Nottinghamshire County Council

Nottingham City Council

Joint City / County Health Scrutiny Committee

Tuesday, 13 January 2015 at 10:15

County Hall, County Hall, West Bridgford, Nottingham, NG2 7QP

AGENDA

1	Minutes of the meeting held on 9th December 2014	3 - 8
2	Apologies for Absence	
3	Declarations of Interests by Members and Officers:- (see note below) (a) Disclosable Pecuniary Interests (b) Private Interests (pecuniary and non-pecuniary)	
4	Outcomes of Primary Care Access Challenge Fund Pilots	9 - 10
5	Nottingham University Hospitals Environment & Waste	11 - 24
6	East Midlands Ambulance Service - New Strategies	25 - 146
7	Work Programme	147 - 152

Notes

(1) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(2) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Julie Brailsford (Tel. 0115 977 4694) or a colleague in Democratic Services prior to the meeting.

(3) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

(4) A pre-meeting for Committee Members will be held at 9.45 am on the day of the meeting.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

Nottinghamshire County Council

Nottingham City Council

MINUTES

JOINT HEALTH SCRUTINY COMMMITTEE
9th December 2014 at 10.15am

Nottinghamshire County Councillors

Councillor P Tsimbiridis (Chair)
Councillor P Allan
Councillor R Butler
Councillor J Clarke
Councillor Dr J Doddy
Councillor C Harwood
Councillor J Handley
Councillor J Williams

Nottingham City Councillors

Councillor G Klein (Vice- Chair)
A Councillor M Aslam
A Councillor A Choudhry
A Councillor E Campbell
Councillor C Jones
Councillor T Molife
Councillor E Morley
Councillor B Parbutt

Also In Attendance

Dr Doug Black – NHS England
Julie Brailsford - Nottinghamshire County Council
Ash Canavan - NHS England
Jane Garrard - Nottingham City Council
Martin Gately - Nottinghamshire County Council
Councillor D Langton - Member for Mansfield West
Vanessa MacGregor – Public Health England
David Spencer - Public Health England
Julie Theaker – NHS England

MINUTES

The minutes of the last meeting held on 7th October 2014, having been circulated to all Members, were taken as read and were confirmed and signed by the Chair.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor M Aslam, Councillor E Campbell and Councillor A Choudry.

DECLARATIONS OF INTERESTS

Councillor G Klein and Councillor B Parbutt declared a private interest on agenda item 5, Daybrook Dental Practice – Apparent Breech of Infection Control.

OUT OF HOURS DENTAL SERVICES

Julie Theaker (JS), Contract Manager Dental and Optometry, Derbyshire and Nottinghamshire Area Team, NHS England gave a briefing on Out of Hours Dental Services in Nottingham and Nottinghamshire. JS also informed the committee that £220,000 funding had been secured to help with the increased demand for out of hours dental services and that working groups had been set up within the CCG's and 111 services to decide where the additional dental services were most needed.

Following the briefing the additional information was provided in response to questions:-

- It was crucial for patients to have clear direction as to where they should go if they required emergency dental treatment. Out of hours emergency dental patients should contact the 111 service for advice, a dental triage nurse had been put in to 111 services on a trial basis to help with the increased demand.
- Accident and Emergency (A&E), 111 and GP's all picked up dental emergencies, with some patients being advised to see their GP for pain relief after receiving dental treatment.
- Information on dental websites belonged to the individual dental practice and was therefore not monitored. NHS England relied on members of the public informing them of incorrect information on websites. The committee felt that monitoring should be done but with 248 dental practices in the area there were insufficient resources to do this.
- Patient's registration at dental practices had not existed since 2006, although there was a pilot scheme to bring this back. Dental practices only had a responsibility to treat a patient that they had seen within the past two months. There was no monitoring of the number of patients attending A&E who did not attend a dentist on a regular basis.
- Patients were not attending dental appointments on a regular basis due to the cost; they would choose to attend the GP or Accident & Emergency department where they received free treatment. NHS dentists had three charge bands and posters detailing the fees were displayed in each practice. Information for patients regarding financial help with the cost of dental treatment was available on the website or from the dental practise. Private and NHS treatments could be mixed by a patient if requested.

- There was a need for dental services to be bought closer to other NHS services as dental emergencies were clogging A&E. Additional funding for dental services was also required. There was ongoing work with schools and nurseries to promote dental hygiene to the under 5's. Also, a mobile dental unit linked with the public health teams was currently out in the area of St Ann's.

- The promotion of NHS Dentistry and encouraging people to use dental services was an ongoing issue. Adverts promoting dental services were in trams, buses, newspapers, cinema, 111 service and in addition a monthly access survey was currently being done.

The committee requested that a letter be sent to the Secretary for Health detailing the committee's concerns regarding emergency dental needs and the impact on our services in Nottingham and Nottinghamshire.

DAYBROOK DENTAL PRACTICE – APPARENT BREACH OF INFECTION CONTROL

Dr Doug Black, Medical Director for NHS England, Notts & Derby gave a briefing on the recall of Nottinghamshire dental patients following the apparent breach of infection control procedures at Daybrook Dental Practice.

Following the briefing the additional information was provided in response to questions:-

- Prior to the press release a briefing note was sent to all dentists and GP's so they could point patients in the right direction for help.

- Concern was expressed by the committee that this issue had taken so long to be exposed. Why had it not been noticed by the dental nurses at the practise or the practise manager? NHS England undertook quality visits but did not regulate dental nurses.

- Why was the amount of money accruing for Mr D'Mello not monitored? The practice had previously been under investigation but Mr D'Mello was not a single practice and there was no contractual lever to adjust the amount being paid.

- Some patients may already have had the blood borne infections being tested for and any new positive results would need to be discussed to establish how the patient had contracted the infection. Patients were asked to complete a medical information form when attending a dental surgery and it was personal responsibility to inform the dentist of any blood borne conditions.

- Dental practices do not have any record of patient's illnesses or medication that they take; this raised a broader issue of information sharing between GP's and dentists.

- Currently the sum of £500,000 was being spent on dealing with this issue and any compensation claims resulting from it. This figure was based on contracts

with current providers. It was debatable how the cost will be recouped and the lawyers at NHS England would be considering this.

- The Care Quality Commision (CQC) was the independent regulator of all health and social care services in England, Dr Black would look at the CQC inspection of dental practices in 2013. The profile of hygiene control at dental practices was very high; patients were questioning dentists following this incident.

- Further publicity to reach more of Mr D'Mello's former patients would be in the form of a 'dear household' letter sent to all houses in the vicinity of the practice as well as press coverage.

- The committee praised the professionalism of the staff in the clinic where patients of Mr D'Mello were invited to attend for a blood test.

- There would be a formal report at the end of the project that would include the lessons learnt. It would always feel like the exercise was incomplete as they would never be able to contact all of the patients concerned. There would be a detailed evaluation exercise taking place in the New Year as this was a unique situation. This had been a successful example of whistleblowing and social media had aided this.

ROYAL COLLEGE OF NURSING

Ms Marie Hannah, Royal College of Nursing Regional Officer for Nottinghamshire and Derbyshire gave a briefing on the issues that nurses currently faced.

Following the briefing the additional information was provided in response to questions:-

- The number of District Nurses (DN) in the East Midlands had decreased by 45% between 2010 and 2013, but patient need had not. Urgent investment in this area was required as patients were being moved in to the community and this was where nursing skills were most needed.

- Overall nurses' morale was very low and there was an increasing rate of sickness absence. There may be over 120 patients in one DN caseload and in addition required to help with other clinics and triage. In a recent survey 4 in 10 nurses said they would leave the job if they could. District nurses were a Band 7 pay grade and required specialist training. It was getting increasingly difficult to recruit nurses with the required skill set to vacant posts.

- Community nursing had been fragmented between various bodies and a leadership team was required to oversee this. Experienced nurses, good strong role models who have the initiatives and the ideas to develop local leadership and to oversee joint working.

- In the past year and a half there had been an increase in nurses from Europe for acute medicine care but not for primary care.

Following the question and answer session the committee requested that a letter be sent to the Chair of the Local Government Association to highlight the nursing crisis and get this problem on the agenda at a higher level.

The committee asked Ms Hannah to return to the committee in a years' time.

During the above agenda item, at 12.00pm, Councillor C Jones left the meeting.

WORK PROGRAMME

The contents of the Work Programme were noted.

The meeting closed at 12.30pm.

Chairman

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
13 JANUARY 2015
OUTCOMES OF PRIMARY CARE ACCESS CHALLENGE FUND PILOTS
REPORT OF HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL) Agenda item: 4

1. Purpose

To consider the outcomes of the primary care access challenge fund pilots and next steps in rolling out learning across the region.

2. Action required

2.1 The Committee is asked to use the information provided to scrutinise the implications for patients in Nottingham and Nottinghamshire of the outcomes of pilots to improve access to primary care services.

3. Background information

3.1 In May 2014 the Committee heard that Derbyshire and Nottinghamshire had been awarded funding of £5.2m from a national challenge fund of £50m to pilot ways of improving access to primary care. This was to be a 12 month project supported by the NHS England Derbyshire and Nottinghamshire Area Team, working with local clinical commissioning groups to test different interventions in different practices. Across the whole area this included increasing access to and availability of appointments through 7 day a week services; new ways of communicating and flexibility in access e.g. using Skype; expanding use of telecare; and joining up services between GPs and hospitals. The aims of an area-wide approach were to share knowledge across the area so that what works could be rolled out at pace and scale; effective achievement of training and workforce planning to support the pilots and into the future; and carrying out evaluation to secure future funding.

3.2 Leads from NHS England and local clinical commissioning groups will be attending the meeting to provide information on the outcomes so far of the pilots which have taken place across the area, how the learning is being rolled out across the area and the implications of this for patients in Nottingham and Nottinghamshire.

3.3 A second wave of the challenge fund has been announced of £100m, aimed at practices not participating in wave one.

4. List of attached information

None

5. Background papers, other than published works or those disclosing exempt or confidential information

None

6. Published documents referred to in compiling this report

Report to and minutes of meetings of the Joint Health Scrutiny Committee held on 13 May 2014

7. Wards affected

All

8. Contact information

Kim Pocock, Constitutional Services Manager
Tel: 0115 8764313
Email: kim.pocock@nottinghamcity.gov.uk

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

13 January 2015

Agenda Item: 5

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

NOTTINGHAM UNIVERSITY HOSPITALS ENVIRONMENT AND WASTE

Purpose of the Report

1. To introduce a briefing on environmental and waste issues at Nottingham University Hospitals (NUH).

Information and Advice

2. The issues of environment and waste were first brought to Members' attention during the consideration of NUH Quality Accounts.

3. A presentation from NUH entitled "Improving our Environment is attached as an appendix to this report. Dr Stephen Fowlie, NUH Medical Director, will attend the Joint Health Committee to present the information and answer questions, as necessary.

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee:

1) Receive the briefing and ask questions.
2) Schedule further consideration, if required

Councillor Parry Tsimbiridis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Improving our environment

Dr Stephen Fowlie
Medical Director

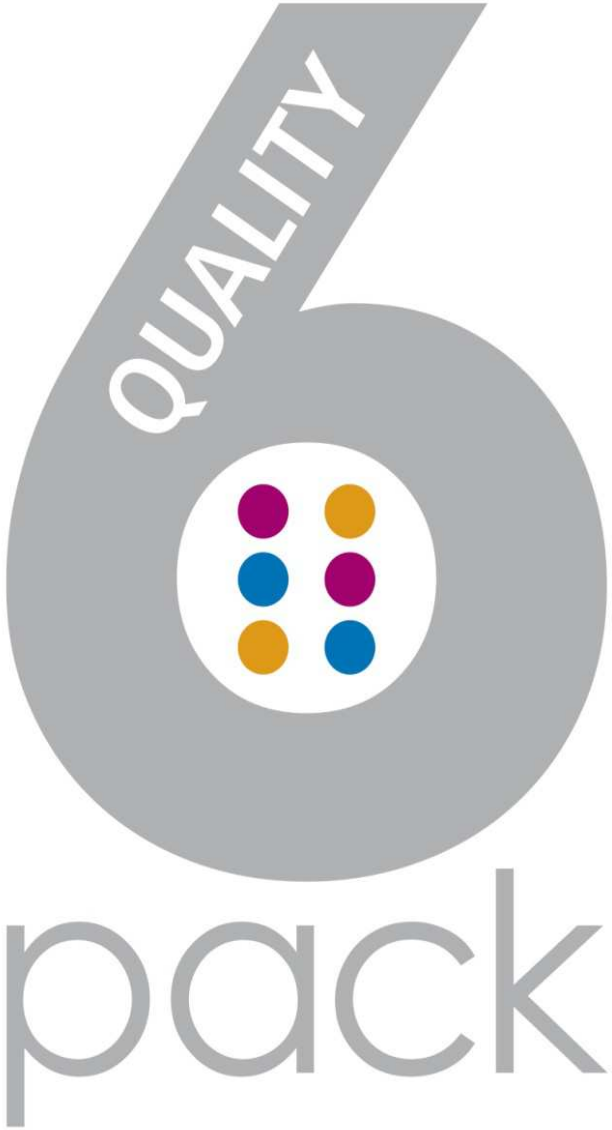
Updates

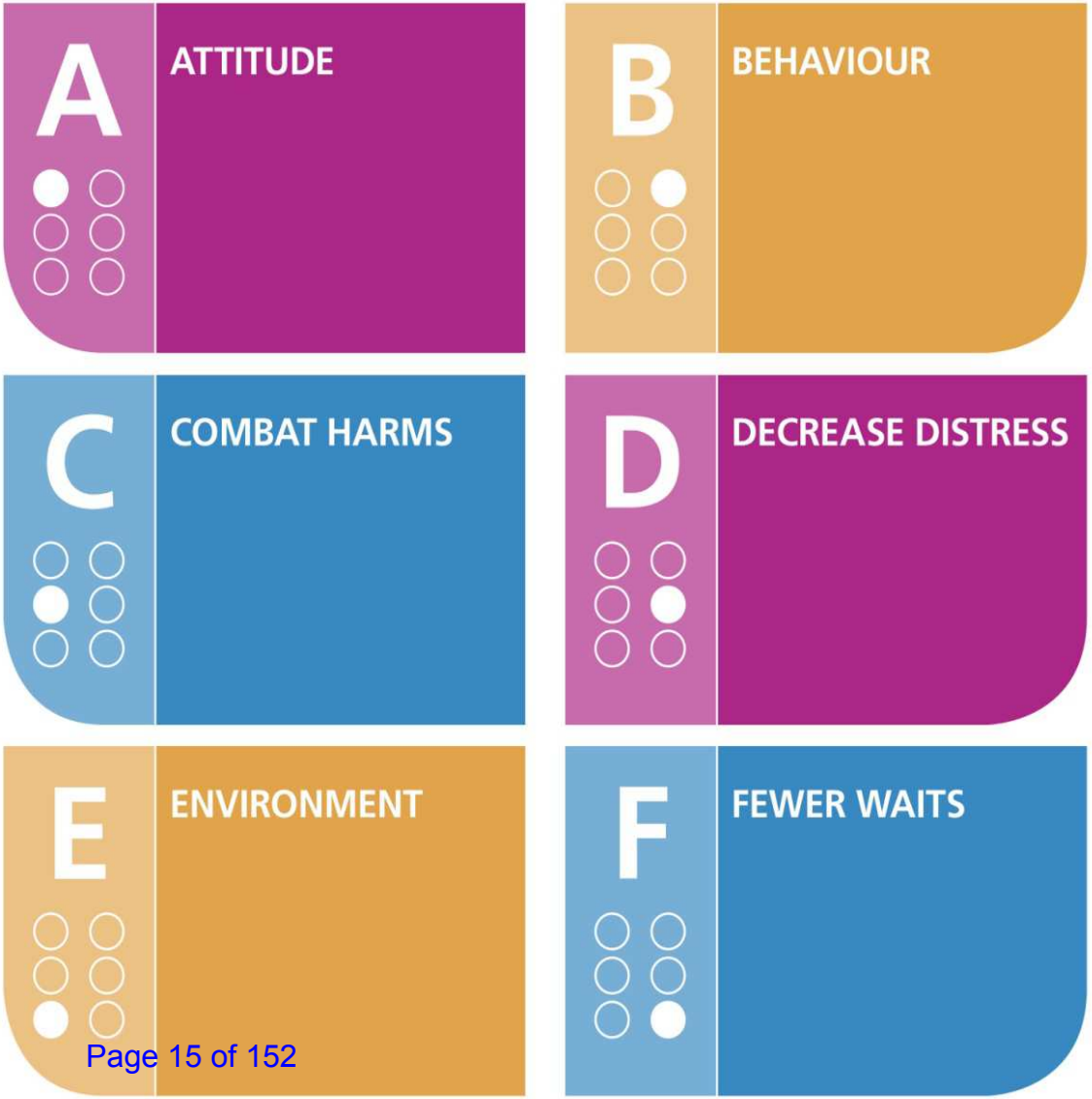
- **14/15 quality priorities**
- **New provider of Estates & Facilities Services**
- **Improving our environment:**
  1. **Cleanliness**
  2. **Smoking**
  3. **Noise at night**

Our 2014/15 quality priorities

My better care, our better care

Nottingham University Hospitals NHS
NHS Trust





Working with Carillion

- Carillion: E&F services July 2014
  Cleaning, catering, car park, laundry, maintenance

- 5 year contract, optional 3 year extension

- 1,200 staff transferred to Carillion

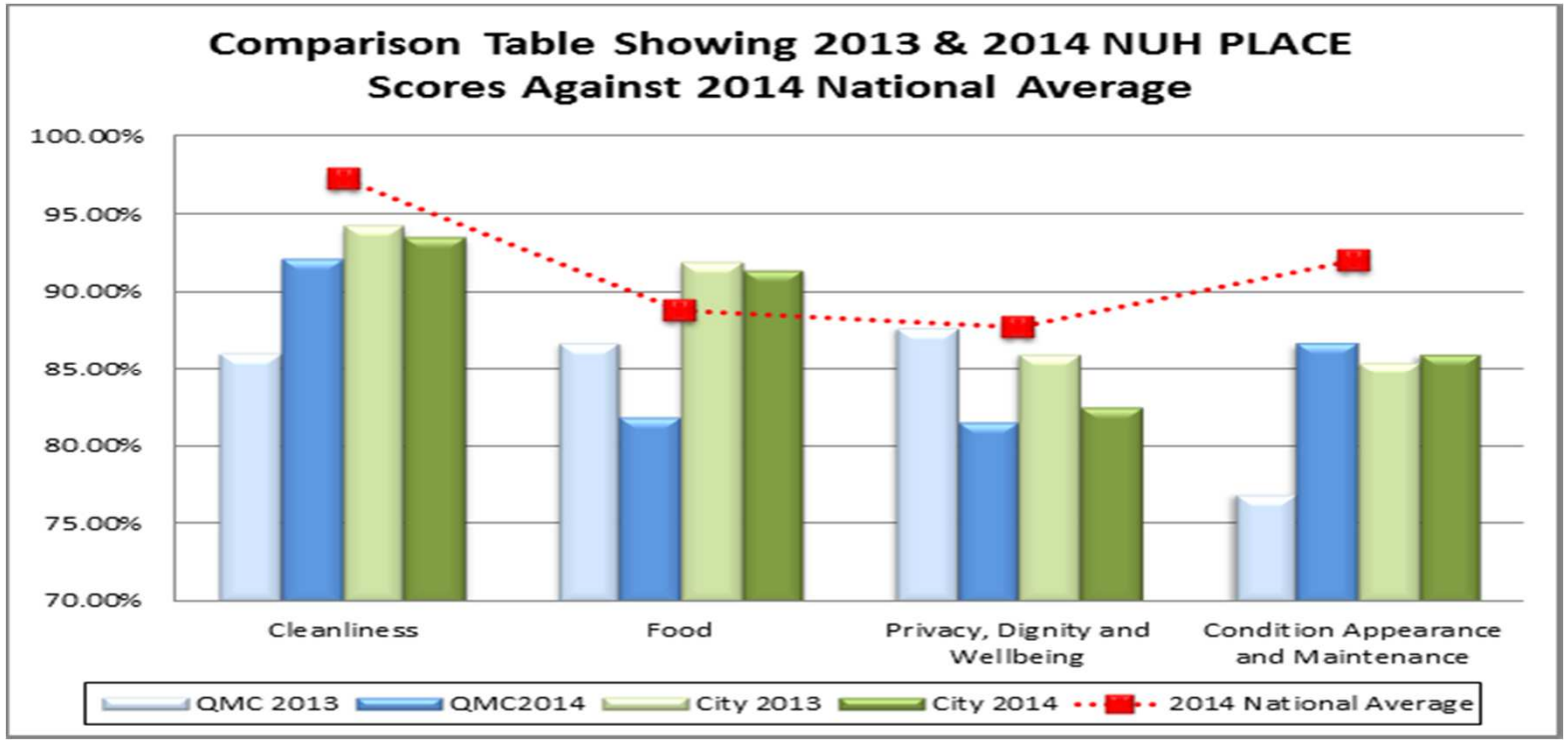
- New E&F Director February 2015

Cleanliness 1

- New Carillion contract sets higher targets for cleanliness standards
- Think Clean Days
  (quarterly inspections)
- New 24/7 E&F helpdesk: enabling rapid responses to cleanliness issues

Cleanliness 2

PLACE Audit Results 2014



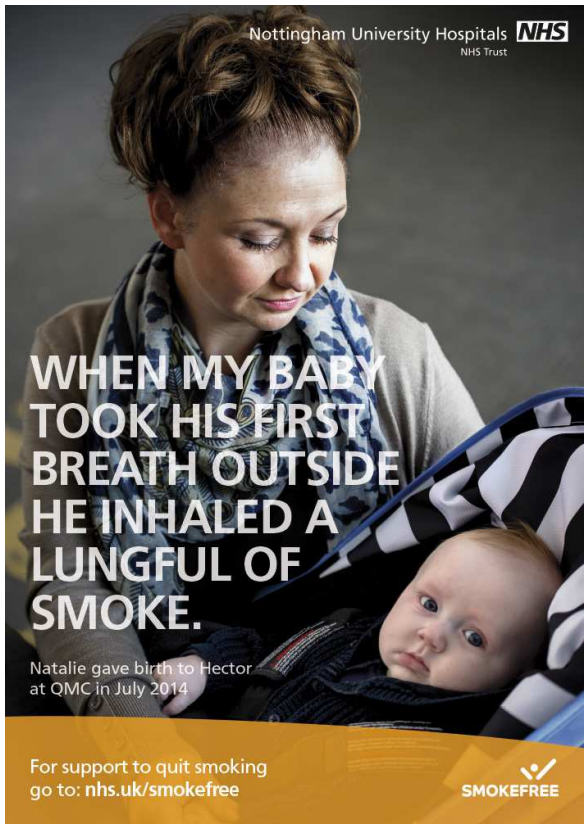
Smoking 1

- Strengthened smoke-free site policy
- New security challenging smokers
- New signage
- Exploring by-law change with LA
- Tougher action against staff
- Smoking cessation support promoted via security and trust comms

Smoking 2

- **Patient-led smoking campaign**

- Most vulnerable patients share their stories
- Local media support
- Social media campaign
- Campaign signage at ‘hot spots’



Reducing noise at night 1

‘Were you bothered by noise at night from staff?’

- April-November ‘14: 12.8% (target <12%)

- Different footwear for ward teams
- Better planning of non-essential treatment/care routines on wards
- Fewer phone calls overnight
- Reminding colleagues and patients to turn mobile devices to silent/vibrate on wards and to be considerate

Reducing noise at night 2

‘Were you bothered by noise at night from other patients?’

- April-November ‘14: 29.5% (target <25%)
- Ear plugs and eye pads to aid rest and recovery
- Trialled ‘SHHH’ campaign to raise awareness at ward entrances

Reducing noise at night 3

‘Were you bothered by noise at night from other patients?’

Focus for 2015:

- Review patient/relative information at ward entrances & visitors’ code
- Limit visiting after 8pm
- Reduce patient movements late at night
- Roll-out ‘SHHH’ campaign across NUH
- Reducing noise from mobile devices used by patients/visitors

Questions

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

13 January 2015

Agenda Item: 6

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

EAST MIDLANDS AMBULANCE SERVICE – NEW STRATEGIES

Purpose of the Report

1. To introduce a briefing on the new and wide-ranging strategies to be implemented by the East Midlands Ambulance Service (EMAS).

Information and Advice

2. The East Midlands Ambulance Service vision is to play a leading role in the provision, facilitation and transformation of clinically effective urgent and emergency care delivered by highly skilled, compassionate staff, proud to work at the heart of their local community.

3. This means it is EMAS' ambition to act as the co-ordinating NHS organisation at the centre of the system; either providing care directly or sign posting or referring patients to the best service to support them in their homes and the community, reducing admission to hospital where appropriate.

4. The proposed future operating model is designed to ensure the most appropriate and effective response to meet the needs of our patients and/or the referring clinicians. In essence, supporting delivery of the right care, with the right resource, in the right place and at the right time.

5. In order to implement this vision, EMAS has developed a number of strategies, as follows: Clinical and Quality Strategy, People, (workforce) strategy, Fleet Services (vehicles) Strategy, Information Management and Technology (IM&T) Strategy, Estates Strategy. A short briefing providing an overview of the strategies is attached as an appendix to this report; following this, comprehensive Trust Board papers on developing the various strategies are attached as further appendices.

6. Senior representatives of EMAS will attend the Joint Health Committee to brief Members and answer questions as necessary.

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee:

1) Receive the briefing and initiate lines of questioning

2) Schedule further consideration, as necessary

Councillor Parry Tsimbiridis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

EMAS – New Strategies Overview

Developing our strategies

Over the last couple of months our key strategies have been brought to our Board meetings for comment or approval. You can access all the paperwork by visiting our website – details of the relevant meeting paper file name and the link to access them are included below.

During January and February, whilst developing our strategies further, we will continue to talk with and listen to our colleagues and key stakeholders.

Updated versions of our developing strategies will be going to our Board meeting on 27 January 2015, with plans to receive final versions at our 31 March 2015 Board.

Developing our Clinical and Quality Strategy
Draft strategy available at http://www.emas.nhs.uk/about-us/trust-board/ under meeting date 28 October 2014, and referring to Board paper file name: PB.14.250.1 and PB.14.250.2

Patients are at the centre of all our services and the focus of all our efforts is the desire to deliver high quality, compassionate and effective care.

This strategy will set out our approach to the national clinical priorities: emergency and urgent care, mental health, the frail elderly, long-term conditions, end of life care and public health and prevention. It is central to the delivery of our draft five-year plan, and is interdependent on our Workforce, Fleet, IM&T and Estates Strategies.

In addition to our stakeholder engagement, throughout January and February 2015, our Director and Deputy Director of Nursing and Quality will be visiting frontline clinical colleagues to engage further with them on the development of this key strategy.

Developing our People (workforce) strategy
This strategy is currently being drafted.

The EMAS workforce is vital to us being able to provide the very best patient care and we plan to invest further in the recruitment and development of colleagues to support our long-term vision.

Our developing People strategy will see us recruit and develop more frontline colleagues including paramedics, technicians and emergency care assistants – all of whom respond to emergency calls out on the road.

When it comes to our Emergency Operations Centre (control), we are recruiting more paramedics and nurses to our Clinical Assessment Team to respond to calls from people who need medical advice or directing to a more appropriate healthcare service.

Our strategy will support us to ensure our colleagues are developed, feel valued and engaged and are supported by peers, line managers and the wider organisation.

Fleet Services (vehicles) Strategy

Strategy available at http://www.emas.nhs.uk/about-us/trust-board/ under meeting date 28 October 2014, and referring to Board paper file name: PB.14.251.1 and PB.14.251.2. Fleet Replacement Programme draft Outline Business Case available via same link, under meeting date 16 December 2014 and referring to Board paper file name: PB.14.297.1 and PB.14.297.2)

We provide emergency and urgent treatment and care at the scene of the incident and in our emergency vehicles. Together with the people to provide the care, our fleet is therefore very important. This strategy includes a fleet replacement plan which is being developed and proposes an investment programme to help create an improved fleet size and age profile.

Information Management and Technology (IM&T) Strategy
Strategy available at http://www.emas.nhs.uk/about-us/trust-board/ under meeting date 28 October 2014, and referring to Board paper file name: PB.14.253.1 and PB.14.253.2

We need to ensure colleagues have access to the right information and communication systems, and that our information management and governance processes enable us to fulfil our mission to achieve the highest standards in emergency and clinical care.

Our future plans will have important implications and requirements for our IM&T, and this strategy addresses the issues as well as detailing how the IM&T developments will support the delivery of our objectives.

Developing our Estates Strategy
Draft strategy available at http://www.emas.nhs.uk/about-us/trust-board/ under meeting date 28 October 2014, and referring to Board paper file name: PB.14.252.1 and PB.14.252.2

Being part of the communities we serve is very important to us; however we don't treat patients in Ambulance Stations. We treat patients at the scene of an incident, in our emergency vehicles as we take them to hospital, or over the phone via our Clinical Assessment Team; it's therefore important that the final Estates Strategy supports other key strategies such as Fleet, Clinical & Quality, and Information Management & Technology, to allow us to continue to improve the care we give to our patients.

Importantly, the strategy is being formed while considering several criteria including operational efficiency, staff and public engagement (in addition to the feedback received during 2013), economics (ensuring estates operating costs support future efficiencies and investment is affordable within the overall Capital Plan), and communications.

Next steps

There is a lot of information contained in this briefing and I am grateful therefore that you have identified some time when we can come and talk with you to ask questions of your group and respond to any queries you may have as a result of this briefing.

We look forward to seeing you in the New Year. In the meantime, I wish you a very Happy Christmas.

Sue Noyes
Chief Executive

East Midlands Ambulance Service NHS
NHS Trust

Developing our Clinical and Quality Strategy

Version: 1.0

Approved by: EMAS Trust Board

Date: TBA

Review Date: TBA

Clinical and Quality Strategy 2014-2019

Contents

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1. Executive Summary
2. Context
3. Strategic Vision and Objectives
4. Implementation of our Plan - Outcomes and Key Performance Indicators , and specific clinical areas for improvement
5. Stakeholder Engagement in the development of our strategy
6. Enabling Quality Improvement

7 Governance and Accountability

8 Finance

9 Risk Analysis

10 Appendices

1. Executive Summary

The purpose of the strategy is to support the delivery of the integrated business plan where we have set out what we want to deliver to our patients, and how we want to deliver it

. The strategy clearly sets out our approach to the national clinical priorities which are emergency care, urgent care, mental health, the frail elderly, long term conditions, end of life care and public health and prevention.

To ensure that there is a clear strategy to support the delivery of a high quality service that is safe, effective and patient focussed, we are we clearly setting out our aims and aspirations for our patient experience, patient safety and clinical effectiveness. This strategy clearly sets out our aspirations for all our services to ensure that we are providing patient centred care and ensuring that **service users are receiving the right care, with the right resource, in the right place and at the right time.**

Specifically our aims are :

- To ensure that all services are clinically sound and well governed and developed in partnership with our patients and stakeholders.
- To meet the requirements of the national context, specifically the recommendations from the two Keogh reviews -of Urgent and Emergency Care; and of high Standardised Mortality rations; , The Berwick review of Safety, and Clwyd review of Complaints.; and the recommendations from the Francis report
- To meet the national ambulance quality indicators and the clinical performance indicators and continue with the improvement plan to ensure that we continue to deliver safe effective care.
- To continue to work with all our clinicians to ensure they have the skills and attributes to not only deliver high quality, clinically effective patient care, but also the unrelenting desire to deliver a positive patient experience.
- To safeguard the delivery of these aims, we will ensure that our clinicians are supported in their provision of care by effective clinical leadership at every level, incorporating well developed, clinically effective structures.
- To ensure a focus on patient safety, including sign up to the national safety campaign which will allow the Trust to build detailed plans on the reduction of avoidable harm.
- To encourage reporting of incidents , with our commitment to be open honest and transparent.
- To ensure that we have robust mechanisms to learn from complaints and compliments and that are responses are patient centred and that we learn from mistakes and are open and transparent in our communications with patients, families and stakeholders.
- To fully embrace patient engagement to work collaboratively with all patient representatives and patient forums and groups, so that we can truly say our patients are involved in our service developments and that we work in partnerships to deliver the care and services that meets the needs of our local populations.

Effective governance is central to the delivery of this strategy and we will ensure that there is effective measurement and reporting of key quality indicators ;to ensure that we understandthe quality of our services ;that we are sighted on the services that are delivering a high quality care and those that need to improve ;and to be assured that those improvements are agreed delivered and monitored.

This strategy is central to the delivery of our Integrated Business Plan, and is interdependanton the Workforce, Fleet , Estates and IMT strategies

The patient has to be the centre of all our services and the focus of all our efforts, central to all our strategies is the understanding and the desire to deliver high quality compassionate and effective care for our population .Iin order to deliver that the Trust has to work in full partnership and collaboration with

our staff, our patients, our patient representatives, our stakeholders and the general public. This theme runs through all our strategies as we endeavour to deliver a better patient care programme.

