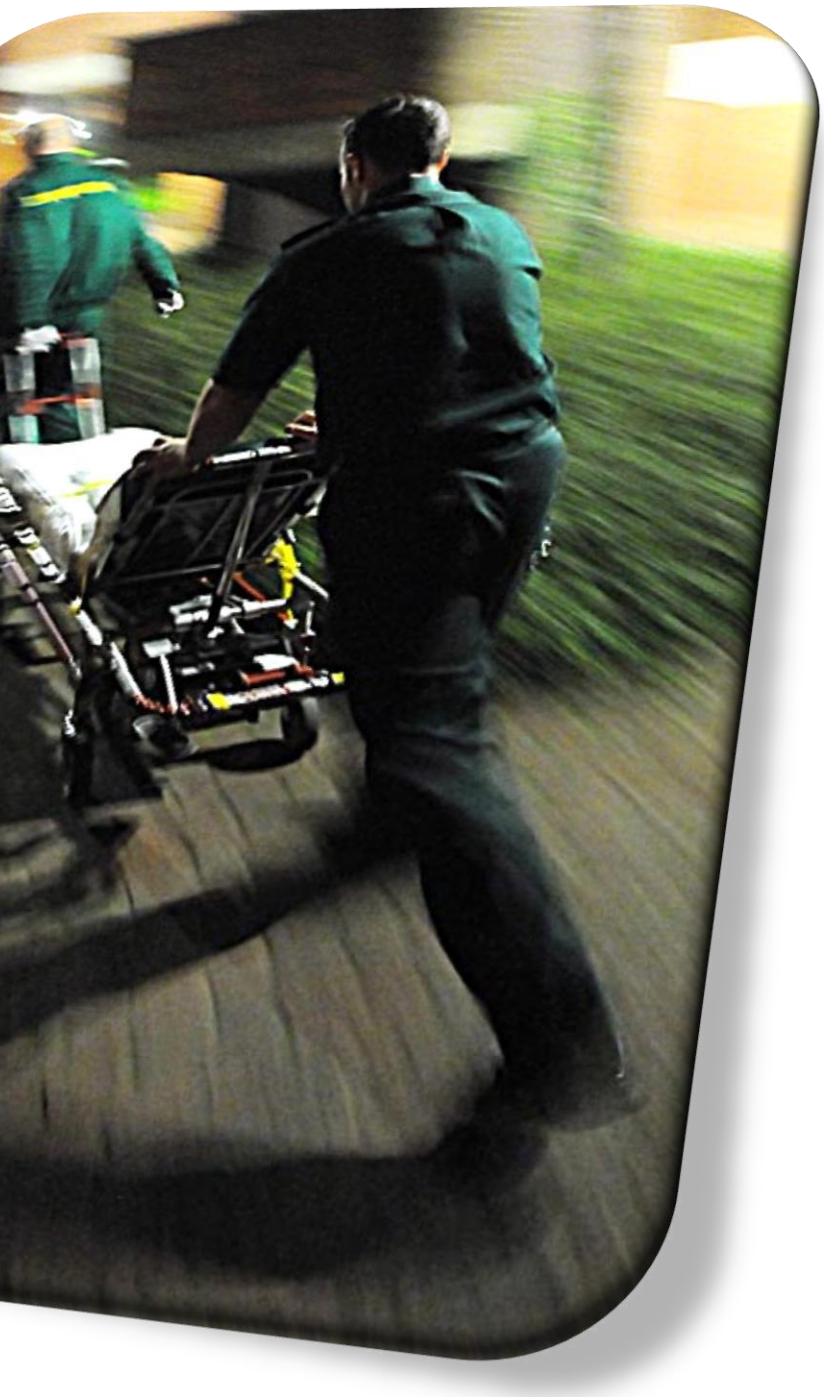
Appendix **A**

East of England Ambulance Service NHS
NHS Trust



Delivering better services for our patients

The turnaround plan for the East of England Ambulance Service NHS Trust

April 2013

Contents

1. Introduction

We are not delivering our 999 service, which is our core business, well enough. We are letting both patients and staff down. This is not acceptable and we need to completely transform the organisation to better support our patients and staff. We need to provide more front line resources, particularly double staffed ambulances; improve our clinical outcomes; and improve staff morale, engagement and empowerment. This will require a turnaround approach based on clarity, pace, rigour and delivery. The changes we require will not all happen overnight but all parts of the organisation will need to work together from the outset. All parts of the organisation need to see their role as supporting the delivery of high quality front line services to patients. This plan sets out the scale of the issues the Trust faces and the actions that will need to be taken to turn things around. Any other plans in the Trust will support and underpin this turnaround plan. This plan has been drawn up following extensive engagement with staff and stakeholders. It will be kept under constant review and will be updated as new issues or further changes come to light. The views of staff and stakeholders will continue to be sought as the plan is implemented.

2. The challenges we face

We face a number of challenges and they cover a mix of both internal and external issues. These challenges can be grouped under four key headings:

Leadership; Our people; Clinical operational delivery; Systems and processes.

In summary, the challenges are as follows:-

Leadership

- The lack of clear and visible leadership from the Board.
- The Executive Team and the wider Senior Leadership team lack a shared sense of purpose, identity and togetherness.
- A sense of 'learned helplessness' from some managers across the organisation, partly due to our not having valued leadership or management enough across the organisation.
- The absence of a clear and compelling clinical strategy or narrative from the Board which is understood and owned throughout the organisation. This covers issues such as vision, purpose, objectives, values, clinical strategy.
- There needs to be a stronger clinical focus to Board meetings.
- The need to move on from analysing and defining problems to taking swift action to put things right.
- Finances will be tighter than ever in future years. This will require us to do more with less. This also requires us to be very focused on what we do and how we do it. Carrying on as we are is not an option.
- An insufficient focus on the health of the organisation, in pursuit of performance response targets. Performance and health need to be pursued in tandem. This means an increased focus on issues such as leadership, direction, culture, learning, motivation, capability, accountability, co-ordination, external focus.
- The pursuit of Foundation Trust (FT) status, in line with Department of Health (DH) timelines and expectations has resulted in a lack of focus on the core business. This needs to be avoided as we continue with our FT application. FT status needs to be seen as a by-product of being clinically excellent, financially sound, well governed; and not as an end in its own right.

