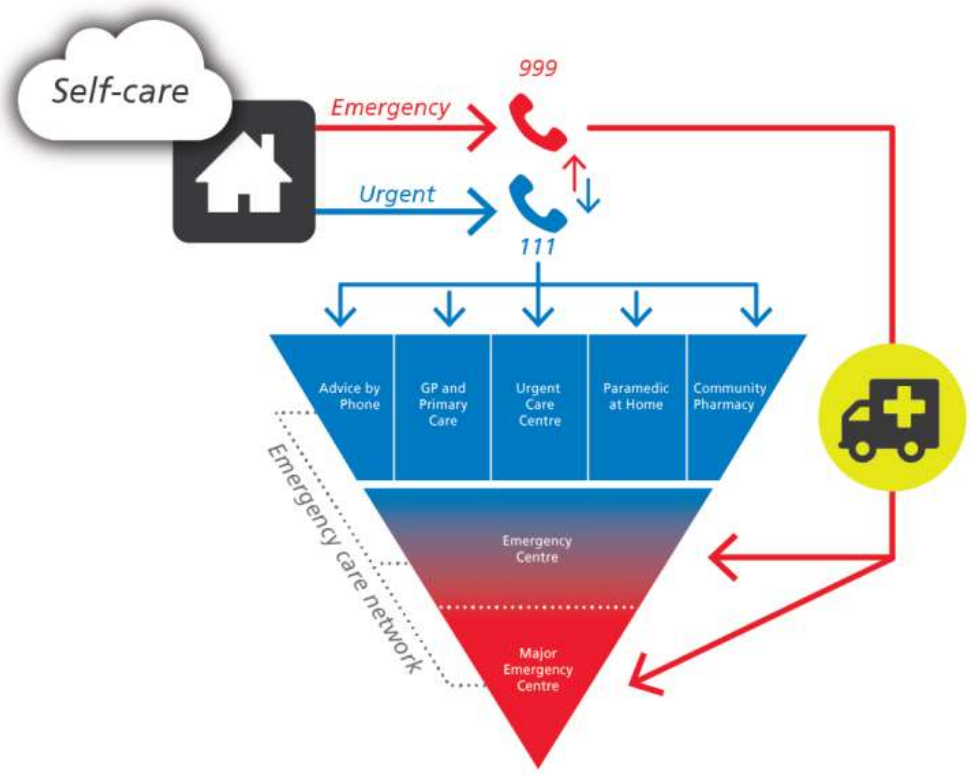
Introduction

This document sets out our plans and priorities for the next two years, both to ensure safe and effective delivery of our current services, and also to continue along our strategic path.

Towards Excellence – saving lives and enabling you to get the care you need

SCAS is more than a traditional (transporting) ambulance service. Increasingly, it is also a critical player in local care systems, offering simplified access to clinical assessment and sign-posting for people who are ill, injured or concerned about their health.

We continually strive to offer the 'right care, first time', tailored to each individual's circumstances and needs, whether this is the immediate dispatch of an emergency team, clinical treatment in your own home, transport between health settings, referral to another service or simply telephone-based advice.



Contents

1 Overview of strategy

1.1 Service strategy

Right care, first time

Past

Future

	SCAS role	*Strategic objectives*
Care Coordination	To enable you to identify and access the care you need	› To develop our assessment, signposting and advice services › To coordinate care across systems, sharing infrastructure with partners
Mobile Healthcare	To save lives and improve outcomes To enable you to stay safely in your home or local community	› To enhance our 24/7 mobile healthcare service › To offer person-centred care, coordinating services with health, social care and voluntary partners
Patient Transport	To enable you to travel safely between home and care settings	› To modernise and enhance our patient transport services › To offer services to support people returning home from hospital
Helicopter view	To support efficient and effective flow around systems of care	› To transform our analytical capability and capacity › To offer a 'helicopter view' of flows around local care systems

1 Overview of strategy

1.2 Trust strategy

	SCAS aims	*Strategic objectives*
Provider of choice	To secure our competitive position and to win contracts, in order to deliver our service strategy	> To improve clinical outcomes and ensure patient safety > To provide a positive patient experience > To achieve call answer and response time standards consistently
Partner of choice	To ensure right care, first time	> To offer person-centred and locally-responsive pathways of care > To develop and grow our services to meet a range of customer needs > To work with partners to improve pathways across local care systems
Employer of choice	To attract, recruit, develop and retain the workforce to deliver our service strategy	> To lead and engage staff in a culture of learning and improvement > To motivate and enable our people to deliver excellence
Sustainable and dynamic organisation	To ensure sound governance, value for money and a strong financial-standing	> To transform our cost base > To ensure future sustainability by winning viable contracts

