



Right Care, Right Place, Right Time

# ANNUAL PLAN 2011/12



*To make a difference by integrating care and transport in pursuit of equity and excellence for our patients*

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We wish to make a difference to our patients in the North East by continuously making quality improvements and efficiencies in our core A&E and PTS services. To make that difference we are fully engaged in the North East's forward thinking transformation agenda. As a Trust that operates an emergency care service we work extremely closely with a number of out of hours and urgent care providers, we therefore feel that we are well positioned to help improve upon the integration of emergency and urgent care services. Through our; research agenda, innovative service improvements and commitment to service efficiency, we intend to help drive through the implementation of transformational ideas, as well as the latest advancements in clinical care. In short, we wish to lead in the provision of emergency care; to be a key partner in urgent care reform; to transform patient transport services; to have sound financial health; to be a first-rate employer; and to be well-governed and accountable.

As a result of an abundance of preparatory work in support of our vision, the year 2011/12 puts in motion a critical programme of work that will help deliver the necessary improvements to our A&E and PTS services and join up the emergency and urgent care systems that exist through the procurement of an NHS 111 service for the North East. After commencing a DH pilot for a new free of charge NHS 111 number for Durham and Darlington last July, the Trust wishes to be a major player in developing this initiative further across the whole of the North East.

With Foundation Trust status beckoning, this is a significant and exciting year for the Trust as we start to realise aspects of our long term vision however, we begin the financial year with a number of challenges. We start 2011/12 on the back of having come through the worst Winter in 100 years of recorded history, coupled with the highest ever growth in A&E activity. We continue to achieve our performance targets and we are confident that the quality of our services will be enhanced in the next year, which we will be able to demonstrate through the introduction of the new array of quality measures for ambulance trusts.

Therefore our focus for 2011/12 includes:

- Quarterly achievement of our two national response targets:
  - To attend to life-threatening emergencies within 8 minutes, 75% of the time (CatA8),
  - To provide patient-carrier transport within 19 minutes of the request, 95% of the time (CatA19);
- Development and delivery of the new array of outcome quality measures for ambulance trusts;
- Joining up the emergency and urgent care system, working closely with our partners in delivering a transformational 111 service for the North East; and
- Delivery of over £4.5m in cost improvement savings, without adversely affecting the quality of the services we provide.
- To secure Foundation Trust status during the year and put in place the formal mechanisms for public accountability.

## 2.1 CHIEF EXECUTIVE'S SUMMARY OF THE YEAR

2010/11 was another year of focused and determined achievement for the North East Ambulance Service in pursuit of our vision of integrating care and transport in pursuit of equity and excellence for our patients. Our staff worked tirelessly to meet the demands placed upon our service, in spite of the pressures placed upon us by the worst winter experienced in the UK for over 30 years. The winter saw an unprecedented amount of snowfall combined with freezing temperatures for two months from late November, which made our job extremely difficult, but the perseverance and commitment of our staff allowed us to continue to respond to patients in a timely manner, despite the treacherous conditions. A team effort by staff across all directorates within the Trust, along with the support of local commissioners, resulted in us achieving our A8 and A19 target. We narrowly missed our B19 target.

We have made significant advancements in the care we deliver to our patients; we piloted the new Electronic Patient Report Form (E-prf) in the Teesside region, which allows our staff to record patient information in a more robust manner, as well as enabling us to pre-alert hospital staff with patient information before we arrive at the hospital. Last year also saw the refurbishment of our Scotswood House training site, allowing our trainers to deliver high quality training in a state of the art environment, as well as providing further Contact Centre resources. We have continued to lead the way on how we deal with assessing patients' needs through the continued use of NHS Pathways and the enhancement of our directory of services which we expect to prove invaluable in sourcing the most appropriate care for our patients. We proudly became a pathfinder site for the 'NHS 111' service in the County Durham and Darlington area and this service, having proved to be very successful, will be rolled out across England by 2013; we plan to tender for the North East wide 111 service in 2011/12.

We are well placed this year to succeed in our bid to become a Foundation Trust; we have passed all the preliminary tests and are now awaiting the final due diligence from Monitor, the regulatory body governing Foundation Trusts. We have elected our Council of Governors this year, made up of members of the public, as well as our own staff who will have significantly more input into the running of our services, as well as how our services are governed and provided. Quality remains high on our agenda and with the introduction of the Government's new ambulance indicators for 2011/12, patient outcomes, as well as our response times will be closely scrutinised.

There are many achievements and developments which could be mentioned here, however I will leave the specifics for you to read in detail in the pages which follow. I hope you enjoy reading this report and share in the pride I have in the services we have been able to provide for our patients in the last year, and will continue to provide in the future.

### OUR 2010/11 SUCCESSES

- We maintained our Category A performance to a very high standard, even with the challenging winter.
- For the second year running we were identified as being in the top 100 Stonewall's Workplace Equality index.
- We were awarded first prize for Hand Hygiene practice.
- We successfully went live with e-PRF in Teesside.

## 2.2 INTRODUCTION FROM THE CHAIRMAN



Another year has raced by. It is now eight years since I became Chairman and I think I can safely say that those years have seen progress and improvement across the whole of the organisation. I am confident that what you read in the Annual Plan will bear out my assertion.

I had hoped that we would have achieved Foundation Trust status during the year. In the event we did not manage to, but we are well placed to succeed in the current year. We have passed through all the preliminary tests and are now awaiting the final due diligence from Monitor, the regulatory body governing Foundation Trusts.

The year has been challenging in a number of different respects. The Department of Health have proposed a number of changes to the NHS, which, if the Health Bill is enacted, will result in fundamental differences for ambulance services. The most far reaching would see a change in the way that our services are commissioned with responsibility passing from Primary Care Trusts, who will be abolished, to GP's. There are already a number of GP consortia operating as pathfinders in our region and we have begun the process of engagement with them to better understand how they wish to operate and to ensure continuity for our services as the system changes.

Another change requires every NHS Trust to become a Foundation trust by 2013; this generates extra motivation for us to maximise our bid to succeed in our application. Although the NHS is protected from the type of financial cuts which have affected other public sector bodies, it would be wrong to assume that the austere financial climate leaves us unscathed. We are required to achieve challenging efficiency targets of 4-5% in each of the next 5 years. We have already introduced a tough cost improvement programme covering all aspects of our activities and we have set up a robust monitoring process to ensure that we are successful, and that we do not sacrifice quality.

On a brighter note, the year was notable for the introduction of the 111 service. It makes me proud that we were the first ambulance service to introduce the system and it was only fitting that the Secretary of State for Department of Health, Andrew Lansley, visited HQ to officially launch 111 as the first national pathfinder site in the UK. Of course, it was not so new to us because the system had been in operation for almost a year as the 'Single Point of Access' and has been commended for its safe and efficient track record. So 5 years after being the first ambulance service to introduce Pathways, the system was highlighted as being the most appropriate basis for 111.

Finally I must mention the winter of 2010/11 – widely held to be the worst for 30 years (or longer). It was the most severe challenge to all of us. Again, I can say how proud I was of our response. Everyone who asked for an ambulance got one, albeit not always as quickly as they would normally expect. Our PTS service also maintained a service, the only one in the UK to do so. There are many stories of bravery and courage and a determination not to be beaten that I shall not try to highlight any specific examples. Let me just repeat what I said at a Board meeting reviewing our winter performance, when I gave my view that maintaining our services was an absolutely heroic effort on behalf of all who work for us.

So there are my highlights of the year gone by. There is much more to read in the Annual Plan and I hope that you enjoy finding out for yourselves.

## 2.3 FINANCIAL PERFORMANCE REVIEW

The Trust has achieved a strong financial performance for the year. Our year-end surplus was £1,351,000, lower than our plan due to in-year asset impairments. Table 1 below compares our outturn performance against plan in each of our business areas.

**Table 1 Planned and actual I & E performance 2010/11**

Description		2010/11 Plan (£000s)	Actual: 31 Mar 11 (£000s)	Variance (£000s)	Variance (%)
Income	A&E SLA Income	74,016	68,830	-5,185	-7.0%
	PTS SLA Income	17,891	22,456	4,565	25.5%
	ECR Income (Non-SLA)	971	699	-272	-28.0%
	Commercial Services	958	997	39	4.1%
	Income Reserves	3,988	3,511	-477	-12.8%
	Other Income	9,153	9,785	632	6.9%
<b>Total Income</b>		<b>106,977</b>	<b>106,278</b>	<b>-699</b>	<b>-0.7%</b>
Expenditure	Pay	-70,686	-69,340	1,346	-1.9%
	Non-Pay	-24,213	-24,792	-579	2.4%
<b>Total Operating Costs</b>		<b>-94,899</b>	<b>-94,132</b>	<b>767</b>	<b>-0.8%</b>
<b>EBITDA</b>		<b>12,078</b>	<b>12,146</b>	<b>68</b>	<b>0.6%</b>
<i>EBITDA Margin</i>		<i>11.3%</i>	<i>11.4%</i>	-	-
	Depreciation	-7,059	-7,027	32	-0.45%
	Amortisation	0	-33	-33	100.0%
	Losses on PPE Disposals	0	-218	-218	100.0%
	Investment Revenue (Interest Receivable)	100	20	-80	80.0%
	Finance Costs	-411	-449	-38	9.2%
	PDC Dividend Payable	-1,400	-1,320	80	-5.7%
<b>Retained Surplus</b>	<i>(Before Impairments)</i>	<b>3,308</b>	<b>3,119</b>	<b>-189</b>	<b>-5.7%</b>
<i>Surplus Margin</i>		<i>3.1%</i>	<i>2.9%</i>	-	-
	Impairments of Property, Plant & Equipment	-768	-1,768	-1,000	130.2%
	Impairments of Intangibles	0	0	0	100.0%
<b>Retained Surplus for the year</b>	<i>(after impairments)</i>	<b>2,540</b>	<b>1,351</b>	<b>-1,189</b>	<b>46.8%</b>
<b>COST IMPROVEMENT PROGRAMMES</b>		<b>3,829</b>	<b>3,829</b>	<b>0</b>	<b>0.0%</b>

### **Income and expenditure**

Trust income was £0.7m below plan whilst overall expenditure was also below plan with a £0.767m under-spend being reported. This resulted in the planned Earnings Before Interest, Taxation, Dividends and Amortisation (EBITDA) of £12.078m, realising an increased actual net earnings position of £12.146m by the year-end. The reduction in income is due to a £0.7m payment in respect of a performance penalty being incurred in year. We were also able to agree the re-alignment of existing A&E and PTS contract values with Commissioners in-year by adjusting for a historical cross-subsidy and this is reflected in the variance against planned A&E and PTS income in Table 1 above.

The Trust's pay budget was under spent by £1.346m, realising a non-recurring savings arising from vacancies. However, the over-spend on non-pay budgets which was £0.579m, reflects additional variable costs incurred to meet and manage the additional levels of demand for services in year. In addition, the Trust transferred expenditure in respect of condition deficiency works - previously accounted for within capital expenses - to the revenue account. In future years, provision has been made in respect of such works to continue to be accounted for as revenue.

Before taking impairment losses on asset revaluations into account the Trust achieved a surplus of £3.119m, which is £0.189m below plan and equates to a surplus margin of 2.9%.

International Financial Reporting Standards (IFRSs), adopted in 2009/10, requires the Trust to undertake a revaluation of all of its estate assets in-year. As a result of the property revaluation for 2010/11, a £1.768m impairment loss was realised to leave the Trust with an overall retained surplus for 2010/11 of £1,351,000.

The Trust's Cost Improvement Plan of £3.829m was achieved with operational schemes delivering £1.581m and corporate schemes delivering £2.248m.

### **Capital expenditure**

The Trust spent £8.612m on capital projects during 2010/11, which represented an undershoot against capital resources of £24,000 before the book values of assets disposed of in-year, were taken into account.

The Trust continues to invest in a rolling ambulance fleet replacement programme and total spend on our A&E, rapid response and non-emergency vehicles and equipment was £4.2m. Other major schemes included refurbishment of Scotswood House for training and Contact Centre facilities (£0.5m), improvement of the car park and security facilities at the Pallion site (£0.4m), completion of two new ambulance stations at Hartlepool (£0.4m) and the sluice refurbishment programme (£0.4m).

The Statement of Financial Position (SOFP), formerly known as the Balance Sheet, for the Trust at 31st March 2011 is shown below in Table 2 and compares outturn SOFP performance against plan.