2.Context

National Policies

Several key reports outline the recommendations that Trusts need to adopt to ensure that they are delivering patient focussed, safe and effective care.

Keogh Review of Urgent and Emergency Care

The review of urgent and emergency care, undertaken by Sir Bruce Keogh 2013, sets out a vision of a system where patients with urgent but non -life threatening needs have access to highly responsive, effective and personalised services outside of hospital, which are delivered in or a s close to patients' homes as possible. Additionally, for those patients with serious or life threatening emergency needs, the vision is for their treatment in centres with the best expertise and facilities in order to reduce risk and to maximise their chances of survival and a good recovery.

- **Emergency Care** - Continuing to improve the clinical care for patients with life threatening conditions remains a fundamental priority for ambulance services.
- **Urgent Care** - Ambulance services need to work in partnership with other health care providers to help deliver a coherent 24/7 urgent care service. Ambulance services should become and be seen as community based mobile urgent treatment services rather than solely a means of transportation

This is a critical review process which we will need to consider carefully and ensure our strategy is focusses upon delivery of a service model which meets the opportunities it provides

Keogh Review into the quality of care and treatment provided by 14 hospital trusts in England .

- The main focus of the report was to ensure that the Trust board and patients and the public had access to accurate insightful and easy to use data about quality at service line level.
- Patients and carers and member of the public are treated as equal and vital partners in the design and assessment of their local NHS. They should feel confident that their feedback is being listened to and see how it impacts on their own care and the care of others.
- No Trust however small or remote will remain an Island and professional, academic and managerial isolation will be a thing of the past.
- Staffing will be monitored and skill mix will appropriately reflect the acuity and dependency of the patients that they are caring for.
- Organisations' will ensure that they are engaging and supporting staff and understand the impact of staff satisfaction has on the patient experience and patient outcomes.

Berwick Report on Patient Safety

The Berwick report A promise to learn and a commitment to act Improving the safety of patients in England (2013). The report focussed on the following key principles to ensure the delivery of a safe and effective service

- The report focussed on the need for the NHS to ensure that patients remain the focus of all services and that patient safety is seen as the keystone dimension of quality.
- There is a strong patient and carer presence in the organisation and that patients' are present and powerful within all levels of the Trust. The patient voice has to be heard and heeded at all times.
- To place the needs of patients, families and carers at the centre of all of the work of the Trust, treating them with courtesy and respect .and ensuring that we treat colleagues with the same dignity and respect.
- Acknowledge when care goes wrong and to be an open honest and transparent service.
- The Trust needs to recognise with clarity and courage the need for systemic change
- Abandon blame as a tool and trust the goodwill and good intentions of the staff

- Reassert the primacy of working with patients and carers to achieve health care goals.
- Use quantitative targets with caution, such goals do have an important role en route to progress but should never displace the primary goal of better care.

Francis report on Mid Staffordshire Foundation Trust

The report focussed on the common themes arising from the inquiry which focussed on the failings in the care provided at the hospital and the delays in this being reported and acted upon.

- There were negative aspects of culture.
- A lack of openness to criticism
- A lack of consideration for patients and a defensiveness.
- A willingness to look inwards instead of outwards,
- Secrecy
- misplaced assumptions about the judgements and actions of others
- A failure to put the patient first in everything that is done.

To change there has to be a relentless focus on the patient's interests and the obligation to keep patients safe and protected from substandard care. This means the patient must be first in everything that is done, there must be no tolerance of substandard care, frontline staff must be empowered with responsibility and freedom to act in this way under strong and stable leadership in stable organisations

Conclusions on national context

These reports have informed and shaped the Trust quality agenda and to ensure that the care that is delivered is safe, effective and patient focussed, that there are clear links between front line services and the Board and that the Board has a clear sight of the services that they are delivering and the patient experience and patient outcomes. We have benchmarked against elements of these key reports to ensure that we fully integrate the principles and recommendations into our strategy and to ensure that we continue to drive forward the quality in care. However there is more work to be done to ensure that we deliver all of their recommendations

. In addition, we will need to ensure we deliver the relevant recommendations from the Saville report , in order to to protect all patients and staff and to ensure robust safeguarding and whistleblowing polices are in place and that honesty and openness is supported, encouraged and championed.

Organisations need to show that they are continually listening, learning and improving services to deliver the highest standard of care consistently. It is therefore essential to ensure all voices are heard e.g. deaf and hard of hearing, blind or sight impaired, learning disability, mental health, language or cultural, religious observance, sexual identity etc. That lessons are learnt in a no blame culture and that we openly honestly admit when care goes wrong to patient relatives and staff and ensure that lessons are learnt and changes result from that experience.

3. EMAS Vision & Strategic objectives

3.1We are a healthcare provider. We provide healthcare on the move and in the community, and our vision is for EMAS ***to play a leading role in the provision, facilitation and transformation of clinically effective urgent and emergency care delivered by highly skilled, compassionate staff, proud to work at the heart of their local community***.

We believe this will support CCGs and other health and social care providers across the East Midlands in the delivery of a long-term, sustainable healthcare system.

The five-year plan maps our transformation journey from a mainly emergency focused service in 2014/15 to a future operating model whereby the organisation sits at the centre of the urgent and emergency care system.

This means it is our ambition for EMAS to act as the co-ordinating NHS organisation at the centre of the system, either providing care directly (e.g. over the phone or on the scene) or signposting/referring

patients to the best service to support them in their homes and the community, reducing admissions to hospitals where appropriate.

This model is designed to ensure the most appropriate and effective response to meet the needs of our patients and/or the referring clinicians. Put simply:

"…..supporting delivery of the right care, with the right resource, in the right place and at the right time."

3.2 Future Operating Model

Our current Integrated Business Plan (IBP), completed in June 2014 and covering the five year period 2014-2019, articulated that, in order to realise we will:

Years One and Two (2014-2016)

The current service model is based upon core clinicians (paramedics) operating on frontline vehicles and the dispatch of the nearest available resource to attend to patient care irrespective of the clinical need.

This model involves the deployment of our most skilled staff in all circumstances, and makes no allowance for case mix. Additionally, the majority of patients are transported to the nearest Accident and Emergency facility with little opportunity for our skilled staff to exercise the full range of their clinical judgement.

Whilst this model is effective at one level, in that patients are seen and treated promptly, we regard it as being unsustainable in the longer term where demand is increasing within a decreasing financial envelope.

In developing options for the future, we (working with our Commissioners) are clear we will want to retain elements of the model that support delivery of consistent operational performance and financial sustainability, whilst operating at the centre of a more integrated urgent and emergency care system.

- Focus on continued delivery of performance, delivering at a county level on a sustained basis.
- Further develop our Clinical Assessment Team to increase hear and treat and support our teams in the field in the use of alternative pathways and admission avoidance services (supported by Paramedic Pathfinder), utilising all local health and social care providers.
- Work in partnership with CCGs, acute trusts, community trusts, local authorities, private providers and the voluntary sector to develop and implement integrated admission avoidance services (e.g. Falls, Discharge services, Acute Visiting Services etc.).
- Build our capacity and capability to support future integrated strategic developments (e.g. eDoS, Paramedic Pathfinder and Telehealth & Remote Monitoring).
- Support delivery of the right care, with the right resource, in the right place and at the right time.
- Deliver excellence in patient experience and outcomes.

Years Three to Five (2016-2019)

Our proposed future operating model has, at its core, a whole system approach to urgent and emergency care, with EMAS acting as the co-ordinating entity at the centre of the system, either providing care directly or signposting to other services.

This model ensures the most appropriate and effective response to meet the needs of our patients and/or the referring clinicians. Put simply:

"…..supporting delivery of the right care, with the right resource, in the right place and at the right time."

- Be at the centre of the urgent and emergency care system, generating efficiencies across the healthcare system (e.g. multi-skilled staffing, better use of admission avoidance schemes, reduced conveyance to emergency departments).
- Provide a regional platform for an efficient and sustainable integrated urgent and emergency care system (e.g. integrated care records, coordinated assessment services, care plans, direct booking into services etc.).
- Identify gaps in the system, facilitating improvements, managing demand and pressure regionally.
- Aim to provide a significant portion of the patient transport services in the region, so we will be a provider of transport services across the whole spectrum of urgent, emergency and planned care.
- Aim to be a partner in 111 services, developing strategic partnerships and working more closely with other providers.
- Provide other services and new models of care as opportunities arise.
- Continue to support on-going delivery of the right care, with the right resource, in the right place and at the right time.
- Continue to deliver excellence in patient experience and outcomes.

In summary the EMAS strategy over the five years of this plan is to transform ourselves into an organisation that is able to achieve key performance and quality standards, supporting reductions in emergency admissions, in a consistent and sustainable way (years one and two).

From this position, we seek to expand our service offering, building on our unique position as a regional provider with core skills, infrastructure, capacity and capability in call centre management, clinical assessment and provision of transport, to position ourselves as the platform upon which the urgent and emergency care system in the East Midlands can become sustainable (years three to five).

Please see appendix two for a further breakdown the range of services and call category for ambulance Trusts.

We recognise that successful delivery of our strategy will be dependent on the achievement of a number of strategic objectives. We recognise that a key objective is the delivery of a quality service, and that we need to build a reputation among stakeholders as an organisation that can deliver a quality service. By quality, we mean delivering consistently within all three domains of quality: patient safety, patient experience and clinical effectiveness. In order to build a strong reputation, we will need to develop innovative service offerings that help to address the current and future challenges in the urgent and emergency care system in the East Midlands, and we will do this through working with partners to provide and facilitate greater integration. This will be delivered through skilled and motivated staff working within an effective and efficient organisation.

We have, therefore, identified six strategic objectives. These elaborate on the vision and strategy overview and provide a more detailed focus on how the vision will be delivered:

Our Quality: We will respond to our patients with a high quality service which consistently meets national ambulance targets quality indicators

Our Reputation: We will be recognised nationally as a reliable provider of high quality out of hospital and community based care across the East Midlands

Our Innovation ambition: We will be recognised nationally as a leading innovator in out of hospital and community based care

Our Integration approach: We will work in partnership with our local health care, social care, and voluntary sector partners to deliver and enable integrated patient services and care pathways across the East Midlands

Our People: We will consistently develop and support our people to be highly skilled, highly motivated, caring and compassionate professionals

Our Efficiency: We will make the most effective use of all our resources, delivering upper quartile performance on our indicators for money, staff, premises, and fleet.

The IBP identified that the development of our strategy would be underpinned by a series of supporting strategies, one of which is this Clinical and Quality strategy. The IBP also recognised that each of these supporting strategies would be reviewed to ensure they reflect, are consistent with and support the strategy and future operating model detailed in our plans.

Our IBP includes a future operating model that reflects the fact we know, in years one and two of our plan, we must place significant emphasis on:

- The delivery of core performance at a county level
- The delivery of clinical indicators
- the provision of a sustainable service

4. Implementing our strategy – Outcomes and Performance Indicators

Ensuring we are delivering our clinical and Quality strategy will require us to consider a variety of outcomes and indicators.

4.1 Ambulance Quality Indicators ('AQI's)

We publish our quarterly clinical effectiveness report detailing our performance against the national Ambulance Quality Indicators (AQIs) and Clinical Performance Indicators (CPIs). These are a nationally agreed set of clinical metrics essential to review the quality of clinical care delivered.

The current AQI/CPI topic areas are as follows:

- National CPIs
- Asthma
- Falls in elderly patients (commencing 2014)
- Febrile convulsion
- Single limb fracture

In addition there are monthly indicators which we monitor :

- Cardiac arrest – return of spontaneous circulation (ROSC) and survival outcomes.
- STEMI – patients transferred for primary percutaneous coronary intervention (PPCI) within 150 minutes.
- Stroke care
- Face, Arm, Speech, Time (FAST) test positive stroke patients, potentially eligible for thrombolysis within local guidelines, transferred to a hyperacute stroke unit (HASU) within 60 minutes.

Locally agreed CPIs

- Exacerbation of COPD
- Suspected fractured neck of femur

4.2 Clinical audit

Our clinical audit team reports all CPIs and AQIs internally every month, to enable closer monitoring than the national programme allows. This detailed information, including county-level breakdowns, is disseminated to stakeholders each month. In addition this data analysis allows for the development of services, care and individuals in order to improve care delivery.

We are committed to illustrating the clinical effectiveness of its interventions and as such will continue to support and educate clinicians in these care bundles, build the structures and increase the awareness of the positive impact that focusing on these interventions will mean to patient care.

Future developments in respect of Clinical Performance will focus towards a greater emphasis on clinicians 'owning their performance' with greater accessibility of an individual clinicians own delivery against these measures. Forming part of each staff members' annual review and ensuring each paramedic and ambulance clinicians has a complete understanding of their delivery against established evidence based practice

4 .3 Commissioning for Quality – ' CQUINNS '

Requires form of words to be agreed with commissioners

4.4 Regulation – Care Quality Commission

The Care Quality Commission is our regulator who ensures that Providers meet essential standards of quality and safety within a well governed and financially robust framework.

Our most recent inspection has resulted in a programme for improvement and progress against these standards is monitored through the Better Patient Care Programme that reports directly to the Trust Board

The approach for ambulance trust inspection is currently undergoing change and our approach towards ensuring we meet the requirements for satisfactory compliance will be updated and refreshed as this strategy develops

4.5 Specific areas for improvement

4.5.1 Cardiac Arrest

We have been keen to focus our attention upon the improvement of successful Return of Spontaneous Circulation (ROSC) rates in cardiac arrest. The gathering of AQI data has illustrated this is a worthy emphasis and as such the organisation developed a cardiac arrest strategy, aimed to deliver these advances. Following publication of the strategy, we have invested heavily in the delivery of a more clinically effective means to care for these critically ill patients. This has included the provision of mechanical CPR, the adoption of the 'pitstop strategy' or managing cardiac arrest, ensuring cardiac arrest attempts are streamlined with the provision of a number of interventions intended to support ambulance clinicians in these stressful situations. Early indications are illustrating a positive impact from these interventions but we are keen to ensure this growing momentum is built upon. Subsequent developments will work to provide clinical leadership at the scene of incidents of this nature, focusing on the most appropriate care needs of the patient and supporting clinicians through a positive team-based approach. (Please see cardiac strategy in appendix one for further details.)

We have a robust essential education programme that ensures that staff are sensitive to the needs of the population that it serves and that our policies and procedures are fully compliant with the equality and diversity legislation and best practice. We must ensure that it has strong links with our local communities to ensure joint planning in place to meet the needs of our local population

4.5.2 Mental Health - Mental Health patients are often overlooked, and it is our desire to give parity of esteem to those who are in crisis. Calls to mental health patients are common presentations to 999 and urgent care settings at times of crisis and can result in frequent calls from some patients

.We aim to provide a high level standard of education to our clinicians and a robust pathway for patients who are presenting with mental health issues and for that reason we recognise this is a clinical priority area

.We have recently formed a mental health steering group to ensure that current and proposed work streams that fall under the remit of mental health can be discussed and there are clear governance arrangements and reporting process for new initiatives and projects that allow EMAS to improve the services that it currently provides to this group of patients

EMAS has signed up to the national mental health crisis concordant and is meeting with each multi professional locality to agree the plans that will radically change the care of patients who at their most vulnerable dial 999, to ensure that our response is measured patient focussed and ensures that patients can access the most appropriate service to meet the presenting complaint. Part of this response is the mental health triage car that has been piloted in Lincolnshire and has dramatically improved the care of these patients and ensured that they can access mental health services rather than the local A/E. .

4.5.3 The Frail Elderly and Falls- Falls are one of the most common primary presenting complaints to ambulance services and we appreciate the fact that we have an ageing population placing additional demands upon services. The frail elderly commonly present to ambulance services and represent a large proportion of acute admissions to hospital. NICE (2013) state that the over 65's have the highest risk of falling, with 30% of people older than 65 and 50% of people over 80 falling at least once a year. Given that ambulance services are commonly the first point of contact following the falls episode; opportunities for improvement in care are significant. EMAS has a falls service which aims to assess patients and agree a care plan that ensures that they can remain at home rather than being conveyed to hospital when they require no medical intervention

4.5.4 Long term conditions - Patients with long term conditions should have a personalised care plan and along with carers and relatives be supported in how to manage their own condition. However, many people may be undiagnosed or have an exacerbation and feel it necessary to access emergency or urgent care. EMAS needs to recognise this need and work with partner providers to manage these patients' more effectively within a community based setting.

4.5.5 End of Life Care - Ambulance services may be involved at any stage of a patient's care towards the end of life. Planned journeys include transferring patients who are approaching the end of life, for example from acute setting to preferred place of death. Unplanned involvement is common when a patient has a sudden crisis or deterioration, worsening symptoms and anxious carers and family members call 999. Paramedics are frequently at the scene at or shortly after the point of death, and have to make decisions on whether resuscitation is required or if it would be futile, often based on limited knowledge of the patient or their end of life plan at this point. EMAS has signed up to the leadership alliance for dying and is ensuring that it is working across all communities to ensure the sharing of information that allows all patients to access appropriate services and assistance to enable them to remain in their preferred place of care. EMAS needs to continue to ensure that we are culturally sensitive and knowledgeable about the values and faiths of the communities that we serve.

4.5.6 Public Health & Prevention - Ambulance services can make significant contributions to the public health agenda. Ambulance clinicians are routinely in situations and in patient's homes where they can identify health care prevention issues such as lack of heating, social care needs, mental health needs and the recognition of vulnerable adults. This information needs to be shared with other health and social care partners and more referral pathways developed .Engaging with health partners and networks and participating in collaborative health improvement initiatives is an essential and very important

engagement activity for the Trust. If we do not do retain the capacity to effectively work with our stakeholders, this will compromise the Trust's credibility effectiveness and reputation

5.0 Strategy Stakeholder Engagement

Requires this section to be expanded

5.1 The strategy has been developed and will be shared across all departments and clinical areas to ensure that it is shared and everyone has an opportunity to comment on the content.

5.2 It will be shared with our external stakeholders our patients' and Public including our patient forum, health watch and our commissioners.

5.3 Through the equality and diversity manager to ensure that we reach the hard to reach and vulnerable members of our community

5.4 Shared through the communications team to ensure that it is communicated internally and externally through the agreed channels.

6. Enabling Quality Improvement

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6.1 Ensuring Patient safety

Patient safety is the priority for all health care organisations and is the priority in all aspects of the care delivered by all staff and is part of the framework that underpins decision making within the organisation.

We need to ensure that we have a no blame culture and a comprehensive whistle blowing policy to ensure that patient and staff are confident that they can report concerns and ensure that they are dealt with fairly and with a no blame culture.

It is essential that we have a robust patient engagement strategy and a clear strategy for patient participation that ensures that we have a strong and effective patient voice on all service improvement initiatives and committees to ensure an equal and valued partnership.

We will need to develop a carer's strategy that ensures that we are listening and valuing the contribution that carers can make to the focus and development of services.

We will also need to ensure that are patient involvement is not tokenism but is a key facet of all our care and is respected and valued.

The Trust has to meet its statutory requirements including those dictated by Health and Safety legislation.

EMAS is following the NPSA seven steps to patient safety and Manchester Patient Safety Framework (MAPSAF) methodology.

The Trust has in place a Strategic Learning Review Group, supported by Divisional Learning Review Groups which facilitate learning across the whole trust and encourage service improvement for patient safety.

These initiatives will be tracked through the Better Patient Care Programme to ensure that we are delivering our key strategic aims.

6.2 Effective Risk management

It is essential that if we are to deliver a safe service that we have a robust risk management framework and that we manage risk and that we have a process in place to learn from incidents and reduce harm.

This is with the sole aim of preventing avoidable harm by identifying risks and mitigation against harm, to ensure robust learning when harm has occurred and that there is a process to ensure that the Board is assured that the Trust has the correct processes and procedures in place.

EMAS has a robust method of recording incidents through the ULYSSES system and reports incidents in line with the national standards and format. The data is reported through the clinical and operational governance structures through to the board and has robust action plans and monitoring in place. There are also Strategic and Divisional Learning Review Groups in place to ensure that identify lessons learnt and ensure that we continue to learn and develop services.

Quarterly thematic analysis takes place to ensure that we complete deep dives and investigation for any reoccurring themes and these are shared across the organisation.

This is monitored internally through the Better Patient Care Programme, Clinical Governance Group, Quality Governance committee and the Trust Board. It is shared externally with the Quality and Governance Commissioning Group.

Serious Incidents represent a failure of process or care delivery, and EMAS has a responsibility to ensure that there is a culture of reporting incidents in order to ensure that learning takes place. The SI reporting/learning is shared externally with the Commissioners and the Trust Development Agency patients and families to ensure we are open, honest and transparent.

6.3 Creating an open and transparent reporting environment

As part of the Trust incident reporting system incidents which caused moderate harm or had the potential to cause moderate and/or significant harm to patients are also investigated thoroughly and undergo root cause analysis to ensure that learning takes place.

Assurance is provided to the Board on the embedding of risk management and quality processes at a local level via the quality audit and safety inspections programmes.

We have launched a 'HOT' internal campaign that stands for being Honest Open and Transparent to encourage the reporting of incidents and near misses to ensure that we have a culture of reporting incidents and improving our safety culture.

We have also signed up the National sign up to safety campaign which means that we have agreed to pledge to reduce harm over the next three years in the following areas:

- Pressure ulcers
- Mental health
- Delayed response
- Patient Injury

The Trust will collect baseline data against each of these and ensure that we agree a robust action plan that will ensure an agreed reduction in incidents relating to these four areas.

6.4 Creating the right Health and Safety environment

All organisations have a responsibility to ensure that the health and safety of their employees and others affected by their activities.

Staff are trained and competent to carry out their jobs safely and are fully aware of their responsibilities in relation to health and safety.

Staff are fully aware of and understand the risks associated with their work activities and the control measures that are in place to reduce and manage them. This is facilitated by a Trust wide risk assessment programme which ensures are roles, premises and equipment including vehicles are adequately risk assessed.

Staff are fully consulted and engaged with in relation to ensuring their own health and safety and as well as that of others affected by the Trust activities. This is achieved by through the Divisional Health, Safety and Security Groups and the Risk, Safety and Governance Group.

All untoward incidents including RIDDOR incidents are reported in a timely manner and the number of incidents are reduced, by ensuring lessons are learnt and that risks are monitored and managed.

All untoward incidents including patient safety incidents and RIDDOR are reported internally through the Clinical governance framework and are reported through to Quality and Governance Committee and the Trust Board.

We conduct an annual self-assessment against the NHS Employers Health, Safety and Wellbeing Partnership Group Standards for Health and Wellbeing to ensure they meet the legislative requirements relating to health, safety and wellbeing.

6.5 Ensuring we safeguard Vulnerable Children and Adults

All organisations and individuals have a responsibility to help protect the most vulnerable in society.

Staff understand and act in accordance with their roles and responsibilities in relation to safeguarding and promoting the welfare of children, young people and vulnerable adults.

Staff are trained and competent to safeguard vulnerable children and adults effectively

Senior managers are committed to the welfare and safety of children, young people and vulnerable adults and we work closely with Local Children Safeguarding Boards to ensure shared learning and best practice.

Safeguarding helpline to be supported and managed directly by the safeguarding team to ensure good support and supervision is available to the staffs working on the helpline.

There will be continual review of current practice against national reports, and publications to ensure that we implement all recommendations, and good practice indicators, within safeguarding.

The continual review of current practice following external visits and assessments to ensure robust practices are in place and the service continues to develop and implement recommendations.

6.6 Effective Infection and Prevention and Control (IPC)

Infection prevention and control is a key part of patient safety and EMAS is committed to achieving and maintaining a consistently high standard.

IPC is everyone's responsibility and will continue to be embedded as such within the organisation.

Full compliance and maintenance of high standards in relation to the Hygiene code, the Health and Social Care Act 2008.

We will review of current practice against National and local initiatives and policy to ensure that we implements all recommendations and best IPC practice.

To ensure that EMAS can respond to communicable disease activity whether this be on a global, national or local level, thus protecting staff and patients, we will work in line with best IPC practices. (Examples being hand hygiene, PPE and employee vaccination and immunisation programmes.)

An annual programme of IPC quality inspections is maintained to ensure monitoring of practice and policy and give compliance assurance. The programme includes vehicles premises and staff compliance and targets for this are agreed with commissioners.

Monitoring of the vehicle deep cleaning programme as provided by the ambulance support team will provide assurance that operational vehicles of all types meet IPC standards.

6.7 Learning from Patient Experience

Patient experience is captured through multiple sources, focus groups, patient surveys, patient stories, complaints, compliments and the reporting incidents process. We will take steps to ensure feedback is captured across seldom heard or hard to reach groups.

It is essential that if we continue to collect and analyse patient feedback to ensure that we continually learn from this feedback and ensure that patients remain the focus of our services

Our continued development and growth will only occur successfully if we ensure that patients are central to our service. As part of the Trust Board cycle patient and staff stories are presented on a regular basis. This needs to reflect our local population and ensure there is a robust process to ensure that all our patients have an opportunity to present their story at Trust Board and that we have the support in place to assist patients and carers.

There will need to be a plan to engage more collaboratively and strengthen our relationship with the EMAS patient forum and this will be accomplished by the Director of Nursing and Quality becoming the chair of this forum. The long term aims and objectives of the group will be determined by the group.

Membership will be reviewed to ensure that is a true reflection of our local populations and the long term strategy is to ensure a patient presence and membership at key meetings to ensure the service developments have a strong user voice. High profile complaints are shared at the board and the actions lessons learnt are reviewed.

We will also roll out of the Friends and Family test in line with National guidelines.

Internal surveys of patient groups to ensure that improvements identified through the national surveys make the intended changes to the patient experience.

In line with the Clwyd Review, we will focus on ensuring our complaint responses demonstrate that EMAS is open honest and transparent and ensures that we provide compassionate, patient focussed responses. This will also include how accessible the process is for equalities groups i.e. learning disabilities, sight impairment and language.

It is imperative that we ensure that all patient feedback is listened to and there is a mechanism for ensuring that feedback changes and refines services and that will be monitored through the patient forum which will be the way that we are held to account by our patients and stakeholders to ensure that we are responding, listening and acting on those patient concerns and views to ensure that we are a patient focussed service that puts patients at the centre of all our services.

We have to work collaboratively and in partnership with patient carers and the public and to do this we need more patient involvement and a clear strategy to deliver a patient focussed service. Our progress will be monitored through the patient forum, to the better patient care programme and report to the Trust board.

To ensure we learn from our patient experience there will be regular integrated learning reporting and “deep dive” analyses into emerging themes.

We will also continue to monitor improvement against national and local targets in our response times to complaints and PALS queries and concerns

Robust action plans in place and monitored effectively that address the national and local survey results to ensure that we address patient experience concerns and views of EMAS. This will be reported through to the Quality and Governance committee and the better patient care programme

We undertake annual self-assessment of our patient experience processes using the Trust Development Authority Patient Experience Development Framework

6.8 Developing our clinicians and Clinical Leaders for the future

Paramedics continue to develop from their historical role of delivering first aid and transportation to hospital, towards a greater emphasis on decision-making, and our staff can now make a fundamental contribution to unscheduled and urgent care

There is significant potential for further development of the paramedic role to enable an enhanced clinical service for the benefit of patients. The future approach will include a move towards a professionalised paramedic workforce with enhanced clinical capabilities, clinical leadership and clinical decision making skills, to work autonomously with the support and recognition from other professional colleagues.

The paramedic evidence based education project (PEEP) published in August 2013 reviewed the existing evidence to support the future direction of paramedic education and training. It recognised that local training currently being delivered differs dependent on location, and therefore provides trainees with different experiences and levels of support. The report proposed the introduction of a national education and training framework for paramedics. The recommendations in the report are now being reviewed by Health Education England.

As this agenda develops EMAS will play its part as a leading employer of paramedics to ensure that not only effective and fit for purpose education for paramedics at the start of their career but also ensure there is a structured educational development plan for learning beyond registration.

Clinical leadership is regarded as a process by which an individual influences others to set standards, accomplish objectives and directs the organisation to greater consistency. Leaders are generally identified by a number of key characteristics; knowledge, skills and attributes. Therefore clinical leadership that covers a range of areas will encourage clinicians to inform strategy, improve and drive quality, service design and resource utilisation.

Clinical Leadership development within our organisation will be designed to engage with the workforce, develop succession plans and inspire talent to become future organisational leaders.

There is a need to establish a tiered system of clinical leadership, throughout the organisation and to create an aspirational career pathway within the paramedic profession

There will be several key strands to our clinical leadership development approach :

- Developing and supporting the current and future workforce profile and skills mix. Working with the Local Education & Training Board to commission the programmes which will ensure our workforce has the skills and characteristics to more effectively manage the patients we see.
- Work with clinicians, commissioners and clinical leaders to introduce decision making support tools (such as Paramedic Pathfinder) to assist paramedics in streaming patients away from Emergency Departments into community based care closer to home.
- Increasing and improving the level of clinical support available to the front-line from the Emergency Operations Centre. Developing the Clinical Assessment Team to take a proactive role in managing service user's needs by working directly with operational clinicians through a region wide single point of access.
- A continuation and development of the current support through appraisal of clinical performance indicators, PDR reviews and operational performance.
- A network of clinical leaders across the Trust, educated over and above that of registrant level (academic level 6, 7 & 8). Providing a tiered system of clinical leadership to the practitioners working within the teams they clinically lead.

Whilst leading the clinical change across the frontline, all these extended role practitioners will practise at a level above that of base registrant with the ability of offer a greater degree of assessment, diagnostic, treatment and referral capabilities than that currently available. Possessing the ability to assess and treat conditions, reduce admissions to ED and ensure more patients are managed closer to home.

Additionally, and just as important is a greater ability to offer assessment, clinical decision making and intervention to serious and life threatening conditions with the focus upon reducing morbidity and mortality within this critical patient group.

Clinical Leadership will be a 'strategic enabler' and its effects and influence will be far reaching, linking with many other strategies and developments.

6.9 Research & Development

East Midlands Ambulance Service NHS Trust's (EMAS) reputation as a leader in pre-hospital research has increased over the past five years. The trust is now collaborating in more high quality externally funded studies and leads a prestigious £2 million National Institute for Health Research (NIHR) Programme for Applied Research: Pre-hospital Outcomes for Evidence Based Evaluation (PhOEBE) in partnership with the Universities of Sheffield, Lincoln and Swansea. One of the drivers for increased ambulance service research in England has been the National Ambulance Research Steering Group (NARSG), set up in 2007 with support from EMAS' Chief Executive, and chaired by EMAS' Associate Clinical Director, Prof Niro Siriwardena. The role of NARSG is to set a strategy and develop the pre-hospital research agenda for ambulance services in England.

Our success has enabled us to source funds for research in excess of £2.5 million since 2008. We are currently collaborating on, or leading a number of research studies, more than half are eligible for registration on the National Institute for Health Research Clinical Research Network Portfolio (NIHR CRN). A further four funding applications have successfully achieved funding from NIHR programmes.

We have good working relationships with our East Midlands NIHR Research Design Service, who provide extensive advice and support, through the East Midlands Ambulance Research Alliance (EMARA). EMARA is the strategic research group for EMAS supporting both in-house and external research that aims to develop EMAS as a centre of excellence for patient focused pre-hospital research and evidenced-based practice. Through EMARA we have developed strong links with higher education institutes and healthcare organisations, thereby ensuring all research undertaken complies with the Research Governance Framework for Health and Social Care.

To date there are 3 NIHR portfolio studies about to start in this financial year where EMAS is collaborating with other hospitals and universities in major research which will eventually have an effect on patient care. All these are between 3 -5 year projects. EMAS is also involved with a CLARHC (Collaboration for leadership in Applied Health Research and Care) Study where a hypoglycaemia pathway is being tested. This study will commence in January 2015 for 1 year. These studies will involve our clinicians.

Clinicians are encouraged to sign up to EMAS AIR (Active in Research). To date there are over 70 members who, when required, are called upon to become involved in studies. This is one way of integrating research into every day work, and provides an avenue for research interested clinicians to explore their research ideas and learn of new studies. As research becomes more high profile more clinicians will be encouraged to join EMAS AIR.

The research department will continue to explore not only research ideas in-house but also externally with partners in other NHS organisations and academia. Through these collaborations our clinicians can take part in major research initiatives and the Trust continue to build its reputation as a research organisation

7. Governance and Accountability

7.1 Structure and Process

7.2 Quality governance is the combination of structures and processes at and below board level to lead on trust wide quality performance including.

- Ensuring required standards are achieved
- Investigating and taking action on sub-standard performance

- Planning and driving continuous improvement
- Identifying sharing and ensuring delivery of best practice
- Identifying and managing risks to quality of care.

7.2 Accountability

The governance structure will hold each work stream to account and exceptions and risks will be monitored and reported through to the Trust board. Our patients' stakeholders will hold us to account through our patient forums and patient engagement events and by ensuring they are a member of key groups to ensure that there is a mechanism to allow them to challenge and hold us to account.

