SCAS OPERATIONAL PLAN 2016-17

1 ACTIVITY PLANNING

1.1 Overview of SCAS services

SCAS offers a range of services, with contracts across a number of care systems:

	Emergency 999	HCP / urgent transport	Patient transport	NHS 111 services	Healthcare logistics	Commercial training	Clinical hub services
Thames Valley	Annual contract	Annual contract	Contracts with CCGs+OHFT until 2021	Contract review 2017	OHFT until 2021 OUH to be reviewed 2016	Ad hoc	
Hampshire	Annual contract	Annual contract	Contract until 2019	Contract until 2017		Ad hoc	
Milton Keynes	Annual contract	Annual contract	Contract until 2020			Ad hoc	
Bedfordshire				Contract review 2016			
Luton				Contract review 2016			
Cambridge, Peterborough and W Suffolk				Planning to tender 2016			
Surrey			Tendering in process				
UK							Pandemic flu service

1.2 Assessment of activity in 2016-17

1.2.1

Service	Growth assumption	Notes
999 Incidents	2.4% in total incidents	Increased acuity experienced in 2015-16, with growth of 7-8% in red demand but reduced proportion of green calls
999 Hear and Treat	Increase from 9.4% to 10.6%	
999 Emergency Responses	Zero growth 2016-17 3% growth thereafter	
NHS111 services	3% each year Assume contracts renewed	Most capable provider assessment during 2016-17 for the Thames Valley Services
Patient Transport Services	Zero growth in existing PTS New contracts mobilising 16-17 Assume new contract 2018-19	We will mobilise a new contract in 2016-17 in North Hampshire. This is equivalent to about 30% increase in activity for Hampshire, with activity previously delivered by a competitor.
Commercial Training	Plan does not assume growth	Review of existing contract to be undertaken during 2016-17

Healthcare Logistics	About 20% reduction in activity	Berkshire has taken their logistics and pathology services in house. This will reduce our activity by about 20% and involve TUPE of some SCAS staff to the new organisation.
Clinical Hub Services	OneCall to stop	No activity for OneCall after 31 March 2016
	Plan assumes that the national pandemic flu service continues	

1.2.2 Lessons learned from previous years

The growth for 999 incidents in 2015-16 is flat, compared to a 6% assumption in our plan. The main item of difference is the impact of 111 transfers to 999. The prior year comparative was high in the early part of the year.

This year, we have carried out a more detailed modelling exercise, looking at historic trends and different types of activity, for each geographic area.

1.2.3 Changing patterns of demand

Red demand (life-threatening) continue to grow at about 7-8%. However green 999 demand (non-life threatening) appears to be flattening, with callers potentially moving to NHS111 instead.

This has the effect of rising acuity for our 999 service.

1.2.4 Approach to modelling demand and capacity in 2016-17

For 999 and 111, SCAS reviews demand by hour of day and day of week, comparing with the previous week in the last year and adjusting for in-year trends. This is assessed for each local care system, as well as looking across the region. We are also adjusting our forecasts in light of the rising acuity and longer job cycle times associated with longer hospital handover times.

Capacity requirements are modelled based on these demand profiles, for both the telephone-based staff in the Clinical Coordination Centres and road-based staff, providing emergency responses, care on scene and conveyance to hospital.

For PTS, we profile demand according to our contracts. Although transport resources are currently planned manually, we are looking to automate the resources allocation processes.

1.3 Capacity planning

Overall demand forecasts are based on historic trends over recent years. These forecasts are adjusted for the latest changes. For example, the new definitions for Ambulance Quality Indicators (AQIs) have changed anticipated levels of hear and treat, with this activity moving into see and treat.

These demand forecasts are converted into hours required, using a unit hour utilisation linked to performance delivery. Hours required is defined by geographical area (node) for each day of the year.

Again this process has been revised to reflect the impact of recent changes, including the latest AQI definitions, changes to dispatch processes through the National Ambulance Resourcing Programme (NARP) and contractual boundary changes.

Work effective hours available from Trust staff are calculated for each week of the year, utilising the jointly developed Integrated Workforce Plan and Education plan alongside budgeted abstraction planning levels. The gap between work effective staff hours and the requirements for forecast demand is then identified, and cover planned from private providers and agency staff.