- The HQ is located on a business park away from the actual delivery of the core service. This has led to remoteness and makes it more difficult to immediately gauge service pressures and for interaction to take place with staff.
- There have been too many disconnected plans produced in response to performance problems or at the request of external agencies. There has been no sense of the organisation aligning itself to deliver against a single, owned, credible plan.
- The organisation has not aligned or structured itself such that all parts know the part they play in ensuring successful delivery of our front line services. There has been too much silo working and a lack of joined up thinking and action.
- The leadership team has sometimes failed to deliver on the plans or promises that it made. This has led to a lack of confidence or belief from some stakeholders.
- The pace of delivery and implementation of change and improvements is far too slow. There needs to be a greater sense of urgency and less complacency.
- We have become quite an insular organisation, not well engaged in local health and social care systems with underdeveloped links with local politicians and the media; and not learning sufficiently from good practice elsewhere.
- The degree of governance and grip around both performance and health has been insufficient.
- The public and their representatives have lost confidence in the leadership of the trust due to the many well publicised problems.

Our people

- There is a very poor level of staff morale. This has arisen for a variety of reasons including changes to working patterns and terms and conditions of service; a lack of involvement and empowerment; poor personal development opportunities; and an overbearing management culture in some parts of the organisation.
- The sickness level is far higher than in other ambulance trusts. This sickness has not been well managed and the absence of so many staff makes the delivery of the core service more difficult.
- There has been insufficient focus on career progression opportunities for staff; personal and professional development opportunities; and performance appraisals.
- The workforce strategy and workforce plans have not been sufficiently robust and there has been a lack of clarity around the staff numbers and the skill mix that is required.
- We have not treated our student ambulance paramedics well in terms of completing their training. They all need clear training completion dates.
- There are too many managers and not enough management. The structure of accountability and responsibility is not clear enough.

Clinical operational delivery

- There are not enough front line resources available to deliver the required levels of service in both urban and rural areas. This includes not enough staff or double staffed ambulances (DSAs). This has meant that some ambulance quality indicators have not been met, including Red 1 and Red 2 and A19 response times and the Stroke 60 indicator.
- There has been an over reliance on rapid response vehicles (RRVs) in some areas, particularly rural areas, at the expense of DSAs. The resource deployment model needs to be reviewed and updated.
- There is a need to improve response times in rural areas and to accept that a different deployment model may be appropriate between urban and rural areas.
- The focus needs to be a balance between regional level performance and reporting and local level performance and reporting. The introduction of clinical commissioning groups (CCGs) points to the need for a greater degree of localism.

- Delays in handing over patients at hospital compromises the ability of our staff to get back on the road to respond to further patients. These delays are bad for patients and they are bad for staff morale.
- There needs to be a clear focus on clinical outcomes and the quality of clinical care given; as well as compassion, customer care; and response times. All these factors are important in terms of our responses to patients.
- Our Red calls make up only about one-third of our workload. We need to monitor and report far more about our performance in relation to the other two-thirds, namely our Green calls and our GP Urgents. We also need to performance manage our DSA back-up delays better.
- Sometimes there are strained working relations between our health and emergency operations centres (HEOCs) and our road crews. Efforts need to be made to improve these working relationships.
- Greater clarity is needed on the links between increasing resources or inputs, and the benefits that are derived in terms of outputs, outcomes or improved performance.
- We currently have three HEOCs. The benefits of retaining three HEOCs needs to be reviewed in the context of maintaining resilience; empowering our Sectors; consistency; efficiency.
- We have become reliant on the use of private ambulance services/voluntary ambulance services (PAS/VAS) in order to maximise our front line resilience. This can be less effective than having our own resources. These resources are also not always directed in the right way or to the right call responses. Increasing our own front line resources and tackling our sickness levels will help to reduce this reliance.
- There is variation across our patch in terms of working practices, efficiency, deployment, productivity. The reasons for this variation is not understood well enough and as such, actions to address this variation where it is unacceptable or unexplainable has not always been taken.
- Our front line managers spend too much of their time responding to 999 calls rather than managing and motivating their teams and their services. Whilst it is appropriate for clinical staff to maintain their clinical expertise, they must also be enabled to carry out their management functions.
- The condition of our fleet and our estate is variable. Sometimes this gets in the way of delivering a good service. We need to ensure that our fleet and our estate is fit for purpose. This will also help with staff morale and will help to indicate that we value our staff.
- Demand on our services is rising every year. We need to respond appropriately to those patients who contact us. This requires us to have appropriate responses in terms of 'hear and treat', 'see and treat' and 'see, treat and convey'. This in turn requires work relating to public education; our triage systems; staff confidence; the level of resources we have available; how we use our resources effectively and efficiently; access to alternative pathways. At the moment, too many of our staff report instances of responding to patients under emergency conditions, where the patient could have been directed to other NHS services rather than relying on the 999 emergency service.
- We have over the years expanded our operations to include Out of Hours Services (OOHs) and 111 in some parts of the region. Patient Transport Services (PTS) are regularly subject to competitive tendering and again we provide these services in some parts of the region. We need to ensure that any additional services we provide continue to be high quality and do not detract from our delivery of our core 999 service. These other services should play to our strengths and should offer benefits to the delivery of our core service.
- There is scope for us to direct a greater proportion of our resources to front line services.