**Table 2 Planned and actual Statement of Financial Position (SOFP) 2010/11**

Description		2010/11 Plan (£000s)	Actual: 31 Mar 2011 (£000s)	Variance (£000s)	Variance (%)
Non-Current Assets	Property, Plant & Equipment	46,298	44,774	-1524	-3.3%
	Intangible Assets	49	73	24	49.0%
	Trade & Other Receivables	800	759	-41	-5.1%
<b>Total Non-Current Assets</b>		<b>47,147</b>	<b>45,606</b>	<b>-1,541</b>	<b>2.6%</b>
Current Assets		7,537	9,175	1,638	16.1%
Non Current Assets held for sale		0	435	435	100.0%
Current Liabilities		-5,012	-5,090	-78	-13.8%
<b>Total Assets Less Current Liabilities</b>		<b>49,672</b>	<b>50,126</b>	<b>454</b>	<b>0.9%</b>
Non-Current Liabilities		-7,059	-9,358	-2,299	32.6%
<b>TOTAL ASSETS EMPLOYED</b>		<b>42,613</b>	<b>40,768</b>	<b>-1,845</b>	<b>-4.3%</b>
<b>Financed By:</b>					
Public Dividend Capital		-34,617	-34,617	0	0.0%
Retained Earnings		-3,838	-1,333	2,505	-66.4%
Revaluation Reserve		-3,665	-4,694	-1029	12.7%
Government Grant Reserve		-493	-124	369	100.0%
<b>TOTAL TAXPAYER'S EQUITY</b>		<b>-42,613</b>	<b>-40,768</b>	<b>-1845</b>	<b>-5.4%</b>

The following points should be noted when analysing the statement of financial position performance information (subject to change if required by auditors):

- Property, Plant and Equipment balance movements in year reflect capital purchases less depreciation and impairments charged in 2010/11.
- Current asset balances have increased by £2.1m against the plan. This reflects an increase in cash balances of £0.9m due to an increase in non-current (long term) capital payables. There is also a reclassification of an asset as held for sale, this relates to Hartlepool station and it has been valued at approx £0.4m. The remaining increase relates to additional NHS prepayments and a movement in Inventory held at 31<sup>st</sup> March 2011.
- Non-current liabilities are £2.3m more than the original plan due to the recognition of building finance leases of £1.4m and non-current capital payables of £0.9m. The Trust has one new finance lease in 2010/11, for the Ambulance station at Backworth. The non-current capital payables refer to reparations required to reinstate finance lease buildings at the end of the lease.
- Retained earnings are £2.5m below plan at year-end of this £1.8m relates to impairment charges against our Property, Plant and Equipment assets in 2010/11. The remaining balance of £0.7m is due to penalties from the commissioners for failing to meet performance targets.
- Revaluation Reserve balances have increased by £1.0m due to a Prior Period Adjustment required for impairments recognised against assets in 2009/10. This was a technical adjustment and did not impact on the retained surplus reported in 2009/10.

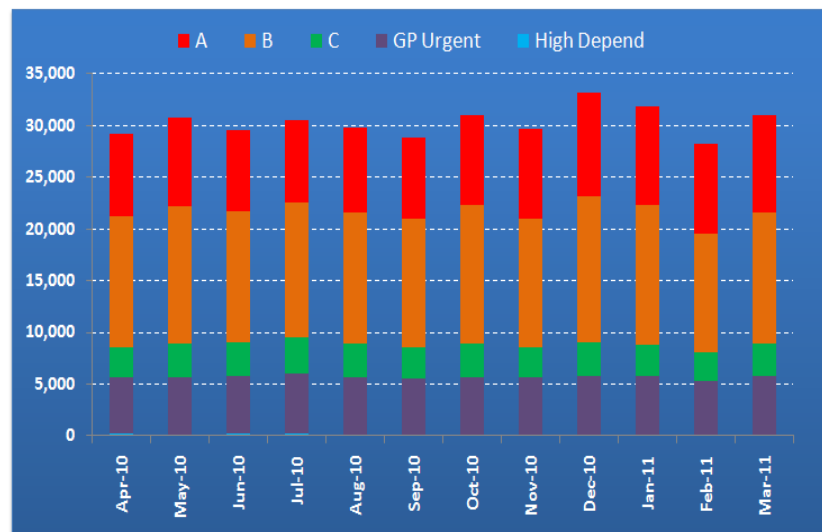
## 2.4 A&E RESPONSE PERFORMANCE

The Trust is committed to the delivery of the national response targets and is now proactively monitoring quarterly based forecast and actual performance.

The Trust successfully achieved all three national targets in the first two quarters of 2010/11:

Performance measure	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Category A 8 minutes	78.67%	78.51%	70.00%	76.64%
Category A 19 minutes	99.16%	99.07%	97.21%	98.46%
Category B 19 minutes	95.19%	95.50%	91.13%	92.31%

The snow that began to fall on the 24<sup>th</sup> November and the ongoing severity of the snowfall and icy conditions that we endured in the third quarter led to significant service disruption that was not restricted to the ambulance service. All services were adversely affected.



Demand for emergency services started to rise in the third quarter, well above contractual levels, there were greater than normal levels of flu incidence and the unprecedented growth in activity continued well into the fourth quarter. Whilst high volumes of activity and hospital delays placed great pressure on all of our services we were able to maintain service provision and we were still able to respond to all our patients who requested a response.

We are continually grateful for the resilience shown by all of our staff, including our PTS staff and contact centre staff, support from other organisations including the Great North Air Ambulance and also those volunteers from organisations including; Mountain Rescue, British Red Cross and St John Ambulance Service who were, once again, able to provide such invaluable support. Also, for the first time we engaged the services of a private ambulance service, East Coast Ambulance Service to offer further flexibility and dynamic deployment of staff during periods of pressure and high activity.

Despite the difficulties we faced, the Trust delivered 75.82% for Category A8, 98.54% for Category A19 and 93.52% for Category B19.

## 2.5 OTHER MAJOR ISSUES

### **Changes to Board Membership**

The Trust has recently appointed Jeff Fitzpatrick to a substantive Non-Executive vacancy following the departure of Chris Suddes. Jeff was previously a designate Non-Executive.

### **External audit**

The Audit Commission continues to be our external auditors.

### 3.1 OUR VISION

#### 3.1.1 TRUST VISION

The North East Ambulance Service NHS Trust has a strong track record of delivering high quality patient care, focussing resources in an efficient manner to produce the most effective outcomes. Our focus on improving patient outcomes and ensuring we are at the leading edge of innovative service design has consistently led to us being one of the highest performing ambulance trusts in the country. Whilst we have recently been affected by the weather conditions and increasing levels of demand for A&E services we have plans in place to ensure future impacts will have minimal effect on our ability to provide services.

We are in a challenging economic climate but through our vision we will drive through improvements in service delivery and work to ensure all of our patients have a positive experience, not losing sight of our requirement to eliminate waste, inefficiency and unnecessary costs. Our mission and vision remain firm:

#### Right Care, Right Place, Right Time

To make a difference by integrating care and transport in pursuit of equity and excellence for our patients

In support of our vision we have put in place six strategic intentions:

#### To lead in the provision of Emergency Care

- we want to be the provider of choice for A&E services and lead through innovation, research and performance.

#### Be a key partner in Urgent Care reform

- we want to help deliver the changes that our patients and our commissioners are asking for using our expertise and infrastructure.

#### To transform our Patient Transport Service

- we want to continue to be the provider of choice for PTS in the North East.

#### To be a first rate employer

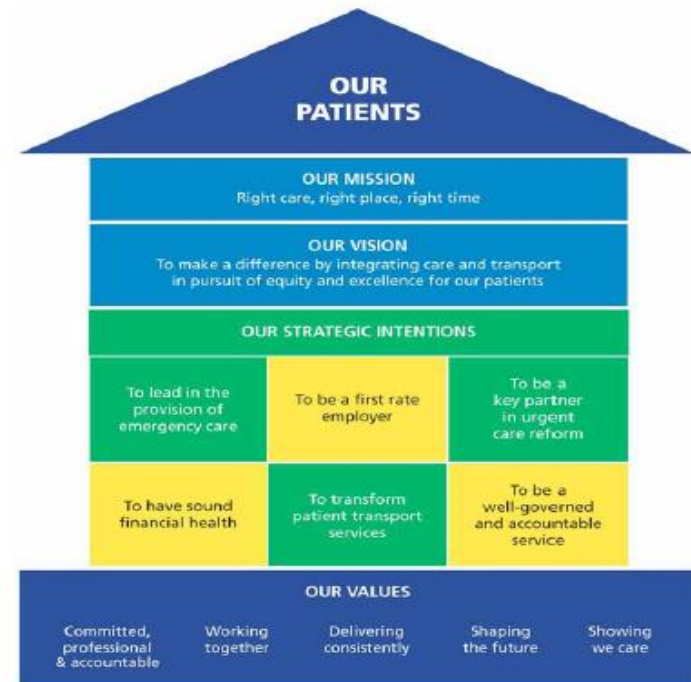
- we want to ensure our staff are appropriately supported, with fair pay and flexible working conditions and a safe productive working environment.

#### To have sound financial health

- we want to maintain strong financial health that enables us to invest in new service developments, constantly taking the organisation forward.

#### To be well governed and accountable

- we want to continue to ensure that the safety and quality of our services to patients remains our highest priority.



Our strategic intentions reflect the Trust's current operating environment and all of our planning continues to be strongly aligned with the intentions of our Commissioners, feedback from patients, service users and staff.

Our values that underpin everything we do are:

**Committed, professional and accountable**

*To each other and in everything we do*

**Working together**

*Colleagues and partners making improvements*

**Delivering consistently**

*High performing, resourceful, safe and resilient*

**Shaping the future**

*Leading in the innovation of the NHS*

**Showing we care**

*Listening to patients and colleagues*

### 3.1.1 TRUST OVERVIEW

The Trust is predicted to have an annual turnover of £105.9m for 2011/12. Serving a population in the North East of approximately 2.66 million people; we employ over 2,000 staff. Our partners include 12 Primary Care Organisations, 2 Mental Health Trusts, 8 Acute Hospitals, 1 Strategic Health Authority and 12 Unitary Local Authorities. The Trust also works very closely with St John Ambulance Service and British Red Cross.

Our Accident and Emergency (A&E) vehicles continue to respond every year to around 300,000 incidents; life threatening within 8 minutes 75% of the time, serious but not life threatening within 19 minutes 95% of the time and others within 60 minutes. We also provide a transport response service within 120 or 240 minutes at the request of General Practitioners for up to 70,000 patients who require an admission to hospital. In addition, our A&E tier also provides transport for up 1,500 patients who require a 'high dependency transfer'.

Our Patient Transport Service (PTS) facilitates vital access to healthcare and treatments for many patients; planning for circa one million transport journeys each year.

Our Contact Centres handle in excess of 1,000,000 calls each year, from A&E '999' calls through to urgent care and planned appointment bookings with our 111 service and PTS booking lines.

## 3.2 STRATEGIC OVERVIEW

### 3.2.1 LOCAL AND NATIONAL CHALLENGES

#### **The Trust faces a number of local challenges**

The North East has some areas with the highest levels of deprivation in the United Kingdom based on the population-weighted economic deprivation index and our population is faced with health challenges, arising from industry and poor lifestyle opportunities and choices such as; COPD, obesity, smoking, teenage pregnancy. This generates demand generally for all types of healthcare but more so acute care, leading to the requirement to rebalance the health care system, moving some of the acute demand to primary and community care.

We have a number of large rural areas which are sparsely populated with isolated dwellings which require innovative response models to be developed.

#### **As a result of the current economic climate we are faced with significant financial challenges**

We have received no funding uplift this year and, in accordance with the '2011/12 NHS Operating Framework for England and Wales', our core SLA income was reduced by 1.5%. Consequently financial pressures, both pay and non-pay, must be largely funded through our cost improvement programme. This year we have a challenging cost improvement target of 4.7%, amounting to some £4.45m, and this must be achieved without adversely affecting the quality of the services we provide.

We expect to experience pressures elsewhere in the health and social systems as our acute hospitals and local authorities also make changes to their own services such as reducing bed numbers and/or reducing public transport services, which may potentially affect our own ability to offer services and manage demand.