1.4 Performance forecasts

Capacity is planned to enable delivery against performance standards, using forecasted demand and workforce levels, alongside known availability of private providers. This delivers sufficient resource capacity to enable performance delivery against both contracts. There remains little contingency in resource to respond to demand spikes or changes in process, such as AQI or NARP changes.

2 QUALITY PLANNING

2.1 Approach to quality improvement

Our quality improvement plan is directly aligned with our organisational values and strategy.

The quality improvement strategy seeks to identify the best practice for each pathway, set out by patient need or condition. This new approach enables us to tailor our care and support to patients, as well as improving service integration with our partners.

A key focus of our strategy is to develop the Trusted Assessor and Trusted Advisor concept, whereby clinical assessments, undertaken either over the telephone or in person, will be accepted by experienced primary or secondary care clinicians.

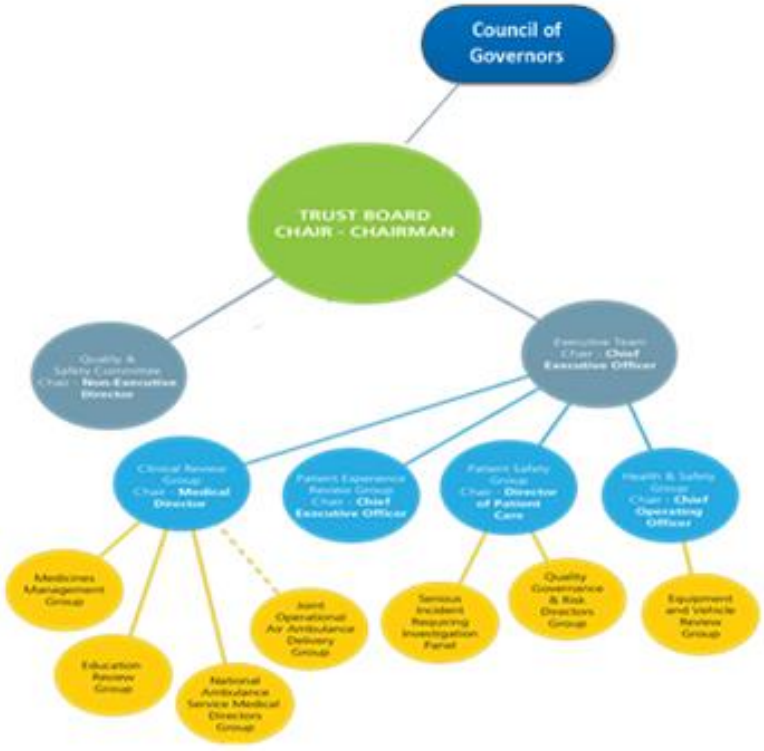
The intention is to develop our Clinical Coordination Centre as a single point of entry to integrated service and seamless pathways across providers. The focus is to increase efficiency in delivering quality care and effectiveness by improving joint working between services.

2.1.1 Improvement methodology

We will support more people in their own homes, by implementing evidence-based practice and by utilising Plan, Do, Study, Act methodology. This will enable us to accelerate our pace of planned change, improve patient outcomes, increase SCAS and partner provider efficiency, generate new ideas using modern technology and enhance joint working with partners.

2.1.2 Quality improvement governance systems

The Executive Director with lead responsibility for quality is Deirdre Thompson. Below is our governance structure for quality improvement.



The Trust received a very positive CQC Inspection Report in January 2015, including observation that SCAS has a 'sound governance system'.

2.1.3 Three quality priorities for 2016-17

We continually strive to improve our services against a wide range of quality and performance indicators, including clinical outcomes and operational responsiveness. Our top priorities for improvement in the next year are:

1. To improve patient safety in the pre-hospital environment, by implementing the National Early Warning Scoring System and piloting a Paediatric Observation Priority Score.
2. To improve on the proportion of patients receiving an emergency ambulance response within 8 minutes and 19 minutes
3. To case manage very high intensity users more effectively, through support, advice and intervention by Demand Practitioners, supported by access to experienced primary or secondary care clinicians 24/7 and care plans

Our Quality priorities are being developed from the clinical risk themes emerging through the year. They are also informed by the corporate risk register, integrated performance report, committees' upward reports, engagement of internal and external stakeholders, and other opportunities identified to improve patient care.

These priorities will be confirmed and detailed in the quality Accounts. They will cover all of our services and reflect the national contract requirements.