2 Programme of change 2017-19

Care Coordination	Provider of choice	Partner of choice	Employer of choice	Sustainable organisation	Maintenance
To win and launch Thames Valley Integrated Urgent Care & NHS111	■	■	■	■	■
To win and mobilise Hampshire & Surrey Heath NHS111	■	■	■	■	■
To trial co-location of OOH GPs in Coordination Centre South		■			
To redesign pathways to support more 999 green calls at home	■	■		■	
To expand Coordination Centre South	■	■	■	■	■
To move NHS111 service onto Adastra	■	■			
To decommission NHS111 for Bedfordshire and Luton				■	
To set up Live Links (video) service	■	■	■	■	
To move onto ICCS DS2000					■
To re-procure 999 CAD					■
To review opportunities and risks for Online NHS111		■			
To review benefits and risks of other technical developments		■			
To enable direct access from CCC into Local Hubs and Community Services		■			
System upgrades					■

Mobile Healthcare	Provider of choice	Partner of choice	Employer of choice	Sustainable organisation	Maintenance
To improve rosters including flexible options	■		■		
To set up Mobile Urgent Care Service	■	■	■	■	■
To prepare contingency plan for OOH in S Hampshire, including face-face service	■	■	■	■	
To consolidate Recruitment and Training into Bone Lane			■	■	
To move into the Tri-Service Resource Centre in Milton Keynes	■	■			
To review service and workforce models	■	■			
To review training efficiency and delivery options			■		
To review training facilities required both short term and after wider training review			■		
To replace training facility at Boars Hill			■		
To expand the role of volunteers and other indirect resources	■	■		■	
To move onto new national radio system (NARP)					■
To respond to national review of Paramedic pay banding			■	■	

2 Programme of change 2017-19

Patient Transport	Provider of choice	Partner of choice	Employer of choice	Sustainable organisation	Maintenance
To mobilise Surrey PTS	■			■	
To stabilise Sussex PTS	■		■	■	
To review and agree PTS business strategy				■	
To redesign processes within PTS Coordination Centre				■	
To re-procure PTS CAD					■
To improve digital platform for volunteers	■			■	

Helicopter View	Provider of choice	Partner of choice	Employer of choice	Sustainable organisation	Maintenance
To provide mananagement information for Commerical Services	■			■	
To provide management information for the Clinical Coordination Centre (CCC)	■			■	
To combine management information to give a complete picture of SCAS incident cycle and flows	■	■		■	
To develop helicopter view, for both internal and external understanding of care systems		■		■	
To increase focus on clinical data (not just activity and time data)	■	■	■	■	

SCAS-wide	Provider of choice	Partner of choice	Employer of choice	Sustainable organisation	Maintenance
To transition to electronic expenses and driver / vehicle checks	■		■	■	■
To realise opportunites and benefits from using ESR more effectively			■	■	■
To move paper files onto eFiling for corporate services				■	
To review medicines management					■
To reprovide estate for fleet maintenance on Battle site (used by 999 and PTS)					■
To deliver cost improvement programme				■	
To implement GRS phase 2			■	■	
To ensure effective eTimesheets in place across SCAS			■	■	

3 Capacity planning

3.1 Demand and capacity modelling

999 Emergency Services

Overall demand forecasts are based on historic trends over recent years. These forecasts are adjusted for the latest changes, including new definitions for Ambulance Quality Indicators (AQIs) that have changed anticipated levels of 'Hear & Treat', with this activity moving into 'See & Treat'.

The forecast activity for 2017-19 was calculated on the basis of actual activity to month 7 of 2016-17. The case mix was then reviewed, extrapolating the increasing 'Hear & Treat' level forward and applying the expected changes from AQIs. These activity assumptions have been discussed and agreed with commissioner during contract negotiations. These demand forecasts are then 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.

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.

NHS111 Service

In a similar manner to the 999 demand, historical trends are reviewed and adjusted for changes in external factors such as service promotion or availability of care pathways. The forecast activity for 2017-19 has been set at 3% in conjunction with commissioners. The expected activity then gets converted into resource required to achieve the national call answer standards. Any gaps in resource availability are fed into the recruitment and training plan, to ensure there are enough staff in place to service the demand.

Patient Transport Services

With our main Patient Transport Services (PTS) secured through tender, the activity forecasts are based on activity plans put forward by the commissioners. The resources were modelled during the tender processes and have been reviewed since, to ensure they continue to provide appropriate cover following the launch of the services.

3.2 Planning assumptions

Clinical Coordination Centre (999 and 111 calls)

111 growth rates have been assumed at 3% for both 2017-18 and 2018-19. For 2016-17, our current forecast is that growth will outturn 1.3% above the prior year.

Urgent and Emergency Field Operations

999 growth rates have been assumed at 3% for both 2017-18 and 2018-19. For 2016-17, our current forecast is that growth will outturn at 3.9% above prior year, which compares to the plan of 2.1%.

Patient Transport Service (PTS)

A key change for PTS is the introduction of two new contracts for 2017-18 (Surrey and Sussex PTS).