#### **The NHS structural changes create some uncertainty regarding future commissioning strategies**

As the details of the new commissioning arrangements unfold, we expect to increase our level of engagement with GP Commissioning Consortia to help further shape or refine our future plans and ensure we are fully aligned to the Health and Wellbeing Strategies to be put in place across the North East.

#### **The new NHS outcomes framework**

We are required to develop a new approach to performance management reflective of the NHS Outcomes Framework and the new quality measures for ambulance trusts. This provides us with an opportunity to demonstrate the quality of care we provide in addition to the timeliness of care we provide.

### 3.2.2 QUALITY

Quality and safety remain a high priority for the Trust:

- all cost improvement projects are being actively tracked to monitor the impact on the quality of care we provide;
- investment is being made in areas of safeguarding practise and clinical quality improvement;
- we are actively seeking views of our users and patients to ensure quality improvements are made to those areas that are most important to them; and
- we are excited about the introduction of the new outcome quality measures to provide a focus for our quality improvements.

**Safeguarding** The Trust is actively reviewing the recommendations proposed in the Munro Review as part of a national drive to improve the quality of child protection and vulnerable adult services. All patient facing staff are to be trained in Level 2 Child Protection/Vulnerable Adults Training during 2011/12 and all other staff trained in Level 1.

**Clinical quality improvement** The Trust is recruiting a Clinical Quality Improvement Officer who will actively participate in the monitoring of the new outcome quality measures, take a lead role in the review of clinical working practises and promote consistency in approaches working closely with front-line staff.

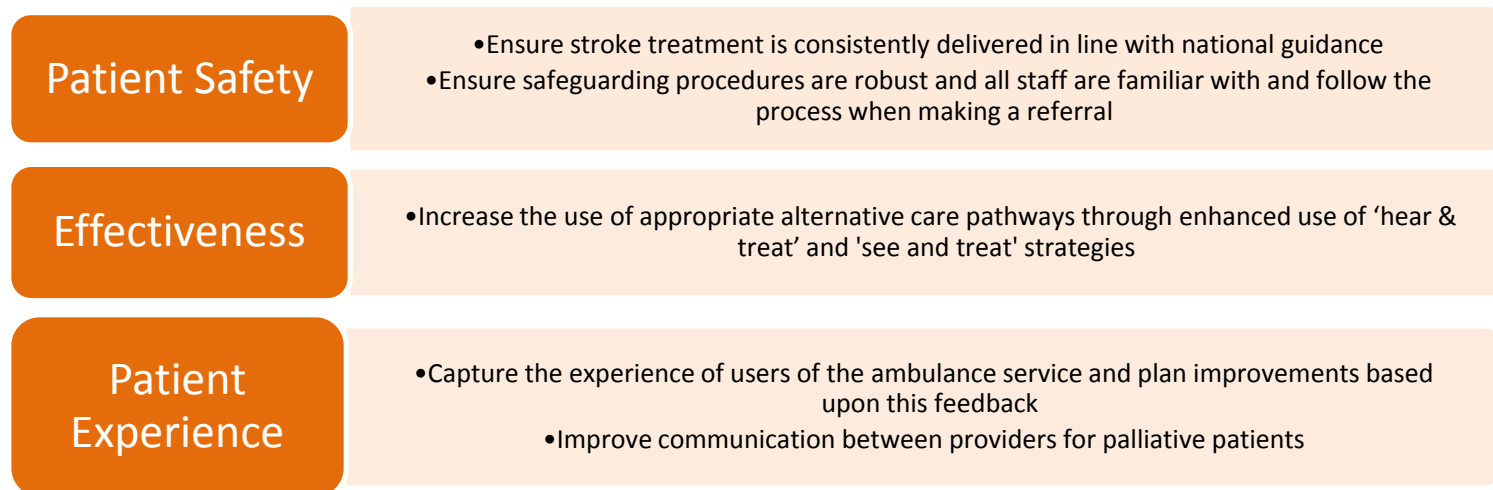
**New quality measures** There are 11 new outcome measures that the Trust will develop throughout 2011/12. These have been introduced to provide focus on the quality of care we provide:

1. Call Abandonment Rate
2. Re-contact rates
  - a) following discharge of care by telephone,
  - b) following discharge of care from treatment at the scene
  - c) Proportion of calls from patients for whom a locally agreed frequent caller procedure is in place
3. ROSC at time of arrival at hospital a) overall b) using Utstein Comparator Group
4. Patient Experience
5. Percentage of patients suffering a STEMI who:
  - a) receiving thrombolysis within 60 minutes of call
  - b) following direct transfer to a PPCI centre, primary angioplasty commences within 150 minutes of call
  - c) receive an appropriate care bundle
6. Percentage of patients who have a positive FAST test stroke
  - a) who arrive at hyperacute stroke within 60 minutes of call
  - b) % of suspected stroke patients who receive an appropriate care bundle
7. Heart Attack who survive to discharge a) overall rate b) Utstein Comparator Group
8. Time to Answer Call - median, 95th and 99th percentile
9. Time to Treatment, time of arrival of a qualified health professional- median, 95th and 99th percentiles

10. Calls closed with telephone advice
11. Incidents managed without the need for transport to A&E

During 2010/11 we introduced the Experience, Complaints, Litigation, Incidents and PALs (ECLIPs) Group which reports to the Quality Committee. The group reviews a wide variety of information to enable them to maintain a sharp focus on the experience of patients. This group will prove invaluable in providing information to support the new requirement to report patient experiences.

We continue to develop our Quality Accounts with our stakeholders, some of which are represented on the ECLIPs group, and following both internal and external consultation, the Trust Board has agreed to 5 specific quality improvement priorities for 2011/12 as set out below:



## CQUIN

Through delivery of service quality, innovation and effectiveness the Trust's CQUIN scheme is set to attract £1.393m additional income. It covers elements of our quality priorities set out above and other whole system measures that aim to support collaborative working across organisational boundaries. These include:

- Increasing the proportion of 999 patients appropriately transported to alternative established community provided services
- Analysing causes of delays of handovers and turnarounds at A&E departments

### SERVICE IMPROVEMENT USING THE NORTH EAST TRANSFORMATION SYSTEM (NETS) METHODOLOGY

The Trust has held 11 successful Rapid Process Improvement Workshops (RPIWs) along with a number of Kaizen events in the last year since the adoption of the Virginia Mason Production System approach to promote and help drive quality improvement activity. RPIWs and Kaizen events are planned for 2011/12. For example, we will be reviewing A&E dispatch - to drive dispatch optimisation which will help to achieve our national A&E response targets and also looking at areas of medicines management and back office functions.

Whilst still early in its development the approach is proving successful.

The Trust will continue to train staff during the year, increasing our total number of certified leaders beyond 10, and ensuring all managers and front-line staff are equipped to undertake service improvement activity within all areas of their work.

The Trust is committed to ensuring staff are fully engaged in developing the services we offer and their ideas are listened to and acted upon to improve the way we deliver services, as well as how best to deliver the cost improvements required. To embed, work will be undertaken to develop a 'Compact' with staff over the next year which will explicitly describe the commitment and expectations of both the organisation and its workforce to continue to improve services for patients and that everyone will play a part. Implementation will take us to the next stage in spreading our service improvement ideas and methodologies.

The methodology is integral to many of our cost improvement projects, working to eliminate waste and inefficiency.

#### 3.2.3 KEY ACTIONS 2011/12

##### *Learning from our patient experiences*

- We will evaluate the results of our first A&E Pilot survey that was undertaken towards the end of 2010/11 and look to introduce the survey more frequently seeking quarterly reports.
- We want to learn what is important to our patients to ensure our quality improvement activity is focussed on the right things.
- We will continue to develop and increase the frequency of our PTS surveys and start to survey patients within specific contracts such as the Durham Urgent Care Transport Contract and 111.
- It is our intention to work more closely with the North East Quality Observatory System (NEQOS) to develop more sophisticated and varied methodology to capture patient experiences.

LINKs and Overview and Scrutiny Committees continue to play a very important role in our community, in giving local residents a stronger voice in how their health services are delivered and actively work with us in developing quality priorities and our annual plans.

### ***Leading in the provision of emergency care***

Innovation, research and evidence-based practices drive leading edge advancements in clinical care. Through our own 'research-friendly' environment, we continue to provide exciting opportunities for our staff and patients to be involved in research. . Our research and development capacity will be enhanced during 2011/12 and we are committed to our membership with the Comprehensive Local Research Networks.

The research initiatives that we expect to be involved in this year include:

- The Head Injury Transportation Straight to Neurosurgery HITS-NS trial following the Trust's successful application to Integrated Research Application Service (IRAS) last year.

We are working with the two regional trauma networks that were launched this year; one centred around the Newcastle Hospitals NHS Foundation Trust and the other being South Tees Hospitals NHS Foundation Trust. Work will be undertaken to complete the HITS-NS trial, model the anticipated workload and train staff in the use of Trauma Triage, in preparation for the planned full implementation from April 2012. A research paramedic will be recruited to oversee the feasibility study.

The Trust will continue to work closely with other networks as more areas are provided by specialist centres that are identified throughout the region, such as Burns Care and Paediatrics.

The Trust is a key partner in Safer Care North East (SCNE). We continue to contribute to the safe care work streams and we will be leading on the Falls initiative in 2011/12 for the North East in conjunction with County Durham & Darlington NHS Foundation Trust. This will lead to:

- Re-design of first line assessment tools that are used by front line crews to refer into localised Falls Teams, integrating with the e-PRF project;
- Improved data sharing process of those patients who experience a fall and are treated and left safely at home; and
- Improved, and where possible, collaborative training for organisations who have contact with this vulnerable group of patients

The Trust expects to receive a number of recommendations set by the Joint Royal College Ambulance Liaison Committee (JRCALC) which will be reviewed and approved internally by the Trust's Clinical Advisory Group prior to implementation. These new guidelines will be produced in 2011 and disseminated to staff through clinical education.

### 3.2.5 SERVICE DEVELOPMENT PLANS

## Accident & Emergency Service

We are continuing to plan for A&E activity to grow in line with recent trends but we will actively work with our partners to limit growth through use of 111 and enhanced community provision. This year's plan focuses on how we can best manage the increase in demand whilst maintaining cost control, achieving response performance and delivering the 11 new quality outcome measures.

To help redesign our A&E model to offer greater flexibility that will help with the attainment of our performance standards longer term, the Trust commissioned an independent review in 2010/11. It is currently being consulted upon with our staff and key stakeholders and subject to approval, which is expected in the early part of 2011/12, the implementation of the new model will commence. There are also many other initiatives planned for this year in support of the redesign and includes projects such as the Intermediate Tier and Review of Dispatching Protocols.

The redesigned delivery model, in conjunction with other initiatives, is set to deliver benefits such as:

- improved response times, achieving quarterly performance of our national targets;
- increased workforce productivity and efficiency through better alignment of resources (and skill mix) and demand; and
- staff satisfaction and morale through ensuring staff attend to patients that require their particular skill-set;

Our A&E service will not immediately look or feel significantly different to patients and service users. The improvements will be incremental and over a longer term will be evidenced through user experience improvements, enhanced provision of clinical care, particularly in areas where evidence-based practice is implemented as it emerges, such as Trauma Care and management of patients with Hyper-acute Stroke, and through greater consistency in the achievement of time critical responses by a Paramedic and arrival at specialist centres.

All staff and key stakeholders will be actively engaged throughout each step of the implementation programme.

### FUTURE CATEGORISATION OF TIME CRITICAL RESPONSES

The removal of the Category B19 minute response category and measure was formally removed as part of the Government's introduction of the NHS Outcomes Framework. The 11 new quality outcome measures replace the single measure and as a consequence there have been some changes to the time critical response categorisation for 2011/12. Most importantly all life threatening emergencies will continue to be responded to within 8 minutes. These will be further categorised as Red 1 for all Cardiac Arrest incidents and Red 2 for all others to enable enhanced deployment practice which will ensure the appropriate first line response and back-up transport is deployed.

All of the incidents that were previously 19 minutes and 60 minute responses (our Category B19 and Category C60's) will be categorised according to local determination with our commissioners, using a national framework of Green 1, 2, 3 and 4 categories, however local determination will be guided by the NHS Pathways Team who will be working to ensure the clinical assessment system continues to reflect the clinical need(s) of the patient to drive the response timeframes. The Trust does not envisage any significant changes and is assured that any changes will be appropriately clinically governed through the mechanisms already in place that govern NHS Pathways.