2.1.4 Three top risks to quality

	Mitigation plans
1. If SCAS cannot recruit, develop and retain enough staff (for the Clinical Coordination Centre or our mobile teams in the 999 or PTS), there is a risk that we cannot provide resilient and sustainable services or innovate to implement our clinical strategy.	Programme underway to become employer of choice, including development of existing staff, introduction of new roles, investment in education and training facilities, international recruitment and activities to improve staff retention. Risk share agreement in place with commissioners to support investment in our workforce.
2. The external and internal financial deficits and constraints have the potential to impact on service delivery by the Trust.	All cost improvement schemes are assessed for the impact on quality, performance and workforce before being approved. SCAS is focussing on supporting more people at home, with right care, first time. This approach benefits both the individual and health economy.
3. The risk of not retaining our existing NHS111 Trust-wide contracts going forward will risk our ability to deliver a fully integrated service to our patients resulting in poor patient outcomes and disabling us from integrating seamlessly with our partners.	We are planning to implement the Adastra system for our NHS111 services, in order to improve our interoperability with other providers, enable a redesigned service model with GP out of hours providers and generally to improve our 111 offer. This is a key part of the changes required to ensure compliance with national requirements and local strategic expectations.

2.1.5 Well-led elements

Our Trust Board comprises Executives and Non-Executive Directors from a wide variety of backgrounds with a wealth of knowledge and experience from healthcare, commercial and other industries. To assure themselves that quality remains at the heart of what we do, the Board draws from information

from a variety of sources, including Leadership Walkabouts engaging with staff and stakeholders, upward reports from groups and committees, and the Integrated Performance report.

The Trust is structured around teams to ensure visible leadership locally and the operational management teams where appropriate mirror to that of the local health economy. The teams are small and are focused on staff development with dedicated team time. Communication with the teams is through a variety of methods, including team meetings face to face, SCAScades of learning, targeted campaigns, via our 'Hot News', newsletters, CEO podcasts and Bright Ideas.

The CQC said *'Governance arrangements were clear and there was an integrated performance report to benchmark quality, operational and financial information. The trust has also identified its quality priorities and could demonstrate progress against these'.*

2.1.6 'Sign up to safety' priorities for 2016-17

We will focus on creating a continuous learning culture that addresses our current failure to consistently learn from incidents and investigations.

In 2016 -17, we will drive forward the five elements of 'Sign up to Safety' and ensure that all our services (999, NHS 111 and PTS) are facilitated by a designated Clinical Governance Lead, who will commit to bringing the five elements to life and to create the right conditions for safer care.

1. Put safety first	Committing to reduce avoidable harm in the Trust
2. Continually learn	Reviewing our incident reporting and investigation processes to make sure that we are truly learning from them and using these lessons to make the Trust more resilient to risks. Listen, learn and act on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are.
3. Be honest	Being open and transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something does go wrong.
4. Collaborate	Stepping up and actively collaborating with other organisations and teams to ensure a sustained approach to sharing and learning across the system
5. Be supportive	Be kind to your staff, help them bring joy and pride to their work. Be thoughtful when things go wrong; help staff cope and create a positive just culture that asks why things go wrong in order to put them right.

We will also revisit our safety improvement plans and refocus on sepsis and falls pathways in particular.

2.2 Seven day services

2.2.1 Progress towards seven day care

SCAS already provides a 24/7 service for 999 and 111 callers, and for urgent transport requests from healthcare professionals. We are also extending the hours of our patient transport services, in line with new contracts.

2.2.2 Improving access to out-of-hours care

A key part of our role is to enable the public to access the most appropriate service available, both during the 'in' and 'out' of hours periods. We are working hard with our partners to achieve this.

There has been, and will be, considerable work with commissioners to ensure that the Directory of Services is comprehensive and up-to-date.

We have introduced mental health and midwifery advisors to our Clinical Coordination Centres, enabling improved assessment and access for relevant 999 and 111 callers. We will continue to extend the coverage of these services in terms of hours and geography, and will also work with partners to enable access to a wider range of specialists.

We are working with local GP out of hours providers to develop a joint service model with NHS111 services, in line with the national specification for integrated urgent care.