Systems and processes

- Many of our internal systems, processes and policies are overly bureaucratic and slow. Adhering to them can become an end in its own right rather than being a means to an end i.e. delivering excellent care to patients. These systems, processes and policies need to be greatly simplified and they need to be applied in an even handed and consistent way across the Trust.

- Our electronic Patient Care Record (ePCR) system is perceived by many to be cumbersome and time consuming. It is seen as a barrier to good care rather than as an aid to it. Further work is needed to make ePCR more user friendly for staff and as a clear contributor to good clinical care.
- We are not always clear and consistent with our data and information. There is not sufficient clarity about what the 'vital signs' are for the organisation. These 'vital signs' are the indicators that should be monitored and reported on in as close to real time as possible and they should be easily accessible. They indicate how the organisation is performing and should act as a prompt for intervention when necessary.
- We have traditionally had high Reference Costs. Whilst this is but one indicator of our performance and level of efficiency, it is frequently used to suggest that we do not offer value for money.

In spite of these numerous challenges, there are reasons for optimism in the Trust:-

- We provide good clinical care to patients.
- We have committed, professional staff at all levels and in all disciplines.
- The public hold our clinicians and other staff in high regard.
- We are financially sound.
- We have accepted that the organisation has got problems and is not in a good place. We are not in denial. We want to do better and accept our responsibility and accountability to do better.

We have shown in the past that we can rise to significant challenges. We recovered from a weak rating from the Healthcare Commission some years ago and made a number of significant changes as a result.

As such, the current situation is sortable. It requires strong leadership and the active involvement, support and hard work of everyone in the Trust. It requires a focus on both service performance and organisational health. Delivery of this Turnaround Plan will help to make our service one that we can all be proud of again.

3. Statement of Change: Our aspiration

As well as taking practical action to tackle all the challenges that we face, we also need to capture what it is we are aiming for and why. We need to set this out in as simple and short a statement as possible. We want this statement to explain what type of organisation we want to be, what we want for patients and staff and how we will know if we have been successful. All of the actions that we subsequently take should be consistent with our statement of change. We should regularly review, with our patients, staff and others, whether we are acting in a way that is consistent with our statement.

Our Statement of Change is as follows:-

We know that we are not where we want to be, especially in terms of how quickly we respond to patients and how we treat our staff. We know that when we get there our staff provide good clinical care with compassion to patients. We want to build on this. We want to become a thriving organisation, which delivers excellent and sustainable clinical services that deliver what our patients want by using our resources well and investing in the knowledge and skills of our staff.

In our transformed organisation, high quality patient care and safety will be at the core of everything we do. We will do the right thing for our patients. We will have a clear and simple delivery model that works. We will work with our new CCG commissioners (the people who fund us) to review the resources we need to deliver our service and we will use these well. We will have transformational leaders and confident managers who will spend most of their time managing and engaging staff. Every member of staff will have a named manager.

We will invest in developing our staff and everyone will have regular 1:1s and a meaningful annual appraisal. Our staff and our patients will be engaged in continuously improving the quality and efficiency of our services. Our staff will describe themselves as a team of dedicated professionals committed to caring for people and saving lives day and night. We will support them to be the best that they can be. We will have slick processes which help our clinicians to achieve the best possible patient outcomes. People will be proud to work for us and will recommend us to their friends and family as a great place to work. Patients will call us knowing that they will get the best possible clinical advice and service.

We will influence national policy on patient care and quality. We will develop innovative care packages that benefit patients and support our colleagues in other health care organisations. We will help the money spent in the NHS go further for patients by delivering overall savings to the health economy in partnership with our commissioners. We will be the leading thinkers and practitioners of pre-hospital care. We will respond quickly to life threatening calls and ensure an appropriate response to individual patient's needs. Our stakeholders will hold us up as an example of successful transformation. The public will have confidence in our service and our friends and family scores will be high. Other Trusts will visit us to learn from our success.

Anyone visiting us will be struck by the energy and passion of our staff and the positive stories they tell. They will hear staff talking about the care we provide to patients with pride, promoting the organisation and boasting about our achievements. They will explain how their ideas were adopted and what a difference this made for patients. People will be eager to learn from each other and will be happy to share their mistakes to ensure that no one else makes the same mistake. Staff will engage in constructive challenge about how we can improve our processes and our service to patients. There will be shared ownership of problems and individuals will take responsibility for delivering solutions. It will feel like a fun place to work and patients and their families will be full of praise for our staff and the service they received. We will set standards of behaviour, care and response times for all our patients no matter what their circumstances or location. We will work together to agree the standards of care we will uphold. We will work tirelessly to ensure these standards are consistently upheld. We will deliver a localised service tailored to the local population and circumstances.

4. Overview of the turnaround plan

As explained in the introduction, this turnaround plan will act as the overarching and prime plan for the Trust.

Other plans such as the Annual Plan and the OD strategy, will all underpin and support this turnaround plan. They will all point in the same direction and be consistent with one another.

The key components of the turnaround plan are summarised below, using the same four headings of Leadership; Our people; Clinical operational delivery; Systems and processes; as used in Section 2 above. The actions are described together with the anticipated completion time – immediate (within one month), short term (within six months), medium term (within 12-18 months). Some items are on-going in nature.

