Strategic Plan Document for 2014-19

South Central Ambulance Service NHS Foundation Trust

Strategic Plan for y/e 31 March 2015 to 2019

This document completed by (and Monitor queries to be directed to):

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Date	**30/6/2014**

The attached Strategic Plan is intended to reflect the Trust's business plan over the next five years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- **The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;**
- **The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;**
- **All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission; and**
- **The 'declaration of sustainability' is true to the best of its knowledge.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	**Trevor Jones**

Signature

Approved on behalf of the Board of Directors by:

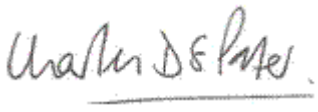
Name *(Chief Executive)*	**Will Hancock**

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	**Charles Porter**

Signature



SCAS STRATEGIC PLAN 2014-19

Executive Summary

SCAS[1] is much more than a traditional (transporting) ambulance service. It is also a clinical assessment and sign-posting service for people who are ill, injured or concerned about their health. We are continually striving to offer the right care, first time for each individual patient.

Looking ahead, the key challenges facing SCAS are to improve the quality and effectiveness of patient care, and to support local systems in managing rising demand, within the context of tightening finances and increased competition. Our vision, strategic plan and the associated transformation programme are designed to enable SCAS to rise to the challenges expected over the next five years.

Vision of SCAS in five years' time

Services

SCAS will help people to identify and access the care that they need. Our Clinical Coordination Centres will provide simplified access for all health and social care, whether someone is in a crisis situation or simply booking an appointment.

SCAS will continue to save lives, with emergency responders dispatched immediately and specialist clinical teams equipped to convey a patient to the most appropriate unit if needed. Our mobile teams will also be available 24/7 to support people in their own homes and local communities, offering advice, assessment, diagnostics and treatment on scene.

SCAS will make proactive welfare calls and monitor the health of people who are frail, at risk of deterioration in their health or who suffer from mental health issues. Our clinicians will work very closely with GPs and other community-based services to keep people safe in their own communities, and we will help to resettle people at home following discharge from hospital.

SCAS has a 'helicopter view' of local systems of care. We will use this unique position to analyse demand patterns, patient flows, clinical outcomes and service gaps. We will work with our commissioners and partners to improve the range and availability of services offered in each local area.

SCAS plans to expand its clinical assessment, signposting and mobile healthcare services into a wider geography. Opportunities will be assessed as they arise, on the basis of strategic fit and compatibility with our core business, as well as clinical, operational and financial viability.

Processes

Our services will be accessible 24/7, either on the telephone or via on-line and digital services. People will be offered high quality clinical assessment, advice and signposting to the relevant services.

We will have rapid, streamlined assessment processes, so that we can identify people in life-threatening situations quickly and dispatch emergency clinicians immediately to scene if needed.

Our services will be underpinned by a comprehensive and up-to-date Directory of Services in each local area, with direct access to care pathways, so that we can offer the 'right care, first time'.

Staff in both our Clinical Coordination Centres and Mobile Teams will be able to access multi-agency care

[1] South Central Ambulance Service NHS Foundation Trust is referred to as 'SCAS' throughout this document.

plans and clinical records, in order to gain an understanding of individual needs and signpost patients to the most appropriate services. Our clinicians will communicate and keep records electronically, and we will also offer these technical facilities to mobile clinicians working for partner organisations.

Organisation

Our Emergency 999, NHS111, Healthcare Professional and Patient Transport Services will work much more closely, so that they can share resources to accommodate peaks in demand, and so that they can tailor the type of response to meet individual patient needs.

We will work seamlessly with GPs, with out-of-hours services either being run or hosted in our Clinical Coordination Centres. We will also host staff with other specialist skills, for example offering advice to people with mental health issues or enquiries about social care.

Our Mobile Teams will include clinicians with advanced practitioner skills, in order to enhance the quality of our clinical assessment, and broaden the range of diagnostics and treatment offered on scene.

Our staff (or at least a sub-set of our staff) will work flexibly in order to accommodate the fluctuating nature of our emergency and urgent business. Our fleet workshops will work extended hours to support our 24/7 service and ensure that the optimal number of vehicles are available during the peak hours.

