasons. KMSS 111 is committed to improving quality and maintaining patient safety and creating a more robust and resilient operating platform. The aspiration is to very much share best practice across both Contact Centres and this should result a sustained level of good operational performance.

**Strategy:** KMSS 111 needs to have a clear pathway mapped out in terms of strategic focus. It is a unique service (NHS Trust/Private entity providers) and as such, cannot operate in the same way as other NHS 111 service providers. By giving clarity to an agreed way of working going forwards, the service should be able to harness opportunities and potential. This is exemplified most obviously with the introduction of a workforce structure which provides a clear pathway for colleagues to develop and progress within both organisations. By also reducing the number of temporary appointments/secondments and appointing permanent staff to key positions, this will bring stability and assurance, both internally and externally.

**External Engagement/Communication:** The full service recovery of achieving the contractually required SLA and abandoned call rate targets is predicated on the external factors that have a profound adverse impact on the KMSS 111 service being addressed and resolved. Whereas the service acknowledges its contractual obligations to provide full staff rotas of the appropriate standard; with suitable leadership; delivering an acceptable level of performance and quality; it cannot be expected to overstaff and compensate for the deficiencies demonstrated by other service providers. This applies in particular to weekends when the KMSS 111 service experiences significant challenges created by the inadequate service provision from some GP OOH’s services. KMSS 111 will continue to work closely with Commissioners and other service providers and endeavour to provide a more “joined-up” and coherent urgent care network across the region.

No one single element of the plan can deliver the outputs required to achieve an acceptable and sustained SLA. All five elements must be delivered to achieve full service recovery.

It would be anticipated that this plan and the subsequent measures will be reviewed regularly and whereas this overarching plan (many sub-plans i.e. recruitment, retention, AHT etc. feed in to this plan) is not an absolute solution to the operational challenges that KMSS 111 is experiencing, it remains very much a working document which will
include future learns and ideas to not only improve the service levels but also maintain these during times of operational pressure.

11.3 Trajectory

Monthly trajectories for NHS 111 have been agreed in principle with commissioners though further work is now required to fully define and understand the impact of external factors on these. It is accepted by commissioners that in order to achieve agreed trajectories work is required to ensure a successful transfer of the East Kent contract to PrimeCare and mitigation of call back following out of hours provider capacity challenges.

The milestone measures that have been included in the tracker as part of this plan comprise; SLA, abandoned call rate, combined clinical KPI and the planned HA headcount (actual vs. required) rate.

SLA: The trajectory for this measure is that it will improve gradually during the first half of 2016/17 and reach an SLA of 90% (amber RAG status) for the month of October. Part of the reason for this is that given our previous experience and learns from other similarly challenged NHS 111 providers, an immediate step change is both unachievable (logistical challenges regarding recruitment, training, NHS Pathways requirements) and unsustainable (with respect to quality assurance). We anticipate that the service will experience a dip in service level when the winter pressures arrive (November – January) however the SLA indicated is consistent with the average national performance looking at previous years. It is planned for full SLA recovery to be achieved and sustained from February 2017 onwards. The additional factor which is hard to plan for is the impact of the exit of the East Kent CCG cluster from the current contract from October onwards. At this stage this trajectory is based on the assumption that the new East Kent contract will “go-live” as per the current CCG indicated time line.

Abandoned Call Rate: This measure is currently moving in the correct direction and is planned to reach the contractual target of less than 5% by November. Despite a minor increase to compensate for December, post Xmas KMSS 111 should achieve the contractual target and maintain this level of performance. The additional resource in place and the better rota fit should provide the resilience required to achieve this goal.

Combined Clinical Performance: This is a combination of the measures of an immediate warm transfer to a clinician and/or a clinician call-back within ten minutes. KMSS 111 very much leads the way nationally (for large NHS 111 services) with regards to this measure and although the Commissioned target is 90% (almost no NHS 111 service regularly achieves this), the trajectory indicated in the tracker (70-80%) would represent a service performance within the upper quartile of national NHS 111 performance over the past three years. The reason why the service does not intend aiming for a higher level of combined clinical performance is that the aim will be to maintain wider system resilience by utilising to support HA’s, especially with regards to 999 referrals.
**PLANNED HA HEADCOUNT (ACTUAL VS. REQUIRED) RATE:** This is a complex measure which factors in the long term predicted call forecast along with the HA requirement to achieve an SLA of 95%. It is calculated utilising measures such as Average Handling Time (AHT) across fifteen minute intervals but does not take into account actual HA capability i.e. this is why although the actual HA headcount may exceed the capacity requirements, the HA proficiency is not factored in and so SLA does not improve immediately. This explains the delay in this measure (along with rota inefficiencies) not delivering an immediate step change in SLA performance. A recruitment tracker is updated weekly which is shared/reviewed by Commissioners and takes into account live recruitment, attrition, forecasts, trainees amongst other factors. It is this weekly recruitment tracker which feeds into this measure on the SLA recovery plan. This is a good indicator of staff required vs. actual available staff.
12. **CLINICAL OUTCOMES**

The Trust is measured on a number of nationally reported clinical outcomes. In addition the Trust has an annual audit plan.