Leadership

L1	Following the resignation of our Chair, a new Chair will be appointed as soon as possible by the NHS Trust Development Authority to lead the Board. There will be other Executive and Non-Executive Director changes at Board level due to terms of office coming to an end and staff leaving the Trust for new opportunities elsewhere. **(Short-term)**
L2	The CEO will review the structure and membership of the Executive Leadership Team (ELT). **(Immediate)**
L3	The Board will appoint one of the Non-Executive Directors to be the Senior Independent Director. The prime responsibility of the Senior Independent Director will be to act as the point of contact for members of the public, stakeholders and other Non-Executive Directors about concerns, where contact through the normal channels has failed to resolve the issue or where such contact is inappropriate. **(Immediate)**
L4	The Board will redefine the vision, strategic objectives and values of the Trust, in collaboration with staff. This will entail pulling together a simple but compelling narrative that is owned and understood by staff. **(Immediate)**
L5	The Board and the Executive Leadership Team will spend more of their time being visible across the Trust, visiting sites, talking to staff and patients, and communicating the transformation and turnaround vision. **(On-going)**
L6	The Chair, CEO and other senior staff will devote more of their time to engaging with staff, patients, Healthwatch, MPs, councillors, overview and scrutiny committees and media. This will allow us to explain our plans and actions, seek feedback and help and also allow public accountability to be exercised. **(On-going)**
L7	The Board will invest in its own development to ensure that it is leading the organisation properly. **(On-going)**
L8	We will ensure that Board agendas have a much stronger clinical and patient care focus and that there is a greater opportunity for stakeholder participation in Board meetings. **(On-going)**
L9	The ELT and other senior staff will play a more active part in working with local health and social care systems on operational plans, strategy development and implementation. This includes developing more effective clinically based working relationships with CCGs. **(On-going)**
L10	As team members change on the ELT, organisational development work will be undertaken to ensure that the ELT works cohesively and provides leadership and vision. **(On-going)**
L11	The CEO will be explicit in holding Executive Directors to account for delivery of their respective actions in this plan. The Chair will hold the CEO to account for delivery of the actions attributed to the CEO and for leading the delivery of the overall plan. **(On-going)**

L12 A Transformation Leadership Team (TLT) will be established, bringing together the ELT and the most senior managers in the organisation. This TLT will focus on delivering this Turnaround Plan. The TLT will also receive organisational development support to ensure that it leads the change successfully. **(Immediate)**

L13 Historically we have not valued management or leadership enough. We will train our managers so that they can confidently manage and engage with our staff better. We are running a series of monthly management workshops. We will commission a management development programme which will ensure that we only appoint managers with the right skills to lead and manage staff and who can demonstrate that they will act in accordance with Trust values. **(Short-term)**

L14 We will implement our recently approved organisational development strategy which addresses issues relating to vision and values, culture, leadership and management development, continuous learning and clinical development, valuing and engaging staff, building capacity and capability. **(On-going)**

L15 The review of our values is being done in consultation with our staff. It is clear that some of our behaviours in the past have been unacceptable and unprofessional. Some staff have talked of being bullied. This approach or behaviour has no place in this Trust. We will work with staff to specify the behaviours that we should expect of each other and we will review our policies and procedures to ensure that they reflect these behaviours. Unacceptable behaviours will be challenged and no member of staff, however senior, will be allowed to get away with poor behaviour. **(Immediate)**

L16 The Board will review its governance processes to ensure that it has sufficient grip of both service performance and organisational health matters. **(Immediate)**

L17 We will explore the potential for staff side attendance at Board meetings. The ELT have already agreed to hold regular discussions with staff side representative and these have begun. **(Short term)**

L18 We will reduce the over-reliance on interim or acting posts, by substantively appointing to posts on either a permanent or fixed term basis or by deleting posts from the structure. Any interim or acting posts will have a clear rationale. **(Short-term)**

L19 We will seek to relocate the Trust's HQ closer to our front line services and away from a standalone business park setting. If this is not possible or cost effective, we will ensure that the HQ building is utilised for more events and purposes, such as training, induction, and staff meetings. **(Short-term)**

L20 We will focus our energies and efforts on getting our core 999 service right. We will only consider bidding for any new business if securing it would support the delivery of our core service. We will review our continued involvement in the current non-core services that we currently provide. **(On-going)**

L21 We will monitor and report against all of our Ambulance Quality Indicators on a regular basis and at both regional and CCG level wherever possible. We will ensure that our focus is on both clinical and response time issues. We will report our performance against not just Red 1 and Red 2 and A19 standards, but also Green calls, GP urgents and back-up delays. **(Immediate)**

L22 We will adopt a more strategic approach to our plans and our thinking, by planning for longer time horizons. We will work through in more detail the consequences for the longer term of decisions we take in the short term. We will set out our plans clearly and concisely and will hold each other to account for delivery. Our Programme Management Office function will ensure that progress is tracked and reported on regularly. **(On-going)**

L23 We will benchmark ourselves against other ambulance services in the UK and abroad and will develop a balanced scorecard approach for managers, showing their key performance indicators. We will import good practice from other organisations in the private and public sectors as part of becoming a learning organisation. **(Short-term)**

L24 We will reduce our overhead costs further, and thus enable us to invest more in our front line core services. **(Short-term)**

L25 We will re-submit our FT application to Monitor when we are confident that we are clinically excellent, financially sound, and well governed. We will negotiate a submission date with the NHS Trust Development Authority and Monitor. In the short term our focus will be on improving our core services, not pursuing our FT application. **(Medium Term)**

L26 We will hold monthly discussions with our Shadow Governors involving the Chair and CEO. These discussions will enable our Shadow Governors to play a more active role in the work of the Trust including acting as critical friends. **(Immediate)**

Our people

P1 We will fill our existing Emergency Operations vacancies along with proactively recruiting to the anticipated staff turnover vacancies likely in 2013/14. In addition we will recruit to new posts made possible by the additional investment of £5m in Emergency Operations in 2013/14. Taken together, this means that we will be seeking to fill the following posts:-