### RURAL AMBULANCE SERVICES REVIEW

Whilst the Trust is embedding the outcomes performance framework which will prove useful to help evaluate the quality of responses in our rural communities when we know that it is difficult to offer a consistent timely response, we have embarked on a piece of work to further enhance a collaborative response from both Community Paramedics and Surgery Clinicians.

It is anticipated that a rural response framework and associated policies will be put in place to enable roll out of future community initiatives.

It is set out within our vehicle replacement programme that vehicles will be replaced with Land Rovers in our most rural locations within Northumberland.

### EMERGENCY PREPAREDNESS

We will continue to ensure Emergency Preparedness complies with our statutory duties under the terms of the Civil Contingencies Act 2004 and work to ensure that no gaps emerge as a result of the NHS structural changes.

During 2011/12 we will actively scope out what sub-national role the Trust could play, as the Health Protection Agency, the SHA and PCTs are abolished and their current responsibilities transfer to the new commissioning bodies and Public Health.

### INFECTION CONTROL AND PREVENTION MEASURES

The Trust is procuring a cleaning service from a single supplier to ensure the high standards of cleanliness of all trust premises. This will ensure consistency and will enable more effective contract management with a single supplier. It is to be in place from June 2011.

The Trust is also exploring with the Operations Directorate how infection control audit programmes can be integrated into the overall performance management reporting framework that is in development to incorporate current Qlikview clinical performance reports and CQUIN.

### ADVANCEMENTS IN CLINICAL PRACTICE

The Trust successfully went live with the pilot of e-PRF in the Teesside division and will continue to roll out to the remaining three divisions throughout 2011/12. Full roll out will be completed by the end of March 2012. During 2011/12 there will be ongoing evaluation of the pilot and testing of the reporting ability that the new system can provide and how it can support performance management and continuous clinical quality improvements.

The Trust is reviewing JRCALC's recommendation to introduce the new oral drug Midazolam to help control seizures and fits which will replace the use of Diazepam and we are driving through a change in clinical practice to treat patients with a heart attack that will improve the chances of survival.

### 3.2.5 SERVICE DEVELOPMENT PLANS

## Contact Centre

The Trust's Contact Centre comprises three key functions:

- i. '999' Emergency Call Handling
- ii. 111 Service for County Durham and Darlington
- iii. Patient Transport Booking and Planning Services

The Contact Centre will undergo a restructure to introduce enhanced management and supervision for all call handlers which will also provide more structured career development opportunities for staff.

#### '999' EMERGENCY CALL HANDLING and 111 SERVICE

All '999' emergency calls are handled by Contact Centre staff using NHS Pathways clinical assessment tool which is now actively being taken up by many other ambulance trusts. During 2011/12 we hope to be accredited as an NHS Pathways End User Training site and help successfully train our ambulance colleagues and others in use of the system.

Our 111 service uses the same system, and during 2011/12 we will be looking to ensure there is effective integration of the two services to optimise resource usage and value for money. The ability to flex staffing resources between the two services was crucial during the winter period last year.

We will be continuing to populate our active Directory of Services (DoS), with a vast array of community services that we can refer patients to, when they do not need an emergency response and also during the year the system will be technically upgraded to offer speedier searches and improved ease of use by provider services to upload their service profile.

We will continue to develop the face to face triage system using the NHS Pathways Clinical Assessment Tool and the DoS, to aid crews to access the most appropriate available service. This is due to tie in with the April 2012 roll out of the e-PRF. In the meantime we will assess the feasibility to introduce a 24/7 logistics desk that crews can access to check community service availability should they wish to refer a patient and also for other professionals who may need to access an urgent care community service for a patient.

### PATIENT TRANSPORT BOOKING AND PLANNING SERVICES

PTS call handlers were once again invaluable in managing resource capability during winter pressures, highlighting the resilience the service can offer to core A&E in maintaining high standards of care and responsiveness.

The Trust is more than ever committed to the transformation of the service and we will enter Phase II during 2011/12. The work programme this year includes:

- Embedding of autopanning; and
- Implementation of service standards and enhanced performance reporting.

### NHS 111 - PROCUREMENT

The Trust is refining its NHS 111 Pathfinder service delivery model and compiling a tender submission in preparation for the procurement of the service in 2011/12.

The Trust has been successfully delivering an NHS 111 Pathfinder service for residents in County Durham and Darlington since July 2010 and is using the learning from this work to effectively and efficiently scale up the service for North East England.

The Trust is confident in the delivery model and that it can offer significant economies of scale. The use of NHS Pathways enables us to employ non-clinical call handlers who are appropriately trained to undertake a clinical assessment which is fundamental in our ability to offer a cost effective call handling solution. Separate out of hours call handling provision can be costly and traditional models require clinical intervention at the call handling stage of assessment. We can also offer longer term savings resulting from synergy with our 999 service and as part of our roll out we have included the refurbishment of existing estate to further contain costs.

We have predicted a call volume of just over 1.2 million for the North East which includes out of hours activity, a shift in calls from NHS Direct, a shift in calls from 999 and a proportion of activity arising from unmet demand through improved access improving equity across the region.

A successful bid will lead to the mobilisation of a North East service from November 2011 to be able to offer the full service from 1<sup>st</sup> September 2012, based on the planned procurement timescales. The procurement is currently being driven by NHS North East.

#### NHS 111 Pathfinder

Our service model offers:

- Safe and immediate dispatch of emergency response where appropriate
- Instant decision making for majority of patients
- Simple, free and robust access to urgent care
- Value for money
- Improved partnership working
- Ability to limit growth in 999 demand, maximising A&E resource availability for life threatening emergencies

### 3.2.5 SERVICE DEVELOPMENT PLANS

## Patient Transport Services

### PATIENT TRANSPORT SERVICES

The PTS Transformation Programme commenced a few years ago and its primary objective was to improve efficiency of the service, realising financial benefits and to protect our existing PTS contracts. The development of Service Line Management and Reporting is supporting improved transparency in the service costs and the Trust is confident that during 2011/12 the Service Line will be financially healthy. However, the focus will continue making further service efficiencies to ensure it is more commercially competitive.

Phase II of the programme will commence and will include:

- Finalising the delivery model for implementation;
- Business case development to roll out the successful pilot volunteer patient escort service;
- Embedding of automated planning;
- Increasing the PTS Bank Service;
- Ongoing development of an integrated transport tier with A&E; and
- Refinement of our urgent care transport service, anticipating future tenders in support of improving access to urgent care.
- Review our use of third party providers to ensure that quality, safety and efficiency are maintained at all times

#### Automated planning

Automated planning was piloted and rolled out last year within a test environment. It is now live and work is ongoing to embed the use of the system. Robust procedures will be put in place and training will be rolled out to all staff involved.

The change in the process will be closely monitored and reporting mechanisms are being put in place to measure the anticipated reduction in workload for Planners, improved service standards and efficiencies achieved through a reduction in miles travelled.

### 3.2.5 SERVICE DEVELOPMENT PLANS

## Commercial Business Services

### COMMERCIAL BUSINESS SERVICES

The Trust's Commercial Business Services is made up of three separate business units providing:

- i. Training Services
- ii. Event Medical Cover
- iii. Driving School

### TRAINING SERVICES

We continue to provide a range of training courses for businesses and organisations across the North East and throughout 2011/12 we will be working with the Northern Deanery, Fire and Rescue Services and Universities. We have recently added Conflict Resolution Training to our menu of courses on offer and we will continue to increase the availability of our programmes throughout 2011/12, as well as continuing to develop new courses and products in response to best practice guidance, legislative changes and customer requirements.

We will increasingly work with third sector and voluntary organisations within the social care community and collaborate with some of our ambulance trust partners to offer training services nationally.

We also soon hope to become an accredited supplier of NHS Pathways End User Training.

Our customers will also benefit from a redesigned web-site, making all of our course availability accessible on-line.

### EVENT MEDICAL COVER

The Trust intends to maintain income generated through the provision of paramedic cover, mainly at major sporting events within the region that require a paramedic presence.

The forthcoming year may be challenging due to the economic climate as it is likely to have an impact on the number of events being planned in the region. We do hope to maintain levels, through our established list of customers to cover repeat events and also this year we will be providing cover at prime concerts at the Stadium of Light which include Take That and Kings of Leon.

### DRIVING SCHOOL

As we are an accredited training centre to train staff in the Driver Certificate of Professional Competence, which was introduced across the European Union in 2009, we will continue to provide training to our own staff during 2011/12. We are one of very few accredited suppliers in the North East and during 2011/12 we will look to scope the business opportunities to offer this service to local businesses.

**SUPPORT SERVICES****– HUMAN RESOURCES AND ORGANISATIONAL DEVELOPMENT****Developing our workforce**

Learning and development is instrumental in underpinning the successful delivery of our long term plan and ensuring staff are fully able to deliver effective and safe patient services.

During 2011/12 we will move towards more flexible learning approaches and introduce a greater range of e-learning courses and ensure we put the right facilities in place to enable staff to access this enhanced range of learning programmes.

In 2010/11 we completed the refurbishment of our training facility, Scotswood House which is based in Newcastle upon Tyne, and this is now a dedicated learning and development site available for use in 2011/12.

Since the Trust adopted the service improvement methodology (NETS), 158 staff have been involved in key development events such as Rapid Process Improvement Workshops (RPIWs) and Kaizen events. We will continue to increase the scope of involvement throughout 2011/12 and deliver the three day service improvement training to the last cohort of managers.

Our educational programmes will support the workforce in understanding the need for change, help them to identify and take part in change initiatives and enable them to develop skills for the future. They will be effectively supported through change by the HR and OD team as well as other Trust leaders as we start to implement our service redesign programmes for both A&E and PTS and as we also make the necessary enhanced structure changes within the Contact Centre.

There are a number of specific training events planned for 2011/12 to equip staff to deal with the difficult financial agenda such as:

- training to understand the QIPP agenda
- budget, waste management and cost efficiency training

We also intend to recruit five full time project managers to directly work on lean initiatives and cost improvement schemes and we will also be expanding our senior management workforce within the Operations Directorate. Over the course of the year we expect our front line workforce to grow by 24 student paramedic.

For our complete workforce plans please refer to **Appendix A**.

Our Health and Well-being Strategy will be a strong focus for 2011/12 in helping to reduce sickness related absences and ensure a motivated and engaged workforce.

## Developing the organisation

**Service Line management** is considered a key enabler to more effectively manage our business, leading to improved transparency in service line income and costs and devolving authority to service line managers to offer greater ownership of their services and control to be able to manage budgets more effectively and drive up efficiency and productivity.

Staff have received and will continue to receive the appropriate training and support to undertake this new initiative and the learning from the Contact Centre pilot will be shared throughout the organisation as we continue to roll out the initiative to the PTS, A&E and Commercial Business Services service lines.

**Performance management** is also to be strengthened throughout 2011/12, utilising the tools at our disposal such as the national Knowledge and Skills Framework, the formal appraisal and objective setting process and regular individual performance reviews. It is acknowledged that the tools and supporting HR Policy are not consistently applied throughout the organisation and there is scope for improvement.

The available performance management tools and techniques will not only be applied to individuals but made available for much wider use to help measure aspects of performance throughout the organisation to lead to clear improvement actions.

### SUPPORT SERVICES - OTHER

The key 2011/12 service development and work programmes of our support functions are detailed in Table 3.