2.2.3 Reducing excess deaths at weekends

SCAS already provides a 24/7 service and works hard to provide a consistently responsive and high-quality service. We will work collaboratively with any partner provider seeking to make changes in order to reduce excess deaths at weekends.

2.3 Quality impact assessment process

2.3.1 QIA sub-board process

The Trust has a robust process to assess and manage the impact of our cost improvement programme on quality. In advance of a scheme being agreed, a quality impact assessment is undertaken with a full clinical challenge testing impacts on safety, clinical effectiveness and patient experience.

2.3.2 QIA Board process

The Director of Quality and Patient Care and Medical Director formally approve all cost improvement programmes at the start of each financial year.

2.3.3 QIA monitoring plan

The Director of Quality and Patient Care is a member of the Cost Improvement Board and assesses each scheme, and this is reported to every public meeting of the Board of Directors.

If additional schemes are added within the year, the quality impact assessment process is undertaken as above.

2.4 Triangulation of indicators

2.4.1 Approach to triangulation

Quality, workforce and financial indicators are reported via the Integrated Performance Report monthly to Trust Board. The information is presented by service in an aggregated form.

2.4.2 Key indicators

The key indicators used for each service are national and contractual performance targets, clinical indicators where applicable, complaints, sickness, appraisals, workforce, training, cost improvement and quality impact assessment.

2.4.3 Use of triangulation information

The Board uses this information to target areas of poor performance and also to understand areas of good practice, in order to share learning, to continuously improve quality of care by service area and further enhance productivity.

3 WORKFORCE PLANNING

3.1 Workforce planning

3.1.1 Approach to workforce planning

The Trust undertakes an integrated approach to workforce planning.

Our Integrated Workforce Planning Group (IWP) includes stakeholders from Workforce, Recruitment, Education, Operations and Finance.

In developing our workforce plan, the IWP Group work together to:

- Ensure recruitment and education plans are aligned with the strategic direction of the Trust
- Provide a planned phasing of new recruits into the Trust, ensuring all new recruits are adequately supervised
- Ensure all recruitment streams offer value for money.

3.1.2 Governance process

Our workforce plans are agreed and monitored by our Workforce Development Board. Membership of this Board comprises of accountable Executive Directors, including the Director of Quality and Patient Care. The primary purpose of this group is to oversee and agree our workforce recruitment and development plans.

The annual workforce plan is agreed during the budget setting process by the Board of Directors, who are provided with regular progress reports and, if required, any identified improvement plans.

3.1.3 Strategic link

The majority of the clinical workforce is made up of HCPC-registered Paramedics. We continue to work with Heath Education England (Thames Valley) to plan the workforce needs for Paramedics, and future education commissioning numbers for our students.

While the main strand of our workforce strategy remains the education, development and recruitment of Paramedics, we continue to increase our clinical abilities within our Clinical Coordination Centres.

Clinical Advisors (nurses and paramedics) work in both NHS111 services and Emergency Operations (999) to provide clinical triage, hear and treat services, telephone advice and signposting to the most appropriate service.

Our growing cadre of Specialist Paramedics/Nurses work to enhance See and Treat services, supporting the emergency service and helping to avoid conveyance to Emergency Departments where this is not appropriate to meet patient needs.

3.2 Workforce transformation

3.2.1 Local workforce transformation or productivity programmes

SCAS has recently introduced Specialist Nurse/Paramedic roles and we will continue to develop this workforce during 2016-17.

The role of Associate Ambulance Practitioner will also be launched, providing our workforce with further career progression route to Paramedic roles.

We will:

- consolidate and improve our education and training facilities, with a new purpose built facility in Newbury due to open January 2017.

- review existing arrangements for bank workers, building our capacity across all core services.
- continue to review opportunities for staff who need or want flexible working patterns.
- complete the restructuring our Planning and Scheduling function, work to better align resources with fluctuating demand
- continue to transform our 999 and 111 service in line with our vision for Clinical Coordination Centres responding to '2 numbers, 1 service'.

3.2.2 New initiatives with partners for Five Year Forward View

SCAS will explore further opportunities for joint working and/or rotational posts for our clinical workforce with local healthcare partners.

For example, the introduction of rotational posts with partner agencies enables us to create more attractive posts incorporating advanced skills development and inter-agency working. We are working closely with the Southern Multi-speciality Care Provider Vanguard, and this may enable funding for further roles.