- 82 Band 6 specialist paramedics
- 149 Band 5 paramedics
- 24 Band 4 technicians
- 96 Band 3 emergency care assistants

This is a total of 351 posts that we will be seeking to fill in 2013/14. The Clinical Capacity Review mentioned elsewhere in this plan, will identify what additional resources are required on top of this recruitment. **(Short-term)**

P2 We will re-launch the Band 4 role in Emergency Operations and keep this role as a career pathway within the Trust. We will recruit to roles at Band 4 in Emergency Operations and will not phase out these roles from our structure. We will set out the scope of practice for these Band 4 roles. **(Immediate)**

P3 We will write to each student ambulance paramedic during April to confirm when their Module 7 training is scheduled for, so that they can complete their paramedic training. We will deliver this training as planned. **(Immediate)**

P4 We will commission 90 university places a year from January 2014 for paramedics for our service. **(Medium-term)**

P5 We will invest in Professional Update (PU) training to ensure that staff in Emergency Operations have 24 hours of PU in 2013/14 plus an operational ride out shift. This is an increase of 12 hours over the 2012/13 level of PU training. **(On-going)**

P6 We will ensure that PU training does not just focus on mandatory training or the refresh of existing skills. It will also focus on the new skills that staff will need in the ambulance service of the future bearing in mind the increasing acuity of patients. **(On-going)**

P7 We will ensure that within our Emergency Operations team that all staff have an annual Personal Development Review and that they get time for discussion with and access to their manager. **(Immediate)**

P8 We will ensure that staff at all levels and all disciplines have access to personal development opportunities, including access to additional training. All staff will have an annual Personal Development Review. **(Immediate)**

P9 We will introduce clear career progression routes for our brightest and best emergency care assistants, technicians, paramedics and emergency care practitioners. **(Short-term)**

P10 We will review and amend our workforce strategy and plans so that they fit better with the service delivery requirements of the Trust. We will be clearer on the numbers and type of staff required, training and education opportunities, career progression. This will include clarity on the percentage of the workforce who should be registered paramedics. **(Short-term)**

P11 We will tackle staff morale in partnership with staff and their representatives. This includes tackling those issues that impact badly on our staff such as late shift finishes, disrupted meal breaks, ensuring that refreshments are available at hospitals, ambulance back up delays, hospital handover delays. These actions will be in addition to the bigger picture of ensuring that we have more front line resources, especially DSAs out on the road. Our staff survey results and pulse survey results will show whether we have been successful in improving staff morale and well being. **(Short-term)**

P12 We have been very clear about the need to push ahead with staff empowerment, engagement and involvement. The sector approach mentioned elsewhere in this Turnaround Plan is an example of this and demonstrates our intention to devolve responsibility, authority and accountability. We have also signed up to 'Listening into Action' which is a nationally tried and tested approach to fundamentally changing the way in which staff are involved in the day to day work, of the organisation. Through 'Listening into Action' we will engage staff in leading the improvement of services and in leading change across the Trust. It will tap into the ideas and innovation of those people who know our services best – our staff. It is a fundamental change to the way that we do things. **(Immediate)**

P13 We will reduce sickness levels in Emergency Operations from the current unacceptable level of circa 10 – 11%. We will reduce this by 1% point per month for each of the 6 months from June 2013. This is with a view to reducing it to a maximum of 5.5% by the end of 2013/14. This will involve improved sickness management information, a shorter and simpler sickness policy and managers taking a more proactive approach to sickness management. Incentives for attendance will also be explored. In the short term, a sickness task group is supporting managers to embed a new approach. **(Short-term)**

P14 We will review how best to quickly bring staff back from sickness into their contracted role, rather than have them aligned to other duties for long periods. **(Short-term)**

P15 We will re-tender our Occupational Health Service and through this service, ensure that staff have good access to counselling and other psychological support. **(Short-term)**

P16 We will ensure that our induction programme for new staff involves early contact with Board members. We will also ensure that all new staff are provided with the necessary equipment and clothing to carry out their role on or before their first day. **(Short-term)**

P17 We will improve the process for handling staff grievances. **(Short-term)**

P18 We will celebrate our successes better; by publicising the good work that our staff do and by applying for awards linked to improving outcomes for patients. **(On-going)**

Clinical operational delivery

O1 We will, through recruiting to our vacancies, reducing staff sickness and reducing our spend on private ambulances, be able to consistently staff the equivalent of 15 24/7 DSAs. The recruitment to our additional posts will enable us to consistently staff the equivalent of 10 24/7 DSAs.

Taken together, this will give us the equivalent of an additional 25 24/7 DSAs provided directly by the Trust. These would be on top of the circa 170 DSAs we currently deploy at peak times of the day.

We will seek to place these additional DSAs in those areas that currently experience the longest ambulance back-up delays. We will agree the locations in consultation with our staff and our CCG colleagues. **(Short-term)**

O2 We will put in place a deployment model in each sector that is fit for now and the future. **(Immediate)**

O3 We will reduce our support functions by £2m (10%) in 2013/14 and move this funding into our Emergency Operations team to support front line services. This will enable us to devote a total of an extra £5m to Emergency Operations in 2013/14. **(Immediate)**

O4 We will review the scope for further reductions in our support functions provided that this is consistent with ensuring the provision of high quality support functions to the front line. **(Short-term)**

O5 We have commissioned a clinical capacity review to quantify the resources needed to deliver our service. This review will determine how much of any gap in resources can be filled by internal efficiencies and changing working practices and how much will need to be discussed with external stakeholders and commissioners. This will report in late May 2013. **(Short-term)**