Progress is monitored through our quality accounts and risks will be highlighted and mitigated through the Risk register.

The Board has established a Quality and Governance Committee with delegated authority to oversee this agenda. This committee report to the Board at each meeting. The Nursing and Quality team is responsible for collating and analysing data relating to quality issues.

Board members undertake quality visits to Accident and Emergency Departments and the Emergency Operation Centres and accompany crews to obtain assurance on quality issues. Executive directors undertake four quality visits per year and Non- executives complete two quality visits per year.

The board programme includes regular patient and staff stories focussing upon continual improvement in relation to patient and staff experience.

7.3 Quality Accounts

Quality Accounts are reports to the public on the quality of services that the individual healthcare organisation provides with a focus on patient safety, experience and outcome.

Their purpose is to enable

- Boards or providers to focus on quality improvement as a core function.
- The public to hold providers to account for the quality of NHS healthcare services they provide.
- Patients and their carers' are able to make informed choices.

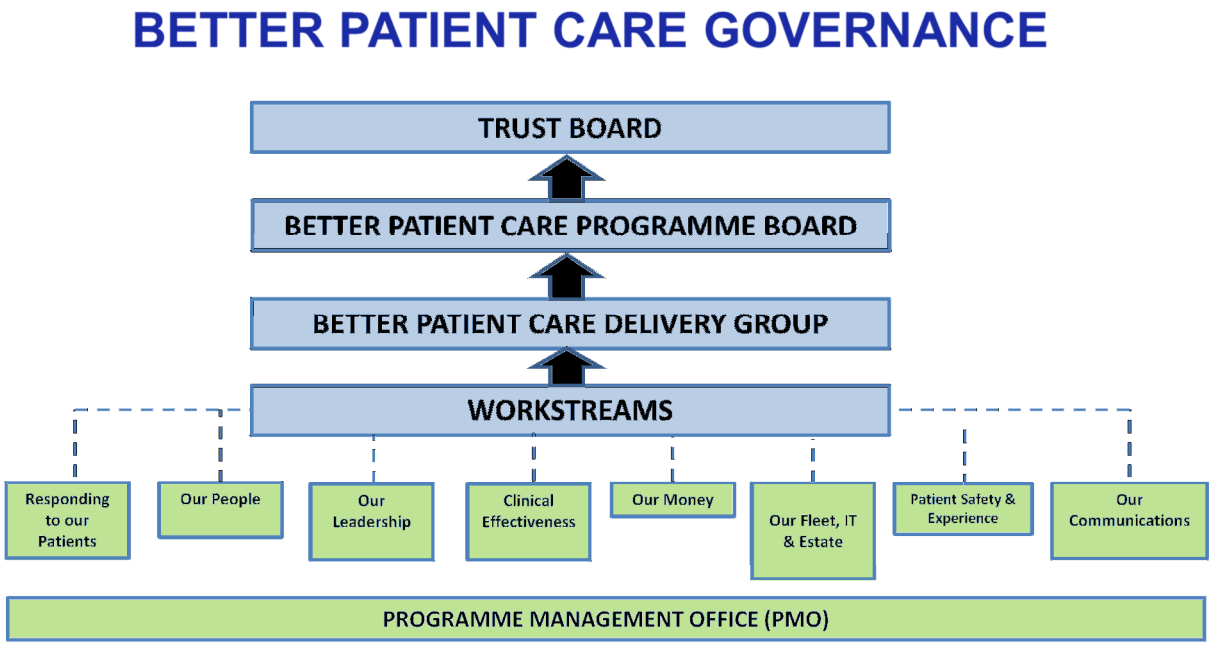
Our annual quality account sets out how we have engaged with the public in order to develop our quality metrics to ensure that they are meaningful to the people that we serve. The quality account includes six priorities which we have pledged to concentrate on.

.

7.3 Better Patient Care Programme

7.4 The Better Patient Care Programme monitors and reports progress against agreed work streams and all work undertaken towards achieving the strategic milestones are risk assessed and monitored through this process. The group meets fortnightly to review progress and identify risks associated with the delivery of agreed actions.

Any new work being undertaken by the teams are added to the Better Patient Care Programme to ensure that all initiatives and work plans are owned and delivered through this central programme. This process also ensures that any new initiatives are brought to this meeting and all aspects of the proposal and potential impact on quality can be discussed and a full assessment made.



8. Finance

Requires – Financial implications to be completed

8. Risk Management

8.1 Risk Analysis

We have robust, comprehensive and effective risk management systems in place to manage clinical, financial and business risks. Underpinning this is the Risk Management Policy and the Governance Strategy. Leadership is given to the risk management process by the Board and through Board Committees, which view risks from a variety of sources.

We have identified lead managers who monitor performance, compliance and assurance against a range of national standards.

The Board Assurance Framework is the key tool used by us to provide assurance of that risk and control mechanisms are in place and operating effectively. Through regular monitoring of the Board Assurance Framework and the operational risk registers, which underpin the risk management process, the Executive Team and EMAS Board ensure that current risks are managed appropriately and there are suitable arrangements for preventing and deterring risk. The Board reviews the Board Assurance Framework every two months. Each risk and its mitigating actions are reviewed and the risk score considered and amended as necessary.

8.2 Risk Registers

The Board Assurance Framework is a high-level register of the risks to the achievement of EMAS's strategic objectives. Controls to mitigate these risks and evidence of those controls are also included.

The Board Assurance Framework also includes risks that have been escalated to the Board from the operational divisions. The following committees review the Divisional Risk Registers and refer strategic risks to the Board:

- Quality and Governance Committee
- Workforce Committee
- Finance and Performance Committee
- Risk safety and Governance group
- Clinical Governance Group

Divisional and Local Risk Registers have been developed to ensure that risks, identified through the business planning process, are managed at a local level. Each Director is responsible for the risk registers within their Directorate. In addition, Directors are also accountable for specific risks in the Board Assurance Framework. The Board of Directors is accountable for controlling and mitigating organisational risk.

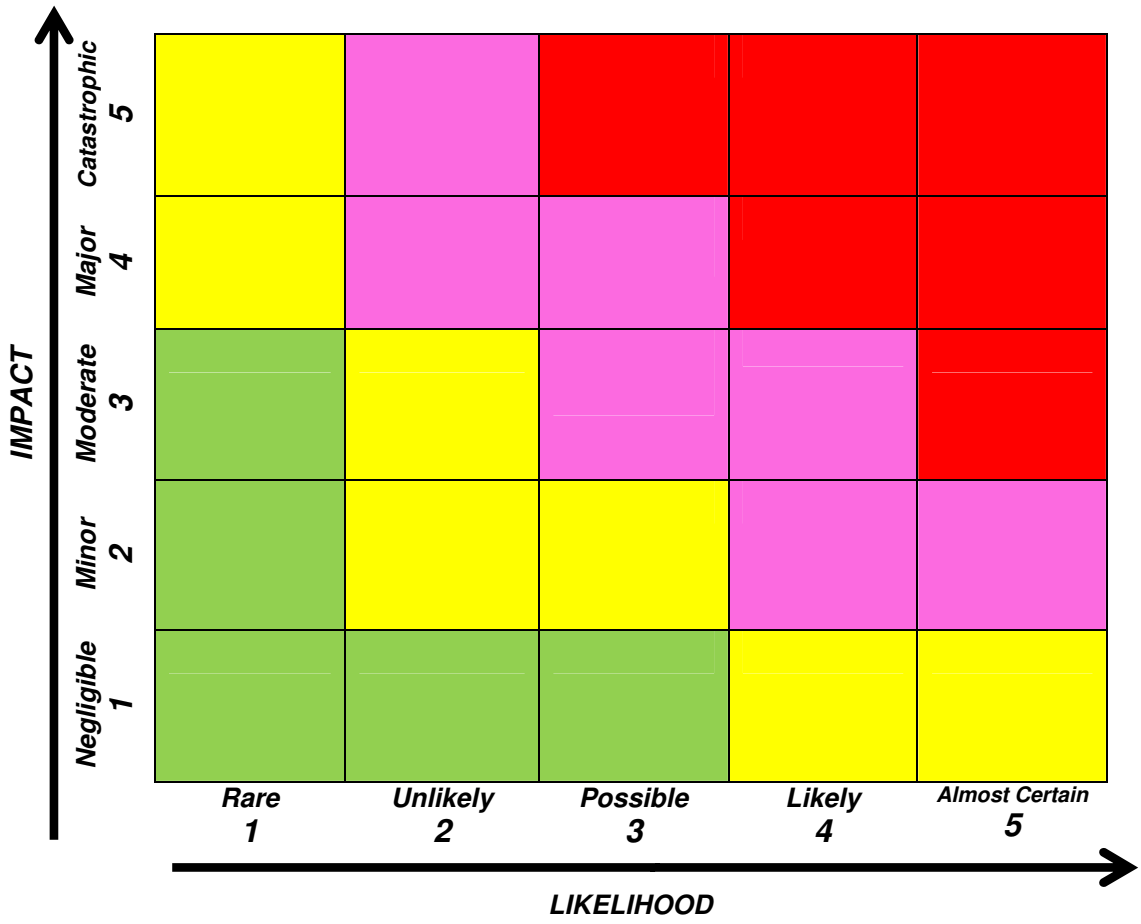
8.3 Key Risks

Please see enclosed risks as highlighted in the risk register

9.3 Risk log, scored and mitigated score

RISK REGISTER TEMPLATE

RISK REGISTER –



The risk that EMAS will not be involved in the development of clinical initiatives that would allow and support the development of services in line with national and local priorities Score: L [3] x I [4] = 12	[REF] 5 EMAS will not effectively review and fund the changes required to ensure the complaints process is inclusive and accessible for equalities group Score: L [3] x I [3] = [9]	[REF] 9. RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]	[REF] 13. RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]
[REF] 2.**Risk that EMAS will not meet the national ambulance quality indicators and will not see the increases in clinical effectiveness and patient outcomes** Score: L [3] x I [3] = [9]	[REF] 6.II RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]	[REF] 10. RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]	[REF] 14. RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]

[REF] **3.** EMAS will not effectively engage with the seldom hard to reach groups and ensure strong and effective patient engagement Score: L [2] x I [3] = [6]	[REF] **7.** RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]	[REF] **11.** RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]	[REF] **15.** RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]
[REF] **4.** RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]	[REF] **8.** RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]	[REF] **12.** RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]	[REF] **16.** RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]

CORPORATE RISKS Risk Register Management Lead – Director of Nursing and Quality								
Risk	**Risk Owner** **Latest Review**	**Source and Date**	**Score** **(L x I =)**	**Controls** **(Currently in place)**	**Planned Mitigating Action** **Implementation Date and Responsibility**	**Actions on Track (R/A/G) Comment**	**Residual Score** **(L x I =)**	**Sources of Assurance**
Objective: To ensure that EMAS will be at the forefront of the development of Clinical initiatives.								
[REF] 1. The risk that EMAS will not be involved in the development of clinical initiatives that would allow and support the development of services in line with national and local priorities	Risk Owner Judith Douglas Latest Review [10/08/15	Integrated business plan and clinical and quality strategy	[3] x [4] = [12]	Agreed Divisional structure with GM, Exec and Non exec lead to ensure that key strategic groups and working groups have EMAS representation. Attendance at key clinical forums to ensure engagement and leadership. Strong IBP that has been shared across the health economy to ensure that we are engaged and involved in urgent care centre involvement, falls services and mental health triage.	To ensure that we are involved in locality driven plans to reduce conveyance and ensure that EMAS has representation and is involved in service developments. Fed back through trust board and executives to ensure the key individuals are aware of progress and commissioning requirements	Amber	[2] x [3] = 6 [ ]	Involvement in key groups, Tendering for services as the current arrangements expire.
					Continued discussion re contracts and commissioning processes and awareness of tendering for services and full involvement of all departments to ensure a robust tendering.			

CORPORATE GOVERNANCE RISKS (Risk Register Management Lead - Director of Nursing and Quality								
Risk	**Risk Owner** **Latest Review**	**Source and Date**	**Score** **(L x I =)**	**Controls** **(Currently in place)**	**Planned Mitigating Action** **Implementation Date and Responsibility**	**Actions on Track (R/A/G) Comment**	**Residual Score** **(L x I =)**	**Sources of Assurance**
Directorate Objective: To ensure that EMAS meets the national ambulance indictors								
EMAS will not meet the national ambulance quality indicators and will not see the improvements patient outcomes	Rashid Sohail	Clinical and Quality strategy. National Ambulance indicators	3 x 3= 9	Robust auditing of current practice and performance against quality indicators. Agreed improvement plans to ensure the adoption of the clinical pathways	CQUIIN payments related to this roust monitoring through clinical governance and trust board	Amber dependant on performance and current focus on operational duties of all staff	3x2=6	CGG QGC Trust board Robust data collection and analysis and governance
EMAS will not make the required changes to the complaints process to ensure that the complaint process ad responses are inclusive and accessible to equalities groups	Judith Douglas	Patient engagement strategy Clinical and quality strategy	3x3=9	Good patient engagement currently the understanding that this needs to be more robust and inclusive. Planned events too hard to reach groups are in process but funded out of charitable account	Engagement strategy, involvement with key stakeholders who attend trust board. Key public events and planned initiatives. Very active and committed equality and diversity manager who is very engaged with the strategy. Trust board and Executive team fully aware and agree the importance of a strong patient voice	RED No agreed funding or budget in place and not classed as a must do	3x3 =9	Monitored through the patient experience reports ad strategy that is reported to CCG, QGC and Trust board.

9.4 How risks will be monitored and implementation of mitigating actions

The risks will be owned and monitored by the Director of Nursing and Quality and the Medical Director where appropriate and reports will be presented at the Quality and Governance Committee and unresolved risks and concerns will be escalated through to the Trust board.

10. Appendices

Appendix 1 –Cardiac arrest strategy

See attached.

Appendix 2

Range of Services

Traditionally the role of the Ambulance service has been to take patients to hospital, whether for emergency, unscheduled or planned care. This role is changing as the health care needs of patients and the NHS in England change. The East Midlands Ambulance service is responding to these changing needs and ensuring all its frontline services are clinically focussed and delivering improved treatment for patients.

Emergency services

Emergency services operate 24 hours a day and are accessed through the 999 number. When a member of the public calls 999 in the East Midlands, they are first assessed by EMAS using the advanced medical priority dispatch system. (AMPDS) to determine the most appropriate response based on clinical need. These calls are categorised in the following way:

Red calls (R1 and R2) - immediately life threatening conditions which require a fully equipped ambulance vehicle to attend the scene.

Green calls (G1 and G2) - conditions which are not immediately serious or life-threatening but urgently require a face to face response.

Green Calls (G3 and G4) - non life-threatening conditions which require telephone clinical assessment by a paramedic or nurse where the patient will be referred to an alternative care pathway, given advice over the phone or upgraded to a more urgent call category.

Following categorisation the call is directed to the most appropriate care pathway for the patient.

Hear and Treat - advice is provided, generally for green calls, directly to the patient over the phone by a clinically trained member of staff (this may include identification of and referral to an alternative pathway).

See and Treat - A clinician attends and provides treatment to the patient on the scene, but there is no requirement to transport the patient to a healthcare facility.

See Treat and Convey - A clinician attends and provides treatment to the patient on the scene, before transporting them to a health care facility for further treatment.

East Midlands Ambulance Service NHS
NHS Trust

Fleet Services Strategy

Version: 1.0

Approved by: EMAS Trust Board

Date: 28th October 2014

Review: October 2016

Fleet Services Strategy 2014-2019

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1. Executive Summary

1.1. This strategy sets out how Fleet Services will support the Trust to deliver the Integrated Business Plan over the current strategic planning period. The strategy highlights how Fleet Services will be transformed over this period to be a service which facilitates operational delivery, works efficiently to high standards, and delivers on a range of core key concepts. The ways in which we will achieve this are set out in chapter 3 of the strategy. It also highlights how investment over the strategic period will create a fleet with a much improved age and size profile, and with a significantly higher level of owned vehicles compared to now.

1.2. The strategy has been developed to ensure it aligns with and is consistent with the Trust's strategic objectives. This is demonstrated at section 3.3 of the strategy. In summary, this highlights the ways in which we will respond to the six strategic objectives of the Trust in the following ways:

Quality

Transform the way vehicles are maintained, serviced, cleaned and prepared to provide a fleet that has an appropriate age profile and ensures resilience on a 24/7 basis.

Reputation

To directly support patient and staff safety by ensuring vehicle specification, procurement, cleaning and preparation are in line with best practice.

Innovation

To maximise benefits of investment in fleet and technology.

Integration

To ensure integration with strategic plans and other supporting strategies.

Workforce

To recruit and retain a skilled and flexible workforce who are well trained and qualified, including registered to a recognised accreditation programme.

Efficiency

To deliver achievable efficiency savings which demonstrate the principles of best value and value for money.

1.3. To facilitate the delivery of the strategy the Trust will need to ensure that we plan an appropriate fleet replacement programme which facilitates a resilient and reliable fleet with an appropriate age profile and which provides the capacity needed as assessed by peak load modelling requirements. The strategy therefore sets out at section 8 a financial plan aimed at securing a maximum seven year age profile by the end of the strategic planning period through capital investment of £19m. In addition,

the strategy outlines the costs and benefits of additional funding to further bring down the age profile of our fleet, and to change the profile of our fleet to one with a higher percentage of owned vehicles.

1.4. We have indicated to the NHS Trust Development Agency (NHS TDA) the headline benefits of additional funding and if there is agreement in principle to this a Full Business Case will be developed to secure additional capital investment. The risk section at chapter 9 provides further analysis of this option.

1.5. It is essential that if the Trust invests 319 million to £24 million in its fleet then that investment must be matched by a real transformational improvement in the way the fleet services are managed and provided. The strategy therefore has those twin aims of investment and improvement.

1.6. Agreement to the strategic objectives and the key concepts in this strategy will enable the Trust to have a clear specification of the Fleet Services it wishes to be provided over the next few years. As with most ambulance services, Fleet Services are currently managed and provided in house, with the exception of a range of maintenance and servicing contracts in Lincolnshire. It is envisaged that the fleet management team will demonstrate through the implementation of this strategy that services are provided to an efficient, high quality standard in accordance with best value principles. Service provision and performance will be reviewed on a regular basis using the Trust's performance strategy principles. In particular, there will be a formal review of the progress made in implementing this strategy in March 2016. Operating principles to facilitate this have been agreed by the Board. The principles which we will work to and which are enshrined in this strategy are:

- The fleet size and age profile will be agreed and maintained, but will represent an improvement on the current profile and will be benchmarked against other comparable NHS Ambulance Trusts.
- Vehicle availability will be maximised, managed appropriately at county level, and facilitate good benchmarking of vehicle cover levels against other comparable NHS Ambulance Trusts.
- Maintenance and servicing will be carried out in accordance with legal, manufacturer and NHS Ambulance Trust agreed requirements.
- Planned preventative programmes will be implemented and maintained.
- Insurance arrangements will be continually reviewed in conjunction with the National Ambulance Insurance Association, and a robust accident management system will be maintained to minimise vehicle loss and downtime.
- The Fleet Services team will contribute appropriately to the sustainability agenda and demonstrate good practice in terms of environmentally appropriate fuel and vehicles.
- Services will be regularly benchmarked against other comparable NHS Ambulance Trusts to support demonstration of value for money and best value.
- There will be continual review of the best way to secure service provision.
- The benefits of Fleetwave will be secured and maximised.
- Fleet Services will deliver efficiency savings and good budget management to contribute to overall financial management when it is deemed appropriate to do so without compromising patient safety.

1.7. The Integrated Business Plan assumes that the services we provide will grow and diversify. This could mean a material change to the fleet size and structure and the fleet management team will have to ensure they are responsive to tendering and contracting proposals and arrangements. Chapter 9 sets out how we will manage these opportunities and risks. The fleet replacement plan can only at this stage make proposals on the current fleet linked to current services and contracts. Individual contract business proposals will need to set out the fleet requirement and funding arrangements, and the fleet services manager will work closely with the Business Development and Strategy Directorate in this regard.

1.8. This strategy contains a detailed implementation plan for the next two years and outline plans for the outer years of the strategy. As such, the Strategy will be reviewed and refreshed in two years' time (October 2016), following the formal review of progress and implementation outlined at Section 1.6.

1.9. The strategy will be implemented in accordance with section 4. Key to the implementation process will be the production of annual plans for fleet services, and the development of business cases to support the key investment areas of fleet replacement, workforce, workshops and ambulance support services.

1.10. The current process for the development of support strategies has seen a strategic shift in terms of strategic investment and strategic contribution away from estates to fleet services, and Executive Directors will need to ensure that this change is reflected in programme and strategy implementation budgets and resources.

1.11. In conclusion this strategy sets out how Fleet services will contribute to the successful implementation of the Trust's Integrated Business Plan and strategic objectives, makes proposals to improve the fleet size and age profile, outlines how fleet services will be transformed to support operational delivery ,and explains how quality services will be secured whilst delivering an efficient service and managing service risks.

2. Context

2.1 EMAS Vision & Strategic objectives

We are a healthcare provider. We provide healthcare on the move and in the community, and our vision is for EMAS ***to play a leading role in the provision, facilitation and transformation of clinically effective urgent and emergency care delivered by highly skilled, compassionate staff, proud to work at the heart of their local community***.

We believe this will support CCGs and other health and social care providers across the East Midlands in the delivery of a long-term, sustainable healthcare system.
The five-year plan maps our transformation journey from a mainly emergency focused service in 2014/15 to a future operating model whereby the organisation sits at the centre of the urgent and emergency care system.

This means it is our ambition for EMAS to act as the co-ordinating NHS organisation at the centre of the system, either providing care directly (e.g. over the phone or on the scene) or signposting/referring patients to the best service to support them in their homes and the community, reducing admissions to hospitals where appropriate.

This model is designed to ensure the most appropriate and effective response to meet the needs of our patients and/or the referring clinicians. Put simply:

"…..supporting delivery of the right care, with the right resource, in the right place and at the right time."

2.2 Future Operating Model

Our current Integrated Business Plan (IBP), completed in June 2014 and covering the five year period 2014-2019, articulated that, in order to realise we will:

Current Model

The current service model is based upon core clinicians (paramedics) operating on frontline vehicles and the dispatch of the nearest available resource to attend to patient care irrespective of the clinical need.

This model involves the deployment of our most skilled staff in all circumstances, and makes no allowance for case mix. Additionally, the majority of patients are transported to the nearest Accident and Emergency facility with little opportunity for our skilled staff to exercise the full range of their clinical judgement.

Whilst this model is effective at one level, in that patients are seen and treated promptly, we regard it as being unsustainable in the longer term where demand is increasing within a decreasing financial envelope.

In developing options for the future, we (working with our Commissioners) are clear we will want to retain elements of the model that support delivery of consistent operational performance and financial sustainability, whilst operating at the centre of a more integrated urgent and emergency care system.

Years One and Two (2014-2016)

- Focus on continued delivery of performance, delivering at a county level on a sustained basis.
- Further develop our Clinical Assessment Team to increase hear and treat and support our teams in the field in the use of alternative pathways and admission avoidance services (supported by Paramedic Pathfinder), utilising all local health and social care providers.
- Work in partnership with CCGs, acute trusts, community trusts, local authorities, private providers and the voluntary sector to develop and implement integrated admission avoidance services (e.g. Falls, Discharge services, Acute Visiting Services etc.).
- Build our capacity and capability to support future integrated strategic developments (e.g. eDoS, Paramedic Pathfinder and Telehealth & Remote Monitoring).
- Support delivery of the right care, with the right resource, in the right place and at the right time.
- Deliver excellence in patient experience and outcomes.

Years Three to Five (2016-2019)

Our proposed future operating model has, at its core, a whole system approach to urgent and emergency care, with EMAS acting as the co-ordinating entity at the centre of the system, either providing care directly or signposting to other services.

This model ensures the most appropriate and effective response to meet the needs of our patients and/or the referring clinicians. Put simply:

"…..supporting delivery of the right care, with the right resource, in the right place and at the right time."

- Be at the centre of the urgent and emergency care system, generating efficiencies across the healthcare system (e.g. multi-skilled staffing, better use of admission avoidance schemes, reduced conveyance to emergency departments).
- Provide a regional platform for an efficient and sustainable integrated urgent and emergency care system (e.g. integrated care records, coordinated assessment services, care plans, direct booking into services etc.).
- Identify gaps in the system, facilitating improvements, managing demand and pressure regionally.
- Aim to provide a significant portion of the patient transport services in the region, so we will be a provider of transport services across the whole spectrum of urgent, emergency and planned care.
- Aim to be a partner in 111 services, developing strategic partnerships and working more closely with other providers.
- Provide other services and new models of care as opportunities arise.
- Continue to support on going delivery of the right care, with the right resource, in the right place and at the right time.
- Continue to deliver excellence in patient experience and outcomes.

In summary the EMAS strategy over the five years of this plan is to transform ourselves into an organisation that is able to achieve key performance and quality standards, supporting reductions in emergency admissions, in a consistent and sustainable way (years one and two).

From this position, we seek to expand our service offering, building on our unique position as a regional provider with core skills, infrastructure, capacity and capability in call centre management, clinical assessment and provision of transport, to position ourselves as the platform upon which the urgent and emergency care system in the East Midlands can become sustainable (years three to five).

We recognise that successful delivery of our strategy will be dependent on the achievement of a number of strategic objectives. We recognise that a key objective is the delivery of a quality service, and that we need to build a reputation among stakeholders as an organisation that can deliver a quality service. By quality, we mean delivering consistently within all three domains of quality: patient safety, patient experience and clinical effectiveness. In order to build a strong reputation, we will need to develop innovative service offerings that help to address the current and future challenges in the urgent and emergency care system in the East Midlands, and we will do this through working with partners to provide and facilitate greater integration. This will be delivered through skilled and motivated staff working within an effective and efficient organisation.

We have, therefore, identified six strategic objectives. These elaborate on the vision and strategy overview and provide a more detailed focus on how the vision will be delivered:

Our Quality: We will respond to our patients with a high quality service which consistently meets national ambulance targets quality indicators

Our Reputation: We will be recognised nationally as a reliable provider of high quality out of hospital and community based care across the East Midlands

Our Innovation ambition: We will be recognised nationally as a leading innovator in out of hospital and community based care

Our Integration approach: We will work in partnership with our local health care, social care, and voluntary sector partners to deliver and enable integrated patient services and care pathways across the East Midlands

Our People: We will consistently develop and support our people to be highly skilled, highly motivated, caring and compassionate professionals

Our Efficiency: We will make the most effective use of all our resources, delivering upper quartile performance on our indicators for money, staff, premises, and fleet.

The IBP identified that the development of our strategy would be underpinned by a series of supporting strategies, one of which is this Fleet strategy. The IBP also recognised that each of these supporting strategies would be reviewed to ensure they reflect, are consistent with and support the strategy and future operating model detailed in our plans.

Our IBP includes a future operating model that reflects the fact we know, in years one and two of our plan, we must place significant emphasis on:

- the delivery of core performance at a county level

- the delivery of clinical indicators
- the provision of a sustainable service

The Current Model

- The current service model is based upon core clinicians (Paramedics) operating on frontline vehicles and the dispatch of the nearest available resource to attend to patient care irrespective of the clinical need.
- This model involves the deployment of our most skilled staff in all circumstances and makes no allowance for case mix. Additionally, the majority of patients are transported to the nearest Accident and Emergency facility with little opportunity for our skilled staff to exercise the full range of their clinical judgement.
- Whilst this model is effective at one level, in that patients are seen and treated promptly, we regard it as being unsustainable in the longer term where demand is increasing within a decreasing financial envelope.
- In developing options for the future, both EMAS and our commissioners are clear we will want to retain elements of the model that support delivery of consistent operational performance and financial sustainability, whilst operating at the centre of a more integrated urgent and emergency care system.

Years Three to Five – Future Operating Model

- Our proposed future operating model has, at its core, a whole system approach to urgent and emergency care, with EMAS acting as the co-ordinating entity at the centre of the system, either providing care directly or signposting to other services.
- This model ensures the most appropriate and effective response to meet the needs of our patients and/or the referring clinicians. Put simply:

"…..S*upporting delivery of the right care, with the right resource, in the right place and at the right time*."

Specifically, the EMAS future operating model is designed to deliver:

- A single urgent and emergency care platform to which other services can align or where we can host for others (e.g. NHS 111).
- A single point of access for 999, NHS 111 and clinicians requiring access to integrated services.
- An early warning system to the East Midlands health economy that will provide advance notice of system pressures, supporting capacity management across the whole system.
- A 24/7 multi-professional access team who will signpost and liaise with other health and social care providers, maximising appropriate skill mix and resource deployment.

- Continued delivery and improvement on performance and clinical indicator requirements as agreed with our commissioners.
- Maintenance of performance standards as per commissioner requirements through appropriate skill mix and resource deployment.
- Creation of a platform for Individual Care Records, Care Planning and direct booking of primary and community services where agreed.

These key features will continue to be underpinned by the following principles:

- Consistent delivery of core performance.
- Services are clinically sound and well governed.
- A collaborative approach in line with Commissioner expectations.

3. Strategic Plan

3.1. The vision and objectives of this strategy are to:

- Deliver an operational fleet that is fit for purpose and affordable in conjunction with the Trust's operational, clinical and financial plans.
- Directly support patient and staff safety and the patient experience.
- Assist with delivery of an effective fleet replacement programme that will drive down the age profile of the fleet to seven years by the end of the 2018/19 financial year.
- Provide a fleet that ensures resilience on a 24/7 basis throughout the year based on forecast rota patterns.
- Deliver a deep cleaning service that ensures operational efficiency that is compliant to internal compliance standards that will withstand scrutiny from the Care Quality Commission.
- Commence the scoping of an affordable and sustainable vehicle preparation service in conjunction with Operations and Estates leads.
- Support key objectives of the Trust in terms of achieving national and local targets.
- Work with specialist departments within the Trust (Emergency Preparedness, HART, Education & Development etc.) to ensure provision of suitable and appropriate specialist single and multi-role vehicles.
- Maximise levels of vehicle availability within fleet numbers.

3.2. There are nine core key concepts that drive this strategy:

Fleet Replacement Plan

- Clear definition of a sustainable fleet replacement plan that fully aligns to the Trust's Integrated Business Plan 2014 – 2019 is required. In the current financial year the need to invest in higher levels of fleet replacement has been recognised by the Board with a reprioritisation of capital investment in favour of fleet replacement being implemented during 2014/15. This strategy sets out how this investment will be expanded to fully align with the Integrated Business Plan to the end of year 2018/19.
- The Trust currently has a fleet profile of 522 vehicles, including Double Crewed Ambulances (DCA's), Fast Response Vehicles (FRV's) and other associated vehicle types. The size and type of fleet operated within the Trust is based on operational requirements and the current Operating Model. For the calculation of vehicle numbers, a DCA is classified as a double crewed ambulance that has been converted to be used for the full range of A&E (999) duties. The Urgent vehicles are a different type of DCA that are not converted to the same standard as an A&E DCA and these vehicles are generally not interchangeable. In order to future proof the organisation, DCA vehicles will be built to a single platform standard to accommodate both A&E and Urgent requirements.
- A significant amount of these vehicles had an original planned lifespan of seven years but due to the level of investment in recent years, some have been kept in

front line service beyond this timeframe. A number of DCA and FRV are now in excess of nine and ten years of age. The result of this is now having a negative effect upon reliability, vehicle off road (VOR or downtime) and operating costs.

- The exception to this are the specialist resource vehicles such as the major incident and Hazardous Area Response Team (HART) vehicles. Due to the relatively low utilisation and mileage, it is more financially responsible to retain these for a longer period. Whilst these vehicles will still require scheduled maintenance, it is more financially viable to retain rather than replace with a realistic and expected 'in service' life of 7 – 10 years.
- During Q1 of 2014/15, a peak load modelling exercise was completed by the Trust's Performance Management Information Team (PMIT) utilising data from the current operational rotas that have been implemented across the Region. This has allowed Fleet Services to fully understand what the peak low, high and average vehicle requirement is by hour of day across the Region and by County for our main resource types (DCA & FRV). This will be re-run on a quarterly basis and when rotas change to ensure that the Trust understands the vehicle resource requirement to support our core operation and to flex vehicle availability as vehicle numbers allow.
- In addition to the numbers of vehicles required to support Operations, a certain number of spare vehicles are also necessary to ensure availability at all times to meet patient need. This capacity is used to support the routine servicing, planned preventative maintenance, safety checks, accident damage and deep cleaning schedules. The Trust currently has a spare capacity of 24% for DCA's and 29% for FRV's (excluding specialised vehicles for HART, Events, Neo-natal transfers etc.). This has been benchmarked against other NHS Ambulance Trusts to determine whether this is a realistic, minimum percentage which will provide a safe and resilient fleet availability whilst make best use of limited resources. Fig.1 shows this comparison against two performing NHS Ambulance Trusts.

Fig 1.