We will also work with clinicians and specialists from partner agencies, with similar benefits for their workforce, as well as progressing towards our vision for Clinical Coordination Centres offering access to a wider range of expertise.

3.2.3 Impact on workforce by staff group

All new initiatives will provide development opportunities for our staff, improve role enrichment and aid improvements in retention.

Qualification Credit Framework (QCF) courses are being introduced by an awarding body called Future Qualifications & Awards (Future Qual). Community First Responders (CFR), Patient Transport and Front line staff will be better able to move between roles, providing career enhancement and progression at the same time. The QCF awards for the new Associate Ambulance Practitioner role should ensure that staff will be able to attend University as Student Paramedics.

The introduction of Future Qual enables the Trust to prove the Care Certificate competencies and provide academic status for Vocational Education, which will ensure external bodies can rate our learning and staff alongside other NHS department and staff grades.

3.3 Workforce supply

3.3.1 Local education and training plans

SCAS meets regularly with Health Education England (Thames Valley) to ensure adequate workforce numbers are trained and they support the University education of our staff.

SCAS has a vibrant Learning Beyond Registration (LBR) programme for both Band 1-4 and post-registration education. We have high numbers of apprentices across many departments and grades.

These initiatives help ensure a sustainable existing workforce, as well as development opportunities for new staff.

3.4 Quality and safety

3.4.1 Triangulation to identify areas of risk

Workforce updates (including escalation of identified risks) are provided via the Trust's Quality & Safety Committee (which is a sub-committee of the Board). Progress, issues and risks are also reported through to Risk, Assurance & Compliance Committee, as part of the Board Assurance Framework.

Quality, workforce and financial indicators are reported monthly via the Integrated Performance Report to the Board of Directors. The key workforce indicators include recruitment, attrition, sickness, appraisals and training. The Board uses this information to identify whether the workforce plans are in line with forecasts. Any resulting remedial action plans are agreed by the Workforce Development Board, with progress monitored and reported to the Board of Directors and its sub-committees.

3.4.2 Quality impact assessment for all workforce cost improvements

The Director of Quality and Patient Care is a member of both the Cost Improvement and Workforce Development Boards. Cost improvement programmes are reported and monitored by the Board of Directors.

3.5 Flexible staffing

3.5.1 E-rostering

We have introduced systems for staff to book leave and overtime on-line.

During 2016-17, we will review the IT system used by the Scheduling Department, in order to facilitate further improvements and make progress towards e-rostering.

3.5.2 Reduced reliance on agency staff

We are setting up a new system for coordinating our private providers, which is regarded as a managed service rather than agency use.

We are also expanding our bank workforce and improving the system for coordinating these resources, as well as reviewing the employment terms and conditions for staff who wish to work flexibly.

3.5.3 Balancing agency rules

The new system used to co-ordinate private providers is fully compliant and supported by NHSE. It is regarded as a managed service provision and therefore outside of the new agency framework.

One of the agencies currently used by SCAS will be fully reviewed for compliance, once the framework is finally published.

3.6 Workforce risks

Workforce is a key item on our corporate risk register, which is monitored on a monthly basis.

Competition to recruit and retain skilled clinical staff, both in our Clinical Coordination Centres and for our mobile workforce remains one of our key challenges. We continue to develop new and innovative solutions to the recruitment challenge, including the launch of dedicated recruitment website, rebranding of our recruitment materials.

4 FINANCIAL PLANNING

4.1 Financial forecasts and modelling

Despite several years of austerity and large cost reduction programmes, the financial outlook is one of more of the same. Whilst there has been a relaxation in the cost savings requirement as part of the tariff inflator, there is a need for SCAS to continue to deliver significant cost savings in order to improve the financial position. We expect there to be a continuing tough stance on public sector pay, but with expectations of increases in private sector pay above the level of inflation, and increasing pay expectations for ambulance staff.

In order to improve the consistency of the plan across different areas of SCAS, a workshop was held in October to identify improvements. They mainly relate to the closer working to ensure finance, resourcing, recruitment and training budgets are all using consistent assumptions. These have been tracked to ensure the actions are carried out.

4.2 Efficiency savings for 2016-17

The environment outlined above is one of increasing costs to deliver the 999 service, which have already impacted in 2015-16 and will increase in 2016-17, a challenging health system environment and continuing tight 999 resource market leading to further costs from development and training.