**Table 3 2011/12 Summary Work Programme**

SUPPORT SERVICE	2011/12 PROGRAMMES
Financial and Risk Management	<ul style="list-style-type: none"> <li>Continue with shadow reporting using the Payment by Results methodology in preparation for a 'go live' from 1<sup>st</sup> April 2012 for A&amp;E</li> <li>Ongoing roll out of Service Line Management</li> <li>Detailed financial tracking for all cost improvement projects</li> <li>Action plan to attain NHSLA Level 2</li> </ul>
IM&T	<ul style="list-style-type: none"> <li>Business case development to procure an Enterprise Information Management solution</li> <li>Business case support to procure a Workforce Management System for the Contact Centre</li> <li>Implementation of additional technologies to support the 111 project</li> <li>Support roll out of e-PRF to remaining three divisions</li> <li>Ongoing development of ASPIRE, the Trust's Information Application</li> <li>Installation of an Access Control System on stations</li> <li>Upgrading of TerraFix which will enable electronic capture of vehicle daily inspection logs</li> </ul>
Communications and Public Involvement / Governance	<ul style="list-style-type: none"> <li>Upgrading of the Trust's website and facilitate the use of video and audio broadcasting</li> <li>Election, induction and implementation of the Trust's Council of Governors</li> </ul>
Clinical Services	<ul style="list-style-type: none"> <li>Completion of the sluice refurbishment programme as part of Infection control and prevention measures</li> <li>Procurement of alternative Rapid Response Vehicles defibrillators</li> </ul>
Estates Management	<ul style="list-style-type: none"> <li>New ambulance stations and relocations utilising shared primary care facilities</li> </ul>
Fleet Management	<ul style="list-style-type: none"> <li>Vehicle and equipment replacement programme; including roll out of 4x4 capability initiative</li> <li>Review of workshop provision</li> </ul>
Performance Management & Business Planning	<ul style="list-style-type: none"> <li>Development of individual performance reporting</li> <li>Ongoing development of internal performance reporting to Service Lines, and supporting contract management</li> <li>Appointment of Project Management resource to support the delivery of the Trust's cost improvement schemes</li> <li>Enhance the business development function</li> </ul>
Environmental Management	<ul style="list-style-type: none"> <li>HQ survey on carbon usage</li> <li>Solar panels installation at Pallion site</li> </ul>

### Our foundation trust status application

The Trust has made its application to Monitor and is awaiting notification for Monitor to commence their assessment.

The Trust is anticipating successful authorisation in Quarter 3 of this year.

Some of the some items in the Capital Programme have already been approved or are supported in outline by the Capital Monitoring Group.

### 3.2.6 SUMMARY OF KEY SERVICE DEVELOPMENTS WITH CAPITAL IMPLICATIONS

A summary of our planned capital and major revenue expenditure for service developments in 2011/12

INITIATIVE	CAPITAL (£'000)	REVENUE (£'000)
Vehicle and equipment replacement programme	3,564	-
IT replacement programme	457	206
IT development programme (approved/supported)	748	-
IT development programme <sup>1</sup>	350	-
E-PRF Roll-out	100	834
Estates replacement/maintenance programme	500	300
Sluice refurbishment programme	102	-
Estates development to support service line redesign programmes <sup>1</sup>	250	-
NHS 111 roll out Contact Centre refurbishment <sup>2</sup>	104	1,087

<sup>1</sup>Subject to Business Case approval

<sup>2</sup>Subject to contract award

### 3.3 SUMMARY OF FINANCIAL FORECASTS

#### 3.3.1 HOW THE PLAN WAS BUILT

The Trust's plans have been developed in accordance with the '2011/12 Operating Framework for the NHS' and take into account agreements in place with Commissioners in respect of base SLA positions and assumptions for income and cost inflation, cost improvement plans (CIPs), efficiency targets and activity growth projections.

The Trust has modelled its financial position in terms of income and expenditure for a five year period from 2011/12 to 2015/16. Assumptions relating to A&E activity growth are shown in Table 4 below, and the financial impact of these growth forecasts is reflected in the surpluses predicted over the next five years.

**Table 4 Activity and growth assumptions 2010/11 to 2014/15**

	2010/11	2011/12	2012/13	2013/14	2014/15
<i>SLA Baseline Activity</i>	350,366	365,000	370,715	375,036	371,952
<i>NEAS Forecast</i>	363,217	370,715	375,036	371,952	369,486
<b>A&amp;E Activity Growth (A&amp;E incidents)</b>	<b>12,851</b>	<b>7,497</b>	<b>4,321</b>	<b>-3,084</b>	<b>-2,466</b>
<b>A&amp;E Activity Growth</b>	<b>%</b>	<b>3.67%</b>	<b>2.06%</b>	<b>-0.82%</b>	<b>-0.66%</b>

Within the financial plan the Trust has assumed that current contracting arrangements for both A&E and PTS services will continue. As a result, in terms of the activity growth forecasts outlined above, the Trust has planned for activity growth up to 367,000 to be paid for by Commissioners at a marginal rate equal to 100% of unit cost. This reflects current over-activity payment arrangements set out in our 2011/12 Ambulance Service Contract.

Overall, the Trust is forecasting a retained I&E surplus of £2.6m in 2011/12. In 2012/13 the Trust has planned to roll-out the SPA model across the patch. Plans will be updated this year to evaluate the impact of '111' roll out. We expect A&E activity growth to slow and actually reduce in 2013-14 as a direct result of the SPA intervention. In 2012-13, additional income through over-activity is balanced off by the 1.5% reduction in core contract values. Furthermore, inflationary pressures on costs and a loss of non-recurring income enjoyed in 2011/12 sees our planned surplus decrease to £1.7m.

Reductions in predicted A&E activity in 2013/14 as a result of 111 roll-out, flat NHS income (with 0% uplifts planned) and pay and non-pay inflationary cost pressures are expected to produce a reduced financial surplus of £1.4m in 2013/14. However, in 2014/15 the I&E surplus will recover to £2.2m as the rate of reduction in activity slows and income reductions are offset by the financial consequences of continuing to meet the recurring 4.7% efficiency target set by Monitor.

Pay expenditure has been assumed to increase by a net 2.72% in 2011/12 – reflecting an annual cost of living increase of 0.55% and Agenda for Change incremental drift of 1.17% and the increase of 1% in the employers' National Insurance contribution rate. The Trust has recognised the 2 year pay freeze, however those posts under £21,000 have been increased by £250 in line with the pay circular (AforC) 2/2011. In addition to this a 0.33% increase has also been applied to a number of spine points within Band 5.

The Trust has assumed that cost of living uplifts of 2%, 2.5% and 3% will be applied to salaries in 2013/14, 2011/15 and 2015/16 - once the current public sector pay freeze ends.

Non-pay expenditure cost inflation for 2011/12 has been calculated based upon the March 2011 Consumer Price Index – equating to a 5.03% cost pressure on 2010/11 non-pay costs mainly driven by fuel, transport and clinical negligence cost increases. This reduces to 4.62% in 2012/13 and 4.2% for the remainder of the plan.

Commissioner income in 2011/12 has been reduced to reflect a 1.5% efficiency saving as outlined in the '2011/12 NHS Operating Framework' and an assumption has been made that this scale of reduction will hold for 2012/13 before reverting to flat cash (0% uplift) from 2013/14. Income due from the non-recurring CQUIN element of core service contracts will continue to be received at 1.5% in 2011/12 and this level of funding has been assumed over the remainder of the plan.

In terms of commercial business income, budgets have been revised to reflect capacity available within the department and a marketing review has been undertaken allowing us to provide for modest increases in our turnover over the period of the plan. Income inflation on commercial services activity has been assumed at 3% for 2011/12 (reflecting the need to maintain existing contracts within the current economic climate) followed by 5% uplifts from 2012-13 as the economy recovers.

The Trust's modelling includes identified inflation-adjusted cost improvement plans (CIPs) of £4.43m in 2011/12, £1.144m of which have already been removed from revenue budgets. Thereafter, after uplifting for the effects of cost inflation, we have calculated the value of future cost improvement schemes within our plan as £4.95m in 2012/13, £4.87m in 2013-14 and £5.03m in 2014/15. On this basis the Trust anticipates meeting the requirement for a 4.7% efficiency gain in each year of the plan.

Progress on achievement of the cost improvement targets is monitored on a monthly basis through the Financial Information Monitoring System (FIMS) returns to the DH which places particular emphasis on delivery of 2011/12 CIPs. Both in-year and long-term CIPs are also reported on and monitored on a monthly basis through the Trusts 'Improvement Steering Group' as well as being managed on an ongoing basis through NEAS' Programme Management Office. In addition, monthly updates on progress are produced for the Business Investment and Finance Committee as part of the Finance Report supplied by the Director of Finance.

### 3.3.2 FINANCIAL ASSUMPTIONS

The income projections on likely future changes in activity and the key financial assumptions that underpin the financial forecasts are summarised in Table 5 below:

**Table 5 Financial assumptions for the 5-year planning period**

		2011-12	2012-13	2013-14	2014-5	2015-16
<b>A&amp;E Activity Growth</b>	Incidents (no.)	370,715	375,036	371,952	369,486	368,032
	Annual % movement	2.06%	1.17%	-0.82%	-0.66%	-0.39%
<b>Income uplifts</b>						
SLA Uplift		-1.50%	-1.50%	0.00%	0.00%	0.00%
CQUIN		1.50%	1.50%	1.50%	1.50%	1.50%
Commercial Income		3.00%	5.00%	5.00%	5.00%	5.00%
<b>Pay inflation</b>	Cost of Living	0.55%	0.55%	2.00%	2.50%	3.00%
	Incremental Drift	1.17%	1.17%	1.17%	1.17%	1.17%
	Employers NI	1.00%	0.00%	0.00%	0.00%	0.00%
<b>Non-pay inflation</b>						
Overall Estimate	Based on Mar 11 CPI	5.03%	4.62%	4.23%	4.20%	4.21%
<b>Efficiency Target</b>						
Per Monitor	Assessor/Base Case	4.7%	4.7%	4.6%	4.6%	4.6%

CPI – Consumer Price Index

### 3.3.3 PHASING

The income and expenditure consequences of the major service developments have been phased in across the period as described below:

**NHS 111** – Given our strength as a provider of NHS 111, we have modelled NHS 111 in our financial plans assume that we become the preferred provider following the procurement. The model is phased in from 1<sup>st</sup> September 2011, with all commissioners cluster going live, with coverage increasing over the life of the plan.

### 3.3.4 INVESTMENT AND DISPOSAL PLANS

The Trust's forecast Capital Programme is attached at **Appendix B**. The Trust is allowed to spend its forecast depreciation and in-year surplus and to supplement this where necessary by accessing its Public Borrowing Limit (PBL).

The PBL is set by the DH taking into account each individual Trust capital asset position and cash position. Any funding accessed via PBL is subject to 3.5% interest chargeable to revenue. This charge is in addition to normal capital charges incurred.

Capital investment and disposal plans over the five-year planning period are based upon the priorities identified within the Trust's Estates Strategy which seeks to maintain and improve the existing asset base of the Trust.

The capital forecasts account for the investment requirements of known IT developments as well as anticipating future strategic IT developments whilst keeping borrowing to a minimum. Apart from the normal cycle of the vehicle replacement and vehicle tracking system replacement programmes these developments constitute the major influence on the Trust's Capital Programme for the period.

The Capital Programme also reflects the on-going Estates Strategy to move towards smaller locations that facilitate the optimisation of A&E response times. The programme includes resources to be raised from the disposal of existing sites at Hartlepool, St John's Chapel, Middleton in Teasdale, Alnwick, Berwick, Haltwhistle, Bellingham and Wallsend as well as the re-provision of more fit-for-purpose facilities in each of these localities. The Trust has also planned for the disposal of its former regional training facility at Fulbeck Grange during 2012-13, with services having moved to existing locations during 2010/11. Estimates of likely sale receipts from these disposals will be closely monitored in the current economic climate as any reduction in potential sales values will have an effect on the capital resources available to fund new facilities. As it stands, the financial strategy has sufficient capital funds remaining to enable the Trust to meet its programmed expenditure for the period.

The capital charges implications of the planned capital programmes have been modelled and taken into account in the revenue projections shown in **Appendix C**.

### 3.3.5 COST IMPROVEMENT PROGRAMME (CIP)

The Trust has formulated its CIP schemes for the planning period to account for both the current challenging economic environment and to reflect anticipated reductions in contracted income of 1.5% in 2011/12 and 2012/13. At present, the financial plan identifies the level of efficiencies required by the organisation each year – although, as detailed in section 3.3.1 above £1.144m of CIPs have already been taken into account within the core revenue plan for 2011/12.

Detailed CIPs that have been developed for 2011/12 include Fleet schemes totalling £476k, PTS modernisation savings of £334,000, Support Services Review £131,000, IT infrastructure savings of £140,000, absence reduction savings of £422,000 (achieved through sickness reduction) and £670,000 saved on training costs due to the reductions in the numbers and change to our approach to student paramedic training.

The Trust has an extensive cost improvement programme for the next five years which we recognise as being crucial to securing the Trust's financial position during a lengthy period of economic uncertainty. The target efficiencies identified for each year of the plan will continue to be monitored by the Trust Board, the Improvement Steering Group and the Trust's Programme Management Office.