	DCA Spare Capacity	***FRV Spare Capacity***
EMAS	24%	29%
Ambulance Trust 1	33%	41%
Ambulance Trust 2	39%	40%

- The vehicle retention and replacement programme in this strategy fully accounts for a variety of factors including affordability, available funding, age, mileage and condition. These criteria will ensure that the optimum combination of age, mileage and use is reached taking into consideration the cost of repair and maintenance to obtain best value during a vehicle's operational life cycle. Fleet Services are proposing a seven year vehicle replacement programme based on existing funding assumptions reducing to five years for FRV's if additional funding can be secured, which would facilitate the following levels of county based capacity:

Fig 2.

	DCA Output	DCA Proposed	% Spare Capacity	FRV Output	FRV Proposed	% Spare Capacity
Derbyshire	38	51	33%	21	28	33%
Leicestershire	35	47	33%	21	28	33%
Lincolnshire	48	67	40%	28	37	33%
Northamptonshire	20	27	33%	15	20	33%
Nottinghamshire	39	52	33%	24	32	33%
EMAS	***180***	***244***	***35.5%***	***106***	***145***	***33%***

- In order to immediately improve the spare capacity numbers for DCA's in particular it is proposed that a total of 11 vehicles will not be decommissioned once the initial 29 replacement DCA's are commissioned for service during Q3 and Q4 of 2014/15. This will help manage the impact of recently written off vehicles and will also increase the DCA spare capacity to a minimum of 33%, with the exception of Lincolnshire which will continue to operate with a 40% DCA spare capacity due to the geography of the county. These will be replaced year on year during the remainder of the fleet replacement plan as required.

Trust Workshop Provision

The Trust has three fully operational fleet maintenance workshops at Alfreton, Leicester (Gorse Hill) and Northampton all of which operate during 'normal, office – type' hours Monday to Friday with a limited Saturday morning service.

- It is the intention to utilise the workshops as efficiently as possible to maximise vehicle availability. This will be supported by the increase in Ambulance Support Team (AST) numbers who in addition to vehicle deep cleaning will assist in reducing the crew downtime by moving vehicles to and from workshops.
- The introduction of workshop Team Leaders especially operating during the extended working hours will significantly improve the management tier within Fleet Services with provision of a supervisory grade. This will assist with first line management, resolution of day – to – day matters, maximising efficiency and ensure that all personal development reviews and staff support are facilitated in a prompt and professional manner at the correct level at the right time.
- In addition to the extended workshop hours a fully modernised mobile mechanic network will also be introduced across all five counties. By benchmarking with other Trusts and adopting successful models for Trust use, the proposition is to provide a total of six fully equipped mobile workshops that will support all of the operational Divisions.
- Recruitment of a specialist Fleet Parts Advisor will reduce down time and subsequent costs by ensuring components are procured in a timely manner and at the optimum discount.
- Fleet Services will continue with a succession plan linked to the vehicle technician apprenticeship programme. It is absolutely crucial that whilst the Trust has participated with this scheme in the past, that we continue to do so to develop young and emerging talent that has been nurtured within our own system and has specialised in ambulance based vehicles.
- Enrolment of all Trust workshop technicians to the Accredited Technician programme to ensure high standards of training, education and workmanship will also continue to

ensure that the Trust continues to recognise the importance of staff development of every grade within Fleet Services.

External Servicing Provision

The Trust has a number of service level agreements for externally based servicing within the Lincolnshire (including North & North East Lincolnshire) operational Division.

- During the first year of this strategy, Fleet Services will comprehensively review these agreements to ensure that they are fit for purpose and provide a cost effective, value for money service.
- During a recent external review, Transtech Consultancy clearly highlighted the difference in hourly pay costs between the external service providers and EMAS workshops, with the difference being a nominal £10.00 per hour in favour of EMAS provided labour.
- Along with the difference in pay costs, the rationale for this review from a qualitative perspective is relatively simple and shows a consistent theme alongside other Ambulance Trusts that have experienced outsourcing of vehicle servicing. Examples of this are:
- When a vehicle is repaired by external contractors the Trust has less control over the quality of the work performed.
- Non-ambulance service mechanics are not trained to repair or maintain ambulance equipment or the additional electrical systems required to fulfil our role.
- All maintenance work conducted in-house remains under the Trust's control; the pace can be varied to take account of variations in operational demand and activity and immediate concerns can be promptly dealt with in a dynamic manner.

Reduction of Preventable Vehicle Damage

During 2013/14 the Trust spent a total of £233,768 repairing damaged vehicles that could, with better management have been prevented. The main cause of preventable accident damage is reversing and slow manoeuvring incidents which in total account for 59% of the Trust's total accident numbers. In order to remedy this excessive spend, Fleet Services in conjunction with the operational divisions and the Driving Tutors within the Organisational Learning Department will robustly manage these types of incidents.

We have undertaken a risk review with our insurers and this will help implement additional initiatives based on best practice from the commercial sector.

Review the VRC Function

The Vehicle Resource Centre (VRC) is currently based within the Horizon Place Emergency Operations Centre (EOC) and is planned to co-ordinate vehicle movements and deep cleaning processes for infection prevention and control measures. It also provides 'real time' intelligence to the EOC's for all matters regarding fleet. A comprehensive review will be undertaken during the remainder of Q3 of 2014/15 of the VRC led by the Assistant Director of Operations (Support Services) to ascertain whether the function they are currently providing is what was originally intended when it was commissioned and what is required to make it more efficient.

Fleetwave

The Trust has recently purchased the 'Fleetwave' Fleet Management System which utilises the very latest technologies to provide a comprehensive fleet management system for all sizes of fleet operation, using an internet or intranet platform. This system is used by other high performing and successful organisations including NHS Ambulance Foundation Trusts. This application will become the single EMAS system for collating and monitoring vehicle and equipment maintenance programmes as we close down and migrate current arrangements over from existing spreadsheets that are in use. Fleetwave will integrate with other Trust systems via a direct link or data upload.

VueTrak

VueTrak is the final piece of software that will ensure that the Trust can track all of its vehicles even when they are non-operational providing a real time location service in conjunction with Fleetwave that will enable Fleet Services to manage the assets in a more efficient manner. The VUEtrak vehicle solution is a complete tracking and telematics system which can be integrated with any VUE camera system (also fitted to Trust vehicles) to give a comprehensive fleet and risk management tool. Incorporating new technology, the unit has a 'text to find' feature which means that you can text a vehicle to find its location.

Deep Cleaning & Vehicle Preparation

The Trust will maintain its existing systems and resources allocated to deep cleaning and vehicle preparation over the next two years, whilst in the same period developing a medium term option appraisal to consider a fundamental and sustainable vehicle preparation system. In the first two years of the strategy, Fleet Services will:

- Ensure that the funding streams for all AST staff are correctly aligned for each division.
- Provide assurance that in line with correct funding, capacity to deep clean all vehicles to required key performance indicator standards is maintained during each deep clean cycle.
- Correctly locate all AST staff in key locations to provide maximum deep clean provision and resilience where required.
- Consolidate and evolve rota patterns across all Ambulance Support Teams to support 24/7 working where demand dictates and is applicable.
- Ensure that all AST staff are trained to a single standard that meets the Trust's requirements for deep clean services.
- Benchmark ambulance deep cleaning services across other NHS Ambulance Trusts and ensure best practice is adopted.
- Assist with auditing of Safer Ambulance Checklists.
- Take responsibility for station consumable stores and stock ordering.

Fuel Management

The current practice for fuel management for Trust vehicles is by two separate routes; fuel cards and bulk storage on Trust owned or leased sites. All operational vehicles are provided with a fuel card which allows fuel to be drawn at a wide number of refuelling stations nationwide that accept fuel cards. From a civil contingencies perspective and to comply with NHS Guidance on Planning for Disruption to Road Fuel Supply, the Trust aims to maintain fuel bunkering to provide for 20 day's fuel for the operational fleet. In conjunction with the requirement to comply with the NHS Guidance on Planning for Disruption to Road Fuel Supply, the strategy will, during year 1 clearly review fuel storage and management across the Region and ensure that a standardised approach is adopted that provides best value for money and required efficiencies. Additionally, the new double – crewed ambulances that will be commissioned during Q3 & Q4 of 2014/15 will also have a variable speed limiter fitted. This will restrict the maximum speed of these vehicles to 60 mph which is in line with the allowed speed for this weight of vehicle on a dual carriageway. This will not compromise 999 responses as upon engaging the 999 mode in the vehicle, the speed restrictor is removed giving access to full power. It is proposed that this is also fitted to all vehicles that are considered to be viable in life (i.e. those that are five years of age or less). All DCAs that have a minimum of two year's operational life left will also be fitted with this system. Again, there will be an investment cost, but based on an assumed maximum 8-10% fuel saving per vehicle (at 60 mph) it is expected that the amount invested will be offset by the amount saved on fuel costs. The same system will be fitted to all fast response vehicles and other ambulance support vehicles which will ensure that the Trust is ensuring that maximum fuel efficiency is gained when vehicles are not engaged in 999 activity.

3.3. The implementation of this strategy will support the delivery of the Trust's Strategic Objectives. In particular the strategy will reconcile to each of the 6 strategic objectives in the following ways:

Quality

Fleet Services will transform the way in which vehicles are maintained and serviced to maximise vehicle availability. Provision of an operational fleet that ensures resilience on a 24/7 basis and implementation of an approved fleet replacement plan thereby reducing the age profile of the fleet will assist in driving the quality agenda for the Trust.

Reputation

In order to enhance the Trust's reputation, Fleet Services will directly support patient and staff safety and the patient experience by implementing the key elements as stated in section 3.3.1.1. The views of both staff and patients will be taken into account during vehicle design and specification and guarantee that an appropriate response is made with respect to Care Quality Commission (CQC) recommendations to ensure the Trust remains CQC compliant. To ensure vehicle specification and

procurement are in line with best practice. A more robust Ambulance Support Team function will ensure deep cleaning standards are consistently achieved.

Innovation

Fleet Services will maximise the benefits from investment in technology so support fleet management and required reporting. Provision of a modern ambulance borne fleet using procurement and extensive design experience will continue to secure innovative vehicle design and provision.

Integration

Integration and alignment with other support strategies such as Estates and ICT will further embed the Fleet Services Strategy within all elements of Trust business and eradicate any suggestion of 'solo' based working. Fleet Services will continue to facilitate and support Trust wide initiatives and developments as required.

Workforce

Recruitment and retention of a skilled and flexible workforce who are well trained and provide a quality services will be crucial in establishing Fleet Services as a nationwide leader of ambulance service maintenance provision. Further support will provided to the vehicle technicians ensuring that they receive appropriate training and registration through a recognised industry body to ensure optimum skills for specialised vehicles. The Trust will continue with development of a succession plan linked to the vehicle technician apprenticeship programme. It is absolutely crucial that whilst the Trust has participated in this scheme in the past, that we continue to do so to develop young and emerging talent that has been nurtured within our own system and has specialised in ambulance based vehicles.

Efficiency

Fleet Services will deliver achievable efficiency savings which demonstrate the principles of VFM and Best Value and continue to contribute to the Trust's Cost Improvement Programmes without compromising quality or patient safety. Continuation of appropriate tendering facilities and good use of resources in vehicle purchasing and procurement will further contribute to efficiency savings as necessary. A full review of fuel usage and the implementation of fuel management plan will complement the efficiency savings during the life of this strategy.

3.4. There are key benefits from all nine core Fleet Services workstreams:

Fleet Replacement

The key benefits for fleet replacement are mainly from a qualitative perspective:

- Reduction of the Critical Vehicle Failure Rate to <1:25,000 miles.
- Operating of vehicles within their economic timeframe will reduce running and maintenance costs accordingly.
- Appropriate Fleet numbers will provide the correct spare capacity by Division and assist with the reduction of downtime.

Trust Workshop Provision

- Extended opening hours will allow the Trust to maximise the amount of time workshop provision is available.
- Allow Fleet Services to schedule servicing during hours in which the Trust's ambulance provision reduces due to demand patterns (i.e. after 1700 hours and weekend periods).
- Ensure that vehicle 'down time' is further minimised due to servicing requirements by operating extended hours.
- Schedule deep cleaning cycles during the evening and night periods in conjunction with scheduled evening service requirements.
- Better first line management, resolution of day to day matters, assisting with maximising efficiency and ensuring that all personal development reviews and staff support are facilitated in a prompt and professional manner.
- Provision of a mobile workshop service to remedy minor vehicle faults across the Trust's multiple sites at the commencement of shifts and during shift time where it is more practical to travel to a site rather than recover or drive a vehicle with a minor defect to a workshop.
- Reduction in call out fees for our 3rd party vehicle mechanic support.
- Reduction in the downtime that occurs at the commencement of shift by having an appropriately equipped and resourced mobile service available.
- Recruitment of a specialist parts advisor will also assist with reduction of downtime by ensuring components are procured in a timely manner and at the optimum discount.

External Servicing Provision

From a qualitative perspective, removing the external servicing provision in Lincolnshire will have the full support of the local operations management team. The expected benefits from this are:

- Better control and subsequent flexibility in repair and return for vehicles that require servicing and repair.
- Improvement in the quality of repair due to adherence to Trust policies and procedures and in conjunction with manufacturer's requirements.
- Assurance that vehicle technicians working on Trust vehicles are fully trained to maintain ambulance borne equipment and the specialist, additional electrical systems fitted.
- Ability to schedule maintenance to take into account variations in operational demand and activity and allow for immediate concerns to be dealt with promptly in a dynamic manner.

Reducing Preventable Accidents

A total of 240 incidents (59%) of vehicle collisions recorded by the Trust during 2013/14 were classified as avoidable. It is envisaged that by robust management of these types of incident in partnership with the local divisions and the Education and Development teams, a 50% saving of circa £100k. In tandem with this, the Trust's

reputation will also significantly improve amongst our peers and stakeholders if we are seen to be improving avoidable collisions.

Review the VRC Function

Reviewing the Vehicle Resource Centre will ensure that the Trust has an assurance that the VRC provides the services that was intended when it was commissioned. If deemed viable, the key benefits of the VRC will include:

- An awareness of vehicle resourcing and the ability to map that to the staff resource requirement.
- Scheduling of routine maintenance at optimum times to ensure service compliance to CQC standards.
- Scheduling of deep clean cycles in conjunction with routine vehicle maintenance at optimum times to ensure service compliance to CQC standards.
- Identifying and co-ordinating vehicle movements and replacements during in shift time and reduce the amount of time spent on this task by operational Team Leaders.

Fleetwave

Fleetwave has a number of qualitative benefits that include:

- Quick identification of warranty claims (for work that might otherwise be paid for).
- Has accident, contract, workshop, pool vehicle management modules available.
- Highlights 'rogue' vehicles and drivers by identifying patterns of driving behaviour.
- Has a fleet status tool that instantly highlights tasks that are overdue, due or need to be carried out shortly.
- Can view stock levels at all Trust sites and carry out inter-site queries.
- Stores full vehicle details for all the different types and specifications of vehicles - regardless of whether they are ambulances, fast response vehicles, support or other specialised vehicles.
- Schedules diary dates for routine, planned servicing, MOT's and deep clean cycles.
- Warns of statutory requirements in advance.
- Sends reminders to all relevant parties automatically via mail, email or text.

VueTrak

VueTrak's main benefit is the ability to locate all of our core resources (ambulances and fast response cars) at any time irrespective of whether the ignition is on or off. It incorporates new technology with a 'text to find' feature which means that you can text a vehicle to find its location. A reply message will show where our vehicles are on Google maps, even if the vehicle is shutdown with the ignition switched off.

Deep Cleaning & Vehicle Preparation

Benefits of improving and evolving the EMAS deep cleaning function are:

- Consistently achieving the required deep clean key performance indicators resulting in better Infection, Prevention & Control compliance.
- Providing assurance to internal and external stakeholders (including the CQC) that the Trust is able to deep clean its operational vehicles to a required and consistent standard.
- Ensuring appropriate financial alignment to Divisions will provide a cost effective and efficient deep cleaning service.
- Aligning rotas to demand based activity will enable the Ambulance Support Team staff to deep clean more vehicles at times when they are not being utilised minimising downtime.
- Some of the identified benefits of a full vehicle preparation system (if adopted fully) are:
- Ensuring that operational staff commence each and every shift with an appropriately stocked, checked and clean vehicle and equipment.
- Removal of pre – shift checks by operational staff provides more time to respond to patients.
- Improved compliance with consumable stock management.
- Improved monitoring of cleanliness and infection control standards of vehicles and equipment.
- Reduction in vehicle downtime by concentrating vehicle resources at key sites.

Fuel Management

The highlighted benefits in addressing the issues identified with fuel management are:

Improvement in control and issue of bulk fuel by installing and networking the Merridale fuel monitoring system to all sites deemed as viable in conjunction with the Estates Strategy.

Reviewing and potentially decommissioning a number of bunkered fuel tanks will remove the need to service an excessive amount of fuel tanks on an annual basis.

Ensure that fuel consumption figures are collated accurately within the newly installed Fleetwave system and reported on regularly as part of key performance indicators.

Installation of speed limiters on emergency ambulances when not engaged on emergency calls has the potential to save 8% - 10% on fuel costs per vehicle.

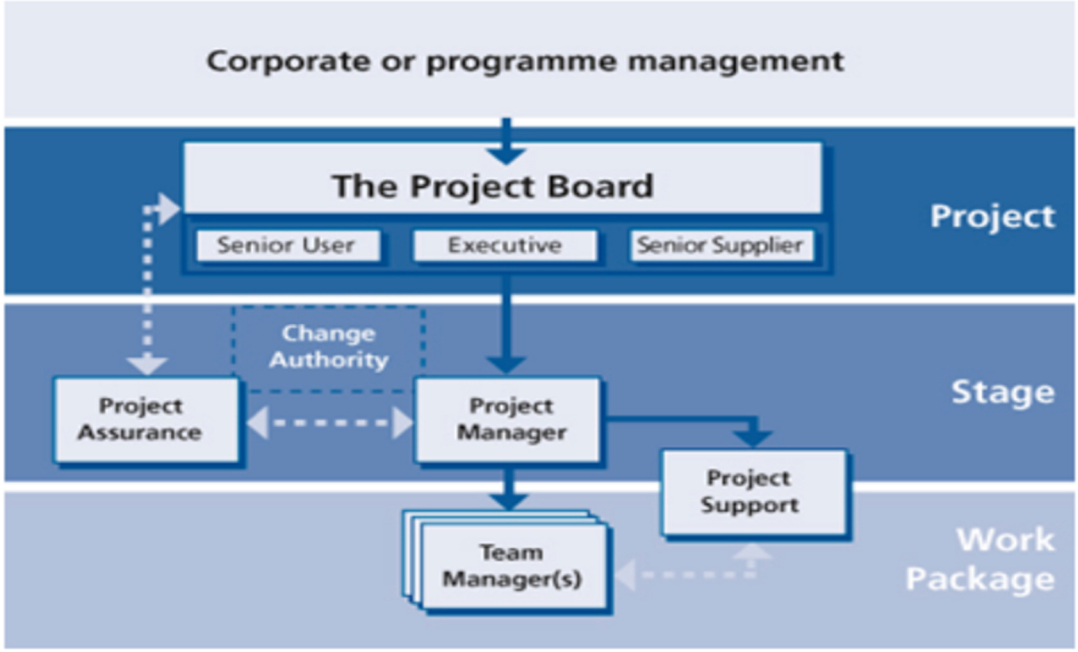
Review of the fuel card system will ensure that the Trust receives best value without attracting attracting transaction fees.

4. Implementation of the Strategy and Monitoring

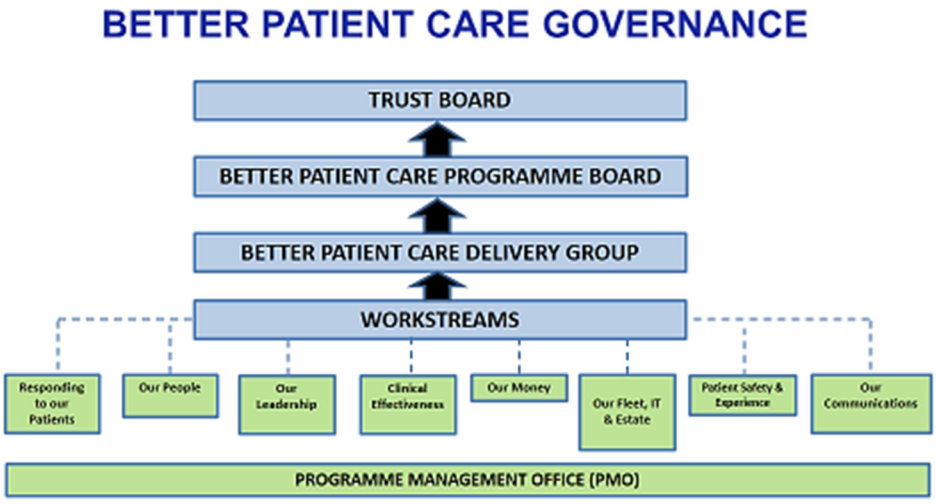
4.1. Following full Trust Board approval of the Fleet Services Strategy, implementation will be facilitated by the production of business cases for each relevant work stream. These will be developed in conjunction with the Finance Department's support and presented for approval through the Trust's decision making processes.

4.2. The Fleet Services management team will develop an annual plan on the basis of implementing and delivering this strategy on a year by year basis commencing from 1 April 2015.Appropriate arrangements for monitoring of the annual plan and the associated individual core work streams will be put in place, and the broader objectives of the Fleet Services strategy will be aligned to the Trust's Scheme of Delegation.

4.3. It is anticipated that each of the core work streams will have a programme/project management infrastructure attached to it as required. A typical structure that would be considered for this is shown below:



4.4 Directorate governance for the nine core Fleet Services workstreams will be through the Operational Senior Management Team meetings chaired by the Director of Operations. From a corporate governance perspective, these workstreams will report through the Better Patient Care governance framework as shown in the diagram below.


BETTER PATIENT CARE GOVERNANCE
TRUST BOARD
BETTER PATIENT CARE PROGRAMME BOARD
BETTER PATIENT CARE DELIVERY GROUP
WORKSTREAMS
Responding to our Patients
Our People
Our Leadership
Clinical Effectiveness
Our Money
Our Fleet, IT & Estate
Patient Safety & Experience
Our Communications
PROGRAMME MANAGEMENT OFFICE (PMO)

5. Strategy Stakeholder Engagement

5.1. Absolutely key to the success of this strategy is to ensure robust communications channels and effective liaison with internal and external stakeholder groups including Ambulance Commissioners, Health & Social Care Providers and other 999 services where applicable.

5.2. The Fleet Services Management Team will seek to develop an effective partnership and teamwork approach with all stakeholders to ensure that the fleet operation is integrated with and fully supports the aims and objectives of the Trust.

5.3. From a business development perspective, Fleet Services will continue to engage with the Director of Strategy and Business Development to ensure that opportunities to expand business are fully supported from inception to operation.

5.4. External engagement will be expanded to include the Collaborative Commissioning Groups and other key external stakeholders to ensure that they are fully aware of our plans and that input where required is received and considered.

5.5. Operationally, the Head of Fleet Services will meet as required with Operational Managers within Divisions to ensure that any issues with or regarding Fleet provision have their place on both local, Directorate and Trust agendas. This will guarantee that any issues that may have an impact upon Fleet Services can be relayed back for appropriate action. Issues that have the potential impact could be a change in the Operational Model requiring a different Fleet profile and provision or additional resources being deployed.

5.6. Internal staff engagement is already firmly embedded within Fleet Services and this will continue to be the case going forward. In particular the following are examples of how Fleet Services interact with our staff:

- Structured vehicle design workshops where operational staff and staff within other Trust directorates can input into the design and layout of Trust vehicles.
- Formal feedback forms following development of vehicle design so that staff who do not participate within the structured workshops have the facility to ensure that their views and observations are considered during the next phases of vehicle design.
- Via formal Listening into Action workshops and events as part of the Trust's wider LiA work stream.

5.7. Collaborative opportunities will be exploited through the National Strategic Ambulance Fleet Group to improve quality, standardisation and reduction of costs through economies of scale whenever and wherever possible.

6. Enablers/Interdependencies of the Strategy

6.1. Patients that use our services and EMAS clinicians that provide them will be totally reliant on this strategy being affordable and sustainable in the long term. An approved strategy that meets these key requirements will provide an effective and efficient Fleet Service that supports patient care and provision of an appropriately designed and maintained vehicle to respond in.

6.2. This strategy has key relationships with the following Trust Directorates as key enablers and interdependencies of the Fleet Services strategy:

- Operations
- Finance
- Strategy and Business Development
- Information & Performance
- Workforce & Organisational Learning
- Medical & Nursing

6.3. The following strategies and other key documents are also closely linked to the Fleet Services strategy:

- EMAS Integrated Business Plan 2014 – 2019
- Estates Strategy
- ICT Strategy
- EMAS Sustainable & Adaptation Development Plan

7. Quality and Governance

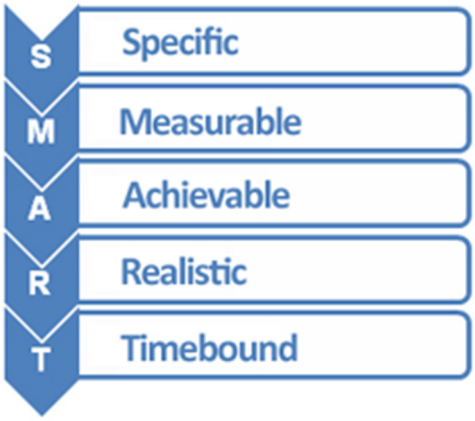
7.1. A financially efficient and effective Fleet Services strategy will be instrumental in providing the correct type of ambulance resource for operational staff.

7.2. Continuation of peak load modelling exercises by Division and by Region will allow Fleet Services to continue to understand and match resource demand by vehicle type based on current operational rotas. As demand increases and operational rotas evolve, further peak load modelling exercises will be undertaken to ensure resource demand requirements are met.

7.3. Production of the correct resource demand by type will assist the operational Divisions in meeting national response times and other agreed performance standards. Vehicle design groups that also assess the viability and clinical effectiveness of equipment and consumables on vehicles will continue to be scheduled with input from the Deputy Medical Director, Consultant Paramedics and representatives from Infection, Prevention and Control staff. Input from operational staff will also be instrumental in maintaining a front line focus on clinical effectiveness.

7.4. Fleet Services will continue to deliver achievable efficiency savings which demonstrate the principles of best value and value for money. This will be scoped and managed in conjunction with the Trust's Cost Improvement Plans as required.

7.5. Monitoring the quality of Fleet Services will be shown within a balanced scorecard against SMART and agreed objectives and key performance indicators. The balanced scorecard is currently being developed with specific focus on the operational Divisions. The governance and monitoring for the balanced scorecard and key performance indicators will be undertaken during the Operational Senior Management Team meetings chaired by the Director of Operations and specific performance meetings jointly chaired by the Director of Operations and the Director of Information and Performance.



8. Finance

8.1. This section sets out the financial elements of the Fleet Services strategy and outlines the revenue budget, management arrangements and proposals for additional investment in Fleet Services, assumptions on efficiency and the proposed capital investment programme over the next four years.

8.2. ***Revenue Budgets***: The revenue budget for Fleet Services is £15.3 million per annum, and therefore the Trust spends approximately 10% of the total Trust resource on its fleet. The revenue budget can be summarised as :

	(£m)
Pay- Workshops	0.8
Management and Administration	0.6
Ambulance Support Team	0.8
Maintenance and Insurance	3.7
Fuel	4.7
Capital Charges	2.5
Leasing	2.6
CIP	(0.4)

	15.3

8.3. ***Budget management:*** The revenue budget and its management arrangements are currently under review. In 2014/15 the budgets are overspending as a result of underachievement of a challenging CIP programme and concerns about baseline budget setting on non-pay. It is expected that budgets are re-set for 2015/16 on an appropriate basis and that budget management improves. At present budgets are devolved to divisions but for 2015/16 budgets will be centralised under the Assistant Director of Operations (Support Services) to ensure that management arrangements and accountability are aligned.

8.4. ***Efficiency:*** Fleet Services will aim to deliver annual cash releasing efficiency savings both to contribute to the Trust's overall efficiency savings requirements and to demonstrate best value and value for money in the way Fleet Services are provided. The plan assumes Fleet Services contribute a programme of up to 4% in the first two years of the strategy, reducing to 2% in the later years of the strategy. This would be based on pay and non- pay budgets (i.e. excluding capital charges).This equates to £1.2 million savings over the strategic planning period; section 3 of the strategy outlines some of the key ways in which efficiency gain will be delivered over the next two years. In addition, the fleet management team will support the Trust's service growth and income generation proposals by playing a key role in planning and delivering the transport requirements associated with new contract opportunities, in particular related to PTS.

8.5. ***Development Programme:*** The strategy outlines the revenue investment required to deliver the strategy, particularly focussed on workforce, the Ambulance Support Team, the VRC function and the fleet contribution to the future estates model and an enhanced vehicle preparation system. In addition, it is assumed that Fleet Services will be appropriately funded (via new contract income) for the transport costs of new service contracts such as PTS.

8.6. ***Capital Investment:*** The Trust's overall strategic capital programme assumes that £3.9m will be available to spend in 2014/15 and that over the following four years a further £19.3m will be invested in the fleet replacement programme. This level of investment will allow the purchase of 211 vehicles between 2015 and 2019, facilitate an overall age profile for our fleet of a maximum of seven years by 2019 and start to provide a higher percentage of owned vehicles compared to current numbers. The proposed utilisation of capital resources and the number of vehicles to be purchased are set out in the tables below:

a) Utilisation of resource

	2015-16	2016-17	2017-18	2018-19	Total
	(£m)	(£m)	(£m)	(£m)	(£m)
Double Crew Ambulances	3.7	4.5	4.0	4.0	15.6
Fast Response Vehicles	0.4	1.1	0.4	0.4	2.3
HART	1.0	0.0	0.0	0.0	1.0
Other	0.0	0.2	0.1	0.1	0.4
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Total	5.1	5.8	3.9	4.5	19.3
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b) Number of vehicles

Double Crew Vehicles	30	36	27	32	125
Fast Response Vehicles	12	30	12	12	66
HART	10	0	0	0	10
Other	0	5	2	3	10
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Total	52	71	41	47	211
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8.7. In addition to the above programme, the Trust will need to manage the impact on vehicle requirements of the Patient Transport Services we provide. The Trust

currently leases 30 vehicles which support the Northern Lincolnshire PTS contract. The lease period ties in with the contract period and it is currently assumed that the requirements for PTS vehicles both for this contract and any other contract we bid for will be covered in the business proposal and business case for those contracts, with a planning assumption that PTS vehicles would continue to be leased.

8.8. ***Enhancing the Fleet Replacement Programme:*** This capital programme provides a higher and sustained level of investment in fleet replacement than seen historically, but further capital investment over this level would have additional benefits. In section 9 of the strategy on risk management the possibility of further investment is considered on a '*going further faster'* basis. The Board have recognised these benefits and have initiated discussions with the NHS TDA about the possibility of a loan to make further investment in our fleet to reduce the age profile further, particularly for Fast Response Vehicles.

8.9. ***Business Cases:*** It is assumed that any investment proposals for implementing this Fleet Services strategy will be based on the approval of business cases. A range of business cases will be developed over the strategic planning period, the main ones being to support further investment in fleet replacement, further investment in Ambulance Support Teams, invest to save style proposals and cases for revenue investment as summarised at section 8.5. The business cases will set out the benefits and anticipated return on investment. It is assumed the strategic direction for estates based investment will be led jointly through the Estates Strategy and Fleet Strategy teams, and funded via the estates capital investment budget.

9. Risk Analysis

9.1. Approach

- We have robust, comprehensive and effective risk management systems in place to manage clinical, financial and business risk. Underpinning this is the Risk Management Policy and the Governance Strategy. Leadership is given to the risk management process by the Board and through Board Committees, which view risks from a variety of sources.
- We have identified lead managers who monitor performance, compliance and assurance against a range of national standards.
- The Board Assurance Framework is the key tool used by us to provide assurance of that risk and control mechanisms are in place and operating effectively. Through regular monitoring of the Board Assurance Framework and the operational risk registers, which underpin the risk management process, the Executive Team and EMAS Board ensure that current risks are managed appropriately and there are suitable arrangements for preventing and deterring risk. The Board reviews the Board Assurance Framework every two months. Each risk and its mitigating actions are reviewed and the risk score considered and amended as necessary.
- The Board Assurance Framework is a high-level register of the risks to the achievement of EMAS's strategic objectives. Controls to mitigate these risks and evidence of those controls are also included.
- The Board Assurance Framework also includes risks that have been escalated to the Board from the operational divisions. The following committees review the Divisional Risk Registers and refer strategic risks to the Board:

    - Quality and Governance Committee
    - Workforce Committee
    - Finance and Performance Committee
    - Risk, Safety and Governance Group
    - Clinical Governance Group

- Divisional and local Risk Registers have been developed to ensure that risks, identified through the business planning process, are managed at a local level. Each Director is responsible for the risk registers within their Directorate. In addition, Directors are also accountable for specific risks in the Board Assurance Framework. The Board of Directors is accountable for controlling and mitigating organisational risk.