Our response is in four main areas:

- Continue to press ahead with the strategy and initiatives contained within it
- Continue to deliver CIPs, and maintain them to 3.8%, above the 2% assumed in the deflator
- Get agreement for a change in funding formula from CCGs reflecting the increase in red calls, and to get funding for or get an amendment to the recent AQI changes.
- Continue to invest in capital schemes, renewing the vehicle fleet and consolidating much of the estate for training in one location in Newbury.

NHS organisations including ourselves are finding it increasingly difficult to deliver yet another year of savings at 3-5% level. In order to mitigate the risk of non-delivery, we have engaged specialist ambulance consultants (Lightfoot). They will benchmark our performance, review our efficiency and make recommendations for improvement. This will provide more detail on our current CIP plan for next year, and is expected to give us new areas where efficiencies can be made.

The main areas of the cost saving programme are as follows:

- Cessation of the overtime incentive scheme
- Cycle time reduction – using Team Leaders to analyse and then manage the appropriate elements of cycle time
- Response ratio – reduction in the number of resources that are used for each 999 incident
- 999 private provider reduction / bank improvement
- Commercial private provider efficiency
- Commercial crew KPI performance management

4.3 Capital planning

The capital plan supports the clinical strategy, with the main projects continuing to be investment in ambulances and a new education centre, to ensure that clinical staff can progress and develop their clinical skills. A prioritisation process occurs as part of the budget cycle. Non- essential schemes have been removed, and estates schemes have been prioritised with the low priority ones removed.

The main areas of the £8m capital programme are as follows:

- IT – continued investment in this area, supporting the strategic agenda, with various projects, including the move to Adastra for 111, and the improvement of IT at our resource centres.
- Fleet – procurement of 23 front line ambulances, continuing replacement of 999 fleet
- Estates – the largest project is the rationalisation of the education and training centres in the Newbury area on to one site.

5 SUSTAINABILITY AND TRANFORMATION PLANS

5.1 Hampshire and Isle of Wight

5.1.1 Vision for local health and care system

This system is currently developing its overarching vision and has identified 10 'wicked' questions that need to be addressed.

There has already been significant work, with a vision for 'local, better, care' as part of the Vanguard scheme. This is based around creating local hubs offering multi-specialty care in each community.

Localities have an average of 50,000 populations. The aim is to bring together practices that naturally consider themselves to be part of the same community. Therefore, actual populations seem to range from about 25,000 to 110, 000 in size.

Southern Health FT is the lead provider, working closely with local GP practices. There is a short term focus on the setting up hubs in areas where there is an acute shortage of GPs. For the longer term, the focus will be on using this experience and learning to roll out the multi-speciality care provider (MCP) service model across Hampshire, and possibly parts of Surrey.

The Portsmouth and SE Hampshire areas are also exploring ways to address the access issues in their urgent and emergency system, which have raised clinical, operational and financial issues locally, plus a ripple effect across other parts of Hampshire in recent months.

Similarly, the north-mid Hampshire area is concentrating on designing the configuration required in acute services in order to ensure clinical, operational and financial resilience in their system.

5.1.2 SCAS contribution to this vision

SCAS is involved in the Vanguard Steering Group, plus the redesign of services in Portsmouth and SE Hampshire and the design of New Models for Care for north-mid Hampshire.

SCAS is likely to be the provider of telephony and digital access to the multi-disciplinary care models and to direct patients as appropriate to the local hubs. There are tentative discussions in progress about the investment required for SCAS to contribute to the Vanguard service model.

SCAS is increasingly involved with commissioners on contingency arrangements to mitigate risks associated with access to GP out of hours services (complementing the role that Southern Health appears to be playing with regard to areas with fragile GP services in hours).

5.1.3 Key milestones in 2016-17

The milestones need to be developed once the Sustainability and Transformation Plan is available, in at least draft form. It is likely to require the following:

- SCAS to move the NHS111 service to the Adastra system for various reasons: in order to improve interoperability with other providers, to contribute to the Vanguard model of local better care, and to help to mitigate the risks around GP out of hours services, as well as ensuring compliance with the national specification for integrated urgent care.
- SCAS to increase the Paramedic workforce and to develop rotational posts, in order to support both the local hubs and multi-disciplinary home visiting services.
- Expand the Clinical Coordination Centre in Otterbourne, so that the GP out of hours service can be hosted 'under the same roof'.