O6 Alongside the recruitment of additional staff mentioned elsewhere in this turnaround plan and the subsequent availability of more DSAs, we will seek to reduce our reliance on private and voluntary ambulance services. We will set ourselves monthly targets relating to reduced spending on such services. We envisage reducing these costs by at least £0.5m per month. The current level of spending is neither desirable nor appropriate. Where we use these services we will predominantly direct them to GP Urgents and lower priority Green calls. **(Short-term)**

O7 We will seek to build internal capacity within our PTS to support emergency operations especially during the winter months. **(Short-term)**

O8 We will work with CCGs, hospitals and social care and community care colleagues to reduce hospital handover delays. This will include the joint posts; better escalation procedures; better use of capacity management systems and working with colleagues to ensure better flow through hospitals. **(Short-term)**

O9 We will improve ambulance back up delays through a combination of extra DSA resources on the road and by reducing handover delays at hospital. **(Short-term)**

O10 Linked to the work on reducing handover delays at hospital, we will work with our staff to put in place the necessary support systems to enable them to be ready to take new calls within 15 minutes of handing over their patient at the hospital. This is in line with the penalty terms contained in the 2013/14 contract with our commissioners. **(Immediate)**

O11 We will seek to expand our community first responder (CFR) schemes and review what additional support is required to enable such schemes to thrive. **(Short-term)**

O12 We will use the additional staff and DSAs that we are able to provide, to reduce response times as set out in our 2013/14 contract with commissioners. This will entail directing a significant proportion of any additional resources to rural areas, where our current performance is poorest. This approach entails a move away from predominantly monitoring and reporting performance on a regional level, to an approach that also entails monitoring and reporting at CCG level. **(Short-Term)**

O13 As well as reducing out of service time, we also need to better understand the variation in our cycle times. We will all have a part to play in this both in terms of challenging existing behaviour and practices, but also in terms of coming up with new ideas for how we can become more effective and efficient. This involves, for example, thinking about the next patient as well as the current patient. **(Short-term)**

O14 We will manage abstractions better through the more effective management of sickness and annual leave requests and by reviewing our relief rate. **(Short-term)**

O15 We will work proactively with local health and social care systems to develop admission avoidance and demand management processes, that still ensure that patients receive a response appropriate to their needs. As part of this we will put in place the necessary processes to support our staff in making decisions to not convey patients to hospital, when in their clinical opinion it is safe to do so. **(Short-term)**.

O16 We are moving to a three-sector (West covering Bedfordshire, Hertfordshire, Cambridgeshire; North covering Norfolk and Suffolk; South covering Essex) operational model for Emergency Operations with devolved responsibility, accountability, staffing and budgets, in order to deliver a tailored service at local level and to create a sense of 'place'. We will continue to make appointments to this structure and will review what other support services and functions need to be aligned to this sector way of working. The ELT will agree with sectors the standards of care and governance that will be delivered, including which aspects are suitable for local discretion and which must adopt a region wide approach. Quarterly reviews will be held with each sector to discuss service performance and organisational health issues. These reviews will allow us to work together to identify what additional help and support can be provided to further enhance local services. We are working through the appointments to the management roles in the sectors in order to ensure that we have the right numbers of people in the right roles with the right skills and attitude. **(Short-term)**

O17 We will structure the sectors such that local managers are able to spend their time managing rather than responding to 999 calls. This will enable managers to play a greater part in engaging with local staff welfare issues; taking part in ride outs with staff to monitor clinical standards and provide development support; motivating their teams; resolving local service problems; engaging with local stakeholders; planning service developments; managing rotas, budgets, fleet and estates issues. This will not stop managers who are clinicians from doing occasional shifts to maintain their skills. **(Short-term)**

O18 We will complete the Band 6 and 7 management appointments in the Emergency Operations Directorate. We envisage having fewer Band 7 posts in order to maximise the resources that can be devoted to responding to 999 calls. **(Short-term)**

O19 We will work with staff to minimise out of service time so that they can spend more time in each shift working directly with patients. This includes addressing issues such as vehicle re-stocking and cleaning through a 'pit-stop' approach at hospitals and simplifying ePCR. **(Short-term)**

O20 We know that the rota redesign process upset staff. It aimed to ensure that within the resources at our disposal that we had staff in the right place at the right time. We have acknowledged in this turnaround plan that we do not have enough front line resources, especially DSAs and we are employing extra staff and carrying out a clinical capacity review to address this shortfall. In the meantime, we have asked local teams to review their rotas in case there are immediate improvements that can be made within the resources currently available. Rotas will be kept under constant review. **(Short-term)**

O21 We will update our fleet plan to ensure that we have a modern fleet that is fit for purpose, with clear replacement and renewal schedules. This will also involve seeking to improve the time that is lost due to vehicles being out of service by reviewing our arrangements for securing quick and effective repairs and servicing. Staff will be involved more in influencing these fleet decisions. **(Short-term)**

O22 We will update our estates plan to ensure that we have buildings that are fit for purpose. It is not acceptable that we ask staff to work from dilapidated buildings. We will confirm our plans relating to depots and standby points. We will ensure that we are not wasting money through occupying too many buildings. **(Short-term)**

O23 We will increase access to a simple Directory of Services for our staff so that they know what alternative care pathways are available for patients. This will help to reduce unnecessary conveyance to hospital and will ensure more appropriate responses for patients. We will to increase the ability of our staff, through direct referral or via the Single Point of Contact (SPOC), to refer patients to alternative pathways. **(Short-term)**

O24 Through combining responsibility for HEOCs and Operations under Sector Leaders, we will work to improve the relationships between these two groups of staff. This may involve giving staff the opportunity to spend time in the different functions; and facilitated development sessions involving both groups. **(Short-term)**

O25 We will review the benefits and disbenefits of continuing to operate with three HEOCs, in the context of maintaining resilience; consistency; efficiency; empowering our Sectors. **(Short-term)**