9.2. Risk analysis and management will be conducted in conjunction with the Trust's Risk Management Guidance. Risk management can be defined as all the processes involved in:

- Identifying, assessing, analysing and treating risks.
- Assigning ownership for risks.

- Taking action to mitigate or anticipate risks.
- Reviewing progress made in managing the risks.

9.3. Risk management is not a standalone activity that is separate from the main activities and processes of the Trust or of this strategy; it is part of the responsibilities of management and an integral part of all of the Trust's processes, including strategic planning and all project and change management processes.

9.4. The risks contained in this section of the Fleet Services strategy have been scored against the nine core work streams and are considered to be strategic risks. Strategic risks can be defined as key corporate risks which could prevent or seriously impact on the achievement of the Trust's objectives as set out in the Integrated Business Plan and the Annual Plan. Strategic risks, and associated action plans, are recorded in the Board Assurance Framework.

9.5. Local risks are lower level risks relating to Fleet Services' on-going day-to-day business will be managed at a local level by directorates and recorded on directorate risk registers.

9.6. The key risks for the Fleet Services strategy will be scored against the nine core work streams and the failure to deliver and kept locally with appropriately high scored risks escalated as per Board Assurance Framework guidelines.

9.7. Risks will be monitored and implementation of mitigated action will be via:

- The Board Assurance Framework (BAF) provides the Trust Board with assurance that the risks which could prevent the Trust meeting its strategic objectives are managed effectively.
- Local risk registers record risks which may affect the performance or achievement of those directorate objectives.

9.8. Sensitivity Analysis

This strategy has been developed on the basis of the Integrated Business Plan, and as such reflects the strategies, challenges, ambition and funding parameters set out in that strategic plan. A key risk to the delivery of the strategy will be the availability of an appropriate fleet. Section 3.2 of this strategy sets out the need for a clearly defined fleet replacement plan, and identifies how a fleet with a better age profile and appropriate level of cover can contribute materially to the operational performance of the trust through optimum availability and reliability of our fleet. Our current age profile does not benchmark well against other ambulance services, particularly in relation to Fast Response Vehicles where other Trusts report plans to work to a four or five year profile for those vehicles which are key contributors to Red performance delivery. We have also received criticism from the Care Quality Commission related to our fleet profile and vehicle availability. For all these reasons the Trust has initiated a proposal with the NHS TDA to provide additional capital for investing in the fleet replacement programme on a '*going further faster*' basis to increase the capital investment over the next four years from £19.3m to £24.3m. This would be subject to a business case which would need to demonstrate the operational, performance and

financial benefits of such an investment. The business case will be developed once further discussions have been held with the NHS TDA. A secondary benefit would be that such investment would further increase the percentage of owned vehicles compared to leased vehicles, and that change would support financial affordability.

If further finance was available then the priority for investment would be FRVs. The table below gives an indication of the fleet replacement programme we would implement if a further £5m was available to spend on fleet replacement over the next two years:

a) Use of resources

	2015-16 (£m)	2016-17 (£m)
Double Crew Vehicles	1.3	0.5
Fast Response Vehicles	1.2	2.0
Total	2.5	2.5

b) Number of vehicles

Double Crew Vehicles	10	4
Fast Response Vehicles	34	54
Total	44	58

9.9 The fleet management team are committed to supporting the organisation to manage and respond to risks. This chapter has identified the process for managing local risks and the reporting of fleet based risks in the Trust's BAF. Further sensitivity analysis against strategic risks will be considered as part of the Trust's overall strategic risk planning and sensitivity analysis.

East Midlands Ambulance Service NHS
NHS Trust

Developing our Estates Strategy

Version: 2.0

Approved by: EMAS Trust Board

Date: TBA

Review Date: TBA

Developing our Estates Strategy

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1. Executive Summary

1.1. Purpose of strategy

This developing Estates Strategy describes the Trust's existing estate and proposes the principles to be adopted to support any proposed changes for the future.

The developing strategy is intended to deliver a cost effective estate that provides appropriate and fit for purpose accommodation to support and enable the full range of the Trust's business activities, assist in achieving optimum operational performance, provide a safe and fully inclusive environment for Trust staff and visitors and embed an environmentally sound approach to developing and operating the estate.

The strategy includes a brief description of the service, an analysis of the current estate and considers how the current estate performs in support of the Integrated Business Plan Trust Vision and Strategic Objectives.

1.2. Key content detailed in the strategy

In 2012 the Board approved an estates strategy which set out a number of objectives, and in which a hub and spoke estates model was considered to be a key enabler. This model consisted of the establishment of 108 community ambulance stations which would facilitate more bases for staff to stop off at whilst they were away from their main base; and also allow for the twinning of certain ambulance stations as part of an overall reduction in current numbers, with an eventual move to 28 main stations in a hub and spoke model.
This original estates strategy set out how the implementation of the community ambulance station model would be supported in the interim by concentrating resources within fewer Ambulance Station Hubs.

Since November 2013, the main twinning process and development of the hubs has been on pause whilst the organisation has focussed on the delivery of our core service, and reassessed its key priorities. Some of the community ambulance stations have been implemented, in order to provide additional facilities for staff at standby points and as part of our approach for being an essential element of the communities we serve.
Now, having prepared a draft Integrated Business plan earlier this summer, we are ready to commence looking at our estate again over the next few months, to ensure that we have an approach which meets our needs.

However, in the intervening two years since the original strategy was developed there have been a number of key changes which we must now take account of:

- The move away from Divisions to a five County approach, recognising the importance of working closely with all our partners (health, social care and other emergency services in those counties)

- Our key role in those counties in the development of urgent and emergency care, which incorporates the recommendations from the Keogh review, whereby support to our patients in their communities and reducing conveyance to hospital is critical

- The continued tightening of public finances and the increased focus on ensuring our Fleet and Information technology solutions have sufficient investment so that they are fit for purpose for the future

- The importance of taking account of the views of our staff, our stakeholders and the public in the decisions we take around how our services are configured.

With all of these factors in mind, we will now be taking a more pragmatic approach to our estate footprint.

Over the next few months we will be working with staff, stakeholders and the public to look at what would be an appropriate solution for our premises, taking account of all of the factors listed above. This work will look at three types of estate, ambulance stations; our education estate and our headquarters facilities.

Some of the principles we will look at in respect of each of these three groupings include:

- Ambulance Stations to support the provision of urgent and emergency care
  - Ensuring we maintain or develop facilities in local communities
  - A community Ambulance Station development programme, which includes co-location with other emergency services, focused on high activity areas supporting flexible operating model
  - Transparency through doing the detailed business case work for local change including appropriate due diligence, listening, patient engagement and an evaluated approach.

- Education estate to support developing our workforce
  - Developing business case options which support education provision for developing our staff and future clinical leaders.

- Headquarters facilities,
  - Ensuring best utilisation to support efficient delivery
  - Efficient working to modern standards and building resilience into the estates infrastructure.

1.3. Key Criteria we will use to test out options:

The key criteria we will need to use to test out our options include:

- Operationally efficiency- proposals developed by each county management team and support performance delivery
- Staff engagement- including our staff in the planning and development of the outcomes
- Public engagement -bring learning and intelligence to bear on the proposals to test out patients and stakeholders expectations.
- Timescales and interdependencies-ensure timescales realistic and align with all other interdependencies
- Economics-ensuring estates operating costs support future efficiencies, and investment is affordable within the overall Capital Plan
- Communications-ensuring there is a clear plan in place to support keeping all parties informed as the strategy is implemented.

Continuous communications is particularly important because of the interdependencies between this strategy, clinical and quality, workforce, fleet, IMT and business development strategies.

Evaluation of changes resulting from the implementation of the strategy will be subject to benchmarking and impact review to ensure they are meeting the principles and have hard performance metrics applied.

1.4. Concluding statement

The development of this Estates Strategy is a key enabling process in support of our Integrated Business Plan for developing EMAS into the organisation we want it to be.
In respect of urgent and emergency care in the East Midlands, the strategy outlines plans to review and update the existing estate to address major issues, including developing local Community Ambulance Stations to support staff and service performance. It aims to ensure education provision can be delivered effectively and efficiently to support developing our workforce and that best use is made particularly of owned buildings such as headquarters and emergency operations centres to assist resilience and cross team working.

This document outlines some of the estates activities which are necessary for the delivery of the strategy and the enabling structures. Key issues to be addressed, as identified in this document are:

- Maintenance of the estate and evaluation of the effectiveness of the estate
- Compliance with legislation
- Improved energy management and carbon reduction
- Continuous monitoring of the performance of the Estate.

In order to ensure successful delivery of the strategy annual plans will be agreed prior to the commencement of the financial year and will reflect the resource assumptions for delivery of the business plans of the Trust, based upon agreed capital and revenue funding. Annual plans and risk assessments will be subject to an on-going review of progress in order to ascertain necessary variations to the strategy because of changes in expected demand and internal and external environment.

2. Context

2.1. EMAS Vision & Strategic Objectives

We are a healthcare provider. We provide healthcare on the move and in the community, and our vision is for EMAS to play a leading role in the provision, facilitation and transformation of clinically effective urgent and emergency care delivered by highly skilled, compassionate staff, proud to work at the heart of their local community.
We believe this will support CCGs and other health and social care providers across the East Midlands in the delivery of a long-term, sustainable healthcare system.
The five-year plan maps our transformation journey from a mainly emergency focused service in 2014/15 to a future operating model whereby the organisation sits at the centre of the urgent and emergency care system.

This means it is our ambition for EMAS to act as the co-ordinating NHS organisation at the centre of the system, either providing care directly (e.g. over the phone or on the scene) or signposting/referring patients to the best service to support them in their homes and the community, reducing admissions to hospitals where appropriate.

This model is designed to ensure the most appropriate and effective response to meet the need of our patients and/or the referring clinicians. Put simply:
"…..supporting delivery of the right care, with the right resource, in the right place and at the right time."

2.2. Link to Integrated Business Plan

Our current Integrated Business Plan (IBP), completed in June 2014 and covering the five year period 2014-2019, articulated that in order to realise we will:

Current Model

The current service model is based upon core clinicians (paramedics) operating on frontline vehicles and the dispatch of the nearest available resource to attend to patient care irrespective of the clinical need.
This model involves the deployment of our most skilled staff in all circumstances, and makes no allowance for case mix. Additionally, the majority of patients are transported to the nearest Accident and Emergency facility with little opportunity for our skilled staff to exercise the full range of their clinical judgement.
Whilst this model is effective at one level, in that patients are seen and treated promptly, we regard it as being unsustainable in the longer term where demand is increasing within a decreasing financial envelope.
In developing options for the future, we (working with our Commissioners) are clear we will want to retain elements of the model that support delivery of consistent operational performance and financial sustainability, whilst operating at the centre of a more integrated urgent and emergency care system.

Years One and Two (2014-2016)

- Focus on continued delivery of performance, delivering at a county level on a sustained basis
- Further develop our Clinical Assessment Team to increase hear and treat and support our teams in the field in the use of alternative pathways and admission avoidance services (supported by Paramedic Pathfinder), utilising all local health and social care providers
- Work in partnership with CCGs, acute trusts, community trusts, local authorities, private providers and the voluntary sector to develop and implement integrated admission avoidance services (e.g. Falls, Discharge services, Acute Visiting Services etc.)
- Build our capacity and capability to support future integrated strategic developments (e.g. eDoS, Paramedic Pathfinder and Telehealth & Remote Monitoring)
- Support delivery of the right care, with the right resource, in the right place and at the right time
- Deliver excellence in patient experience and outcomes.

Years Three to Five (2016-2019)

Our proposed future operating model has, at its core, a whole system approach to urgent and emergency care, with EMAS acting as the co-ordinating entity at the centre of the system, either providing care directly or signposting to other services.

This model ensures the most appropriate and effective response to meet the needs of our patients and/or the referring clinicians.
Put simply:
"…..supporting delivery of the right care, with the right resource, in the right place and at the right time."

- Be at the centre of the urgent and emergency care system, generating efficiencies across the healthcare system (e.g. multi-skilled staffing, better use of admission avoidance schemes, reduced conveyance to emergency departments)

- Provide a regional platform for an efficient and sustainable integrated urgent and emergency care system (e.g. integrated care records, coordinated assessment services, care plans, direct booking into services etc.)
- Identify gaps in the system, facilitating improvements, managing demand and pressure regionally
- Aim to provide a significant portion of the patient transport services in the region, so we will be a provider of transport services across the whole spectrum of urgent, emergency and planned care
- Aim to be a partner in 111 services, developing strategic partnerships and working more closely with other providers
- Provide other services and new models of care as opportunities arise
- Continue to support on-going delivery of the right care, with the right resource, in the right place and at the right time
- Continue to deliver excellence in patient experience and outcomes.

In summary the EMAS strategy over the five years of this plan is to transform ourselves into an organisation that is able to achieve key performance and quality standards, supporting reductions in emergency admissions, in a consistent and sustainable way (years one and two). From this position, we seek to expand our service offering, building on our unique position as a regional provider with core skills, infrastructure, capacity and capability in call centre management, clinical assessment and provision of transport, to position ourselves as the platform upon which the urgent and emergency care system in the East Midlands can become sustainable (years three to five).

We recognise that successful delivery of our strategy will be dependent on the achievement of a number of strategic objectives. We recognise that a key objective is the delivery of a quality service, and that we need to build a reputation among stakeholders as an organisation that can deliver a quality service. By quality, we mean delivering consistently within all three domains of quality: patient safety, patient experience and clinical effectiveness.

In order to build a strong reputation, we will need to develop innovative service offerings that help to address the current and future challenges in the urgent and emergency care system in the East Midlands, and we will do this through working with partners to provide and facilitate greater integration. This will be delivered through skilled and motivated staff working within an effective and efficient organisation.

We have, therefore, identified six strategic objectives. These elaborate on the vision and strategy overview and provide a more detailed focus on how the vision will be delivered:

Our Quality: We will respond to our patients with a high quality service which consistently meets national ambulance targets quality indicators
Our Reputation: We will be recognised nationally as a reliable provider of high quality out of hospital and community based care across the East Midlands
Our Innovation ambition: We will be recognised nationally as a leading innovator in out of hospital and community based care
Our Integration approach: We will work in partnership with our local health care, social care, and voluntary sector partners to deliver and enable integrated patient services and care pathways across the East Midlands
Our People: We will consistently develop and support our people to be highly skilled, highly motivated, caring and compassionate professionals
Our Efficiency: We will make the most effective use of all our resources, delivering upper quartile performance on our indicators for money, staff, premises, and fleet.

The IBP identified that the development of our strategy would be underpinned by a series of supporting strategies, one of which is this developing Estates strategy. The IBP also recognised that each of these supporting strategies would be reviewed to ensure they reflect, are consistent with and support the strategy and future operating model detailed in our plans.

Our IBP includes a future operating model that reflects the fact we know, in years one and two of our plan, we must place significant emphasis on:

- The delivery of core performance at a county level
- The delivery of clinical indicators
- The provision of a sustainable service.

2.3. National policy, legislation, best practice and horizon scanning

The Trust is required to comply with all statutory and regulatory requirements. In the field of Estates this is constantly developing, particularly with regards to Health, Safety and Environmental legislation. There is specific legislation related to the estate associated with asbestos, legionella and waste that pose risks to the Trust, staff, visitors and patients. Management of these risks and the associated policies and procedures will continue and will be reflected in the Operational Estates Plans.

2.4. Local Context

East Midlands Ambulance Service NHS Trust (EMAS) was formed on 1 July 2006, as a result of the merger between the former ambulance Trusts. We serve a resident population of 4.8million across the East Midlands (Derbyshire, Leicestershire and Rutland, Lincolnshire (including North and North East), Northamptonshire and Nottinghamshire), across 6,425 square miles. The Trust has an annual budget of £150m and employs some 3,000 staff.
The Trust does not deliver any healthcare on any of its premises, rather we receive and respond to 999 calls from the public, respond to urgent calls from healthcare professionals e.g. GPs, provide non-emergency patient transport services in areas of Lincoln and inter-hospital transport services linking hospital sites in Nottingham.

2.5. Current Position

The current Trust estate as at September 2014 comprises a total of 67 ambulance stations, 50 owned properties, 13 leased properties and four disused sites distributed throughout the East Midlands region.

The total gross internal area (GIA) of the property owned by the Trust is 36,804 square metres and the total land area of Trust sites is approximately 20.6 hectares.

In functional terms the current Trust estate comprises:

Ambulance Stations
Both Accident & Emergency (A&E) Service and some Patient Transport Service (PTS) operations are supported from a number of ambulance stations that provide facilities for staff to report for duty. All have facilities for staff breaks including staff room provision, kitchens and male and female WCs; some also have offices and stores. Ambulance stations may provide garaging for some or all operational vehicles. As at September 2014 EMAS operated from 63 ambulance stations.

Office/Support Facilities
Trust Headquarters, (Horizon Place in Nottingham) which also incorporates the principle Emergency Operations Centres (EOC) and Clinical Assessment Team with a secondary EOC at the regional office in Lincoln.

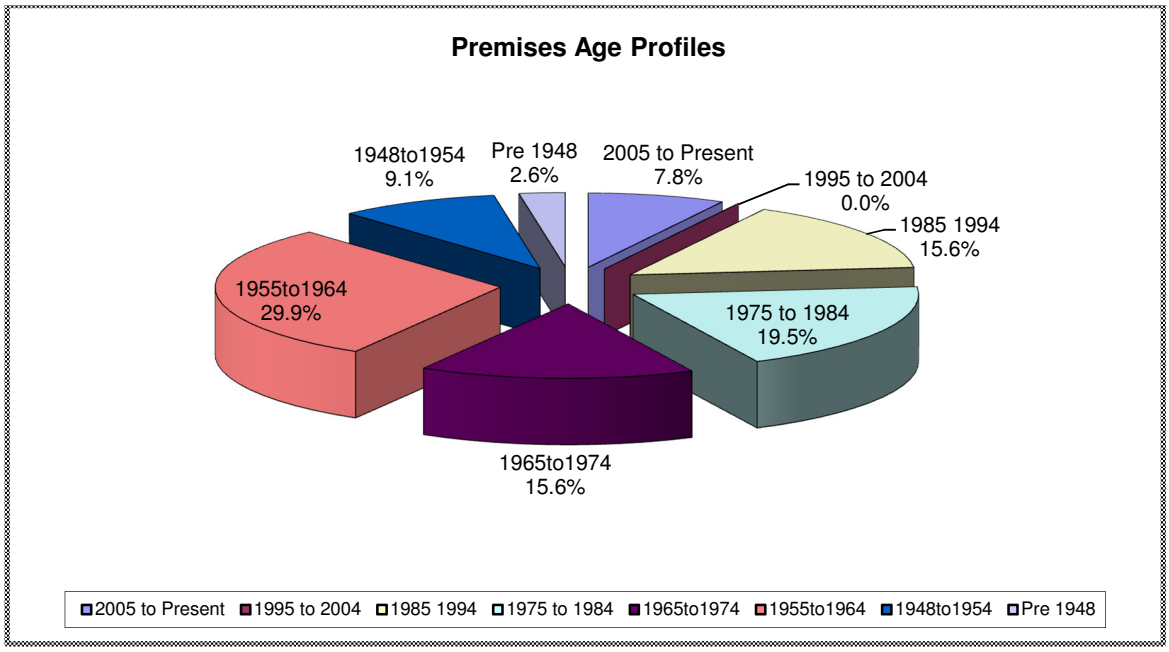
Some support service functions are provided at the Rosings in Leicester, Beechdale in Nottingham, Raynesway in Derby and Cross O'Cliffe in Lincoln, Mereway in Northampton. Fleet services are provided from Alfreton, Gorse Hill and Northampton North.

Logistics and stores
Logistics covers supplies, medicines management, procurement and documents archive. These functions are provided from Alfreton. Medical Device Engineering is performed at Alfreton and provides maintenance for all medical devices across the Trust.

Training Centres
Three dedicated training centres are provided at Kingsway in Derby, Meridian in Leicestershire and Bishops in Lincoln.

Standby Points
The Trust also operates its Accident and Emergency service from a number of facilitated roadside standby points as determined by the System Status Plan, these standby points do not form part of the Trust estate. Standby points are ranked in order of priority and are updated and revised from time to time to ensure optimum coverage and performance.

Estate Profile
The Strategy has to be developed in the light of the legacy estate inherited by EMAS whose age profile is shown below.



2.6 Previous 'Being the Best 'proposals

As set out in our Integrated Business Plan June 2012:

In 2012 the Board approved an estates strategy which set out a number of objectives, and in which a hub and spoke estates model was considered to be a key enabler. This model consisted of the establishment of 108 community ambulance stations and 28 main stations in a hub and spoke model, supporting a previous operating model.

This original estates strategy set out how the implementation of the community ambulance station model would be supported in the interim by concentrating resources within fewer Ambulance Station Hubs, thus enabling EMAS to pool resources (staff, vehicles and support

services) to support a management re-structure and to enable stations to be closed, releasing efficiency savings required to deliver financial performance.

In addition, the strategy described 10 initial twinning projects and confirmation that further projects would be identified. A revised programme of 18 twinnings was approved by the EMAS Board on 30th September 2013, with confirmation that twinning would only proceed where the relevant CAS had been established.

The assumptions in this strategy were subject to financial modelling to assess the capital and revenue impact of delivering the strategic estates plan (excluding support services) and this identified a capital gap of circa £29m and a recurrent revenue gap of £1.3m at the point the 28 hubs in the original plan were scheduled to be operational.

3. Strategic Plan

3.1 Outline approach to developing the plans

Recognising the need to concentrate the efforts of the whole organisation on the delivery of the Better Patient Care Programme in November 2013, a decision was taken to "pause" the strategy, in respect of the twinning of stations and the development of the hubs. We now recognise that since the original estates strategy was announced in 2012, the following issues will also have an impact on any future plans for our estate:

- Our future operating model, including expansion of the EOC
- The future of urgent and emergency care following the Keogh review
- The increased need for priority investment in our fleet, to support our mobile workforce
- The increased requirement for technology enabled services
- Our emphasis on partnership working will afford opportunities to co-locate with other providers
- The feedback we received from staff and the public about the impact of the estates programme since it was first announced.

For this reason, we are working to produce a revised estate strategy during 2014/15 which will reflect a number of new assumptions based on all of the above factors and map out an affordable locality driven direction, aligned and supporting other strategies as part of a refreshed integrated business plan.

The strategic approaches considered were:

A. Do nothing except continue to maintain the current Trust estate

B. Review and update the existing estate to address major issues and develop local Community Ambulance Stations to support deployment.

C. Develop the estate to move towards a hub and spoke model as proposed under the "Being the Best" Vision.

D. Develop the estate to move towards a modified hub and spoke model based on consultation with Operational Managers and the current System Status Plan.

With regard to approach C, it was considered the recommendations previously put forward for under the "Being the Best" vision were unaffordable and not supported by public or staff. For these reasons approach C was discounted.

On further consideration of the two shortlisted strategic approaches, B and D it became clear that the estates capital and revenue costs associated with approach D would be substantially higher than those for approach B, In addition approach B offers more opportunities for rationalisation of the estate in time and it was generally agreed that there are no clear operational benefits in adopting approach D.

Consequently it is proposed to the Board that approach B would form the basis for the Trust's estate strategy from 2014 onwards and will be tested with locality teams to produce a draft strategy for wider discussion.

Once the implementation stage of this developing strategy is reached the Trust aims to:

- Develop a cost effective and fit for purpose estate that will provide appropriate buildings and facilities located to fully support all of the Trust's business activities and contribute towards achieving operational performance improvements
- Meet its strategic objectives as set out in the Trust's Integrated Business Plan
- Ensure the Trust meets its statutory obligations
- Enhance the Trust's community image and reputation
- Ensure that partners and stakeholders have been consulted and their feedback taken into account
- Achieve best value for money and ensure resources are appropriately directed in the long term, thereby maximising resources for patient services and care
- Encourage a widespread consideration of the impact of all Trust operations upon the environment, with the promotion of initiatives such as carbon emissions reductions, waste minimisation and recycling and energy conservation, and deliver services in accordance with principles and policies focusing on protection of the environment and sustainability of the earth's resources
- Manage the Trust's capital asset base to achieve the most cost effective and appropriate provision of buildings and facilities necessary for the performance of its services
- Align itself with the Department of Health's Strategy on Sustainable Development and the Environment and recognise that environmental considerations, at work and in the community, can impact significantly on people's health and can often also result in financial benefits for example through reduction in energy usage and waste.
- Support service developments such as "Make Ready" should Commissioners seek to support and fund new ways of working. (Note – the Make Ready concept will be subject to the development of a separate Business case to establish its shape and suitability for our service).

3.2 Key concepts

The key change is moving from an East Midlands hub and spoke model to locality driven solutions.

Ambulance Stations for provision of urgent and emergency care

- Maintain facilities with local communities and reassure patients

- Community Ambulance Station programme, including co-location, focused on high activity areas supporting flexible operating model to support service performance
- Transparency through doing the detailed business case work for local change including appropriate due diligence, listening, patient engagement, and a evaluated approach
- Business case options for key site changes, alongside consideration of Operations support services to exploit local opportunities.

Education estate to support developing our workforce

- Development business case options for education provision.

Headquarters facilities, ensuring best utilisation to support efficient delivery

- Efficient working to modern standards and building resilience into the estates infrastructure

Workstreams will include evaluation and measurement to test out assumptions and overlay geographic scientific data analysis with local knowledge and experience, in support of a fit for purpose Operations model for urgent and emergency care. This will be updated as service lines change as part of Business Development plans.

3.3 Changes made since 2012

The Integrated Business Plan will be refreshed during the second half of 2014/15 to incorporate the direction once the strategy is fully developed and the changes which have taken place so far:

Community Ambulance Stations developed since 2012

We are seeking opportunities to develop facilities for our staff at standby points; this includes co-location with either Police or Fire and Rescue Services where possible. These present a low implementation cost and no planning constraints. Details of the new Community Ambulance Stations which are operation are set out in table 1 below:

Table 1 New Community Ambulance Stations in operation

Area
Derby South
Nottingham Central
Basford
Sutton-in-Ashfield
West Bridgford
Bingham
Melton Mowbray
Rushden
Chapel St. Leonards

Other Station changes since 2012
Moves of ambulance stations, a limited number of changes to ambulance stations have taken place since 2012.

Table 2 Moves of Ambulance Stations in 2012 and 2013

West Bridgford to Wilford
Arnold to Carlton
Rushden to Wellingborough
Melton Mowbray to Oakham (Lease ended on Melton site)

Refurbishment of existing stations, a programme of refurbishment works takes place which also takes account of feedback from Listening into Action staff events. Refurbishment including kitchen facilities and showers for staff has taken place at Grimsby, Scunthorpe, Narborough and Mereway, Northampton.

Disposals -The Trust Board approved disposal of the following stations, which are vacant, at its meeting on 1 May 2014. Offers are being received and considered and proceeds from sale will be reinvested into the capital programme approved by the Board.

- Arnold Ambulance Station Nottingham
- West Bridgford Ambulance Station Nottingham
- Syston Ambulance Station Leicestershire

3.4 Proposed Key dates/ milestones for assessing any future changes to our estate

The following describe the outline timetable to develop the estates strategy for the period 2014 - 16.

October 2014

Development strategy considered by the Board including

- Alignment with other strategies
- Links to wider health community strategies
- Consideration of future proofing

November 2014 – January 2014

Locality discussion and engagement to form the platform for discussion with

- Staff, Unions, Commissioners, Local Authorities and wider stakeholders
- Patients, public, Healthwatch and media interests
- NHS Acute and Community Hospitals and other healthcare providers
- Trust Development Authority and NHS England

January – February 2015

- Updates on the draft strategy to be considered by Trust Board

March 2015

Draft strategy to be considered by Trust Board, including a draft implementation plan alongside 2015/16 Financial and Operating Plan.

4. Implementation of the Strategy and Monitoring

4.1. How will the strategy be implemented

Implementation of our Estates Strategy will be managed by the Director of Finance, who has responsibility for ensuring our estates programme is implemented correctly and with

the appropriate resources and services. The trust will utilise its own internal resource to lead each project with external advice to ensure successful project delivery.

The estates programme will be monitored through the trust Better Patient Care Board, ensuring a strict focus on delivery, quality and risk management.

Trust and European Union procurement methods will be employed when identifying solutions to the estates developments contained within this document. The trust's board will be assured on delivery of our estates strategy through two routes;

- The Better Patient Care Board reports to the Trust Board;
- Regular reports to the Finance and Performance Committee of the Trust Board, through the routine finance report

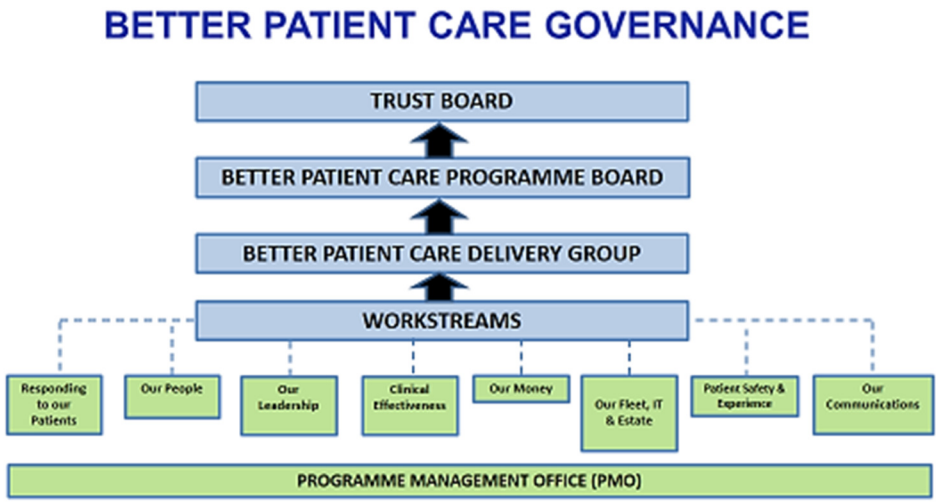
The Programme Manager (Estates) has delegated responsibility for the management and development of our Estates Strategy and is specifically responsible for:

- Planning, managing and delivering Capital projects in line with the approved Capital Programme;
- Financial control of Capital projects in conjunction with Finance Department staff as appropriate;
- Providing the Director of Finance with regular reports detailing progress on the delivery of the Estates Strategy 2014 to 2016;
- Consulting with Operational Managers, Functional Managers and staff to ensure that the Estates Strategy accurately reflects to business needs of the Trust;
- Reviewing and updating the Estates Strategy each year and producing a revised five year Plan for incorporation within the Integrated Business Plan.
- Developing metrics to evaluation the performance of range of key strategic estates-related deliverables

Support will also be provided through other colleagues in the trust to ensure that we can develop a strategy which is meaningful, robust, and one which all parties are able to support.

4.2. Project Infrastructure

Estates forms part of the Our Fleet, IT and Estate workstream under the Better Patient Care Programme and the developing strategy will be monitored through that programme.



4.3. Detailed timeline of actions and milestones

The detailed timetable of actions and milestones will form part of the full strategy.

4.4. How will the implementation be monitored

The governance and monitoring of this Strategy will be subject to a 3-tier model:

- The Trust Board will be briefed as required on matters of Strategy and Programme Delivery
- Exceptions and overall delivery summary will be provided as required to the Better Patient Care Board
- The Finance and Performance Committee will receive regular reports on in year progress through the monthly finance report and through review of the Board Assurance Framework.

Risk Register

The risks identified as part of the strategy risk assessments will be incorporate in the Finance Department Risk Register which will be monitored by the Governance and Risk Group.

5. Strategy Stakeholder Engagement

5.1. Engagement undertaken during development and planned future engagement

During the course of writing this developing strategy we have engaged with the following groups of colleagues within the trust: Divisional General Manager, Locality Managers and Team leaders; Estates staff; Trust Executive team; Listening into Action representative and Operations management. We have also had informal discussions with colleagues on Overview and Scrutiny Committees which have informed our thinking

Following Trust Board approval of the proposed development path for the strategy and the principles proposed we will want to engage with other local providers, Healthwatch, local clinical groups, including Commissioners and wider EMAS staff, Unions, public and patients through Health and Wellbeing Boards, and Overview and Scrutiny committees.

6. Governance

6.1. How Estates Decisions Will Be Made

The Trust wants an estate that is well-managed and which is run as efficiently and effectively as possible. This covers issues such as good corporate governance and value for money. The Trust will maintain and seek to increase the level of professional skills devoted to the effective management of the estate.

The Trust Board has overall corporate responsibility and accountability for the estate and for material investment decision and, consequently it is proposed the Board consider the following roles and responsibilities:

Trust Board

The Trust Board will be responsible for:

- Approving the Estates Strategy

- Ensuring appropriate structures and resources are in place to implement and deliver the Estates Strategy over the time period
- Committing those financial, managerial, technological and educational resources necessary to adequately control identified risks.