## 4.1 GOVERNANCE RISK

### 4.1.1 GOVERNANCE COMMENTARY

In preparation for foundation trust we adopted the governance requirements as defined in the Compliance Framework for Foundation Trusts back in 2009/10. Table 6 summarises our self assessment.

**Table 6 Monitor Compliance Self-assessment**

REQUIREMENT	COMMENTARY
<b>Legality of constitution</b>	In preparing its draft Constitution, the Trust adopted areas of best-practice of existing Foundation Trusts, took account of the NHS Act 2006 and the NHS Foundation Trust Code of Governance.  It was reviewed following our consultation and more recently updated to reflect the changes in the NHS FT Code of Governance Update released in 2010 for the year 2010/11. Any changes arising in year from the Health and Social Care Bill will be monitored against our Constitution to ensure it continues to be fit for purpose.
<b>Growing a representative membership</b>	A membership strategy was approved by the Trust Board following extensive consultation with patient and public representatives. We have a membership base of around 10,000 and we intend to grow this by targeting areas of representation to align with the profile of our population according to the Office for National Statistics. Our plans will be reviewed during 2011/12 now that the majority of Governors have been appointed.
<b>Appropriate Board roles and structures</b>	The role of the Board, in its broadest sense, is outlined in the Trust's Constitution and is in line with available guidance.
<b>Service Performance (targets/national standards)</b>	The Board is assured that plans are in place to more effectively mitigate against severe weather conditions and the senior management team are actively working with commissioning colleagues to alleviate the pressures created from increasing demand. With this work underway it is predicted that we will achieve all of our national targets and standards.
<b>Clinical quality and patient safety</b>	Effective arrangements are already in place to monitor the continuous improvement of patient safety and the quality of healthcare delivered to our patients. We continue to be registered with the Care Quality Commission has without conditions and where applicable we ensure all of our partners and sub-contractors are also registered.
<b>Effective risk and performance management</b>	Risk management procedures are in place and our compliance framework is now aligned to the Trust's strategic intentions and objectives. The role of Performance Management within the Trust continues to be enhanced to effectively improve areas of performance in all of the Trust's business.
<b>Cooperation with NHS bodies and local authorities</b>	The Trust works in partnership with the Department of Health, North East Strategic Health Authority, Local Primary Care Organisations, NHS Trusts and Foundation Trusts, community transport providers, voluntary agencies, the Local Involvement Networks and Local Authorities in the North East.

### 4.1.2 SIGNIFICANT RISKS

The Trust's significant risks in relation to governance are shown in Table 7.

**Table 7 Governance risks**

Governance risk description	Impact	Risk Rating	Actions to rectify /mitigation	New Risk Rating
Unable to secure staff engagement or involvement in strategic and annual plans. Resistance to change from staff.	Strategic implementation plans may be delayed if unsupported by staff. Ongoing requirement for change adversely effects staff well-being Unable to recruit to Council of Governors	15	Minimising staff resistance to plans through effective engagement strategies Staff representation on all key committees and working groups Regular communications with all staff groups and dissemination of briefing updates Staff and trade union involvement in changes Continuous involvement of staff in service improvement activity Addressed areas of staff survey – this work will be ongoing	10
Inability to implement our plans due to annual and long term financial targets and objectives not being met.	Unable to invest in our service development plans, clinical innovation and future initiatives. Viewed as a performance failure Staff training programmes under threat	15	Robust financial controls in place Introduction of Service Line Manager offering enhanced control of costs A programme of CIP schemes has commenced. These will be formally monitored by the Improvement Steering Group, chaired by the CEO using Programme Management processes. The Trust is committed to working with Commissioners to develop and explore how we can support their QIPP plans. A number of mitigating CIP schemes have been identified to address any shortfalls against current planned schemes or additional requirements arising from changes in government policy.	10

## 4.2 MANDATORY SERVICES RISK

### 4.2.1 MANDATORY SERVICES COMMENTARY

The Trust will continue to provide Accident and Emergency Services. The contracted incident activity for 2011/12 is 365,000. There are financial penalties in place with our Commissioner for failure to achieve both the Category A 8 minute and 19 minute performance targets trust-wide. Nationally, the Trust is still only required to deliver trust-wide performance.

The call handling and triage of 999 calls from the general public and other calls and requests from healthcare professionals, where a response is required within 4 hours will be maintained by the Trust and all calls are to be prioritised and classified in line with guidance published from time to time by the DH utilising NHS Pathways triage system or manual fall back arrangements as either Categories A or C (or R1,2 and Green1-4 as described early).

The main block contracts have been agreed for our Patient Transport Services amounting to 891,924 journeys.

We will continue to provide emergency preparedness services to deliver our obligations as a Category 1 Responder under the relevant legislation including but not limited to the Civil Contingencies Act 2004, and in line with the requirements of the DH's Emergency Planning Guidance.

**Table 8 Mandatory services risks**

Mandatory risk description	Impact	Risk Rating	Actions to rectify /mitigation	New Risk Rating
Uncertainty of conditions that contribute to significant 'spikes' or fluctuations in demand. The external influences affecting operational delivery.	<ul style="list-style-type: none"> <li>Performance failure, threatening their recovery/chance of survival</li> <li>Failure to achieve quarterly performance of Category A targets</li> <li>Risk to staff working in treacherous driving conditions</li> <li>Staff shortfalls (Olympics and sickness)</li> <li>Increased cost to deploy additional resources</li> <li>Increased activity linked to marginal rate payment for over activity</li> <li>Care delivery compromised</li> </ul>	<b>12</b>	<ul style="list-style-type: none"> <li>The Trust has plans in place to deal with emergencies. REAP to protect category A response.</li> <li>Plans are in place with our partners; a national framework for winter planning for all of those involved in emergency and urgent care.</li> <li>Olympic planning</li> <li>Proactively reviewing indicative clinical performance of new measures</li> </ul>	<b>8</b>
Significant change in commissioning could destabilise contracting process. Unwillingness to fund developments e.g. JRCALC recommendations.	<ul style="list-style-type: none"> <li>Complex contract negotiations</li> <li>New performance/penalty framework requiring adjustments to be made to long term plans</li> <li>Potential loss of PTS contracts</li> <li>Potential reduction of Financial Risk Rating</li> <li>Potential weakening of organisational resilience</li> <li>Potential patient safety implications</li> </ul>	<b>12</b>	<ul style="list-style-type: none"> <li>Early relationship management development with GP Consortia</li> <li>GP Advisory Board established</li> <li>Proactive marketing of our services to the GP community</li> </ul>	<b>8</b>

## 4.3 FINANCIAL RISK

### 4.3.1 FINANCIAL RISK COMMENTARY

The financial plan for 2010/11 covers all known risks included in the Trust's financial risk register, which is updated monthly and presented to the Board. Should financial risk begin to increase, mitigating actions are recommended to and approved by the Board.

There are a number of financial risks that could materially affect financial performance and these are outlined in our downside scenarios in Table 9.

### 4.3.2 SIGNIFICANT RISKS

Our significant financial risks are shown in Table 9.

**Table 9 Financial risks**

Financial risk description	Impact	Risk Rating	Actions to rectify /mitigation	New Risk Rating
Loss of income arising from reduced activity does not equate to the cost of service provision that is required to sustain current levels of A&E service provision and performance.	Inability to deliver a safe and effective service, putting patients at risk Complex contract negotiations	8	Modelling negates risk of activity reducing to a level that would destabilize A&E provision Ongoing development of PbR, encourage transparency of costs.	6
Inability to secure understanding and 'buy-in' to achieving long-term financial plan / failure to communicate meaning of FRR / lack of commitment to cost improvement plan	Unable to achieve long-term strategies and CIP's due to lack of support. Potential weakening of Trust's reputation Potential weakening of Trust' financial position	15	Board receives regular update reports Articles communicated in Pulse to staff. Improvement Steering Group includes staff side representatives. RPIW reports and action plans Joint management and staff meeting to plan modernisation of Accident and Emergency services	10

### 4.3.3 SERVICE LINE REPORTING

Service Line Reporting continues to improve within the Contact Centre pilot and is gradually being rolled out to the other service lines. The development of the Trust's information system, ASPIRE, is enabling the linking of financial and operational information. The Contact Centre pilot will be formally evaluated during 2011/12 and the learning will be used to inform the roll out.

The roll out timetable is shown below:

Phase II	Complete the roll out to service lines and profit centres
	Put appropriate management arrangements in place
	Establishment a comprehensive set of service level agreements
	Establishment of information and key performance requirements
	Performance management framework put in place
Phase III	Development and agreement of service line autonomy arrangements
	Redesign of Trust's Integrated Performance Report to provide a SLM perspective
	Project Evaluation to be completed
	Implementation of new autonomy rules

## 5.1 BOARD STATEMENTS

The Trust Board is composed of 15 members; a Chairman, five Non-Executive Directors, two Non-Executive Directors (designate) and seven Executive Directors, one of whom is the Chief Executive.

The role of the Board is to:

- provide active leadership for the organisation
- set its strategic direction and aims, ensuring that both financial and human resources are in place, and
- monitor and review management performance.

The Board also determines the organisation's values and standards and ensures these are maintained in the conduct of the business of the whole organisation. All Board members subscribe to the 'Codes of Conduct and Accountability in the NHS'. A key function of the Board is to ensure that there is effective dialogue between the local community on its plans and performance.

In essence, the Board upholds the following principles:

- focuses on the organisation's purpose and quality of services for patients
- ensures the organisation performs effectively in clearly defined functions and roles
- promotes and demonstrates the values of good governance through its behaviour
- takes informed, transparent decisions and manages risk
- develops its capacity and capability to be effective
- engages stakeholders and makes accountability real.

Non-Executive Directors contribute to the development of strategy and have an important role in scrutinising the performance of management in meeting agreed goals and objectives and monitoring the reporting of performance. Non-Executive Directors are drawn from the local community and therefore, have a particular duty to it. They can ensure that the voice of the public is heard in decision-making and that the interests of patients and the community remain at the heart of Board discussions. Non-Executives also have a role in working with the Chairman in the appointment and remuneration of the Chief Executive and other Board members, as members of the Trust Remuneration Committee and Terms of Service.

Executive Directors share the same corporate responsibilities as Non-Executive colleagues but bring detailed knowledge of the organisations management systems and processes and of the health sector, as well as specialised clinical and managerial expertise.

As reported by the Chairman in his introduction to this Annual Plan, much of the Board's attention has been focused upon monitoring the quality of our services to ensure that high standards of care are maintained during a period of significant organisational development as the Trust prepares for foundation trust status.

The Board reviews its performance annually and has undergone development work in-year to build a confident, capable and cohesive Board that is equipped with the competencies required to successfully and effectively govern.

The Trust Board can confirm that:

- It is satisfied that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability.
- The Trust's selection process and training programmes ensure that non-executive directors have appropriate experience and skills and that the management team has the capability and experience to deliver its Annual Plan and organisational objectives for the next five years.

### **Clinical quality**

The Board of Directors is required to confirm the following:

- The Board is satisfied that, to the best of its knowledge and using its own processes (supported by Care Quality Commission information and including any further metrics it chooses to adopt), the Trust has and will keep in place effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.
- The Board is satisfied that, to the best of its knowledge and using its own processes the plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements; and
- The Board is satisfied that processes and procedures are in place to ensure that all medical practitioners (nurses and paramedics) providing care on behalf of the Trust have met the relevant registration and revalidation requirements.

### **Mandatory services**

The Board of Directors is required to confirm the following:

- The Board is satisfied that it expects its Trust to be able to continue to provide its mandatory services.

### **Service performance**

The Board of Directors is required to confirm the following:

- The Board is satisfied that plans are in place to ensure ongoing compliance with all existing targets (after the application of thresholds) and national core standards, and a commitment to comply with all known targets going forwards.

### **Risk management**

The Board of Directors is required to confirm the following:

- Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner;
- All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned;
- The necessary planning, performance management and risk management processes are in place to deliver the Annual Plan;
- A Statement of Internal Control (“SIC”) is in place, and the Trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to most up to date guidance from HM Treasury ([www.hm-treasury.gov.uk](http://www.hm-treasury.gov.uk)).
- The Trust has achieved 80% compliance performance against the requirements of their Information Governance Statement of Compliance (IGSoC) in the Department of Health’s Information Governance Toolkit.