O26 We will, as part of our review of the pros and cons of having three HEOCs and our review of our deployment model, review our despatch processes in our HEOCs. **(Short-term)**

O27 We will review our HEOC processes to identify whether we can increase our 'hear and treat' responses to better guide patients to the most appropriate service and thus reserve our resources for emergency responses. **(Short-term)**

O28 We will ensure that our Regional Operations Cell provides appropriate co-ordination, support and challenge to our sectors. **(On-going)**

O29 We will continuously improve our performance during 2013/14 so that we make progress towards the key standards that we have set as part of the success criteria for this Turnaround Plan. These key standards are summarised at Appendix A. This will entail us setting the baseline for each standard and the trajectory for delivery. We will improve our ways of calculating trajectories. **(Immediate)**

O30 We will agree with our staff what the maximum waiting time should be for a back-up ambulance to arrive on scene to transport a patient to hospital. We will work with our staff to put in place the changes to deliver this maximum wait. **(Immediate)**

Systems and processes

S1 We will systematically review all of our systems and processes to ensure that they are safe and fit for purpose and that they contribute to the delivery of better patient care and a more efficient organisation. **(Short-term)**

S2 We will ensure that our governance and risk management processes are focused on taking effective action to protect patients and staff. **(Short-term)**

S3 We will refocus our information and analytical staff to create a single team that provides reliable real time management information for all staff. We will use this information to ensure that the decisions we make will help to achieve the best outcomes for patients. We will use real examples to illustrate how the better use of information has benefitted patient care. **(Short-term)**

S4 We will identify and openly report in an easily understood way on the 'vital signs' that indicate how the Trust is performing in terms of both service performance and organisational health. We will agree these vital signs with our staff and our commissioners. **(Immediate)**

S5 We will review the IT road map and revise it to ensure that we are using technology fully to support our services to patients. We will review our IT investment to ensure that we are making the best use of IT and are maximising the opportunities for integration. **(Short-term)**

S6 Too often, problems and blockages take too long to fix. A 'fix it' group has been set up to swiftly address problems and implement immediate solutions. This is a short term solution. In the medium term, our managers will manage and will overcome these sorts of problems as part of their day to day business. **(Immediate)**

S7 We will improve the timeliness and reliability of our recruitment process. We will recruit and promote people based on their values and attitude as well as their knowledge, skills and experience. **(Short-term)**

S8 We will review and improve our internal communication methods to ensure that we target our communication and engagement with staff more appropriately. This will involve using all forms of communication including social media in order that we target our communications effectively. **(Short-term)**

S9 We will continue to provide the media with regular examples of all of the good work that our staff do. Whilst we realise that our media profile will only get better when our service, and the perception of it, improves, we will continue to show that we get things right far more than we get it wrong. When we do get things wrong, we will be open about it and will give explanations, apologies and evidence of learning being implemented. **(Immediate)**

S10 We will improve our website so that it contains more up to date information about our activities and our performance. **(Short-term)**

S11 We will review how best to communicate with patients and their representatives about what the Trust does and how best to access and utilise our services. This includes spending time in schools. **(Short-term)**

S12 Due to the increase in complaints as a result of our delays in responding to some 999 calls, the number of complaints we receive has risen. In the short term we need to bolster our internal processes so that we are better and quicker at responding to complaints. In the medium term, as our service improves and the number of complaints reduces we must get better at learning from complaints and any serious incidents that happen. **(Short-term)**

S13 We will improve our response to Datix reports including making sure that staff know the actions that have been taken as a result of the reports they have submitted. **(Short-term)**

S14 We will seek to make ePCR easier for staff to complete and will discuss with staff how to maximise the clinical benefits that can be derived from ePCR. The information it provides will assist in embedding within the health system, the clinical importance of our clinicians. **(Short-term)**

S15 We will automate our Unit Hours of Production reporting and forecasting and ensure that this is forecast on a 24/7 basis. **(Short-term)**

5. Implementation

We will put in place the necessary processes to monitor implementation of this Turnaround Plan. This will include a detailed action plan drawn from this overarching plan; a Programme Board chaired by the CEO with a Senior Responsible Officer and a Programme Manager; Board progress reporting in public; access to continuing advice from the National Ambulance Service Advisor at the Department of Health; and clear identification and reporting against success criteria linked to patient outcomes.

6. Funding

The cost of implementing this turnaround plan is predominantly going to be found from within existing budgets. An additional £5m has been made available to the Emergency Operations team in 2013/14 to fund the recruitment of additional staff to allow permanent DSAs to be put on the road. Any new funding requirements identified as a result of the actions in this plan, will be discussed by the Board with a view to identifying the potential sources of this funding. This may involve seeking transitional funding from elsewhere in the wider NHS. A summary of the 2013/14 budget is attached at Appendix B. The Clinical Capacity Review may identify the requirement for additional resources that cannot be met by the Trust becoming more efficient and productive or through changes in working practices. If this happens, we will enter into discussions with our CCG colleagues about what joint action is needed to bridge the gap.

7. Conclusion

We need to make progress on all areas of this turnaround plan in order to recover the health of the organisation and deliver sustainable performance and high quality services for our patients. We know we work in changed times, we know that this is having an impact on the lives of our staff and we know that we are failing some of our patients. We have to change. We have to demonstrate better leadership. We have to support Staff better. We have to provide more resources for front line service delivery. We have to deliver good clinical outcomes for our patients. We have to ensure we make better decisions about how we use our valuable emergency response vehicles. We have to use our clinical skills better to guide patients to access the health service in a way that will support their long term health. We believe that by doing this we can keep more people at home, when it is appropriate to do so.

We must push for investment in the service when this has been proved to be justified and we must create a service that delivers what our patients need. We must support staff to make changes locally and we must listen to patients more.