Director of Finance

The Director of Finance has delegated Executive responsibility for the delivery of the Estates Strategy and is specifically responsible for:

- regularly assessing the financial risks to the Trust in liaison with Executive Directors and directorate managers
- Providing the Finance and Performance Committee with regular reports detailing progress of the delivery of the Estates and Facilities Strategy
- Oversee the development of business cases for major capital property developments
- Monitor the performance of range of key strategic estates-related deliverables
- Ensure that all risks identified are discussed and escalated in line with the Trust Risk Management and Escalation Policy and Procedure.

7. Finance

7.1. Summary of headline financials

The Trust land and building assets were valued at £45 million as at 31 March 2014.

Property

2013-2014	Land	Buildings excluding dwellings	Total
	£000's	£000's	£000's
Cost or valuation:			
At 1 April 2013	**18,606**	**27,282**	**45,888**
Additions Purchased	0	755	**755**
Upward revaluation/positive indexation	100	576	**676**
Impairments/negative indexation	0	(25)	**(25)**
At 31 March 2014	**18,706**	**28,588**	**47,294**
Depreciation			
At 1 April 2013	**0**	**1,296**	**1,296**
Impairments	0	142	**142**
Reversal of Impairments	0	(526)	**(526)**
Charged During the Year	0	952	**952**
At 31 March 2014	**0**	**1,864**	**1,864**
Net Book Value at 31 March 2014	**18,706**	**26,724**	**45,430**
Asset financing:			
Owned - Purchased	18,706	26,078	**44,784**
Held on finance lease	0	646	**646**
Total at 31 March 2014	**18,706**	**26,724**	**45,430**

7.2. Existing budget and future budgets

The Capital Programme for 2014/15 was approved at the August 2014 meeting of the Board.

Estates revenue budgets covering Building Engineering and Equip Maintenance and Repair, Refuse and Clinical Waste, Depreciation of Owned and Leased Assets, Utilities, External Contract Domestics, Rates, Rent, Sewerage and Water was £4 million in 2013/14.

Backlog maintenance identified across all sites and reported through the national Estates Return Information Collection was £8.9 million.

8. Risk Analysis

8.1. Approach

Structures

We have robust, comprehensive and effective risk management systems in place to manage clinical, financial and business risk. Underpinning this is the Risk Management Policy and the Governance Strategy. Leadership is given to the risk management process by the Board and through Board Committees, which view risks from a variety of sources.

We have identified lead managers who monitor performance, compliance and assurance against a range of national standards.

The Board Assurance Framework is the key tool used by us to provide assurance of that risk and control mechanisms are in place and operating effectively. Through regular monitoring of the Board Assurance Framework and the operational risk registers, which underpin the risk management process, the Executive Team and EMAS Board ensure that current risks are managed appropriately and there are suitable arrangements for preventing and deterring risk. The Board reviews the Board Assurance Framework every two months. Each risk and its mitigating actions are reviewed and the risk score considered and amended as necessary.

Risk Registers

The Board Assurance Framework is a high-level register of the risks to the achievement of EMAS's strategic objectives. Controls to mitigate these risks and evidence of those controls are also included.
The Board Assurance Framework also includes risks that have been escalated to the Board from the operational divisions. The following committees review the Divisional Risk Registers and refer strategic risks to the Board:

- Quality and Governance Committee
- Workforce Committee
- Finance and Performance Committee
- Operational Governance Group
- Clinical Governance Group

Divisional and local Risk Registers have been developed to ensure that risks, identified through the business planning process, are managed at a local level. Each Director is responsible for the risk registers within their Directorate. In addition, Directors are also accountable for specific risks in the Board Assurance Framework. The Board of Directors is accountable for controlling and mitigating organisational risk.

Glossary

A & E	Accident and Emergency
Backlog Maintenance	Backlog maintenance costs are a measure of the condition and associated risks relating to fixed building components and engineering assets (sub-elements)
ERIC	Estates Return Information Collection: an annual return submitted by NHS organisations to NHS Estates providing data on Estates and Facilities Management.
Estatecode	NHS Estates guidance to NHS organisations for the effective management of their estate.
Estatecode Condition B	Estatecode property appraisal rating; property in physical condition B is sound, operationally safe and exhibits only minor deterioration.
Executive Directors	The Executive Directors are senior employees of the NHS Trust who sit on the Board of Directors and will include the Chief Executive and Finance Director. Executive directors have decision-making powers and a defined set of responsibilities thus playing a key role in the day to day running of the organisation.
Exemplar Estate Strategy	NHS Estates guidance for the development and presentation of estate strategies.
GIA	Gross Internal Area, the overall internal area of a property measured within the perimeter walls with allowances made for projections, indentations, insets, voids and courtyards; usually measured in square Metres.
Governance	Governance arrangements are the 'rules' that govern the internal conduct of an organisation by defining the roles and responsibilities of key offices/groups and the relationship between them, as well as the process for due decision making and the internal accountability arrangements.

East Midlands Ambulance Service NHS
NHS Trust

Information Management and Technology Strategy

Version: 1.7 FINAL

Approved by: EMAS Trust Board

Date: 16th October 2014

Review Date: October 2015

Information Management and Technology Strategy 2014-2019

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1. Executive Summary

1.1. Purpose of Strategy

This information management and technology (IM&T) strategy sets out how the East Midlands Ambulance Service NHS Trust (EMAS) will develop its information and communications systems, and information management and governance processes to support the trust to achieve its strategic objectives.

1.2. Terminology

The document is written as an IM&T strategy whilst the terms information and communications technology (ICT) strategy or information technology (IT) strategy have often been used in the past. The distinction is deliberate: ICT (and IT) focuses on the strategy for the technology being used ('boxes and wires') whilst IM&T covers the technology and the management of the information.

1.3. Strategic Context

EMAS has agreed an ambitious strategy to play a central role in the urgent and emergency care system in the East Midlands and to become the ambulance provider that sets the benchmark for quality and efficiency. Our strategy will be delivered in two phases: phase one over years one and two will result in EMAS 'getting the basics right' and creating a solid foundation upon which to grow – our focus will be to help the wider system to achieve its goals such as reducing emergency hospital admissions. In years three to five (phase two) we will grow our business by expanding beyond core emergency ambulance services into areas ranging from patient transport to NHS111 and potential tele-health/ tele-care monitoring.

Achieving our aims depends upon transforming the services' operating model to one that is designed to deliver; a single urgent and emergency care platform; a single point of access for 999, NHS 111 and clinicians requiring access to integrated services; an early warning system providing advance notice of system pressures; a 24/7 multi-professional access team; continued delivery and improvement on performance and clinical indicator; and creation of a platform for individual care records, care planning and direct booking of primary and community services. Each element of this 'future operating model' has important implications and requirements for our IM&T.

Our proposed future operating model has been developed in response to a combination of national and local factors which create significant challenges for the whole health (and social care) system, but which also create opportunities for ambulance services, which for too long have been an overlooked element within the NHS, to contribute to the system transformation needed to ensure the entire NHS remains clinically, operationally and financially sustainable in the future.

The future operating model cannot be supported without changes to our existing operational or support systems, our information governance, our information management or our IM&T team. Looking ahead the future operating model will require technology that:

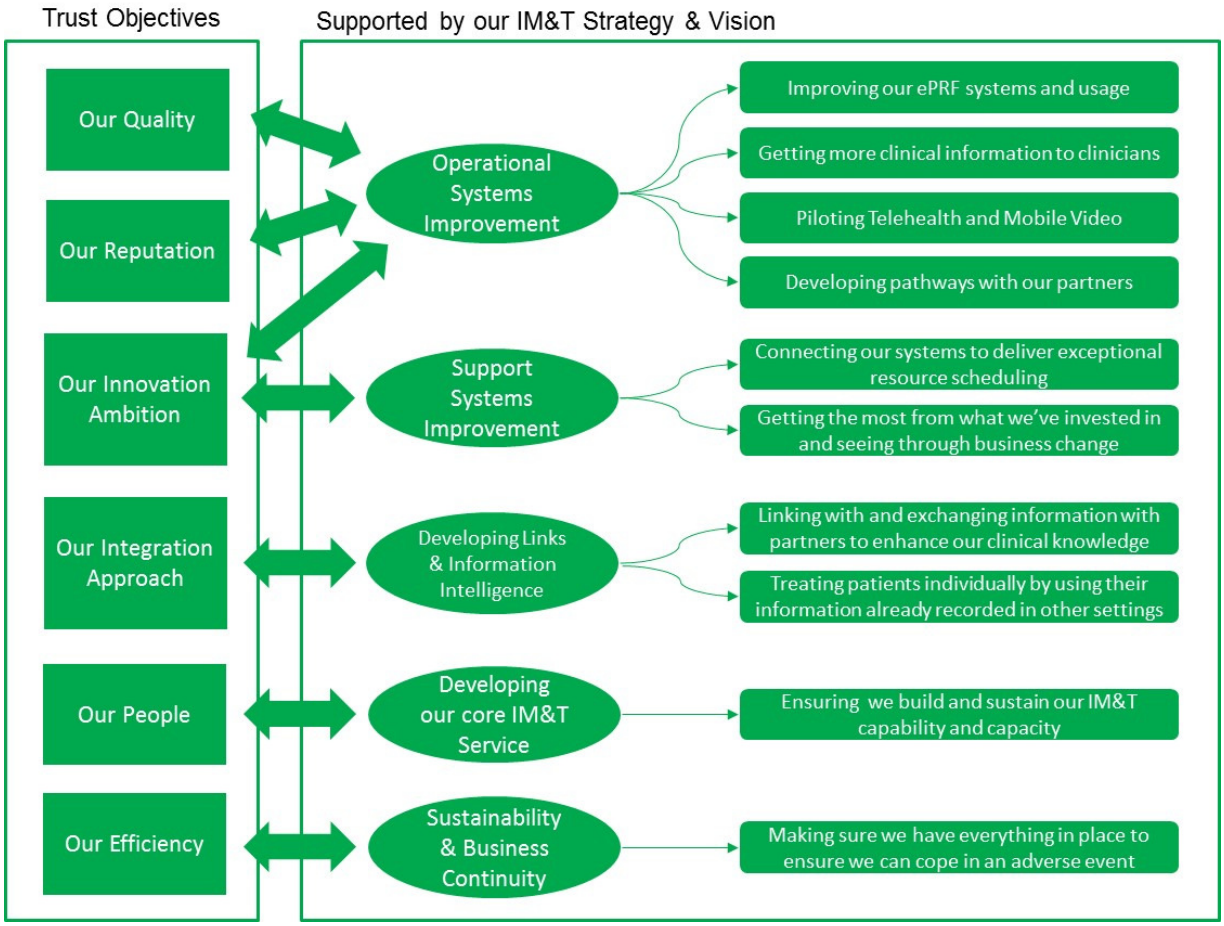
- Provides appropriate decision support to our call handlers and the clinical Assessment team (CAT) i.e. helps reduce variation in decision making;
- Provides real-time information about patients to our front-line crews;
- Allows our clinicians access to summary care records from other parts of the health and care system;
- Enables staff to liaise in real-time with clinicians from other services e.g. GPs;
- Provides an electronic directory of services (eDoS) providing information about alternatives to A&E;

- Supports capacity management within EMAS e.g. optimises the deployment of vehicles;
- Supports capacity management across the whole system e.g. supports the matching of demand to capacity;
- Avoids duplication e.g. of data entry;
- Provides accurate data and robust information to support operational and strategic decision making;
- Guarantees excellent information governance.

1.4. IM&T Strategic Plan

In response to the need for IM&T to get better, we have agreed the following IM&T vision, '*to provide the trust with enhanced information and management technology services that enable the organisation to fulfil its mission to achieve the highest standards in emergency and clinical care'*. The link from the IM&T vision and associated IM&T objectives, to the trust's objectives is illustrated below.

How the IM&T strategy and vision supports delivery of Trust Objectives



There are five key components to our vision for IM&T which are set out in the diagram below.

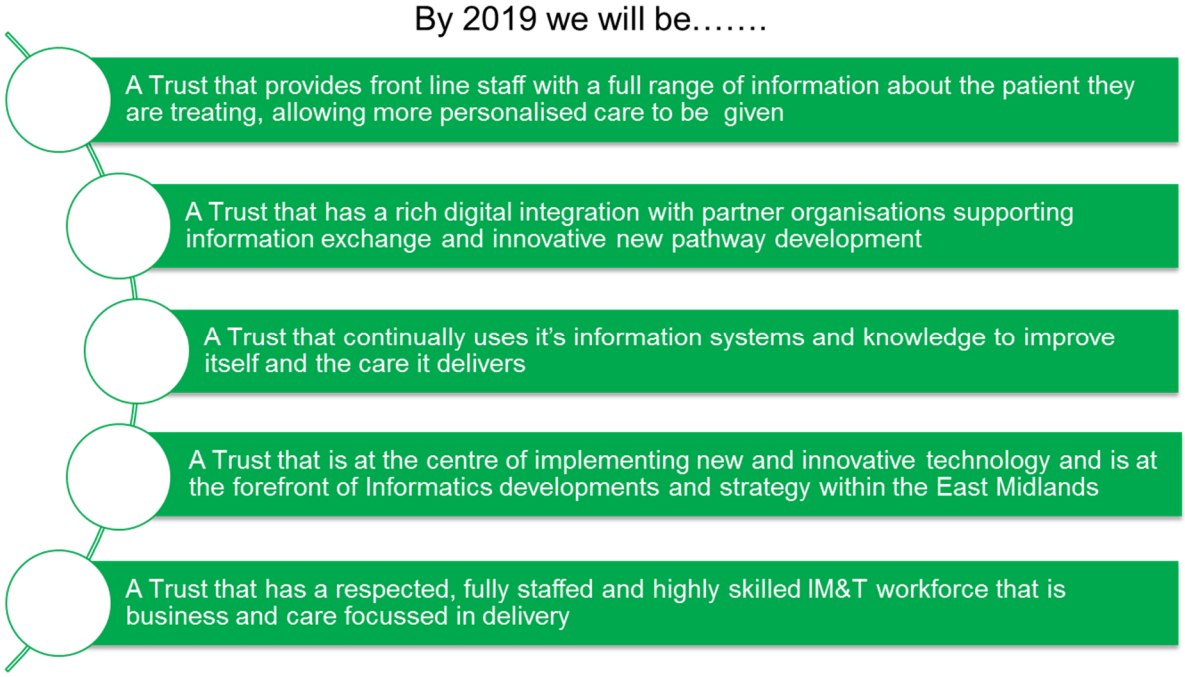
Our IM&T Strategy – Five key components

The five components summarise what we will do over the next five years:

- **Operational systems improvement** - we will focus on ensuring our clinical information systems are selected, configured, implemented and supported to ensure that each system supports the delivery of clinically effective care;
- **Support systems improvement** - we will enhance and embed our support systems to ensure we are gaining the full benefits of previous investments. Benefits will include improved unit resource availability ('right people, right equipment, right place, right time') and improved efficiency;
- **Developing links and information intelligence** – we will ensure that our front-line staff have access to as much relevant patient information as possible to help them make the most informed clinical judgement for the patient as possible;
- **Developing our core IM&T service** – we will build upon our current focus on information and communications technology to also focus on information management;
- **Sustainability and business continuity** - we already have excellent business continuity plans in place, so will ensure this remains to be the case against the backdrop of change to our IM&T portfolio.

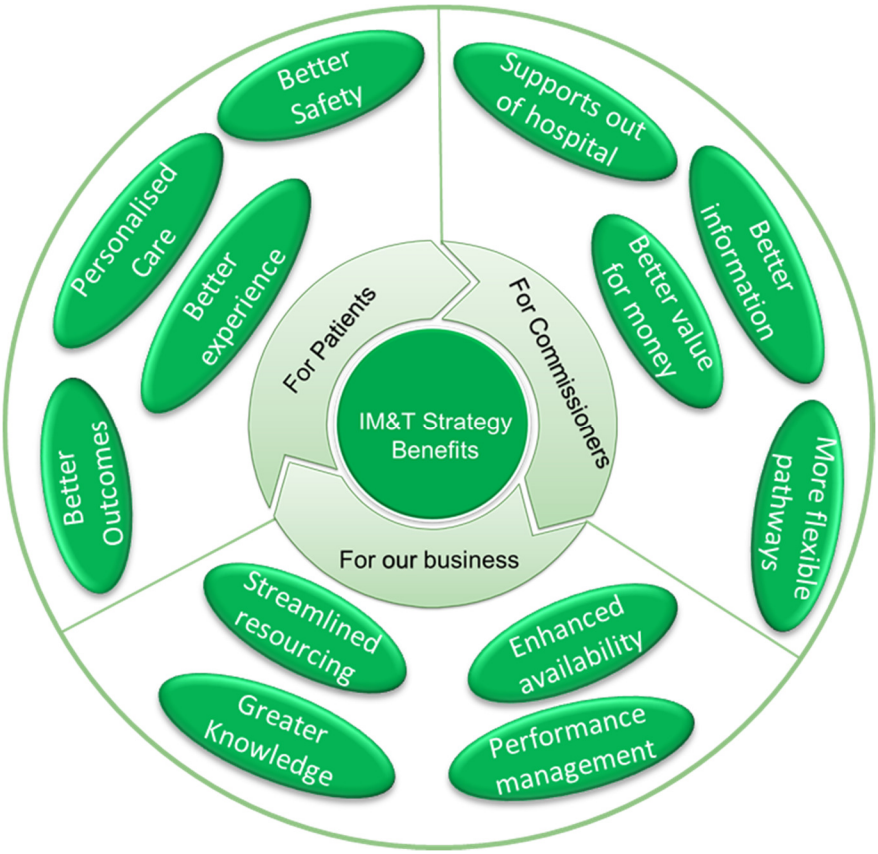
As a result our IM&T will be transformed.

Transformed IM&T capability



Excellent IM&T is not an end itself. Delivering the vision encapsulated in this IM&T strategy will have direct and significant benefits for the patients we serve, the commissioners who are charged with delivering maximum quality and value, and for the commercial and financial performance of EMAS.

Summary of benefits



The projects we will run to deliver the benefits set out above are described below.

IM&T strategy component	Project name	Explanation
Operational systems improvement	Airwave replacement	The replacement of the Airwaves radio system which will enable the development of services that leverage new communications abilities.
	CAD re-procurement	Design, procurement and implementation of a robust and resilient replacement for the CAD system. A more modern CAD platform should facilitate tele-health and will offer efficiency gains in the EOC through innovations such as; text back patient follow-up appointments with providers from eDOS; video pre-ambulance arrival instructions to smart phones for callers requiring guidance on self-help; tele-conferencing between crews on scene and CAT; and the use of video streaming of patient conditions / injuries to better support diagnosis.
	Live video (tele-medicine)	As above – online consultations, advice and support.
	Triage (AMPDS/NHS Pathways)*	EMAS needs to decide on whether to replace the existing EOC system AMPDS with NHS Pathways (which is linked to NHS111) or to use both systems – linked to our ability to win NHS111 contracts
	Mobile WIFI hubs (MDT replacement/ upgrade programme)	Upgrade/ replacement of vehicle-based data terminals needed to take advantage of communication advances enabled by new CAD system. EMAS vehicles will become mobile WIFI hubs.
Business systems improvement	ePRF improvement programme	Upgrade to existing e-PRF system, additional change support and dedicated project leadership. Investigating and resolving reasons for low usage rates for e-PRF
	ePRF re-procurement	The national ePRF contract ends in 2015 – this project will see the tendering and selection of a new backend system and the provision of a refreshed client device and software.
	Capacity management	Project to provide real-time information on whole health system capacity
	Enterprise architecture	The design of a Service Orientated Architecture (SOA) and implementation of an Enterprise Service Bus (ESB) to provide full master data management of trust information.
	Email platform re-provision	Upgrade/ re-provision of email
	Remote working and VPN enhancements	Improvements needed to improve electronic communications in poor signal areas and to enhance ability of staff to work remotely
	Scheduling software*	Needed to assist bidding for patient transport tenders
	Information integration engine	Reduces duplicate data entry and enables provision of integrated information – 'one truth'
	Trust Website and Intranet Platform & Design	Redevelopment of the Trust Intranet and Website Platform giving more dynamic functionality and greater flexibility for different device use
	Digital wallboards	
Developing links and information intelligence	e-Directory of Services (DoS)	An electronic DoS is needed to facilitate increased use of alternatives to A&E by ambulance crews
	Direct booking	Would enable EMAS CAT to directly book callers for urgent GP consultations
	Tele-health/ tele-care hub system*	Would support provision of tele-health/ tele-care monitoring service
	Partnership clinical portal integration (e-record sharing)	Enables EMAS crews to access e-patient records belonging to other services
Developing our core IM&T service	IM&T service development project	OD programme needed to ensure IM&T service makes the transition from being purely a technical support service to a support service that can also provide strategic advice and application management and ownership
	Ownership versus leasing	A project to review the risks and benefits of a leasing instead of ownership model for IM&T equipment
	Strengthening PMIT	Extending the role of PMIT to include information management as well as performance reporting
	Extending self-service reporting	Extending self-service reporting across all support systems
	Review of IM&T support provision model	To ensure the Trust is getting the best quality and value for money possible from its IM&T revenue investments.
Sustainability and business continuity	IM&T elements of the EOC strategy – enhancing the ability of the Lincoln EOC to cover the Nottingham EOC and vice versa	The IM&T infrastructures of the systems that support the EOC are not fully resilient. The current programme of remedial work will improve the situation and enable limited operations to be carried out from Lincoln in the event of a failure at Nottingham.
	Rolling equipment replacement programme	EMAS needs to introduce a rolling equipment and software replacement/ upgrade programme
	Standardisation and centralised support	Need to rationalise the number of systems and range of equipment used across EMAS: related need to ensure that all systems are supported by IM&T i.e. there are no 'departmental systems' supported locally in isolation.

1.5. Implementation and Monitoring

The IM&T programme will be managed by the Director of Information and Performance and monitored through the trust's Better Patient Care Board. The Trust Board will receive assurance via:

- Better Patient Care Board reports to the Trust Board;
- The Information Governance Group that reports to the Finance and Performance Committee.

The proposed timeframe for the key projects within this strategy is set out below.

Project timeline

		Deployment Years				
IM&T strategy component	**Project name**	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**
Operational systems improvement	Airwave replacement					
	CAD re-procurement					
	Live video (tele-medicine)		Pilot			
	Triage (AMPDS/NHS Pathways)*					
	Mobile WIFI hubs (MDT replacement/ upgrade programme)		Pilot			
Business systems improvement	ePRF improvement programme					
	ePRF re-procurement					
	Capacity management					
	Enterprise architecture					
	Email platform re-provision					
	Remote working and VPN enhancements					
	Scheduling software*					
	Information integration engine					
	Trust Website and Intranet Platform & Design					
	Digital wallboards	Pilot				
Developing links and information intelligence	e-Directory of Services (DoS)		Pilot			
	Direct booking					
	Tele-health/ tele-care hub system*					
	Partnership clinical portal integration (e-record sharing)					
Developing our core IM&T service	IM&T service development project					
	Ownership versus leasing					
	Strengthening PMIT					
	Extending self-service reporting					
	Review of IM&T support provision model					
Sustainability and business continuity	IM&T elements of the EOC strategy – enhancing the ability of the Lincoln EOC to cover the Nottingham EOC and vice versa					
	Rolling equipment replacement programme					
	Standardisation and centralised support					

1.6. Communications and Links to Other Strategies

Throughout the development and implementation of this strategy we will continuously talk to our stakeholders, particularly those within EMAS. Continuous communications is particularly

important because of the interdependencies between this strategy and our fleet, workforce, clinical and quality, EOC, estates and business development strategies.

1.7. Financial Impact

The estimated costs of the IM&T projects set out above are shown in the table below.

Financial implications

		Funding Capital					Funding Revenue				
IM&T strategy component	**Project name**	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**
Operational systems improvement	Airwave replacement				£1,000,000						
	CAD re-procurement			£1,000,000	£1,000,000			£250,000	£250,000	£250,000	£250,000
	Live video (tele-medicine)		£150,000	£150,000	£50,000			£5,000	£25,000	£25,000	£25,000
	Triage (AMPDS/NHS Pathways)*		£1,000,000					£50,000	£50,000	£50,000	£50,000
	Mobile WIFI hubs (MDT replacement/ upgrade programme)				£250,000	£250,000				£50,000	£50,000
Business systems improvement	ePRF improvement programme	£233,000	£150,000								
	ePRF re-procurement		£750,000	£750,000				£100,000	£100,000	£100,000	£100,000
	Capacity management		£50,000	£50,000							
	Enterprise architecture		£500,000					£75,000	£75,000	£75,000	£75,000
	Email platform re-provision		£250,000								
	Remote working and VPN enhancements		£50,000	£50,000				£0	£0	£0	£0
	Scheduling software*	£250,000	£250,000				£50,000	£50,000	£50,000	£50,000	£50,000
	Information integration engine		£75,000	£40,000							
	Trust Website and Intranet Platform & Design		£90,000		£40,000						
	Digital wallboards	£50,000	£250,000								
Developing links and information intelligence	e-Directory of Services (DoS)	£10,000									
	Direct booking										
	Tele-health/ tele-care hub system*										
	Partnership clinical portal integration (e-record sharing)		£100,000	£100,000	£100,000						
Developing our core IM&T service	IM&T service development project	£150,000	£150,000	£150,000	£150,000	£150,000	£0	£0	£0	£0	£0
	Ownership versus leasing		£75,000								
	Strengthening PMIT						£50,000	£50,000	£50,000	£50,000	£50,000
	Extending self-service reporting										
	Review of IM&T support provision model				£75,000						
Sustainability and business continuity	IM&T elements of the EOC strategy – enhancing the ability of the Lincoln EOC to cover the Nottingham EOC and vice versa	£100,000	£150,000					£50,000	£50,000	£50,000	£50,000
	Rolling equipment replacement programme	£150,000	£150,000	£150,000	£150,000	£150,000					
	Standardisation and centralised support	£100,000	£100,000	£100,000	£100,000	£100,000	£50,000	£50,000	£50,000	£50,000	£50,000

This strategy will require approximately £9.86m capital spend over the life of this plan. The three most significant components of this are the replacement CAD, replacement Airwave and replacement ePRF systems.

The net revenue cost impact of this strategy will be to increase IM&T costs by around £750k per annum, excluding capital charges.

1.8. Risk management

Risks associated with the delivery of the projects within this strategy will be managed using the trust's risk management structures and processes such as the use of local risk registers and the board assurance framework (BAF) which are reviewed by the executive team and the trust's board.

2. Strategic Context

2.1. EMAS Vision & Strategic objectives

We are a healthcare provider. We provide healthcare on the move and in the community, and our vision is for EMAS to play a leading role in the provision, facilitation and transformation of clinically effective urgent and emergency care delivered by highly skilled, compassionate staff, proud to work at the heart of their local community.

We believe this will support CCGs and other health and social care providers across the East Midlands in the delivery of a long-term, sustainable healthcare system.
The five-year plan maps our transformation journey from a mainly emergency focused service in 2014/15 to a future operating model whereby the organisation sits at the centre of the urgent and emergency care system.

This means it is our ambition for EMAS to act as the co-ordinating NHS organisation at the centre of the system, either providing care directly (e.g. over the phone or on the scene) or signposting/referring patients to the best service to support them in their homes and the community, reducing admissions to hospitals where appropriate.

This model is designed to ensure the most appropriate and effective response to meet the needs of our patients and/or the referring clinicians. Put simply:

"…..supporting delivery of the right care, with the right resource, in the right place and at the right time."

2.2. The Future Operating Model

Our current Integrated Business Plan (IBP), completed in June 2014 and covering the five year period 2014-2019, articulated that, in order to realise we will:

Current Model

The current service model is based upon core clinicians (paramedics) operating on frontline vehicles and the dispatch of the nearest available resource to attend to patient care irrespective of the clinical need.

This model involves the deployment of our most skilled staff in all circumstances, and makes no allowance for case mix. Additionally, the majority of patients are transported to the nearest Accident and Emergency facility with little opportunity for our skilled staff to exercise the full range of their clinical judgement.

Whilst this model is effective at one level, in that patients are seen and treated promptly, we regard it as being unsustainable in the longer term where demand is increasing within a decreasing financial envelope.

In developing options for the future, we (working with our Commissioners) are clear we will want to retain elements of the model that support delivery of consistent operational performance and financial sustainability, whilst operating at the centre of a more integrated urgent and emergency care system.

Years One and Two (2014-2016)

- Focus on continued delivery of performance, delivering at a county level on a sustained basis.
- Further develop our Clinical Assessment Team to increase hear and treat and support our teams in the field in the use of alternative pathways and admission avoidance services (supported by Paramedic Pathfinder), utilising all local health and social care providers.
- Work in partnership with CCGs, acute trusts, community trusts, local authorities, private providers and the voluntary sector to develop and implement integrated admission avoidance services (e.g. Falls, Discharge services, Acute Visiting Services etc.).
- Build our capacity and capability to support future integrated strategic developments (e.g. eDoS, Paramedic Pathfinder and Telehealth & Remote Monitoring).
- Support delivery of the right care, with the right resource, in the right place and at the right time.
- Deliver excellence in patient experience and outcomes.

Years Three to Five (2016-2019)

Our proposed future operating model has, at its core, a whole system approach to urgent and emergency care, with EMAS acting as the co-ordinating entity at the centre of the system, either providing care directly or signposting to other services.

This model ensures the most appropriate and effective response to meet the needs of our patients and/or the referring clinicians. Put simply:

"…..supporting delivery of the right care, with the right resource, in the right place and at the right time."

- Be at the centre of the urgent and emergency care system, generating efficiencies across the healthcare system (e.g. multi-skilled staffing, better use of admission avoidance schemes, reduced conveyance to emergency departments).
- Provide a regional platform for an efficient and sustainable integrated urgent and emergency care system (e.g. integrated care records, coordinated assessment services, care plans, direct booking into services etc.).
- Identify gaps in the system, facilitating improvements, managing demand and pressure regionally.
- Aim to provide a significant portion of the patient transport services in the region, so we will be a provider of transport services across the whole spectrum of urgent, emergency and planned care.
- Aim to be a partner in 111 services, developing strategic partnerships and working more closely with other providers.
- Provide other services and new models of care as opportunities arise.
- Continue to support on going delivery of the right care, with the right resource, in the right place and at the right time.
- Continue to deliver excellence in patient experience and outcomes.

In summary the EMAS strategy over the five years of this plan is to transform ourselves into an organisation that is able to achieve key performance and quality standards, supporting

reductions in emergency admissions, in a consistent and sustainable way (years one and two).

From this position, we seek to expand our service offering, building on our unique position as a regional provider with core skills, infrastructure, capacity and capability in call centre management, clinical assessment and provision of transport, to position ourselves as the platform upon which the urgent and emergency care system in the East Midlands can become sustainable (years three to five).

We recognise that successful delivery of our strategy will be dependent on the achievement of a number of strategic objectives. We recognise that a key objective is the delivery of a quality service, and that we need to build a reputation among stakeholders as an organisation that can deliver a quality service. By quality, we mean delivering consistently within all three domains of quality: patient safety, patient experience and clinical effectiveness. In order to build a strong reputation, we will need to develop innovative service offerings that help to address the current and future challenges in the urgent and emergency care system in the East Midlands, and we will do this through working with partners to provide and facilitate greater integration. This will be delivered through skilled and motivated staff working within an effective and efficient organisation.

We have, therefore, identified six strategic objectives. These elaborate on the vision and strategy overview and provide a more detailed focus on how the vision will be delivered:

Our Quality: We will respond to our patients with a high quality service which consistently meets national ambulance targets quality indicators

Our Reputation: We will be recognised nationally as a reliable provider of high quality out of hospital and community based care across the East Midlands

Our Innovation ambition: We will be recognised nationally as a leading innovator in out of hospital and community based care

Our Integration approach: We will work in partnership with our local health care, social care, and voluntary sector partners to deliver and enable integrated patient services and care pathways across the East Midlands

Our People: We will consistently develop and support our people to be highly skilled, highly motivated, caring and compassionate professionals

Our Efficiency: We will make the most effective use of all our resources, delivering upper quartile performance on our indicators for money, staff, premises, and fleet.

The IBP identified that the development of our strategy would be underpinned by a series of supporting strategies, one of which is this IM&T strategy. The IBP also recognised that each of these supporting strategies would be reviewed to ensure they reflect, are consistent with and support the strategy and future operating model detailed in our plans.

Our IBP includes a future operating model that reflects the fact we know, in years one and two of our plan, we must place significant emphasis on:

- the delivery of core performance at a county level
- the delivery of clinical indicators
- the provision of a sustainable service

2.3. National policy and context

Our future operating model is our response to the national and local context discussed below.

Ambulance services are a frequently overlooked part of the health and social care provider landscape despite their crucial and often high profile role. There are encouraging signs that this is beginning to change with EMAS and our colleagues at least 'having a seat at the table' when health and social care strategic planning is undertaken. The reasons for this change can be seen in a number of national drivers, each reflected more locally throughout the East Midlands.