Following previous successful mobilisations of new PTS contracts, the Trusts usual project management approach is being followed to ensure that the expansion can be delivered successfully. The activity levels in Sussex are more uncertain due to the transition arrangements.

3 Capacity planning

3.3 Capacity to deliver agreed activity

Clinical Coordination Centre (999 and 111 calls)

SCAS operates two Clinical Coordination Centres (CCC), which are run virtually, with the NHS111 service backed up by a third call centre run by a private provider for resilience (Conduit).

CCC capacity planning is based on the Erlang C model. Demand is modelled using a tool that gets more accurate as it learns from previous weeks and months, and that is translated into call handler and clinician requirements, which are then deployed using the GRS planning and rostering system.

There are no plans to use the independent sector for 999 services but we intend to keep a contract with Conduit, in order to provide resilience in the 111 service. They will provide between 10-20 WTEs, as the picture of demand dictates.

When performance drops, each CCC has a series of pre-planned and rehearsed escalation measures to bring performance back on line.

There is an overarching resilience plan which is tested several times a year when we practice operating from a single site. This is done when we need to change hardware, but also provides real resilience testing in the live environment.

Urgent and Emergency Field Operations

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.

The amount of Agency and Private Provider cover required is calculated on a quarterly, monthly and weekly basis to get the total 999 cover as close to the short term forecast as possible. The forecast is that we will need similar numbers of private ambulances as we have used in 2016-17.

The use of the dynamic planning model means that resources can be adjusted by the week to address shortfalls in the previous weeks. That said, it takes time to mobilise additional crews from external sources, and so the Trust uses well understood and rehearsed immediate escalation plans to make immediate recovery possible.

Each year, some winter funding is made available for additional resources during the winter months. The Trust relies on that funding to increase the amount of private cover that is required during the busy winter months. It has been confirmed that this funding will still be available.

As in 2015-16, during 2016-17 there has been an increase in the proportion of incidents that are in the red category (so acuity is increasing). Funding has been agreed of £1.5m relating to this increase which is a major reason for not achieving the national targets in 2016-17. This is partly to be expected as many patients with lower acuity conditions have started to call 111. A more granular pricing mechanism has been agreed as part of the contract with different prices for red and green see and treat and red and green see treat and convey. The modelling described above takes account of the proportion of red calls.

4 Quality planning

4.1 Approach to quality improvement

In September 2016, the CQC rated SCAS as 'good' overall following an inspection of all services.

Approach to improvement

The Executive Director for Quality and Patient Care leads on quality improvement.

SCAS has a robust Trust-wide approach to ensure compliance across all key standards. Our review, report, action, monitor framework is embedded across all services and corporate functions.

Assurance is gained through reports and monitoring, using a three-tier approach:

1. internal local area
2. Executive Management Committee, Quality and Safety Committee and Board of Directors
3. External assurance by commissioners, Health watch, Health and Overview Scrutiny Committee and the CQC local team reviews.

The bi-monthly Quality and Safety report to the Board of Directors sets out our approach to improving clinical governance and quality.

Governance system

The Board of Directors receives a range of reports on Trust performance, as well as reports from Board sub-committees. In particular, the Integrated Performance Report reviews performance against regulatory and contractual obligations, as well as other indicators agreed with the Board.

Comprehensive Leadership and Compliance walk-arounds by Executive Directors, Non-Executives, Senior Managers and the Head of Compliance provide a vital additional level of assurance.

Independent advice is sought where appropriate, and there have been examples of this.

Capacity and capability

Clinical Governance Leads are aligned to each service and, together with the Trust's Team Leaders, they drive compliance and improvements on an ongoing basis. In addition, the Accelerated Clinical Transformation Programme is led by the Executive Director of Quality and Patient Care.

Clinical improvement strategy

One of the Trust's core values is innovation and continuous improvement, which was recognised by the CQC as being in evidence as a value during their inspections.

The quality improvement strategy seeks to identify the best practice for each pathway, set out by patient need or condition. This 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.

Key indicators on impact and benefit to the local care systems

The key measures used to evaluate the system-wide impact of SCAS investment in quality improvement are the increase in 'See & Treat' and 'Hear & Treat' rates for 999 calls, with a corresponding impact in 'See, Treat and Convey' rates, resulting in conveyance rates to hospitals.

Other ways to measure the system-wide impact of our clinical improvement strategy and plans are the use of alternative pathways into other providers via the Directory of service.

4 Quality planning

4.2 Summary of the quality improvement plan

Compliance with national quality priorities

Benchmarking

SCAS performs well against a wide range of standards and benchmarking analysis.