12.1 **CURRENT STATE**

Clinical audit underpins the reporting of clinical outcome data and highlights variation in practice. The current audit systems are reliant on scanned paper records and therefore predominantly manual processes limiting the capacity to audit. This and shortfalls in capacity within the department has meant that much of the 2015/16 audit plan was not delivered.

Without this data and analysis the improvement and control of the DMAIC cycle cannot be effectively implemented.

Whilst all CQI data was provided by the audit team in 2015/16 as required nationally the audit rectification plan will allow further breakdown of this data to support improvement in clinical outcomes at a local level.

There are areas of exceptionally good practice within the Trust, such as cardiac arrest downloads, which require further embedding to contribute to good practice but cannot be seen in isolation, and this underpins the importance of ensuring adequate resources are in place to provide data to drive quality improvement, as well as national reporting metrics.

12.2 **PRIORITIES**

Based on the current state the initial priorities in this area are to improve data collection, through continued roll out of ePCR, and to strengthen the clinical audit function.

A review by internal audit of our clinical audit function has highlighted a number of areas for development, which is the basis for initial action set out here. Further actions will be developed to support improvement of clinical outcomes over the coming weeks, which will be supported by improved data collection and analysis.

Once clinical audit is rectified, consideration must be given to making data available to the workforce in a more dynamic way. Retrospective data is less useful to the wider workforce, and providing timely feedback in a range of areas can drive sustainable change in quality.
13. **FINANCIAL SUSTAINABILITY**

The importance of financial sustainability is addressed in the above context section and the Trust has submitted an Operational Plan which sets out the approach to financial sustainability in detail. Key elements are included here for reference.

### 13.1 CURRENT STATE

The underlying assumptions which have been built into the plan are based on the assumptions set out in the NHSI guidance received in December 2015. These are:

- Tariff Inflator of 3.1% which includes the price of pension increases
- Inflation on certain expenses at 1.7% and on drugs at 4%
- Activity growth matched by the supply of resources to meet it is 3.3%
- Any growth above that commissioned would be funded at the Marginal Rate Tariff of 65%

The outlook for 2016/17 by service line is compared with 2015/16 in the table below:

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Turnover 2015/16</th>
<th>Surplus in 2015/16</th>
<th>Turnover 2016/17</th>
<th>Surplus in 2016/17 APR</th>
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<tr>
<td>999</td>
<td>£180.7M</td>
<td>£1.6M</td>
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<td>PTS</td>
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<tr>
<td>Total</td>
<td>£202.3M</td>
<td>(£1.9M)</td>
<td>£205.9</td>
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</table>

The 2016/17 plan includes investment in new ways of working and helps the Trust to deliver a sustainable and resilient service. This continues the investment in 2015/16 of £1.7M, which enabled the design of its 999 delivery model to move to an Operating Unit model. The main element of this was to move away from central reporting to a more locally focused management of resources and deployment. The plan assumes all future investment will release efficiencies equivalent to any investment required.

The reduction in the PTS income relates to the expiry of the Sussex contract on the 31st March 2016. The Surrey PTS contract runs until 31st March 2017. The plan assumes that the Surrey PTS service will deliver a small profit in 2016/17. SECAmb is currently awaiting the outcome of the tendering process for the Surrey PTS provision for 2017/20 for which a bid has been submitted.
The contractual terms of the 111 service have been renegotiated and from 2016/17 the increased price per call, means SECAmb and its partner, Care UK will break even on the contract. The Trust has extended its contract with 17 of the 21 CCGs. The remaining 4 CCGs have been extended until 30 September 2016 to tie in with their current procurement of Urgent Care services in East Kent.

13.2 COST IMPROVEMENT PROGRAMMES

Despite this externally imposed financial challenge SECAmb remains committed to identifying efficiencies within its own internal processes and has set CIPs of £4.5m aligned to these operational efficiencies. A further £3.4m of CIPs are expected through procurement and non-pay operating expenses. This £7.9m total represents 4.2% of operating expenditure for 2016/17.

All CIPs have been reviewed for any impact on quality, patient safety and experience and staff safety by the Chief Nurse and the Risk Management Committee has assured this process. Quarterly monitoring of delivery will be tracked by the PMO, assured through the audit process and reported to the appropriate committees to ensure they are assured of both delivery and internal processes.

Delivery of this financial performance is subject to external factors such as activity growth and handover delays as set in more detail in the contractual and system context sections below.
14. **CCG MATRIX**

The below matrix provides triangulation for lead CCGs on the workstream through which their concerns are included in the plan or will be included as further detail is added.

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