The development of our plans is taking place at a critical juncture in the history of the NHS. After a decade of investment and reform that has delivered real improvements for patients, the NHS has entered one of the toughest financial climates it has known. The NHS faces an unprecedented set of complex, interconnected challenges for the foreseeable future which will require an unprecedented response framed around QIPP. The key issues for the NHS as we plan the next five years can be summarised as:

- **Improving quality and outcomes** including specifically; reducing the number of years of life lost by the people of England from treatable conditions (e.g. stroke, heart disease, respiratory disease); improving the health related quality of life of the 15 million+ people with one or more long-term conditions; reducing the amount of time people spend avoidably in hospital through better and more integrated care; and increasing the proportion of older people living independently at home following discharge from hospital;
- **Rising demand and expectations**. Demand for almost all health and social care services has increased significantly over the last decade driven by population growth and ageing within the overall population. People's expectations are also rising as we become a more consumerist society and patient's rights are embedded in initiatives such as the Patient's Charter;
- **Financial control**. Rising demand against a backdrop of the post-crash squeeze of public finances led to the 'Nicholson Challenge' to deliver £20bn in efficiency savings by the end of 2014/15. The NHS is almost at the end of this first 'challenge', but is now facing an additional £30bn funding gap in the period to 2020/21. If delivered by 2020/21 the NHS will have delivered £50bn efficiencies from a budget of circa £113bn. These financial pressures are reflected in the annual expectation of circa 4% cost improvements from all providers;
- **Providing care that is better joined-up (integrated care)**. The quality and productivity gains we need to make often lie at the interface between different health services and between health and social care. There is now a much greater focus on working in partnership to integrate services across organisational boundaries: this is of particular resonance to ambulance trust which service large geographical areas and which interface with multiple providers. NHS England has announced the creation of an integration transformation fund of £3.8bn, which will be committed at local level with the agreement of Health and Wellbeing Boards. The fund is ring-fenced for improvements in out of hospital care;
- **Transformation of service delivery**. Expectations are rising and there is a recognition that for the NHS to remain free at the point of need against a backdrop of financial austerity, the way services are delivered must be transformed. The Keogh review, 'Transforming Urgent and Emergency Care Services in England', is important to EMAS in this respect. The review has the vision of a system where patients with urgent but non-life threatening needs have access to services outside of hospital,

whilst those patients with emergency needs have access to treatment in centres with the very best expertise and facilities.

Meeting the national challenges set out above requires a transformational approach to the way services are delivered: a vital enabler of this transformation is better IM&T. The contribution IM&T can make is set out in 'Liberating the NHS: An Information Revolution' (2010) and more recently the national information strategy 'The power of information' (2012). Key themes from these publications and other national strategies are:

- The need to support integrated care in the broadest sense – health and social care, primary, community and acute care, physical and mental health;
- The need to adopt standards for interoperability between different providers' information systems, supported by robust information governance to protect the confidentiality and quality of electronic records and communications;
- More empowerment of patients and public, including online services such as booking and information, to support service user access to their own records; access to information on service quality; and access to advice and support to support self-care;
- New quality indicators and greater transparency, with particular emphasis on equality and effectiveness;
- Support for new models of care such as 'virtual wards' and tele-health.

The NHS Mandate sets out the changes the Government expect NHS England to make over the period to March 2015. These changes include making better use of technology (one of four key areas). The mandate lists six 'expectations', two of which relate to GPs, with the remaining four impacting directly on EMAS:

- That NHS England should promote the implementation of electronic records in all health and care settings and should work with relevant organisations to set national information standards to support integration;
- Clear plans will be in place to enable secure linking of these electronic health and care records wherever they are held, so there is as complete a record as possible of the care someone receives;
- Clear plans will be in place for those records to be able to follow individuals, with their consent, to any part of the NHS or social care system;
- Significant progress will be made towards 3 million people with long-term conditions being able to benefit from tele-health and tele-care by 2017; supporting them to manage and monitor their condition at home, and reducing the need for avoidable visits to their GP practice and hospital.

Investment in informatics systems and services can support delivery against these themes and national expectations.

Finally it is important to recognise that the continuing policy to open the NHS market to greater competition through the use of tendering will lead to greater competition and plurality of provision in the healthcare market. Providers must expect to hold an ever changing portfolio of service contracts and must be able to integrate their own IT systems with that of a changing array of partners.

2.4. Local Context

The local context as reflected in commissioning strategies and our existing plans draws on the national context set out above. We have worked extensively with commissioners to

understand the future role that EMAS could play in delivering a transformed emergency and urgent care system (it is important to recognise that as a 'regional provider' we operate across several emergency and urgent care systems). Commissioner's feedback is that:

- EMAS is best placed to support the local care system at a regional and local level - a call centre(s) at the heart of service delivery and the ability to respond with a tiered and appropriate level of resources is key;
- The Keogh report is about managing demand and capacity across the health care system, providing the right care at the right time - EMAS has the foundations to do this, and there is a need to reinforce this position and demonstrate that it has a real presence and capability in the local health care system;
- There needs to be a fundamental shift for the ambulance service from being the health arm of the emergency services towards being the urgent and emergency arm of the health service;
- Where the solution is regional, EMAS is best placed to be the system leader and where the solution is local EMAS is best placed to be the key stakeholder;
- Commissioners are clearly looking to see EMAS make a step change in terms of how it delivers its current services, and once it has rebuilt confidence in its ability to be a credible and reliable provider, for it to take a more central role in the delivery of urgent and emergency care services in the region.

We have agreed the following set of principles that will guide development of our future service model and engagement with the wider system:

- EMAS to act as an enabler of an integrated urgent and emergency care system, generating efficiencies across the healthcare system (e.g. multi-skilled staffing, better use of admission avoidance schemes, reduced conveyances to emergency departments etc.);
- EMAS to be a community-based provider of mobile urgent and emergency healthcare, fully integrated within urgent care networks;
- Utilisation of a single point of access platform to which all services can align (including social care);
- Utilisation of a simple, easy to access "One Number" approach for service users, clinicians and stakeholders – a 'route of least resistance';
- Creation of a platform for individual care records, care planning and direct booking of primary care services where agreed;
- To ensure the right care, with the right resource, in the right place and at the right time.
- Utilisation of all locally specific health and social care providers including prevention services;
- Identification of gaps in the system, facilitating improvements;
- Managing demand and pressure regionally;
- Delivery of a one stop, end-to-end service for patients to deliver the best possible outcomes.

We consider that the vision of the commissioners for the future direction of the ambulance service is aligned with and supportive of our vision which is set out below.

2.5. Current IM&T Position

2.5.1. Information Technology Systems

The current IM&T systems landscape is divided into two areas:

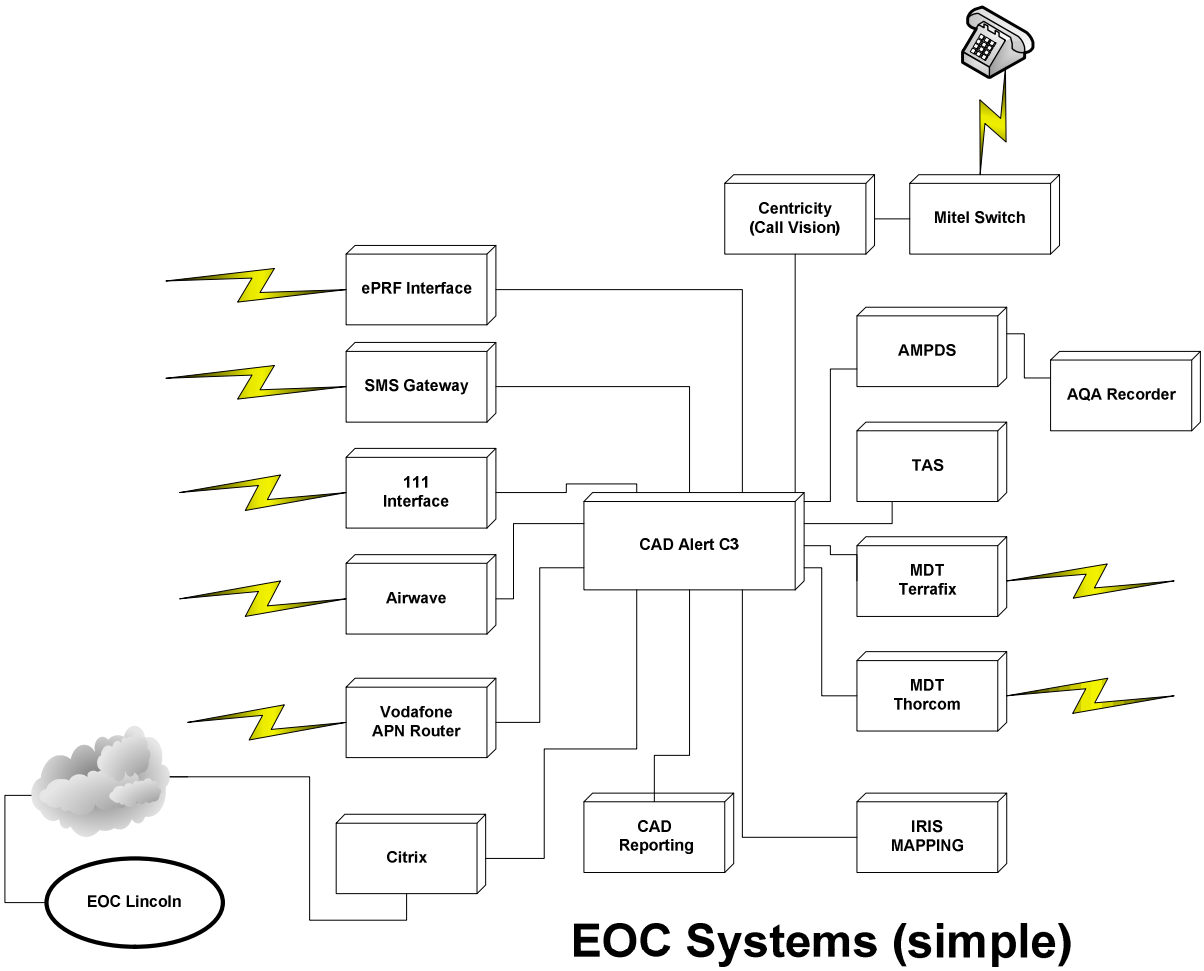
- Operational systems;
- Support systems.

2.5.2. Operational Systems

The main **operational systems** provide the 999 emergency and urgent response services in the Emergency Operation Centres (EOC) at Nottingham and Lincoln. The Lincoln EOC is a satellite centre which uses the systems and functionality sited in Nottingham via a citrix link traversing the wide area network.

The following diagram represents some of the major EOC components involved but it is not an exact technical representation of the systems and their interfaces.

EOC Integration diagram



The infrastructure architecture and applications used in the EOC has evolved over time and is highly complex. Support for the running of EOC systems is split between the ICT team, EOC support and numerous third party suppliers. There is no single person or function that is responsible for the maintenance and development of the end-to-end service creating a fragmented support model and difficulty in determining and agreeing plans which cross

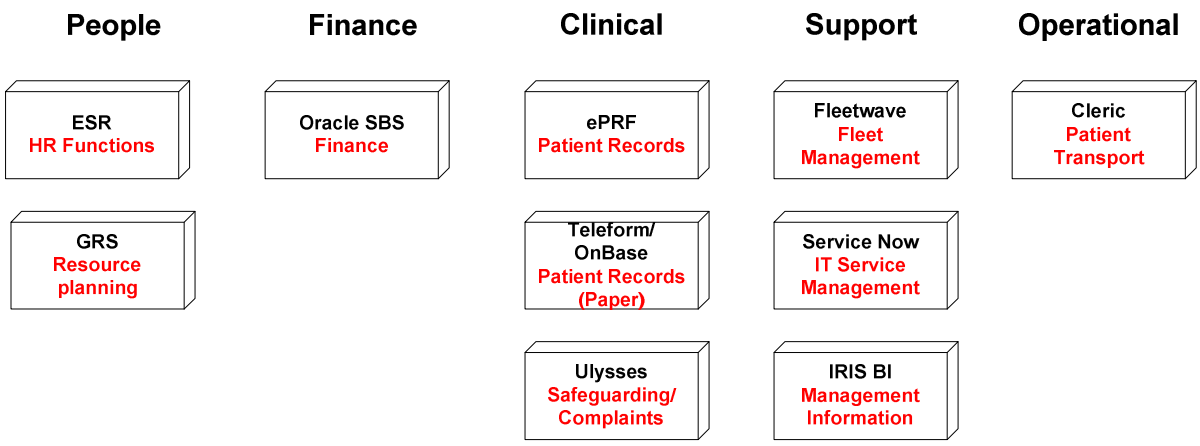
separately managed support functions. There are a number of operational systems which will need upgrading or replacing over the life of this strategy:

- The **Airways radio system** will be replaced as part of the Emergency Services Mobile Communications Programme (ESMCP) which is a cross departmental programme led by the Home Office. ESMCP will deliver a new Emergency Service Network (ESN) featuring voice and data services replacing operational communication services currently supplied by Airwave Solutions Ltd. Airwave is relatively expensive and cannot provide broadband data services.
- Design, procurement and implementation of a robust and resilient replacement for the **Computer Aided Dispatch (CAD)** system. Beyond 2016 the CAD will need to be reviewed for replacement (see EOC strategy). The review will need to review opportunities for a 'step change' in operation for the EOC function through 'cloud hosting' and remote working, whilst not compromising the needs for absolute resilience in the CAD and 999 telephony platform.
- Each vehicle is equipped with a **mobile data terminal (MDT)** which will need to be replaced to ensure front-line crews have the equipment needed to receive enhanced electronic communications from the new CAD. Ambulance vehicles will be fitted with new digital services providing enabling high speed communications using commodity mobile telephony services (e.g. 4G). The vehicle will then be able to function as a **mobile WIFI hub** allowing any type of approved device to connect and benefit from the improved connectivity.

2.5.3. Support Systems

The **core support systems** used within the trust are illustrated in the diagram below.

Support Systems



Core Applications Systems

Support systems are operated both in-house and externally, in part reflecting an unco-ordinated approach to the procurement of IT systems. Issues include their being little integration between systems which leads to data duplication and separate management in turn leading to the risk of information errors.

The national contract for the electronic patient report form (ePRF) comes to an end in July 2016 (there is an option to leave in 2015). We will need to procure and implement a successor system beforehand. At the time of writing there remains uncertainty regarding the

funding of a new system: the national contract is centrally funded meaning our commissioners and therefore, EMAS does not have funding for this contract. There is a risk of a significant cost pressure to EMAS if funding is not transferred from the centre to EMAS / our commissioners.

2.5.4. Information Management Reporting

Information management and reporting support to EMAS is provided by the Performance Management Information Team (PMIT) which provides business information to the Trust Board, our divisions and services using a 'self-service' approach to reporting. Reporting primarily focuses on performance i.e. reporting against key performance indicators and other measures. Our aim is that the focus of PMIT will expand to also include the provision of advice and data/ information interpretation to assist managers manage the business. This change will also include extending the use of self-service reporting to include a wider range of business support systems including complaints, incidents and fleet management systems.

2.5.5. Information Governance

EMAS has established information governance (IG) processes which have unfortunately received some negative publicity recently with the loss of a disk containing patient data. The report into this breach of security will be available in late September i.e. after the submission of this strategy.

Currently the IG function is separate from the teams that deal with Freedom of Information (FOI) requests and records management.

2.5.6. The IM&T Function

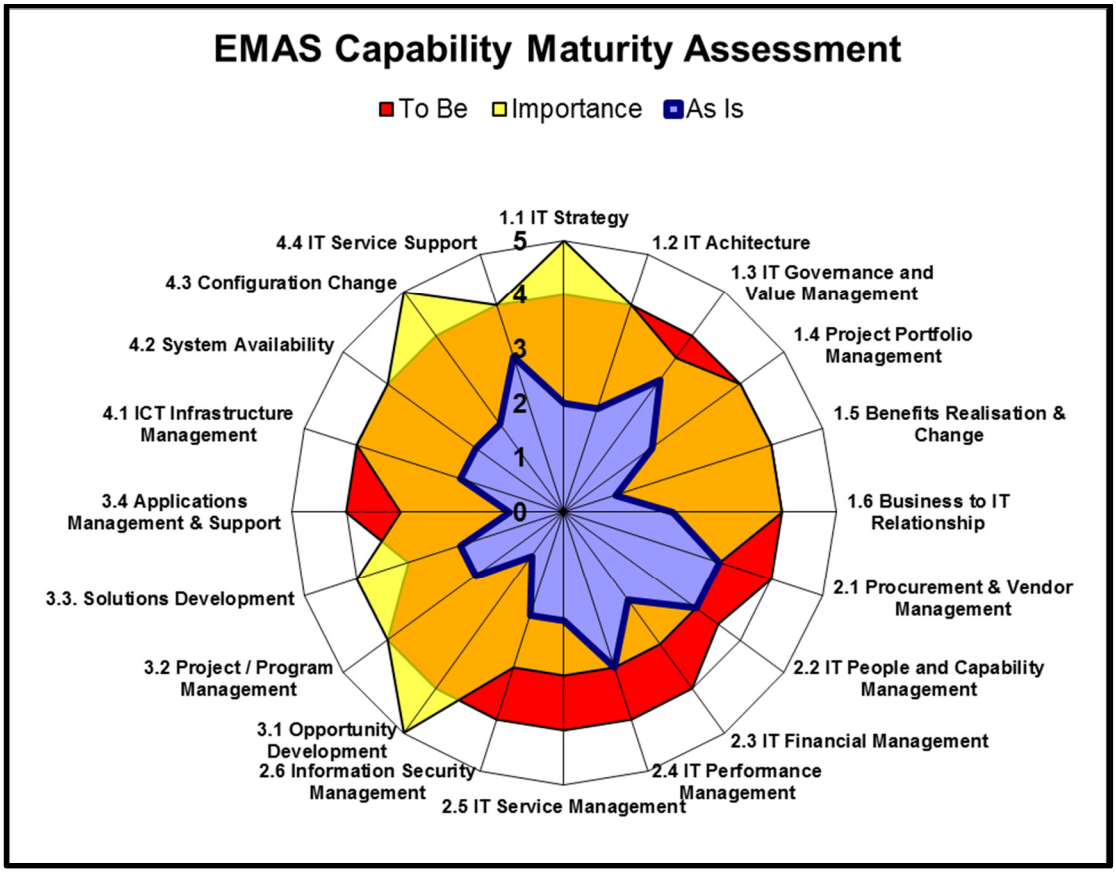
An important enabler of the successful implementation of our plans is the IM&T service itself. We have carried out a capability maturity modelling exercise. The maturity model contains four areas - business alignment, IT management, system development and service delivery.

Each capability is scored one to five as per the following scale:

1. Reactive;
2. Basic control;
3. Service/ product focus;
4. Customer focus;
5. Business led.

The results for EMAS IM&T service are illustrated below – these set out the 'as is' assessment and the 'to be' rating which assumes the changes set out in this strategy are implemented.

EMAS IM&T maturity assessment results



The model clearly indicates areas where improvements are required and where they are most urgent. There are weaknesses in many areas but the most pressing needs are seen to be in project management, benefits realisation, business relationship, opportunity development, service management and delivery.

The IM&T service's maturity assessment 'as is' scores in part reflect issues with resourcing and skill mix e.g. the service does not currently have enough of the appropriate skills to be able to support implementation of this strategy. The service's staffing profile will need to be developed and augmented to provide the necessary skills and expertise that will be required for successful delivery. For example, currently there is a high ratio of contractors to permanent staff which is leading to a cost pressure and which prevents us developing teams with the required skill sets. There is therefore, an imperative to strengthen the skills of number of permanent staff.

This strategy has been written assuming that the IM&T service remains in-house, but the potential to outsource all or part of the function has not been ignored. Appraising the outsourcing option is not an immediate priority, although it should be noted that outsourcing could be a risk mitigation strategy – see discussion of risks below.

2.6. Summary Case for Change

The external and internal context descried in the sections above is summarised below as the 'case for change'.

Driver	Link to IM&T
Need to Improve quality and outcomes	EMAS staff need appropriate IM&T systems, equipment and skills to help them provide individualised high quality, safe and effective services.
	Need for systems to promote improved quality for example through reducing variation in treatments and care pathways; improving diagnostic accuracy; providing decision support as part of clinician workflow; improving communication between professionals; and providing more timely data sharing.
	Need to report against new quality indicators and greater transparency, with particular emphasis on equality and effectiveness, and related CQUIN reporting.
Rising demand and changing expectations	More empowerment of service users and public, including online services such as booking and information to support service user access to information on service quality; and access to advice and support to support self-care.
	The trust needs operational systems that actively support the digitalisation of the service user's care record and promote improved access to healthcare services and information.
	Need for systems that allow easy patient feedback.
	Systems that enable direct booking by EMAS Clinical Assessment Team into GP urgent appointment slots.
	IM&T that supports real-time access to information e.g. A&E waiting times.
£30bn financial challenge	The need for IM&T to support and enable the transformation of service delivery. For example, systems must actively support the mobile nature of service provision, support for new models of care such as 'hear and treat' and 'see and treat' and the use of alternatives to A&E.
Integrated care	The need to adopt standards for interoperability between different providers' information systems, supported by robust information governance to protect the confidentiality and quality of electronic records and communications.
Need to transform service delivery	The need for systems which support new service models such as access to alternatives to A&E as envisaged in Keogh, for example electronic directory of services (eDoS).
Support The delivery of our 2019 future state	The need for technology that:
	• Provides appropriate decision support to our call handlers and the CAT i.e. helps reduce variation in decision making.
	• Provides real-time information about patients to our front-line crews.
	• Allows our clinicians access to summary care records from other parts of the health and care system.
	• Enables staff to liaise in real-time with clinicians from other services e.g. GPs.
	• Provides an eDoS providing information about alternatives to A&E.

	• Supports capacity management within EMAS e.g. optimises the deployment of vehicles.
	• Supports capacity management across the whole system e.g. supports the matching of demand to capacity.
	• Avoids duplication e.g. of data entry.
	• Provides accurate data and robust information to support operational and strategic decision making.
	• Guarantees excellent information governance.
	• Is supported by a well-resourced, but efficient and effective IM&T service.
Support to EMAS' growth ambitions	The need to make a decision about what EOC system to use (AMPDS or NHS Pathways).
	The need to purchase a dynamic real-time scheduling tool to support the trust's patient transport offer.
	Review potential to offer a capacity management service underpinned by real-time view of system capacity (e.g. waiting times and bed availability).
	Need to invest in IM&T to support tele-health offer – this may be a mix of video conferencing type technology to enable the provision of real-time senior clinical advice to ambulance crews and hub-based tele-health monitoring technology.
	The need for IM&T to be embedded in service developments and business case development to ensure that the potential benefits of technological advances are built into EMAS' future TOM.
Current operational system issues	Need to replace the Airways radio system.
	Need to procure a replacement for the CAD system and use the re-procurement as an opportunity to make a step-change in the EOC service without compromising resilience.
	Need for a MDT replacement programme and transformation of vehicles into mobile WIFI hubs.
	Need for support for all operational systems to be brought under the control of the IM&T service.
Current support systems	Need to replace the nationally funded ePRF by July 2016 – uncertainty around funding of the replacement.
	Need for more integration between systems to avoid data duplication.
	Need for support for all systems to be brought under the control of the IM&T service.
Information Management	Need to extend role beyond performance reporting to include provision of advice and management information, interpretation and analysis.
Information Governance	Need to appraise options for extending the remit of IG to include FOI and records management.
Improving Education	Need to provide technological solutions to assist in delivery of education to staff in an efficient, new and modernised manner.

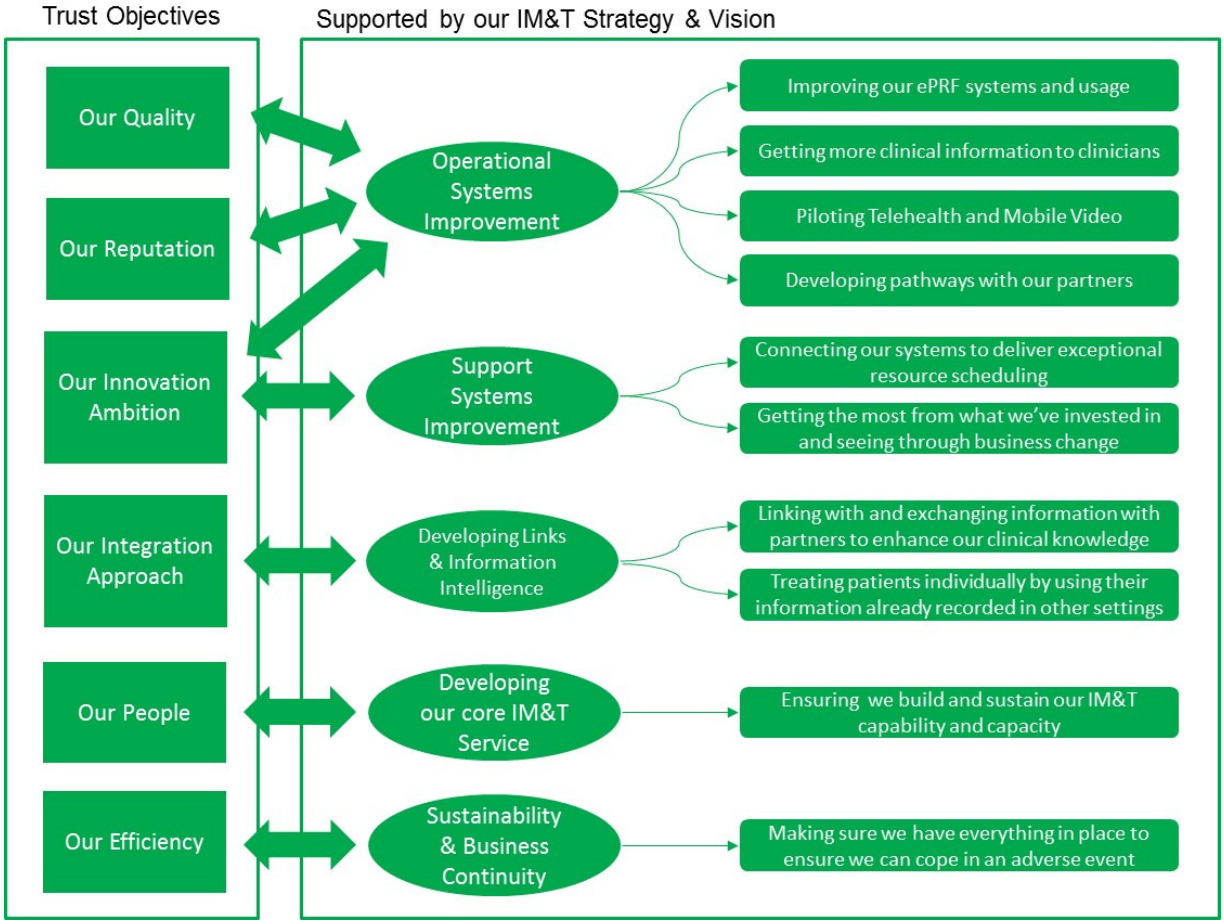
3. Strategic Plan

3.1. IM&T Strategic Vision and Objectives

This chapter sets out our vision for IM&T at EMAS which is designed to directly respond to the context described in the previous chapter and to support the trust's vision and delivery of its key strategic objectives.

Our vision is '*to provide the trust with enhanced information and management technology services that enable the organisation to fulfil its mission to achieve the highest standards in emergency and clinical care'*.

How the IM&T strategy and vision supports delivery of Trust Objectives



There are five key components to our vision for IM&T which are set out in the diagram below.

Our IM&T Strategy – Five key components

The five components summarise what we will do over the next five years:

- **Operational systems improvement** - we will focus on ensuring our clinical information systems are selected, configured, implemented and supported to ensure that each system supports the delivery of clinically effective care by:
    - Ensuring our front line staff have immediate access to the information and knowledge they need when they need it.
    - Improving data quality and clinical information knowledge to enable clinical research and care pathway planning.
    - Providing more granular data to support clinical audit and benchmarking of outcomes.
- **Support systems improvement** - we will enhance and embed our support systems to ensure we are gaining the full benefits of previous investments. Benefits will be wide-ranging and will include improved unit resource availability ('right people, right equipment, right place, right time') and improved efficiency. Better data quality and better information across all of our core business functions will ensure we manage and monitor our services more effectively.
- **Developing links and information intelligence** - it is essential that our front-line staff have access to as much relevant patient information as possible to ensure they can make the most informed clinical judgement for the patient as possible. This means we must develop our ability to exchange information securely with our partners to ensure we can access information about patients they hold and vice versa. Information exchange can also benefit the whole system: for example we believe that we are uniquely placed to have a system-wide view of real-time demand and capacity (waiting times, bed state etc), so can develop a system-wide capacity management role which would assist the matching of demand to available capacity.
- **Developing our core IM&T service** – we want to build upon our current focus on information and communications technology to also focus on information management. By doing so we have the capability and capacity to be central in the future business planning for the trust, ensuring EMAS seizes the opportunities

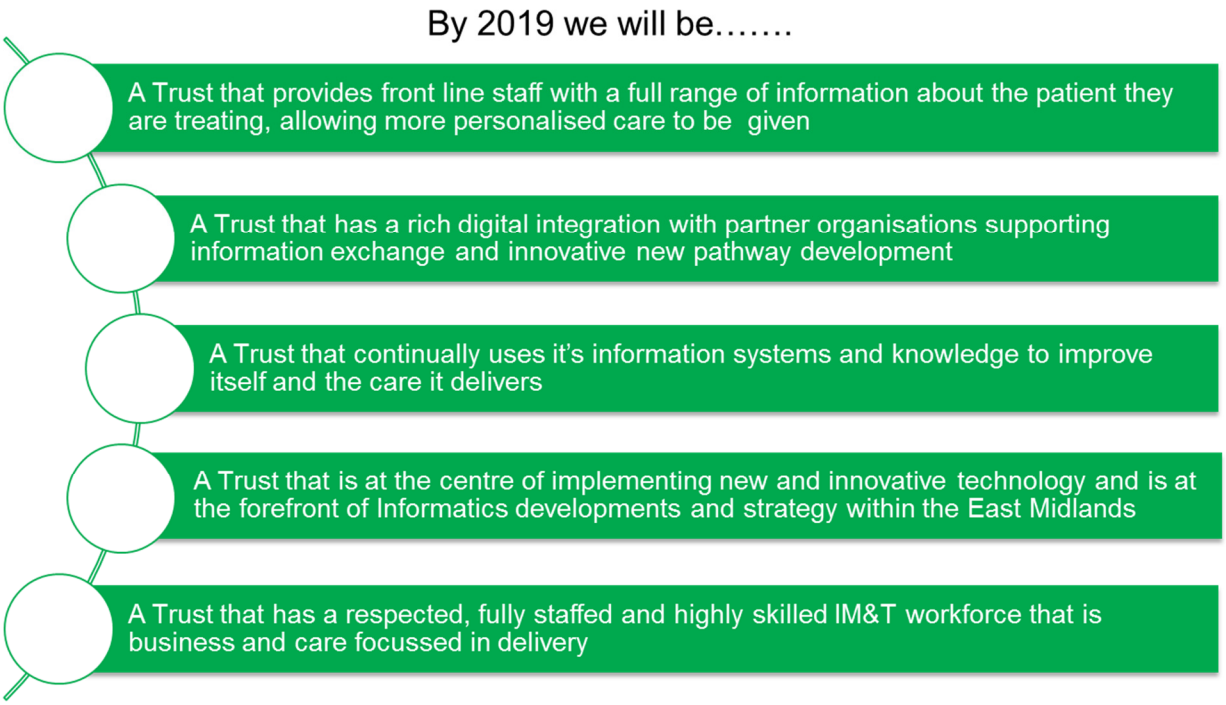
afforded by rapidly changing technology, to transform services. We also want to reduce staff stability and retention in the IM&T team.

- **Sustainability and business continuity** - it is imperative that we have robust appropriate business continuity plans in place for all of our operational and support systems. We already have excellent business continuity plans in place, so will ensure this remains to be the case against the backdrop of change to our IM&T portfolio.

3.2. Benefits

Each component of our IM&T strategy includes a number of key changes and projects, for example improving uptake of the e-PRF. By delivering these projects we will transform IM&T in EMAS and deliver the 'future state' vision for 2019 set out in the diagram below.