Key areas requiring improvement include:

Red 1 and Red 2	Emergency response times
Stroke 60	Time to respond and convey to a hyper-acute stroke unit
STEMI	Outcome from acute ST-elevation myocardial infarction
Asthma	Compliance with care bundles
Febrile convulsions in children	Compliance with care bundles
Single limb fractures	Compliance with care bundles

National clinical audits

SCAS is actively involved in the National Ambulance Service Clinical Quality Group, which identifies trends, best practice and works nationally to ensure consistency of methodology and data collection. There is currently a national review of both Ambulance Response standards and Clinical Quality Indicators, intended to replace them with more outcome-focused indicators.

National and local priorities

Seven-day services - SCAS provides 24-hour services, 7 days a week, including Bank Holidays.

Better births - SCAS hosts a Labour Line. This is run by midwives and located in our Clinical Coordination Centre, alongside the call handlers and clinicians for 999 and NHS111 services.

Serious incidents - SCAS has a robust process for investigating serious incidents. An aggregated review of themes, trends and lessons from Serious Incidents, Complaints, Claims and Coroner Hearings is presented to the Trust's Quality and Safety Committee, and also reported to the Board of Directors. The Trust already uses numerous ways to share learning throughout the organisation, e.g. patient stories, case studies, SCAScade to all staff, and Hot News. In 2017-18, we will continue to mature our learning and share recommendations from these incidents.

Infection Prevention and Control (IP&C) - The Trust was rated as 'good' for the fundamental standards relating to infection prevention and control in May 2016. The Trust has comprehensive IP&C policies and procedures, which are monitored locally by Team Leaders and audited by the Infection Prevention and Control Lead. Compliance is reported to the Patient Safety Group. In case of any non-compliance, recovery action plans are reported upwards to ensure improvements are made in a timely manner. Senior Leadership walk-arounds also focus on IPC in all areas of the Trust, both clinical and corporate.

Falls - SCAS is committed to improving its management of fallers, and work has developed over several years. We have a falls risk assessment process, with referrals to community-based Falls teams. The aim is to ensure safety and, when appropriate, to avoid hospital admissions. SCAS is also piloting the use of Hampshire Fire & Rescue to provide a 'pick up' service for uninjured fallers. The pilot will be evaluated in early 2017 and, if successful, implemented across SCAS.

Sepsis - Early recognition of life-threatening sepsis is essential for Ambulance Services to initiate life-saving therapy. In 2017-18, SCAS aims to implement the first pre-hospital early warning tool to enable the early recognition in the community and thereby save more lives. SCAS staff will have the knowledge and tools to recognize sepsis and treat patients, appropriately and with speed.

4 Quality planning

End of life care - SCAS is working to increase support for people at the end of life, whether in their own home or in a Care Home. We will work in partnership with other providers, especially Palliative Care teams. Our intention is to deliver care in line with people's wishes, through use of care plans and by offering clinical support at home to prevent avoidable admissions. We aim to be able to administer medications to keep people comfortable at home.

Patient experience - The Trust aims to respond to patient feedback in a timely manner and to ensure the service is consistently person-centred, responsive, listens and engages with feedback from all sources, in order to enable further quality improvements.

National CQUINs

In conjunction with commissioners, SCAS hopes to develop plans for the three national CQUINs:

NHS Staff Health and Wellbeing – with the aim of improving the support available to NHS staff to help promote their health and wellbeing in order for them to remain healthy and well. This CQUIN enables the Trust to continue the work already started in 2016 -17.

Ambulance Conveyance – with the aim to support the ambulance service to become a community based provider of mobile urgent and emergency healthcare. This CQUIN is aligned to our clinical strategy and will give further focus and impetus.

NHS 111 referrals to A&E and 999 – this aims to increase the proportion of NHS 111 referrals to services other than to the ambulance service or A&E. To achieve this, we need to drive forward the roles of Trusted Assessor and Trusted Advisor, as well as pushing for further enhancements to the Directory of Services, direct referrals rights and booking systems.

Consistency with quality priorities in local STPs

SCAS Clinical Strategy is extremely well aligned with the STPs. Our strategy identifies 16 groups of conditions where we believe there is scope for improvement by looking across services and developing more integrated pathways. Many of the STPs have identified similar condition groups in their delivery plans and workstream structure.

4.3 Summary of quality impact assessment

Governance structure around creation and acceptance of new schemes

Quality improvements and innovations can be suggested by any member of staff through the Bright Ideas scheme. Initially ideas are assessed by the Portfolio Management Office, and smaller initiatives are taken forward on the agreement of the relevant departmental manager.

Bigger schemes (which may be more complex, require investment, extend beyond a single department, or carry greater risk) are assessed through a business case process. For changes to service delivery or quality, business cases are assessed by the Executive Directors, who hold a monthly Executive Transformation Board with dedicated agenda time for project-related matters.

There are also additional review groups that assess particular aspects of schemes and advise the Executive Directors before approval. These include the Quality Impact Assessment process, Clinical Review Group, Senior Operational Management Team, Fixed Assessment Management Steering Group, Cost Improvement Board, Workforce Development Board, and ICT Board.