## 6.1 MEMBERSHIP STRATEGY REPORT

As an aspirant FT the Trust has already started to build a membership. We started the year with more 9,000 members; of which more than 7,300 are public members drawn from the communities we serve.

As we move closer to FT, Trust services will be owned by, and accountable to, local people and our employees. In this way, much stronger connections will be established between our stakeholder communities and us. We do however already seek to involve service users and carers in how we deliver and develop our services. We work closely with Local Involvement Networks, patient groups and community representatives and will continue to do so as a Foundation Trust. We will also continue to use the feedback we receive through local and national patient surveys and Local Authority Health Overview and Scrutiny Committees.

Membership does not change the way people are treated, or give any benefits, but members will:

- Have a say in our success and influence direction
- Receive regular information on our activities and performance
- Be consulted on major plans for future developments and services
- Be able to vote in elections to the Council of Governors
- Have the right to stand for election to the Council of Governors.

We agreed a membership strategy back in 2009-10, which aims to support our vision and this year will continue to see us arranging a number of events and activities to involve our communities in what we do.

## 6.2 COMMENTARY OF MEMBERSHIP

The profile of the NEAS public membership is compared against the records held by the Office of National Statistics (ONS) to determine how representative the NEAS membership is of the North East population.

### *Gender profile*

PUBLIC CONSTITUENCY	Number of members	Eligible population in North East	Over of under representation index
			(100 = ideal representation)
On 1 April 2010	7,203		
New members	567		
Members leaving	434		
(predicted) on 31 March 2011	7,336	2,509,017	
Male	3,774	1,216,238	106
Female	3,543	1,293,997	93

There is a small discrepancy between the member base and eligible population, as defined from the Office for National Statistics (ONS) data, but it is clear that both genders are strongly represented. While the top line findings here show a fairly close match, with a slight under-representation of female membership, the overall profile is skewed by an under representation of women particularly on Teesside and also to some extent in the South of Tyne area.

**Age profile**

PUBLIC CONSISTENCY	NUMBER OF MEMBERS	ELIGIBLE POPULATION IN NORTH EAST	OVER OR UNDER REPRESENTATION INDEX
0-16	1	33,289	1
17-21	438	163,479	91
22+	6,280	2,312,249	93

In the over-70s group there is more than a 5% gain compared to the related ONS data that represents our eligible membership. At the opposite end of the spectrum, there is an under representation of all ages under 51. This is found amongst all areas apart from the South of Tyne constituency, which has a near optimal level of members for the 34 to 42 group; and Teesside, which has a slight over-representation among the 43 to 51 year olds group. There is a portion of people who did not disclose their age, but this does not account for the deficits in the other age groups. There is an over-representation of members in the older groups.

While the membership base profile for age is not a perfect fit to be representative of the North East, no group suffers from negligible representation. It is often common that all membership groups of this type will suffer from slight recruitment apathy from the younger groups, particularly in the health sector. Our current levels are acceptable and will provide adequate representation of the local populous. Given this, some groups would benefit from increasing membership drives.

**Ethnicity profile**

PUBLIC CONSTITUENCY	NUMBERS OF MEMBERS	ELIGIBLE POPULATION IN NORTH EAST	OVER OF UNDER REPRESENTATION INDEX
			(100 = IDEAL REPRESENTATION)
WHITE	6,760	2,449,873	94
MIXED	98	12,231	275
ASIAN	191	33,589	195
BLACK	30	3,867	266
OTHER	50	10,176	168

The overall North East profile presents an excellent representation of all but one of the expected ethnicities. White British show the highest deficit, but this is acceptable as it demonstrates the Trust caters for all ethnicities. The following would benefit from increased recruitment: White, Black Caribbean and White Irish. These groups have slightly lower than optimal representation.

***Socio economic sub group profile***

PUBLIC CONSTITUENCY	Number of members	Eligible population in North East	Over or under representation index
			(100 = ideal representation)
ABC1	3,645	851,203	146
C2	2,265	318,575	243
D	300	402,739	25
E	1,034	399,010	88

A major overrepresentation of professional and associate professional people is found in the overall profile. This overrepresentation is mirrored in each of the four constituencies. These members are likely to be middle class and relatively high earners and are people who are more likely to be engaged and interested in being members of any public body.

There is an under-representation of managers and senior officials, those from elementary occupations and administrative roles.

**6.3 MEMBERSHIP SIZE**

One indicator of the appropriateness of the size of the Trust member base is by setting the ideal sample size for the North East. As any member of the population of the North East may require use of our services it is fair to say that we should attempt to represent the whole region. An ideal sample size is how many people we need to consult in order to get results reflecting the target population precisely.

Currently, our membership level is at 7,203 (March 2011). Having a large and representative membership base, as we have achieved to a satisfactory degree, results in an organisation that can be confident that the decisions that are reached are accountable to its members and more importantly to the public they represent. Ideally, we are looking at recruiting more members, with a target membership level of 9,567, as this should make our membership yet further representative of our region.

## Schedule 1 A&amp;E Activity Plan

1<sup>st</sup> April 2011 – 31<sup>st</sup> March 2012

<b>Contract Activity 2011-12</b>													
	<b>Apr-11</b>	<b>May-11</b>	<b>Jun-11</b>	<b>Jul-11</b>	<b>Aug-11</b>	<b>Sep-11</b>	<b>Oct-11</b>	<b>Nov-11</b>	<b>Dec-11</b>	<b>Jan-12</b>	<b>Feb-12</b>	<b>Mar-12</b>	<b>Total</b>
Northumbria	3,280	3,442	3,279	3,490	3,311	3,282	3,606	3,490	3,766	3,483	3,170	3,426	41,025
North Tyneside	2,081	2,184	2,080	2,214	2,100	2,082	2,288	2,214	2,389	2,210	2,011	2,173	26,026
Newcastle	3,823	4,012	3,821	4,067	3,859	3,826	4,203	4,067	4,389	4,060	3,695	3,993	47,815
<b>NoT Cluster</b>	<b>9,184</b>	<b>9,641</b>	<b>9,183</b>	<b>9,774</b>	<b>9,273</b>	<b>9,193</b>	<b>10,100</b>	<b>9,774</b>	<b>10,547</b>	<b>9,756</b>	<b>8,878</b>	<b>9,595</b>	<b>114,898</b>
Gateshead	2,405	2,524	2,404	2,558	2,427	2,406	2,644	2,558	2,761	2,554	2,324	2,512	30,077
South Tyneside	1,701	1,785	1,701	1,810	1,717	1,703	1,870	1,810	1,953	1,807	1,644	1,777	21,278
Sunderland	3,450	3,620	3,448	3,670	3,482	3,452	3,792	3,670	3,960	3,663	3,334	3,603	43,144
<b>SoT Cluster</b>	<b>7,556</b>	<b>7,929</b>	<b>7,553</b>	<b>8,038</b>	<b>7,627</b>	<b>7,561</b>	<b>8,306</b>	<b>8,038</b>	<b>8,675</b>	<b>8,023</b>	<b>7,302</b>	<b>7,892</b>	<b>94,500</b>
Co. Durham	5,332	5,595	5,330	5,672	5,382	5,335	5,862	5,672	6,121	5,662	5,153	5,569	66,685
Darlington	1,059	1,112	1,059	1,127	1,069	1,060	1,165	1,127	1,216	1,125	1,024	1,106	13,249
<b>Durham Cluster</b>	<b>6,391</b>	<b>6,707</b>	<b>6,389</b>	<b>6,799</b>	<b>6,451</b>	<b>6,395</b>	<b>7,026</b>	<b>6,799</b>	<b>7,338</b>	<b>6,787</b>	<b>6,176</b>	<b>6,675</b>	<b>79,933</b>
Stockton - on - Tees	1,719	1,804	1,718	1,829	1,735	1,720	1,890	1,829	1,973	1,825	1,661	1,795	21,498
Hartlepool	1,109	1,164	1,109	1,180	1,119	1,110	1,219	1,180	1,273	1,178	1,072	1,158	13,871
<b>North of Tees</b>	<b>2,828</b>	<b>2,968</b>	<b>2,827</b>	<b>3,008</b>	<b>2,854</b>	<b>2,830</b>	<b>3,109</b>	<b>3,009</b>	<b>3,247</b>	<b>3,003</b>	<b>2,733</b>	<b>2,954</b>	<b>35,370</b>
Redcar and Cleveland	1,439	1,510	1,438	1,531	1,452	1,440	1,582	1,531	1,652	1,528	1,390	1,503	17,996
Middlesborough	1,780	1,868	1,779	1,894	1,797	1,781	1,957	1,894	2,044	1,890	1,720	1,859	22,263
<b>South of Tees</b>	<b>3,219</b>	<b>3,381</b>	<b>3,221</b>	<b>3,428</b>	<b>3,252</b>	<b>3,224</b>	<b>3,542</b>	<b>3,428</b>	<b>3,699</b>	<b>3,421</b>	<b>3,114</b>	<b>3,365</b>	<b>40,294</b>
<b>Tees Cluster</b>	<b>6,047</b>	<b>6,349</b>	<b>6,047</b>	<b>6,436</b>	<b>6,107</b>	<b>6,054</b>	<b>6,651</b>	<b>6,436</b>	<b>6,946</b>	<b>6,424</b>	<b>5,846</b>	<b>6,319</b>	<b>75,662</b>
<b>Total A &amp; E</b>	<b>29,178</b>	<b>30,626</b>	<b>29,172</b>	<b>31,047</b>	<b>29,458</b>	<b>29,203</b>	<b>32,083</b>	<b>31,047</b>	<b>33,506</b>	<b>30,990</b>	<b>28,202</b>	<b>30,481</b>	<b>364,993</b>

Please note our Out of Area activity is not shown in this contract plan

## Schedule 1 PTS Activity Plan

1<sup>st</sup> April 2011 – 31<sup>st</sup> March 2012

	<b>Total baseline activity 2011/12</b>
Northumberland	139,473
North Tyneside	72,593
Newcastle	97,556
<b>NoT Cluster</b>	<b>309,622</b>
Gateshead	90,418
South Tyneside	68,039
Sunderland	76,971
<b>SoT Cluster</b>	<b>235,428</b>
Co Durham	159,615
Darlington	12,110
<b>Durham Cluster</b>	<b>171,725</b>
Stockton	40,917
Hartlepool	31,065
Redcar	47,916
Middlesbrough	55,251
<b>Teeside Cluster</b>	<b>175,149</b>
<b>Total</b>	<b>891,924</b>

## SUMMARY OF ABBREVIATIONS USED IN THE NORTH EAST AMBULANCE SERVICE NHS TRUST ANNUAL PLAN

<b>CIP</b>	Cost Improvement Programme
<b>C Diff</b>	Clostridium Difficile
<b>CQC</b>	Care Quality Commission
<b>EBITDA</b>	Earnings before Interest, Tax and Amortisation
<b>ECS</b>	Emergency Care System
<b>FT</b>	Foundation Trust
<b>HCAI</b>	Healthcare Associated Infection
<b>HCC</b>	Healthcare Commission
<b>I&amp;E</b>	Income and Expenditure
<b>IFRS</b>	International Financial Reporting Standards
<b>NHSLA</b>	National Health Service Litigation Authority
<b>MPET</b>	Multi-Professional Education and Training
<b>MRSA</b>	Methicillin-resistant Staphylococcus aureus
<b>NMET</b>	Non-Medical Education and Training
<b>NPSA</b>	National Patient Safety Agency
<b>PbR</b>	Payment by Results
<b>PDC</b>	Public Dividend Capital
<b>PCT</b>	Primary Care Trust
<b>SDS</b>	Service Development Strategy
<b>SHA</b>	Strategic Health Authority
<b>SLA</b>	Service Level Agreement
<b>WTE</b>	Whole Time Equivalent