5.2 Thames Valley

5.2.1 Vision for local health and care system

The vision for Thames Valley is likely to include devolution. Another aspect of the vision may build upon the vision created for this system's recent Vanguard bid, which in turn was build up much of the thinking in SCAS's 5-year strategy.

We expect that the focus will be on coordinating the access to care, and then working collaboratively to ensure seamless integrated pathways of care.

5.2.2 SCAS contribution to this vision

We expect that SCAS will be expected to develop a joint service model between NHS111 and GP out of hours services, and to improve the interoperability and onward referral arrangements with other partners, so that patients benefit from seamless integrated pathways of care.

5.2.3 Key milestones in 2016-17

It is likely that requirements will be similar to those in Hampshire:

- SCAS to move the NHS111 service to the Adastra system for various reasons: in order to improve interoperability with other providers, to improve integration with community services and mental health, and to develop a joint service model with GP out of hours services, as well as ensuring compliance with the national specification for integrated urgent care.
- SCAS to increase the Paramedic workforce and to develop rotational posts, in order to support community and primary care teams.

5.3 Frimley

East Berkshire and part of Surrey have formed a separate system for the purposes of the Sustainability and Transformation Plans. This is likely to build upon the Primary and Acute Care Systems (PACS) Vanguard in this area and developments for the Frimley system.

5.4 Bedfordshire and Milton Keynes

Milton Keynes and Bedfordshire have formed another system. The vision for this area is likely to include a review of the acute configuration.

5.5 Cambridgeshire and Peterborough

The service model for this area was articulated in the recent procurement of community services.

Whilst the Uniting Care Partnership contract has been terminated, our understanding is that this system remains committed to the service model and it is likely to form the basis of the Sustainability and Transformation Plan.

SCAS was sub-contracted by the Uniting Care Partnership to provide OneCall, which is a telephony hub for community services. This arrangement will stop in April 2016, as part of the termination of the overall contract.

At this stage, plans are unclear but SCAS will engage in conversations about how best to proceed.

6 LEADERSHIP, MEMBERSHIP AND ELECTIONS

6.1 Leadership changes in 2016-17

We have a new Chief Operating Office and some new Non-Executive Directors starting in Spring 2016. Over the next year, we will also recruit a new Chair and Senior Independent Non-Executive Director.

6.2 Governors elections in previous year and plans for next year

We did not hold any governor elections last year, but public governor elections are planned for 2016-17. The elections will begin in November, with a view to new governors commencing in March 2017.

6.3 Governor recruitment

We run an aspiring governor programme, comprising material s and events designed to explain the role of governor at SCAS and encourage members to stand to become a governor. This is supplemented with a comprehensive training, development and induction programme for new governors.

6.4 Public engagement

SCAS has an extensive programme of public engagement activities across the Trust, covering a wide variety of stakeholders and communities. We work closely also with our Council of Governors to co-produce events and opportunities to maximise public contact and awareness. Examples of activities to facilitate engagement between the public and partner governors include:

- Public events such as county shows, football matches, shopping centre days
- Talks at organisations such as Dementia UK, patient participation groups, etc.
- Patient Forums .

For staff governors we provide opportunities to engage with both other staff members and the public through a range of activities, including:

- Public-facing events, such as recruitment fairs and 'Open Days'
- Drop-in sessions for all staff members
- Regular updates in staff newsletter.

New initiatives for 2016-17 include developing a new range of communications materials to help improve engagement with the public:

- New staff governors direct email
- Re-launching our public web-site with enhanced governors and members areas;
- Making an ambulance / educational vehicle available, specifically for public and youth engagement
- Governors' quiz for public events
- Revamped videos and PowerPoint presentation for engagement activities.

6.5 Membership strategy

We have a wide range of activities to engage a diverse range of members, having met our membership quota, we are still under-represented in a number of areas, this will remain a priority for the coming year, our membership strategy will include:

- Talks at secondary schools, colleges, universities, local ethnic minority and elderly groups
- Working with organisations such as Healthwatch, young people, elderly and ethnic minority groups
- E-communications to various stakeholders.

New initiatives for 2016/17

- Young people mini-site and videos together with bespoke factsheets and membership form
- Campaign on diabetes aimed at Asian people
- Partnership with Age UK being developed.