Additionally, some schemes have to be approved by the Board of Directors, for example if higher levels of investment are required.

4 Quality planning

Quality impact assessment process

The Trust has a robust process to assess and manage the impact of our 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.

The Director of Quality and Patient Care and Medical Director formally approve all improvement programmes, as well as any schemes with an impact on quality.

Monitoring arrangements

SCAS runs a Portfolio Office to oversee the Trusts whole programme of change.

Monthly reports are required from the project managers of all major schemes, providing updates on progress, key issues and risks, plus matters requiring escalation to the Executive Transformation Board. This Board reviews an aggregated report on the key issues and risks across the whole portfolio of change at its monthly meetings.

There is also a separate Cost Improvement Board, as many of these schemes are much smaller and not managed as projects. This Board closely monitors the quality impact, as well as the savings realised, through cost improvement initiatives.

The Executive Director of Quality and Patient Care is a member of both the Executive Transformation Board and the Cost Improvement Board.

Progress against the overarching strategy, agreed programme of change for each year, and the cost improvement programme is reported to the Board of Directors on a regular basis.

We have incorporated progress against the Trust's clinical strategy into the Board report on progress against the overarching strategic plan. This gives the Board of Directors a better overview of clinical and quality improvements across the Trust, to complement the existing reports on specific initiatives.

Key performance metrics

Performance metrics and benefits plans are required as part of the business case process.

Any scheme which impacts on, or has the potential to impact on, key quality indicators, national standards or contractual obligations is highlighted to the Executive Transformation Board by the Portfolio Office.

The Portfolio Office also monitors overall performance against key quality and performance indicators, in case there is an unexpected or unidentified impact of any scheme on service delivery in terms of quality or performance.

Baseline before implementation of change

The Business Information Team works with operational managers and project teams to identify and secure the data required to monitor changes. This includes a baseline assessment prior to the change, specific analysis through the transition period and ongoing monitoring to ensure that benefits are realised.

Whenever possible, SCAS seeks to avoid implementing major change during periods of peak demand or unstable performance. We also endeavour to phase-in changes and to ensure robust fallback plans, ensuring that the risks of any single change are minimised whenever possible.

When pressing deadlines preclude this approach, we assess the balance of risks in managing the business and making the necessary changes. This balance is continually reviewed by the Portfolio Office, with issues or risks escalated to the Executive Transformation Board as appropriate.

4 Quality planning

Oversight of cumulative impact of change

A key role for the Portfolio Office is to oversee the cumulative impact of changes across SCAS. This is done by reviewing the phasing of changes, resource requirements, project dependencies and interfaces, knock-on implications of any delays or other issues, highlighting any double-counting of benefits, and assessing the cumulative risk across the whole programme of change.

4.4 Triangulation of quality with workforce and finance

The monthly Integrated Performance Report brings together indicators on quality, workforce, finance and operational performance.

The Executive Directors meet the Senior Operational Management team on a fortnightly basis to review operational performance, finances and workforce with the senior operational teams.

With the additional monthly reports from the Portfolio Office, on progress, issues and risks across the Trust's whole programme of change, Executive Directors are able to triangulate intelligence on quality improvement schemes and also the impact that other schemes are having on quality.

The Board is introducing further focus on quality and performance metrics to ensure that a whole suite of measures are reviewed together so that the impact of any deterioration in the emergency response times (in light of the contract agreement with commissioners) can be reviewed, and to triangulate quality, workforce and finance. The key indicators are:

- Red performance
- Red and Green long waits
- Performance distribution curves – actual response time for 75% and 95%
- SIRIs
- Complaints
- Unit hour utilization
- Workforce abstractions
- Recruitment
- Financial surplus v plan
- Cost savings delivery

The contract agreement with CCGs includes a focus on transformation with a particular focus on reducing demand and improving performance. Funding for a team focusing on the green calls has been agreed. This team together with CCGs will review and agree projects for either reducing green demand or for treating the demand using alternative pathways either inside or outside SCAS. These schemes together with improvement schemes identified as part of the Lightfoot report will contribute to an improvement in performance standards.

5 Workforce planning

5.1 Approach to workforce planning and modelling

Our plans are designed to deliver continuing workforce improvements, thus supporting:

- Safe and effective patient care and key performance targets
- Workforce sustainability and improving workforce numbers (3-5 years)
- Continued improvement on recruitment, attrition and workforce stability
- Reduced reliance on agency workers and achievement of reductions in agency spend
- Delivery of system transformation plans.

The Trust undertakes an integrated approach to workforce planning across all core areas, i.e. 999, NHS111 and PTS. 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 SCAS
- Phase new recruits into the Trust, ensuring all new recruits are adequately supervised
- Ensure all recruitment streams offer value for money.