## Appendix A – Workforce Plan 2011/12 to 2015/16

		2011-12	2012-13	2013-14	2014-15	2015-16
<b>Staff Group</b>		wte	wte	wte	wte	wte
TL & Paramedics	Establishment	628.00	624.30	612.88	586.37	586.37
	Staff in Post (SIP)	594.47	604.90	600.03	573.30	557.33
	Vacancies	33.53	19.40	12.84	13.07	29.03
	<i>Vacancy %</i>	5.3%	3.1%	2.1%	2.2%	5.0%
Adv Technicians	Establishment	141.43	133.36	123.57	114.50	106.09
	SIP	160.36	147.57	114.50	106.09	98.30
	Vacancies	-18.93	-14.21	9.07	8.41	7.79
	<i>Vacancy %</i>	-13.4%	-10.7%	7.3%	7.3%	7.3%
ECSW & UCAs	Establishment	265.63	270.39	264.80	265.74	274.15
	SIP	290.82	283.30	276.99	277.27	284.55
	Vacancies	-25.19	-12.91	-12.19	-11.52	-10.41
	<i>Vacancy %</i>	-9.5%	-4.8%	-4.6%	-4.3%	-3.8%
A&E Management	Establishment	9.00	7.00	6.00	5.00	5.00
	SIP	9.00	7.00	6.00	5.00	5.00
	Vacancies	0.00	0.00	0.00	0.00	0.00
	<i>Vacancy %</i>	0.0%	0.0%	0.0%	0.0%	0.0%
A&E Control (inc SPA Pilot)	Establishment	214.56	206.56	199.56	192.56	185.56
	SIP	202.21	198.87	191.55	184.28	176.03
	Vacancies	12.35	7.69	8.01	8.28	9.53
	<i>Vacancy %</i>	5.8%	3.7%	4.0%	4.3%	5.1%
EP Staff (inc HART)	Establishment	47.00	47.00	45.00	45.00	45.00
	SIP	42.89	46.81	44.61	44.42	44.24
	Vacancies	4.11	0.19	0.39	0.58	0.76
	<i>Vacancy %</i>	8.8%	0.4%	0.9%	1.3%	1.7%

## Appendix A – Workforce Plan 2011/12 to 2015/16 (Continued)

		2011-12	2012-13	2013-14	2014-15	2015-16
Staff Group		wte	wte	wte	wte	wte
PTS Staff	Establishment	434.47	434.47	434.47	434.47	434.47
	SIP	408.42	408.42	408.42	408.42	408.42
	Vacancies	26.05	26.05	26.05	26.05	26.05
	<i>Vacancy %</i>	<i>6.0%</i>	<i>6.0%</i>	<i>6.0%</i>	<i>6.0%</i>	<i>6.0%</i>
PTS Management	Establishment	3.00	2.00	1.00	1.00	1.00
	SIP	3.00	2.00	1.00	1.00	1.00
	Vacancies	0.00	0.00	0.00	0.00	0.00
	<i>Vacancy %</i>	<i>0.0%</i>	<i>0.0%</i>	<i>0.0%</i>	<i>0.0%</i>	<i>0.0%</i>
PTS Control	Establishment	49.34	45.34	41.34	37.34	34.34
	SIP	49.34	45.34	41.34	37.34	34.34
	Vacancies	0.00	0.00	0.00	0.00	0.00
	<i>Vacancy %</i>	<i>0.0%</i>	<i>0.0%</i>	<i>0.0%</i>	<i>0.0%</i>	<i>0.0%</i>
Operational Support	Establishment	74.60	71.85	70.85	70.85	70.85
	SIP	74.08	71.33	70.33	70.33	70.33
	Vacancies	0.52	0.52	0.52	0.52	0.52
	<i>Vacancy %</i>	<i>0.7%</i>	<i>0.7%</i>	<i>0.7%</i>	<i>0.7%</i>	<i>0.7%</i>
Corporate Staff	Establishment	220.36	217.86	217.86	217.86	217.86
	SIP	220.05	216.15	216.15	216.15	216.15
	Vacancies	0.31	1.71	1.71	1.71	1.71
	<i>Vacancy %</i>	<i>0.1%</i>	<i>0.8%</i>	<i>0.8%</i>	<i>0.8%</i>	<i>0.8%</i>
<b>Total - All Staff</b>	<b>Establishment</b>	<b>2,087.39</b>	<b>2,060.13</b>	<b>2,017.33</b>	<b>1,970.68</b>	<b>1,960.68</b>
	<b>SIP</b>	<b>2,054.63</b>	<b>2,031.68</b>	<b>1,970.92</b>	<b>1,923.59</b>	<b>1,895.69</b>
	<b>Vacancies</b>	<b>32.76</b>	<b>28.46</b>	<b>46.41</b>	<b>47.10</b>	<b>64.99</b>
	<b><i>Vacancy %</i></b>	<b><i>1.6%</i></b>	<b><i>1.4%</i></b>	<b><i>2.3%</i></b>	<b><i>2.4%</i></b>	<b><i>3.3%</i></b>

## Appendix B – Five year forecast capital programmes

<b>FIVE YEAR CAPITAL PLAN</b>	<b>2011-12</b>	<b>2012-13</b>	<b>2013-14</b>	<b>2014-15</b>	<b>2015-16</b>
	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>
<b><u>Vehicle &amp; Equipment Programme</u></b>					
A&E Vehicles	1,574	1,914	1,914	1,914	1,914
Rapid Response Vehicles (RRV)	373	330	330	330	330
RRVs (HART)			55		
PTS Vehicles	750	1,469	1,469	1,469	1,469
Community Vehicles (Northumberland)	200			80	80
Training Vehicles	0	0	0	80	80
A&E Equipment (exc. Defibrillators)	281	281	281	281	281
A&E Defibrillators	0	255	255	255	255
RRV Equipment	22	22	22	22	22
RRV Defibrillators	186	0	0	0	186
PTS Equipment	44	62	62	62	62
Critical Care Trolleys				359	359
HART - Equipment	135			80	
<b>Sub-total Vehicle &amp; Equipment Programme</b>	<b>3,564</b>	<b>4,332</b>	<b>4,387</b>	<b>4,931</b>	<b>5,037</b>
<b><u>IT Programme</u></b>					
Vehicle Tracking (aka MDT/Terrafix)	243	446	0	0	461
IT Hardware replacement	60	100	0	0	100
CAD - Hardware / SAN Reprovision			154		
Russell House control			30	370	
Back up solution				27	
Virtualisation (of servers) solution			12		
Replacement Anti-Virus solution	39				
Network & telephony	15				
IT Developments	350	450	450	450	450
Russell House Firewall N3 connection	11				
PTS Terrafix Incremental Changes	19				
Stores bar coding	25				
Enterprise Information Management	360	12			
Access & Control System	258				
Trust website	55				
Fuel Management system (IT)	6				
<b>Sub-total IT Programme</b>	<b>1,441</b>	<b>1,008</b>	<b>646</b>	<b>847</b>	<b>1,011</b>

## Appendix B – Five year forecast capital programmes (continued)

<b>FIVE YEAR CAPITAL PLAN (Continued)</b>	<b>2011-12</b>	<b>2012-13</b>	<b>2013-14</b>	<b>2014-15</b>	<b>2015-16</b>
	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>
<b><u>Estates Programme</u></b>					
Health and Safety	205	205	205	205	205
Invest to save	205	205	205	205	205
Garage Doors	50				
Sluice Room facilities	102				
Replacement Plant & Machinery	40	40	40	40	40
Control Room - Furniture Replacement			205	80	
Strategic Estates Developments	250	500	500	500	900
Fuel Pumps & Fuel Management system	0				
Scotswood lease - outright purchase					3,000
<b>Sub-total Estates Programme</b>	<b>852</b>	<b>950</b>	<b>1,155</b>	<b>1,030</b>	<b>4,350</b>
<b>Total Gross Base Capital Expenditure</b>	<b>5,858</b>	<b>6,290</b>	<b>6,188</b>	<b>6,808</b>	<b>10,398</b>
<b>Service Developments:</b>					
<b><u>111 Roll-out</u></b>					
Single Point of Access/111 Roll-out (IT)	14	0	0	0	0
Single Point of Access/111 Roll-out (Furniture only)	104	0	0	0	0
	<b>118</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>EPRF System</b>					
EPRF System	100		25		11
	<b>100</b>	<b>0</b>	<b>25</b>	<b>0</b>	<b>11</b>
<b>Total Service Development Capital Spend</b>	<b>218</b>	<b>0</b>	<b>25</b>	<b>0</b>	<b>11</b>
<b>Charge against the CRL</b>	<b>6,076</b>	<b>6,290</b>	<b>6,212</b>	<b>6,808</b>	<b>10,409</b>

## Appendix C – Income and revenue expenditure position 2011/12 to 2015/16

	2011-12	2012-13	2013-14	2014-15	2015-16
	£m	£m	£m	£m	£m
<b>Protected/Mandatory Clinical Revenue</b>					
A&E - Cost & Volume Contract Revenue *	0.4	68.0	67.8	67.3	66.9
Other - Cost and Volume Contract Revenue	0.2	5.9	8.0	7.9	7.9
A&E - Block Contract Revenue *	70.0	0.0	0.0	0.0	0.0
PTS - PCT Block Contract Revenue	19.0	18.8	18.8	18.8	18.8
PTS - Non PCT Block Contract Revenue	1.5	1.5	1.5	1.5	1.5
Other - Block Contract Revenue	11.1	11.1	11.1	11.1	11.1
<b>Protected Revenue, Total</b>	<b>102.2</b>	<b>105.3</b>	<b>107.1</b>	<b>106.6</b>	<b>106.1</b>
<b>Other Operating Revenue</b>					
Education and Training	1.5	1.5	1.6	1.6	1.7
Research & Development	0.2	0.1	0.1	0.1	0.1
PFI Specific revenue	0.0	0.0	0.0	0.0	0.0
Other Operating Revenue	3.2	1.7	1.6	1.6	1.7
<b>Other Operating revenue, Total</b>	<b>4.9</b>	<b>3.4</b>	<b>3.2</b>	<b>3.3</b>	<b>3.4</b>
<b>Operating Revenue and Income, Total</b>	<b>107.1</b>	<b>108.6</b>	<b>110.4</b>	<b>109.9</b>	<b>109.6</b>
<b>Operating Expenses</b>					
Employee Benefit Expenses (Pay)	-70.1	-73.4	-74.9	-73.4	-72.0
Vehicle Leasing Expenses	-0.5	-0.5	-0.5	-0.5	-0.5
Vehicle Insurance Expenses	-1.0	-1.1	-1.1	-1.1	-1.2
Vehicle Maintenance / Other Expenses	-1.9	-1.9	-1.8	-1.8	-1.8
Fuel Expenses	-3.9	-4.2	-4.4	-4.6	-4.9
Other Expenses	-17.6	-17.8	-16.8	-17.1	-16.9
<b>Operating Expenses, Total</b>	<b>-95.1</b>	<b>-99.0</b>	<b>-99.5</b>	<b>-98.6</b>	<b>-97.3</b>
<b>EBITDA**</b>	<b>12.0</b>	<b>9.7</b>	<b>10.9</b>	<b>11.3</b>	<b>12.3</b>
<i>EBITDA margin (%)</i>	11.2%	8.9%	9.8%	10.3%	11.2%

## Appendix C – Income and revenue expenditure position 2011/12 to 2015/16 (Continued)

	2011-12 £m	2012-13 £m	2013-14 £m	2014-15 £m	2015-16 £m
<b>Non-Operating revenue</b>					
Gain/(loss) on asset disposals	0.0	1.0	0.0	0.0	0.0
<b>Non-Operating revenue, Total</b>	<b>0.0</b>	<b>1.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
<b>Non-Operating expenses</b>					
Impairment Losses (Reversals) net	-0.1	-0.1	-0.1	-0.1	-0.1
Total Depreciation & Amortisation	-7.7	-7.3	-7.8	-7.4	-6.9
Interest expense on overdrafts and working capital facilities	0.0	0.0	0.0	0.0	0.0
Total interest payable on Loans and leases	-0.3	-0.3	-0.3	-0.2	-0.2
PDC Dividend	-1.4	-1.4	-1.4	-1.4	-1.4
<b>Non-Operating expenses, Total</b>	<b>-9.4</b>	<b>-9.0</b>	<b>-9.4</b>	<b>-9.0</b>	<b>-8.5</b>
<b>Net Surplus/(Deficit)</b>	<b>2.6</b>	<b>1.7</b>	<b>1.4</b>	<b>2.2</b>	<b>3.8</b>
<i>Net margin (%)</i>	2.4%	1.6%	1.3%	2.0%	3.4%

Notes:

\* It is expected that the A&E contract will be paid on a 'Payments by Results' tariff basis from April 2012, rather than the current 'Block' arrangement

\*\* EBITDA is defined as the net '**Earnings Before Interest, Taxation, Depreciation and Amortisation**' of the Trust