Transformed IM&T capability



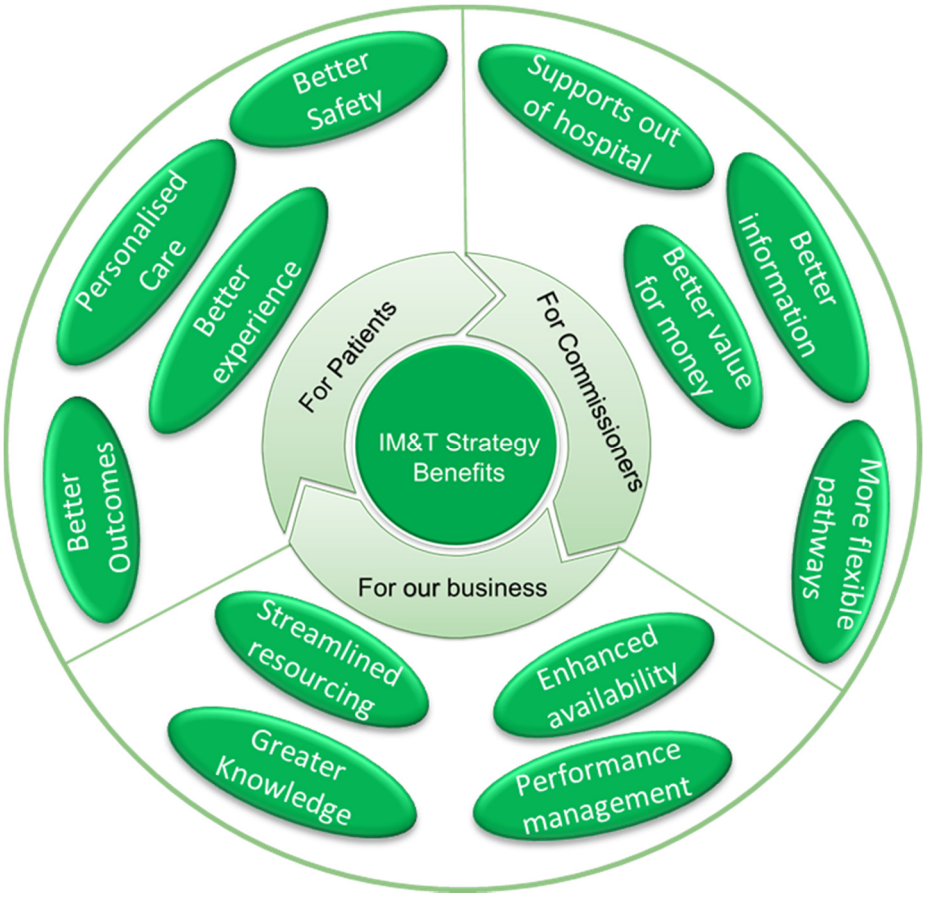
In practice delivery of this strategy means that by 2019 a better IM&T service will:

- **Assist the delivery of better quality and safety:**
  - Staff will have access to all the information they need, when they need it, where they need it (e.g. at the point of care) to ensure they can provide the best possible personalised care for the patient.
  - Information systems will support patient safety – for example through the availability of personal medical information regarding the patient (medications, allergies, current care plans etc.)
  - Integrated information within the Trust and with other providers of healthcare, so that patients experience holistic care. We will have automated links with our partners ensuring the ability to view the whole patient health record where consent is given
- **Enable stronger engagement of patients and service users in service redesign**. We will use a whole range of technologies to enable patients to feedback on the quality of the experience they have had and on their outcomes. This will feed directly into the planning of improved services focussed on the best possible patient experience.

- **Lead to higher productivity** – reducing our costs while still delivering better care for patients:
    - Staff will be able to spend an increasing amount of time directly with patients – we will have redesigned our data entry screens and processes for our electronic patient report forms and we will have minimised any duplicate entry requirement.
    - Ensuring we have linked all of our systems to ensure our vehicle and equipment scheduling is supportive to our front line staff, minimising unavailability and downtime.
- **Provide our leaders with better information to support our business:**
    - The Trust will have a much better record of the work it has actually done – supporting its negotiations with commissioners, and allowing us to provide those commissioners with the information they are looking for to demonstrate the quality and value of our care.
    - Information will be more accurate because clinicians will see it is directly useful for the delivery of their care and will own its accuracy.
    - We will have much stronger information to enable us to understand trends in activity, outcomes, quality, and performance in key areas. Our systems will routinely provide the information we need to support benchmarking of our performance – both within the organisation, and with our peers and competitors.
    - We will have a much stronger capability to 'triangulate' our information, drawing on financial, quality and activity data to ensure a much richer understanding of our business and its performance.
- **Provide our staff with the information they needs** to support them in operating flexibly and effectively to meet the needs of patients - our staff will have the right "information tools" for the job, and will be trained to use them to maximum effect.

Excellent IM&T is not an end itself. Delivering the vision encapsulated in this IM&T strategy will have direct and significant benefits for the patients we serve, the commissioners who are charged with delivering maximum quality and value, and for the commercial and financial performance of EMAS.

Summary of benefits



3.3. Guiding principles

Rapid change brings risk. We have agreed a set of key principles guiding our approach to IM&T which help to mitigate risk. These are:

- A major emphasis on data protection and the security and safety of individual patient data.
- An even greater emphasis in business continuity and disaster recovery – as we become increasingly dependent on IM&T for the operation of our core business it is vital that we have the appropriate safeguards in place to secure our operations.
- 100% data quality – we will have a constant focus on ensuring that our information is accurate, and that its quality is fully owned by the staff who enter it.
- A consistent focus on value for money – recognising that the organisation needs to increase its overall spend on IM&T.
- Deploying IM&T to support service redesign and cultural change to transform the service, rather than simply to automate an existing inefficient system.
- Maximising our capability to integrate our business services within the organisation so we can provide the most efficient internal resourcing.

3.4. Key projects within the strategy

The projects we will run to deliver the benefits set out above are described below.

IM&T strategy component	Project name	Explanation
Operational systems improvement	Airwave replacement	The replacement of the Airwaves radio system which will enable the development of services that leverage new communications abilities.
	CAD re-procurement	Design, procurement and implementation of a robust and resilient replacement for the CAD system. A more modern CAD platform should facilitate tele-health and will offer efficiency gains in the EOC through innovations such as; text back patient follow-up appointments with providers from eDOS; video pre-ambulance arrival instructions to smart phones for callers requiring guidance on self-help; tele-conferencing between crews on scene and CAT; and the use of video streaming of patient conditions / injuries to better support diagnosis.
	Live video (tele-medicine)	As above – online consultations, advice and support.
	Triage (AMPDS/NHS Pathways)*	EMAS needs to decide on whether to replace the existing EOC system AMPDS with NHS Pathways (which is linked to NHS111) or to use both systems – linked to our ability to win NHS111 contracts
	Mobile WIFI hubs (MDT replacement/ upgrade programme)	Upgrade/ replacement of vehicle-based data terminals needed to take advantage of communication advances enabled by new CAD system. EMAS vehicles will become mobile WIFI hubs.
Business systems improvement	ePRF improvement programme	Upgrade to existing e-PRF system, additional change support and dedicated project leadership. Investigating and resolving reasons for low usage rates for e-PRF
	ePRF re-procurement	The national ePRF contract ends in 2015 – this project will see the tendering and selection of a new backend system and the provision of a refreshed client device and software.
	Capacity management	Project to provide real-time information on whole health system capacity
	Enterprise architecture	The design of a Service Orientated Architecture (SOA) and implementation of an Enterprise Service Bus (ESB) to provide full master data management of trust information.
	Email platform re-provision	Upgrade/ re-provision of email
	Remote working and VPN enhancements	Improvements needed to improve electronic communications in poor signal areas and to enhance ability of staff to work remotely
	Scheduling software*	Needed to assist bidding for patient transport tenders
	Information integration engine	Reduces duplicate data entry and enables provision of integrated information – 'one truth'
	Trust Website and Intranet Platform & Design	Redevelopment of the Trust Intranet and Website Platform giving more dynamic functionality and greater flexibility for different device use
	Digital wallboards	
Developing links and information intelligence	e-Directory of Services (DoS)	An electronic DoS is needed to facilitate increased use of alternatives to A&E by ambulance crews
	Direct booking	Would enable EMAS CAT to directly book callers for urgent GP consultations
	Tele-health/ tele-care hub system*	Would support provision of tele-health/ tele-care monitoring service
	Partnership clinical portal integration (e-record sharing)	Enables EMAS crews to access e-patient records belonging to other services
Developing our core IM&T service	IM&T service development project	OD programme needed to ensure IM&T service makes the transition from being purely a technical support service to a support service that can also provide strategic advice and application management and ownership
	Ownership versus leasing	A project to review the risks and benefits of a leasing instead of ownership model for IM&T equipment
	Strengthening PMIT	Extending the role of PMIT to include information management as well as performance reporting
	Extending self-service reporting	Extending self-service reporting across all support systems
	Review of IM&T support provision model	To ensure the Trust is getting the best quality and value for money possible from its IM&T revenue investments.
Sustainability and business continuity	IM&T elements of the EOC strategy – enhancing the ability of the Lincoln EOC to cover the Nottingham EOC and vice versa	The IM&T infrastructures of the systems that support the EOC are not fully resilient. The current programme of remedial work will improve the situation and enable limited operations to be carried out from Lincoln in the event of a failure at Nottingham.
	Rolling equipment replacement programme	EMAS needs to introduce a rolling equipment and software replacement/ upgrade programme
	Standardisation and centralised support	Need to rationalise the number of systems and range of equipment used across EMAS: related need to ensure that all systems are supported by IM&T i.e. there are no 'departmental systems' supported locally in isolation.

*Those items marked with * indicate their support for new Trust business development activity*

3.5. Future state IM&T

As with the trust's overall five year strategic plan the phasing of our IM&T projects means that change will happen in stages.

By the end of **2014/15** all EMAS staff will have anywhere access to core services such as email, roster services and document management. Automated, electronic workflow will become available in high transaction areas to start making paper flow a thing of the past, and where electronic documents are used, it will become significantly easier to locate information quickly, first time, through the use of collaboration services. Some staff, not typically issued with EMAS IT devices, will be able to gain access to basic services, such as email and calendar, via their personal smartphones ('Bring Your Own Device' concept). Staff will have the ability to video link from any place where internet access is available.

Information security will be stronger for sensitive information, but more appropriate levels will be applied for more general information in order to give open access where beneficial. Public networks, such as those offered on trains and in coffee shops will start to play a larger part in access to services such as email and document storage providing greater flexibility as to where staff can work with the right information to hand.

EMAS will continue to be a top performer in IG and at the same time clinicians will have easy but secure access to patient data and clinical protocols allowing them to make the best decisions and offer the best care to our patients.

Our EOC will have the flexibility to deploy staff across at least two IT enabled locations with appropriate business continuity arrangements in place.

Business intelligence systems will offer real time support and guidance to all staff, delivering effective self-service, driving efficiency, and allowing the delivery of performance information (the scorecard) from 'floor to board'. Business intelligence systems will not stop at our boundaries and through health community data sharing this additional knowledge will support our partners improve their own processes. This health community approach will support initiatives such as developing emergency department 'arrival screens' to improve the visibility of resource.

An integrated system to collect and analyse data across incidents, complaints, PALS and claims will be introduced to support a reduction in patient safety incidents.

A number of innovative 'Proof of Concept' pilots will be established, specifically, a pilot for an 'intelligent vehicle' will be underway. Use of the vehicle based IM&T, such as the Toughbook, will continue to be leveraged as a platform to deliver further applications, such as GRS Web, email and e-learning, and at the same time IM&T will review the next generation of vehicle based IM&T to improve the overall experience.

The estate will be transforming and new sites will have additional services including video conferencing, remote training facilities, and digital noticeboards providing dynamic trust information. IM&T provision in these sites will be far greater and options for 'mini-operations-centres' will be available through Smart board and other audio visual technology.

Support arrangements for all IM&T Services will be extended with a new service level agreement agreed and training will ensure greater benefit is realised from the use of technology. Access will be simpler through the developments such as IT self-service, single sign-on, and extended service hours whilst security can remain secure through the use of smartcards and pin numbers.

During **2015/16** and **2017/18** data will be patient centred - anyone delivering care to the patient will have access to their data in the most secure and quickest method possible. Our information will flow with the patient across care boundaries to support the best pathway for that patient. Data will be shared with the patient.

Conveyance rates will reduce through better integration with Primary Care pathways, accessed via the eDoS, and the use of technology to support the remote care of patients in the home. Tele-health advice and Tele-monitoring will become a mainstream service.

Patients contacting 999 will have an improved experience as the flow information between the patient and the EOC is improved. For example patients could receive pre-ambulance arrival instructions direct to their smartphone, and the use of video could better support diagnosis allowing for a more informed choice of care pathway.

The national contract for ePRF will have come to an end in July 2016 and the trust will have by this time procured and implemented the successor to this system. The replacement ePRF will become the computing hub of the intelligent vehicle and provide ancillary systems such as satellite navigation and mobile communications with EOC. The ePRF will also fully integrate across all care sectors providing access to patient history supporting the patient across the full pathway of care.

The Emergency Services Mobile Communications Programme (ESMCP) will already part way through the delivery of the replacement national emergency services network (ESN), replacing Airwave, based on enhanced mobile networks. EMAS will be preparing to migrate to ESN, and to support this, the CAD system will have been updated to provide a unified system for dispatchers. At the same time, the Mobile Data Terminals (MDTs) within the vehicles will be replaced and MDT functionality will be provided within the vehicles new computing system which will incorporate the replacement ePRF.

Handheld radios will also be replaced with commercial smartphone type devices which will interface to ePRF, and other supporting information systems such as Clinical Pathways.

New vehicles will become communications hubs offering access to all EMAS services and, video and data sharing consultation with other professionals. Vehicles will be intelligent with telemetry and real-time monitoring of all vehicle systems to increase efficiency and productivity of the fleet. Through the use of RFID, vehicles will be ‘aware’ of the equipment that is on-board and be able to track and monitor this to ensure compliance with regulation and improve asset management, a significant improvement upon the current ‘passive’ system which requires staff to find and scan items with limited success.

By the end of **2018/19** a significant quantity of IM&T systems will all be remotely hosted by ‘Cloud’ service providers.

EMAS will truly act as mobile urgent treatment service capable of treating more patients at scene so they do not need to be conveyed to hospital. Integrated care and treatment will be possible allowing in the vehicle through very high speed links negating the need to travel. Remote monitoring will allow patients with a greater spectrum of complaints to remain at home reducing the impact to the urgent and emergency care system.

All corporate services will be available anywhere and working mobile or from home with have become the norm.

The number of back office staff travelling to work will be small with many working remotely. EOC staff will have the ability to access the CAD and telephony from home and work flexible shift patterns, including micro-shifts, to cover short term peaks in demand. Our patients will have the ability to elevate a traditional 999 call to video to enable a visual assessment to support determination of the most appropriate response and a series of preparatory

information will automatically be pushed to the patient via SMS or Smartphone Push Messages.

4. Implementation of the Strategy and Monitoring

4.1. Implementation

The IM&T programme will be managed by the Director of Information and Performance, who has responsibility for ensuring the IM&T programme is implemented correctly and with the appropriate resources and services. It is also their role to ensure correct 'end to end' implementations of the new projects, linking clinical change with the requirements of EMAS from an information and performance perspective. The trust will utilise its own internal resource to lead clinical change management, however each project will include additional training and change resource to ensure successful project delivery.

The IM&T programme will be monitored through the trust Better Patient Care Board, ensuring a strict focus on delivery, quality and risk management. We will ensure projects are run to strict PRINCE2 project management principals with appropriate risk, issue and benefit control.

All IM&T developments, procurements and implementations will adhere to information governance requirements and those demanded by the Data Protection Act and Caldicott principals.

Trust and EU procurement methods will be employed when identifying solutions to the IM&T developments contained within this document, and different procurement models will be explored with each development. We will include in each business case the options for procuring through a joint venture, standard purchase (and delivery with incumbent IM&T supplier), outsourced and partnered models.

The trust's board will be assured on delivery of our IM&T strategy and information governance through two routes;

- The Better Patient Care Board reports to the Trust Board;
- The Information Governance Group that reports to the Finance and Performance Committee.

4.2. Implementation timescale

The proposed timeframe for the key projects within this strategy is set out below.

Project timeline

		Deployment Years				
IM&T strategy component	**Project name**	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**
Operational systems improvement	Airwave replacement					
	CAD re-procurement					
	Live video (tele-medicine)		Pilot			
	Triage (AMPDS/NHS Pathways)*					
	Mobile WIFI hubs (MDT replacement/ upgrade programme)		Pilot			
Business systems improvement	ePRF improvement programme					
	ePRF re-procurement					
	Capacity management					
	Enterprise architecture					
	Email platform re-provision					
	Remote working and VPN enhancements					
	Scheduling software*					
	Information integration engine					
	Trust Website and Intranet Platform & Design					
	Digital wallboards	Pilot				
Developing links and information intelligence	e-Directory of Services (DoS)		Pilot			
	Direct booking					
	Tele-health/ tele-care hub system*					
	Partnership clinical portal integration (e-record sharing)					
Developing our core IM&T service	IM&T service development project					
	Ownership versus leasing					
	Strengthening PMIT					
	Extending self-service reporting					
	Review of IM&T support provision model					
Sustainability and business continuity	IM&T elements of the EOC strategy – enhancing the ability of the Lincoln EOC to cover the Nottingham EOC and vice versa					
	Rolling equipment replacement programme					
	Standardisation and centralised support					

*Those items marked with * indicate their support for new Trust business development activity*

5. Strategy Stakeholder Engagement

5.1. Engagement undertaken during development and planned future engagement

During the course of writing this strategy we have engaged with the following groups of colleagues within the trust: IM&T staff; the trust executive team; and EOC management. Following Trust Board approval of the direction of travel shown within the strategy we will extend engagement to clinical commissioning groups, all local providers, Health Watch, suitable local clinical fora and EMAS staff.

5.2. Patient and Public engagement

Engagement with the public and patient representatives will be carried out as necessary for each key IM&T project. This strategy document will be published on the EMAS website.

5.3. Communication of the Strategy

The strategy will be communicated to all appropriate stakeholders through the standard Trust communication channels and an appropriate communication strategy will be devised with the Trust Communications department. The communication strategy for each of the projects contained within the strategy will be devised and executed through the individual PRINCE2 project management boards setup to deliver the required outcomes.

6. Enablers/interdependencies of the strategy

The implementation of this IM&T strategy is dependent on or impacts on a number of other plans and strategies across EMAS. IM&T is dependent upon:

- The Trust IBP and LTFM (Long Term Financial Model)
- The fleet strategy delivering new vehicles which can be equipped with new technologies such as new MDTs;
- The workforce and education strategy providing EMAS staff with the skills needed to effectively use new technology ad with the rights and permissions needed to work more flexibly (e.g. remote working, 'micro shifts' etc).

The IM&T strategy will enable EMAS to:

- Improve quality as set out in our clinical and quality strategy;
- Deliver the EOC strategy;
- Transform the way we use buildings as set out in the estate strategy;
- Win new business as set out in the business development plans and the integrated business plan.
- Educate our staff using the latest technological solutions

7. Quality and Governance

All IM&T projects set out in this strategy will be approved through the trust's business case approvals process which includes consideration of the impact on quality, outcomes etc.

For each of the projects listed within this strategy, a quality impact assessment and patient outcomes assessment will be undertaken as part of the development of the appropriate business case and will be scrutinised as part of the approvals process.

The project initiation document for each of the projects will clearly define the appropriate metrics and key performance indicators to be used to assess both the implementation of the project and the impact of the desired outcomes resulting from it.

The overall impact of the strategy to the trust and to patient outcomes will be measured by through the strategy oversight governance, the Better Patient Care Board.

8. Finance

The key headline financials of the IM&T Strategy are:

- Total capital investment over 5 years totalling £9.86m;
- Total additional revenue requirement over 5 years totalling £2.58m.

Existing financial assumptions/previous assumptions:

- Through the creation of the IM&T strategy, the capital investments shown within the finance profiles are the proposed new capital programme requirements (replacing existing assumptions);
- The revenue implications shown are in addition to the existing IM&T / system cost envelope, however national sources of funding for the replacement ePRF system may enable these costs to be reduced, dependent on national agreement to disseminate centrally held funds currently funding the nationally provided solution;
- All costs provided within the IM&T Strategy are best-effort estimations, with full and final costs only becoming available on production of the individual business cases required for each of the key projects.

The estimated costs of the IM&T projects set out above are shown in the table below.

Financial implications

		Funding Capital					Funding Revenue				
IM&T strategy component	**Project name**	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**
Operational systems improvement	Airwave replacement				£1,000,000						
	CAD re-procurement			£1,000,000	£1,000,000			£250,000	£250,000	£250,000	£250,000
	Live video (tele-medicine)		£150,000	£150,000	£50,000			£5,000	£25,000	£25,000	£25,000
	Triage (AMPDS/NHS Pathways)*		£1,000,000					£50,000	£50,000	£50,000	£50,000
	Mobile WIFI hubs (MDT replacement/ upgrade programme)				£250,000	£250,000				£50,000	£50,000
Business systems improvement	ePRF improvement programme	£233,000	£150,000								
	ePRF re-procurement		£750,000	£750,000				£100,000	£100,000	£100,000	£100,000
	Capacity management		£50,000	£50,000							
	Enterprise architecture		£500,000					£75,000	£75,000	£75,000	£75,000
	Email platform re-provision		£250,000								
	Remote working and VPN enhancements		£50,000	£50,000				£0	£0	£0	£0
	Scheduling software*	£250,000	£250,000				£50,000	£50,000	£50,000	£50,000	£50,000
	Information integration engine		£75,000	£40,000							
	Trust Website and Intranet Platform & Design		£90,000		£40,000						
	Digital wallboards	£50,000	£250,000								
Developing links and information intelligence	e-Directory of Services (DoS)	£10,000									
	Direct booking										
	Tele-health/ tele-care hub system*										
	Partnership clinical portal integration (e-record sharing)		£100,000	£100,000	£100,000						
Developing our core IM&T service	IM&T service development project	£150,000	£150,000	£150,000	£150,000	£150,000	£0	£0	£0	£0	£0
	Ownership versus leasing		£75,000								
	Strengthening PMIT						£50,000	£50,000	£50,000	£50,000	£50,000
	Extending self-service reporting										
	Review of IM&T support provision model				£75,000						
Sustainability and business continuity	IM&T elements of the EOC strategy – enhancing the ability of the Lincoln EOC to cover the Nottingham EOC and vice versa	£100,000	£150,000					£50,000	£50,000	£50,000	£50,000
	Rolling equipment replacement programme	£150,000	£150,000	£150,000	£150,000	£150,000					
	Standardisation and centralised support	£100,000	£100,000	£100,000	£100,000	£100,000	£50,000	£50,000	£50,000	£50,000	£50,000

This strategy will require approximately £9.86m capital spend over the life of this plan. The three most significant components of this are the replacement CAD, replacement Airwave and replacement ePRF systems.

The net revenue cost impact of this strategy will be to increase IM&T costs by £2.58m over the lifetime of the strategy.

Transforming our IM&T capabilities will inevitably add to the overall costs of the organisation. This strategy will lead to IM&T becoming a central component of most clinicians' working lives, core to the delivery of our patient pathways and to the business of the trust. By 2018/19 we will have far more users, using many more systems, much more of the time. Systems, technology and support costs will all need to change to reflect this. We will also potentially lose the benefit we currently have of receiving some systems as a nationally funded 'free good' (although we may receive additional funding to reflect this cost pressure). However, the productivity benefits resulting from these new IM&T systems will be high, and have the potential to outweigh additional costs. Those benefits could be realised through the cost improvement and service development plans of the divisions – the trust board will need to decide what proportion of productivity gains to take as 'cash releasing' savings and what proportion to reinvest in the service .

It is essential that productivity benefits are not 'double counted' – and for this reason, this strategy does not set out specific savings outside the IM&T budget. Specific savings and financial cost benefit analysis will be developed as part of the business case process for each IM&T project.

It is important to note that the financial position discussed within this IM&T strategy has been undertaken within the bounds of the current ICT budget arrangements and does not include all other ICT/IM&T dispersed support staff and budgets.

9. Risk Analysis

9.1. IM&T strategy risks and management

Risks associated with the delivery of the projects within this strategy will be managed using the trust's risk management structures and processes such as the use of local risk registers and the board assurance framework (BAF) which are reviewed by the executive team and the trust's board.

The main risks in relation to the delivery of this strategy and how we will mitigate these risks are set out in the table below.

IM&T strategy implementation risks and risk mitigation

Risk	Risk mitigation
Securing appropriate funding to deliver the IM&T Strategy (capital Investment and ongoing revenue)	Tight programme management of implementation, and ensuring project management approach is robust, with direct front-line clinical engagement at an early stage.
Market risks in relation to the availability of suitably skilled IM&T and information staff to deliver our plans	Engagement with recruitment agencies. Training of existing staff.
Potential for cost over-runs and potential double counting of savings	The strategy has used conservative assumptions on costs. Each individual development of significance within this strategy will have its own full business case carefully exploring the detailed costs and benefits. This strategy has excluded any assumptions on divisional savings in order to avoid any double counting.
Procurement risk, following business case generation there is a risk that the procurement process is unmanaged or does not follow EU regulations	We will ensure all procurement requirements are handled by the EMAS procurement team, following strictly the Trust and EU regulations in line with due tendering process. The trust will form 'tender groups' for all appropriate tenders, ensuring wide engagement and a substantial cross-section of skills and views are incorporated.
Lack of clinical/staff ownership of the strategy – and cultural resistance to change	The strategy is firmly based on providing staff with tools which will support them to provide better care. There is a wide acceptance within the trust of the need to redesign services and use IM&T to support productivity and quality.

There is a risk that the implementation of the IM&T strategy is not correctly resourced, resulting in failed implementation of one or many projects	The Director of Information and Performance has strategic and operational posts within their structure to ensure effective programme delivery
Projects failing to deliver the benefits identified	Each project will be developed into a full business case that includes a focus on benefits realisation planning.
Risk that the pace of change is too great for the organisation to accept culturally, leading to projects failing to deliver the benefits identified	Continued alignment with interdependent strategies and the Trust IBP, working with a proactive communications programme to ensure key stakeholder engagement
Resistance to change	As with any change, we must recognise the importance of involving our staff from the outset. This includes listening and understanding the work which they undertake and also performing a full requirements gathering exercise to scope each project accurately.

9.2. Financial Downside Mitigations

To ensure long-term viability of the investments contained within this strategy it is important to identify the process to be enacted should reduction in the financial envelope for delivery be necessary. This strategy contains two elements of funding, which undertake specifically different tasks.

- Capital investments – used to implement new projects and enhance existing systems;
- Revenue investments – used to support the existing infrastructure both with contracts and staff resources.

In a potential downside scenario where (for example) a 10% reduction in both capital and revenue be sought, the following process would be enacted.

- Capital investments – an assessment of the contractual commitments (legally binding) would initially be undertaken to ascertain the minimum financial and contractual commitments at that moment in time of the programme, then the remainder of the programme would be re-prioritised within the available cash envelope, working within the principal that investments are primarily to support the realisation of our vision and strategic objectives. Following re-prioritisation, the re-worked plan would be proposed through the re-drafting of the capital programme and this IM&T strategy. In addition, the revenue consequences of the re-profiling would be required to be identified and implemented within the annual review of our financial plans;
- Revenue investments – in the scenario where (for example) a 10% reduction of IM&T revenue funding was sought, the existing IM&T support infrastructure would be reviewed. Market testing of IM&T functions could be undertaken to ascertain potential savings and viability in addition to the aforementioned activity.

9.3. Sensitivity Analysis

In order to ensure long term sustainability of the implementation of the IM&T Strategy within the Trust, initial analysis of the impact to the IM&T Strategy of future potential business downside events should be undertaken. Three potential business downside events have been included below;

- Failure to secure new business in line with IBP – the strategy contains several key projects that support the new business growth. These key projects are identified in this document by means of a *, highlighting their relationship to new business. In each business case development for those specific projects risk analysis should be undertaken prior to commencement to ensure that the business developments are secured.

- Potential loss of core 999 and urgent care services for one county - throughout the duration of this IM&T strategy there are significant organisational investments in systems and technology that will be made available Trust-wide. In each procurement and implementation there should be flexibility built-in to each contract award and financial agreement to ensure that downsizing as well as upsizing our Trust requirement is able to be undertaken.

- Change in national performance standards - any potential future change in performance standards at a local or national level have significant consequences for the systems and services implemented throughout the duration of this strategy. All system procurements and support services must be designed in a way that enables flexibility in software setup and design, allowing future changes to be implemented and monitored easily. Appropriate support contracts should be put in place to ensure that any system-specific updates are available from the system suppliers in a timely manner also.

9.4. Risk log management

The individual project risks will be managed in line with PRINCE2 project management principals, escalating their levels when required through regular review, and transferring them onto the appropriate departmental, corporate or BAF risk registers as required.

9.5. How risks will be monitored and implementation of mitigating actions

All risks related to the IM&T strategy will be monitored by the Better Patient Care Board as the oversight group for the implementation of the strategy, however each individual PRINCE2 project board that is setup to manage the implementations contained within, will review, manage and scrutinise all project-level risks.

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

13 January 2015

Agenda Item: 7

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

1. To introduce the Joint City and County Health Scrutiny Committee work programme.

Information and Advice

2. The Joint City and County Health Scrutiny Committee is responsible for scrutinising decisions made by NHS organisations, and reviewing other issues which impact on services provided by trusts which are accessed by both City and County residents.

3. The draft work programme for 2014-15 is attached as an appendix for information.

RECOMMENDATION

1) That the Joint City and County Health Scrutiny Committee note the content of the draft work programme for 2014-15.

Councillor Parry Tsimbiridis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Joint Health Scrutiny Committee 2014/15 Work Programme

10 June 2014	• **Intoxicated Patients Study Group** To consider the report and recommendations of the Intoxicated Patients Study Group • **Terms of Reference and Joint Protocol**
15 July 2014	• **Developments in Adult Mental Health Services** To receive information about developments in adult mental health services (Nottingham City CCG/ Nottinghamshire County CCGs/ Nottinghamshire Healthcare Trust) • **NUH Performance Against Four Hour Emergency Department Waiting Time Targets** To receive the latest performance information (NUH) • **New Health Scrutiny Guidance** To receive briefing on the new Department of Health guidance on Health Scrutiny
9 September 2014	• **Greater Nottingham Urgent Care Board** To consider the progress of the Greater Nottingham Urgent Care Board (Nottingham City CCG lead) • **Patient Transport Service** To consider performance in delivery of Patient Transport Services (Arriva/ CCG lead) • **NUH Pharmacy Information** Information received as part of ongoing review (Nottingham University Hospitals/CCG) • **NHS 111 Performance** To receive the latest update on workforce change implementation (Nottingham City/Nottinghamshire County CCG)

	• **New Health Scrutiny Guidance – Key Messages** Further discussion
7 October 2014	• **Intoxicated Patients Review** To consider the response to the recommendations of this review (NUH) • **Developments in Adult Mental Health Services** To receive information in relation to the consultation response (Nottingham City CCG/ Nottinghamshire County CCGs/ Nottinghamshire Healthcare Trust) • **Mental Health Services for Older People** To receive information in relation to the consultation response (Nottingham City CCG/ Nottinghamshire County CCGs/ Nottinghamshire Healthcare Trust) • **Response to Pressures in the Urgent Care System** To consider immediate and medium-longer term planning to address pressures and demands in the urgent care system (TBC)
11 November 2014 **CANCELLED**	• **Out of Hours Dental Services** An initial briefing following concerns raised at the 9 September committee (Nottingham City CCG, others TBC) • **Royal College of Nursing** Further briefing on the issues faced by nurses (RCN)
9 December 2014	• **Out of Hours Dental Services** An Initial briefing following the concerns raised at the 9 September committee (NHS England) • **Daybrook Dental Practice – Apparent Breach of Infection Control Procedures** (NHS England) • **Royal College of Nursing** Further briefing on the issues faced by nurses (RCN)

13 January 2015	• **NUH Environment & Waste** Initial Briefing (Nottingham University Hospitals) • **Primary Care Access Challenge Fund Pilots** Pilot outcomes and next steps (South Nottinghamshire CCGs and Area Team) • **East Midlands Ambulance Service - New Strategies** Initial briefing (EMAS)
10 February 2015	• **Eye Casualty** (NUH) • **Third Sector Organisations briefing** (HWB3)
10 March 2015	• **Patient Transport Service** To consider performance in delivery of Patient Transport Services (Arriva/ CCG lead) • **NUH Pharmacy Information** Information received as part of ongoing review (Nottingham University Hospitals/CCG) • **NHS 111 Performance** To receive the latest update on workforce change implementation (Nottingham City/Nottinghamshire County CCG)
21 April 2015	• **Urgent Care Winter Pressures – Future Planning** To receive the latest update on lessons learned from winter 2014/15 (Nottingham University Hospitals)

To schedule:

NHS 111 – to consider outcomes of GP pilot and performance following workforce changes
Nottingham University Hospital Maternity and Bereavement Unit
24 Hour Services
Outcomes of primary care access challenge fund pilots
Impact of changes to adult mental health services and mental health services for older people (early summer 2015)
Responses to Pressures in the Urgent Care System (Teresa Cope and Nikki Pownall) - April

Visits:

EMAS
Urgent and Emergency Care Services (various dates)

Study groups:

Quality Accounts
Waiting times for pharmacy at Nottingham University Hospitals NHS Trust (review now taking place as part of the committee meeting rather than via study group sessions)