5.2 Governance process

Our workforce plans are agreed and monitored by our Workforce Development Board. Membership of this Board is made up of Accountable Executive Directors, including the Director of Quality and Patient Care and staff side representatives. 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 appraised of progress regularly and, if required, improvement plans.

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 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 sub-committees.

5.3 Workforce supply and efficiency through collaboration

The Trust actively engages with Health Education England (HEE Thames Valley), STPs and other local health care providers on the development of robust workforce plans for the Paramedic and clinical workforce.

An inaugural Paramedic Summit will be held in March 2017, the purpose of the Summit is to develop a system-wide strategy for the urgent and emergency care workforce, across the Thames Valley. The Summit will be dedicated to exploring and understanding the workforce needs of the urgent and emergency care sector and to understanding the particular workforce demands from all provider organisations to help formulate the first system-wide workforce strategy. During 2017-18, SCAS aims to expand this venture into Hampshire.

5 Workforce planning

SCAS meets regularly with HEE to ensure adequate workforce numbers are trained and they support the University education of our staff.

During 2017-18, the Trust will explore further opportunities for developing more vocational based programmes for Paramedic education, including the Trailblazer apprenticeship and the development of the Certificate in Higher Education programme. The Trust is exploring opportunities with our blue light partners on apprenticeships for our control centre staff.

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.

5.4 Workforce transformation

Whilst a core strand of our workforce strategy remains the education, development and recruitment of Paramedics, we will continue to increase our clinical abilities within our Clinical Coordination Centres, further developing our assessment, signposting and telephone advice services to meet and exceed the national NHS111 service specification, this may include continued development of integrated service models with GPs, out of hours GPs, community teams and mental health, booking of GP appointments and planned care.

As a mobile health care provider, the Trust will continue to work with local partners to find new and innovative ways to support people in their own homes or local communities. Our Specialist Paramedics/Nurses work to enhance 'See & Treat' services, supporting the emergency service and helping to avoid conveyance to Emergency Departments, where this is not appropriate to meet patient needs.

The Trust is currently undertaking a robust strategy refresh, further exploring our ambition to be provider and partner of choice. Our clinical strategy includes development of 'trusted advisor'. We will continue to deliver against this strategy during 2017-19.

2017-18 will also see the introduction of a national Band 6 Paramedic profile alongside new development framework for newly qualified Paramedics. This provides the Trust with further opportunity to review the skills mix within our service delivery model to ensure we are maximising the potential of our current skills mix, i.e. bands 3, 4, 5 and 6 operational grades, whilst ensuring clear pathways for development and progression.

5.5 Reducing spend on agencies

All agencies used by SCAS are compliant with the framework and national caps. The Trust has made positive progress against the agency spend ceiling and will continue to closely monitor and improve during 2017 and beyond.

The Trust will be exploring the possibilities of further expanding our bank workforce and improving the system for coordinating these resources, including the potential to work with partner organisations on the development of a shared bank.

During Q4 2016-17, the Trust will be trialling a new approach to flexible working within our 999 service, if successful this will continue to be developed and implemented in 2017-18.

6 Financial Planning

6.1 Financial forecasts and modelling

Despite several years of austerity and large cost reduction programmes, the financial outlook is one of more of the same and increasing challenges. 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.

The main financial highlights from 2016-17 are:

- SCAS is expected to deliver a £0.7m deficit, in line with the control total.
- Expected to win/retain the Thames Valley 111 contract
- Won the Surrey PTS contract
- Took over the Sussex PTS contract
- Good CQC rating
- Delivery of £5.7m cost improvements.

Cost improvement programme

The environment outlined above is one of largely flat 999 income, increasing inflation particularly in the form of fuel price increases, 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, at the level of £6.4m or 3.2%, above the 2% assumed in the deflator
- Get agreement for a change in funding formula from CCGs reflecting the increase in red calls to appropriately reward for changes in acuity.
- Continue to invest in capital schemes, renewing the vehicle fleet (using our subsidiary company) and investing in a new combined resource centre in Milton Keynes with the fire and police services, which allows disposal of land.
- Increased income from new commercial contracts in Surrey and Sussex

The main areas of the £6.4m cost saving programme are as follows:

- Changing the agreement with staff on meal breaks away from base.
- Cycle time reduction – using Team Leaders to analyse and then manage the appropriate elements of cycle time
- 999 private provider reduction / bank improvement
- Commercial recruitment replacing private providers
- Reduced cycle time in 111 from the introduction of Adastra
- Improvements in 999 relating to non-productive time
- Benefits from recruitment of 999 staff

Our whole cost improvement programme is quality risk assessed, with sign off by our Director of Quality and Patient Care and Medical Director. If the risk is too great, the project is either stopped or mitigations put in place to reduce the risk. Progress against projects and milestones is monitored at our bi-weekly performance improvement meetings, with the overall progress,

6 Financial Planning

new projects and the quality risk assessment reviewed at our monthly cost reduction Board.