The future of this organisation is in our hands. As a Board we know we need to do a better job at leading the organisation. We hope that staff will work with us to implement the changes that are necessary to restore our collective pride and passion in what we do.

Andrew Morgan

Interim Chief Executive

On behalf of the Board

April 2013

Appendix A

KEY STANDARDS 2013/14

RESPONSE TIMES AGREED WITH COMMISSIONERS

Response code	Standard	% to be achieved	99th centile by:
Red 1	8 mins	75%	25 mins
Red 2	8 mins	75%	25 mins
Green 1	20 mins	75%	30 mins
Green 2	30 mins	75%	60 mins
Green 3 Telephone advice	20 mins	75%	60 mins
Green 3 Face-to-Face	50 mins	75%	120 mins
Green 4 Telephone advice	60 mins	75%	120 mins
Green 4 Face-to-Face	90 mins	75%	150 mins
GP Urgents	1 hour	75%	90 mins
	2 hours	75%	180 mins
	4 hours	60%	360 mins

Clinical indicators

Percentage of stroke patients arriving at hospital within 60 minutes of the call – 56%

Percentage of cardiac patients who survive to discharge – 25%

SUMMARY BASELINE BUDGET 2013-14

	£'000	Emergency Ops	Other Service Lines	HART & Resillience	Ops Support	Corporate	Reserves	TOTAL
I1	**2012-13 Income Budgets as Original Budget**	**176,910**	**37,866**	**6,940**	**878**	**5,194**	**-**	**227,788**
I2	Virements & New Contracts in Year etc.	241	(29)	-	42	5	-	**259**
I3	2012-13 Recurrent CIPs achieved	-	285	-	-	-	-	**285**
I4	Remove 2012-13 non-recurrent income (including CQUIN)	(221)	(279)	-	-	(4,385)	-	**(4,885)**
I5	Effect of Forecast 2012-13 Over/(Under)-Activity Out-turn	1,211	(717)	-	-	-	-	**494**
I6	Full Year Effect of New/Lost Contracts	406	(3,054)	(99)	(35)	30	-	**(2,752)**
I7	**Total Recurrent Income at 2011-12 prices**	**178,547**	**34,072**	**6,841**	**885**	**844**	**-**	**221,189**
I8	Inflation @ 2.7%	4,706	-	-	-	-	-	**4,706**
I9	Efficiency Saving @ 4%	(6,971)	-	-	-	-	-	**(6,971)**
I10	**Total Recurrent Income at 2012-13 prices**	**176,282**	**34,072**	**6,841**	**885**	**844**	**-**	**218,924**
I11	Non-Recurrent Income (including CQUIN)	-	279	-	-	4,472	-	**4,751**
I12	2013-14 Forecast Contracted Over-Activity (at 3%)	5,253	-	-	-	-	-	**5,253**
	Total Income Budgets 2013-14	**181,535**	**34,351**	**6,841**	**885**	**5,316**	**-**	**228,928**
E1	**2012-13 Recurrent Expenditure Budgets as Original Budget**	**(108,496)**	**(33,663)**	**(7,763)**	**(35,514)**	**(22,944)**	**(9,394)**	**(217,774)**
E2	Add back 2012-13 CIP Targets	(6,600)	(1,470)	-	(1,500)	(1,060)	-	**(10,630)**
E3	2012-13 Recurrent CIPs achieved (Forecast per M10 Dashboard)	4,100	868	-	2,370	1,227	-	**8,565**
		(110,996)	(34,265)	(7,763)	(34,644)	(22,777)	(9,394)	(219,839)
E4	Reserves Adjustments	(3,194)	-	-	-	(1,200)	7,894	**3,500**
E5	Virements & New Contracts in Year etc.	(83)	3,220	-	177	-	-	**3,314**
E6	Remove 2012-13 non-recurrent costs	-	-	-	102	-	-	**102**
E7	**Total Recurrent Commitments at 2012-13 prices**	**(114,273)**	**(31,045)**	**(7,763)**	**(34,365)**	**(23,977)**	**(1,500)**	**(212,923)**
E8	Developments	-	-	-	-	-	-	**0**
E9	Inflation Pay & Non-Pay	(488)	(77)	(55)	(24)	(260)	(2,000)	**(2,904)**
E10	**Total Recurrent Commitments before CIPs at 2013-14 prices**	**(114,761)**	**(31,122)**	**(7,818)**	**(34,389)**	**(24,237)**	**(3,500)**	**(215,827)**
E11	**Total Recurrent CIPs Target 2013-14**	**4,000**	**0**	**0**	**1,000**	**2,450**	**0**	**7,450**
	CIPs as a % of Recurrent Expenditure Budgets	*3.5%*	*0.0%*	*0.0%*	*2.9%*	*10.1%*		*3.5%*
E12	Emergency Operations Investment Reserve	(4,750)	-	-	-	-	-	**(4,750)**
E13	2013-14 Capacity Investment Reserve	(3,414)	-	-	-	-	-	**(3,414)**
E14	Re-establish Non-Recurrent Contingency Reserve	-	-	-	-	-	(2,500)	**(2,500)**
	Total Expenditure Budgets 2013-14	**(118,925)**	**(31,122)**	**(7,818)**	**(33,389)**	**(21,787)**	**(6,000)**	**(219,041)**
Z1	**Opening EBITDA**	**62,610**	**3,229**	**(977)**	**(32,504)**	**(16,471)**	**(6,000)**	**9,887**
Z2	Interest, Tax and Depreciation (ITDA)					(6,776)		**(6,776)**
Z3	**INCOME AND EXPENDITURE TARGET 2013-14**	**62,610**	**3,229**	**(977)**	**(32,504)**	**(23,247)**	**(6,000)**	**3,111**