In relation to procurement, we currently publish spend over £25k. We will use the benchmarking information to analyse variances across trusts and drive down costs. Whilst accepting that the Carter report is primarily acute-focused, we are adopting, or have already adopted, several of the methodologies. We have been reviewing and changing our rotas to ensure that our 999, 111 and PTS resource is matched to demand by day of the week, and time of day. We have introduced enhanced more flexible management information (using the Qliksense software). In terms of agency, the ambulance market is different to the acute agency market. Our private ambulances only require a relatively small premium to our own costs and provide a flexible and value-for-money service. However we continue to get more value from these services, and continue to manage other agency within the caps (both absolute and price caps).

The main areas of the £9.4m capital programme in 17-18 are as follows:

- IT (£1.3m) – continued investment in this area, supporting the strategic agenda, with various projects.
- Fleet (£4.2m) – continuing replacement of 999 fleet, with 20 new ambulances and the replacement of the HART fleet
- Estates (£3.8m) – the largest projects are the Newbury training centres and spend on a replacement site following the Battle sale.

The main areas of the £8.4m capital programme in 18-19 are as follows:

- IT (£0.6m) – continued investment in this area
- Fleet (£2.9m) – continuing replacement of 999 fleet, with 25 new ambulances.
- Estates (£4.1m) – the largest project is the £2.9m spend on the Milton Keynes resource centre.

Better use of NHS estate

The main item relating to use of the NHS Estate is the disposal of our property at the Battle site in Reading, which is a joint sale with RBH FT. It is planned that we will exchange contracts to sell this during unconditionally in 2016-17, with the cash proceeds of £5m in 2017-18, and 2018-19.

Sensitivity analysis

The main risks are:

- **Additional 999 resource spend**: the Trust has experienced additional costs in 2016-17 from workforce issues, a higher percentage of red calls, and the changes in the Ambulance Quality indicators. There is a risk that this will continue.
- **Potential CIP non delivery**: the Trust has experienced a shortfall in 2016-17 on its ambitious CIP plans. We have reduced the target for the plan years but there is a risk that this may reoccur.
- **STF Funding** – if the control total is not delivered then no STF funding will be received.

A combination of risks and opportunities has been reviewed, including those listed above which gives net risks of £4.1m.

7 Link to Sustainability and Transformation Plans (STPs)

7.1 Local systems

In 2017-19, SCAS will be delivering services in at least six STP footprints:

System footprint		Ref
Buckinghamshire, Oxfordshire and Berkshire West	BOB	44
Frimley Health	FH	34
Hampshire and the Isle of Wight	HIoW	42
Milton Keynes, Bedfordshire and Luton	MKBL	24
Surrey Heartlands	SH	35
Sussex and East Surrey	S&ES	33

7.2 How the visions in the local STPs will be taken forward in this plan

The vision, leadership, challenges and priorities differ in each STP footprint. As a consequence, the delivery plans and governance arrangements vary across STPs. Common themes include:

Promoting health and preventing illness

Many STPs highlight the role that all partners need to play to achieve a step-change in promoting health, as well as preventing accidents or a deterioration in existing health conditions.

SCAS uses its oversight of care systems to identify citizens who are at risk of needing emergency, urgent or crisis services, whether it is because they already have some unmet need, they are vulnerable for non-health reasons, or they are at high risk of a deterioration or exacerbation in an existing condition. SCAS is working with partners to develop plans for these individuals.

Improving emergency responsiveness

Although SCAS is in the top quartile for response times to life-threatening calls, this is a growing national problem and all Ambulance Trusts are struggling to meet key performance standards, due to rising call demand, increasing acuity of conditions, growing workforce shortfalls, widening career opportunities for Paramedics and pressure on pay rates. The urgent need to address poor outcomes and experiences for patients, plus the workforce challenges, is identified in several STPs.

SCAS is actively involved in efforts, nationally and locally, to address these issues and ensure that we (and other Ambulance Services) can respond appropriately to emergency life-threatening calls.

Integrating urgent care systems

In many STPs, extended primary and community teams are being developed, generally to work on a locality basis and in some cases co-located into a 'hub'. The concepts are very similar but there is considerable variation in the terminology used, the range of services and disciplines involved, the opening hours and referral or access arrangements.

In coming months, SCAS needs to understand the detailed aspirations of the various local 'hubs' and to develop appropriate links. The interface with NHS111 services is likely to be pivotal, and we need to ensure that there is visibility and access to these 'hubs' via the local Directory of Services.

In some areas, we are also likely to develop links between our mobile clinicians and other community based teams operating from the 'hubs'. It is proposed that this could include

7 Link to Sustainability and Transformation Plans (STPs)

development of a booking arrangement for a Paramedic Visiting Service, either to undertake face-to-face assessments or to offer treatment at home.

Care coordination

A Care Coordination or equivalent function also features in some STPs. Building on the infrastructure for NHS111 services, this function needs to interface with the emerging new models for primary and community care and utilise new technologies, with the aim of supporting more people in their own homes and signposting more effectively to appropriate services.

Re-procurement processes are underway in all areas where SCAS provides NHS111 services. This situation creates both opportunities and risks in the development of our Care Coordination function. However, with a backdrop of competitive procurement and such high levels of uncertainty, it is not appropriate to set out plans in a document that will be shared outside SCAS.

Local delivery systems

Several areas are moving towards a local delivery system model for the leadership and governance to deliver the STP vision and plans. The arrangements vary across our geography, with some areas moving relatively quickly to a formal Accountable Care System, whilst other areas are developing much more informal collaborative agreements.

For SCAS, this means that we need to develop effective relationships with a wide range of partners and to offer services that can be adjusted to local circumstances and priorities.

7.3 How STP programmes will impact on SCAS

SCAS contribution to STPs

SCAS is committed to working collaboratively with partners in order to design and deliver seamless integrated services to local communities, in line with the visions set out in each local STP. However, given the extensive use of competitive procurement in our areas of business, SCAS's contribution to STPs will be secured predominantly through the outcome of tender processes.

System-wide approach to Paramedic workforce planning and development

As explained, Ambulance Trusts are already facing considerable and deteriorating pressures with workforce shortfalls and pay rates. At present, SCAS only takes half of 999 callers to hospital, as we have developed mobile clinicians who can assess and treat at scene. Unless we can resolve our workforce challenges, SCAS will have to revert to a traditional service, transporting a higher proportion of 999 callers to hospital, resulting in a significant adverse impact across local systems.

If our local STP plans are successful in reducing emergency admissions and supporting more people in their own homes, they will result in a further increase in the demand for skilled Paramedics. With a shift of care from hospital to community settings, there is likely to be a further increase in demand and a rise in acuity of calls to 999 and 111. The introduction of extended primary and community teams is also creating new roles and development opportunities for Paramedics, which was not factored into historical emergency service workforce plans.

SCAS is hopeful that the system-wide approach to workforce planning through STPs will help to overcome the previous silo-approach, which has been unable to prevent the current challenges.

For the Paramedic workforce, the costs/savings and benefits/risks are felt in different parts of the care system. Therefore, it is critical that we look at the Paramedic pipeline across the care system. With system-wide planning and investment, the Paramedic workforce is a potential enabler and catalyst to the successful delivery of many of the aspirations in our local STPs.

STP	Area	Emergency 999	HCP urgent transport	Patient Transport	NHS111 services	Healthcare logistics	Commercial training	Other care coordination
BOB	Thames Valley	✓	✓	✓	Preferred bidder	✓	✓	GPOOH lead contractor if win NHS111 IUC
HIoW	Hampshire	✓	✓	✓	SCAS until March 2018		✓	STP digital role Potential SPA for partners
MKBL	Milton Keynes	✓	✓	✓			✓	
	Bedfordshire							
	Luton							
3 STPs	Surrey			✓				
S&ES	Sussex			✓				
UK	National				Ad hoc contracts as contingency NHS111 provider			Pandemic flu service

8 Membership and Elections

8.1 Governor elections

Public governor elections were held in late 2016 to fill ten vacancies on the Council of Governors, across all four public constituencies. This followed an extensive campaign to engage with the Trust's membership and encourage members to stand to become a governor. In 2017-18, a further round of public and staff governor elections will be held.

8.2 Governor development and engagement

The Trust has a formal duty to ensure that governors are equipped with the skills and knowledge they require to undertake their role. SCAS has provided:

- a comprehensive and tailored induction programme for all new governors
- access to relevant external training
- further extended its informal 'buddying' scheme between individual governors and NEDs
- the opportunity for governors to tour the Coordination Centres, ride-out with crews, and visit ambulance station, to help support their understanding of the Trust and its business
- regular briefings and bulletins.

The work of the Membership and Engagement Committee has been key to the governor's general duty of representing the interests of the members and the public.

During the course of the year, governors have attended a range of membership recruitment and engagement events, and used other opportunities to meet with Trust members and members of the public to ascertain their views on the Trust.

8.3 Membership strategy

SCAS membership is broadly representative of the area we serve, with the exception of the Asian community where members remain underrepresented in comparison with the population of the South Central region.

The representation in the 14-16 age range could also be improved. This is a common denominator in several other trusts.

Two particular examples of new planned activities that the Trust will undertake in 2017-18 to increase membership in the above categories are as follows:

Engagement with young people

Planned activities will include working in partnership on an educational programme with a secondary school from Bicester and Winchester respectively. The programme will then be rolled out across all colleges and secondary schools in our coverage area.

Engagement with Asian communities

Planned activities for increasing the Asian membership will include delivering a programme of diabetes prevention and control roadshows in Asian communities following a successful pilot event in Aylesbury in 2016.