Tools

These services will be supported by a highly resilient virtual telephony platform.

They will be underpinned by a comprehensive and up-to-date Directory of Services in each local area.

All clinical and corporate processes will use electronic communication and record keeping. Our mobile clinicians will use Electronic Patient Records and have visibility of Summary Care Records.

There will be systems in place to predict demand, to plan capacity and to schedule staff and vehicles, in line with predicted demand.

Our fleet mix is likely to change, with a greater emphasis on cars and smaller vehicles in the future, and this would aim to give a better patient experience.

We will make use of new technological developments, such as tele-monitoring, digital applications, image transfer and mobile diagnostics. We will develop an integrated alert system across care agencies.

Information

Our performance scorecards will draw data from all of our systems, with options to drill down into data by individual or team, as well as giving an overview of the organisation as a whole.

Using the NHS number as a common identifier, we will analyse the wealth of data available to us and offer a 'helicopter view' of local systems of care. We will also seek to compare this data with national and international benchmarking data.

We will analyse demand patterns, patient flows, clinical outcomes and service gaps, and we will work with commissioners to understand service gaps and evaluate plans for improvement.

Contents

1 DECLARATION OF SUSTAINABILITY

1.1 CLINICAL SUSTAINABILITY

The organisation is clinically sustainable. Nevertheless, it has identified areas for improvement and development within its strategy.

The key uncertainties are:	*Mitigations*
• If SCAS cannot recruit, develop and retain enough clinicians, for either the Clinical Coordination Centres or the Mobile Teams, there is a risk that we cannot fulfil our strategic intentions.	There is early work to design a new service model and to create the associated workforce, including innovative training and recruitment campaigns. We already use community first responders for appropriate incidents, and we are exploring other ways for volunteers, military personnel and other emergency services to support our clinicians.
• If any reconfiguration of acute services results in long journeys to emergency departments or specialist units, this risks having a detrimental impact on clinical outcomes for patients with life-threatening conditions and associated reduction in SCAS outcome performance.	SCAS is working closely with commissioners and acute providers in any service redesign activities.
• If there is not a sufficient range of 24/7 and accessible care pathways to meet patients' needs, this risks having a detrimental impact on SCAS's scope to direct patients to the most appropriate care, with the associated risk of increased conveyance rates to emergency departments.	SCAS is working closely with commissioners and partner agencies to ensure that there is a comprehensive and accessible range of pathways available in each local systems of care, helping to highlight any service gaps and identify solutions. SCAS is also working with commissioners to ensure that the local Directory of Services provides accurate and up-to-date information about the services that are available.
• If GPs and other health providers use the electronic communication and patient records that are being developed, there is an opportunity for SCAS to make more informed assessments of patient needs and care plans.	SCAS is currently implementing electronic patient records. We are also working with partner agencies to gain access to summary care records.
• With electronic communication and patient records, there is also an opportunity to use better analysis of clinical performance to identify ways to improve patient care, both by SCAS and across local systems of care.	A key aspect of the strategy is to build analytical capability and capacity, so that we can make use of the wealth of data that we have available to analysis patient flows and service gaps. The intention is to use this analysis to gain a better understanding of our performance and also to offer a 'helicopter view' of local systems.

1.2 OPERATIONAL SUSTAINABILITY

The organisation is operationally sustainable. However, it has identified scope to offer more streamlined services to patients, help to address issues facing the wider systems of care, and to become more efficient in terms of operational delivery. The strategy has been developed to address these factors.

The key uncertainties are:	*Mitigations*
• If demand for unscheduled care grows above commissioner plans, there is a risk that there is insufficient capacity across systems of care. This could have a detrimental impact on SCAS operational performance if the public use 999 and 111 as an alternative option, especially if SCAS does not have sufficient resources in place or there is insufficient capacity in other services to respond to the excess demand.	A key aspect of SCAS's strategy is an increase in analytical capability and capacity, so that we can make use of the wealth of data that we have available regarding demand trends and service gaps. The intention is to use this analysis to gain a better understanding of our own performance and also to offer a 'helicopter view' of the local systems of care. SCAS will use its assessment and signposting services to direct patients to the right care, first time to meet individual needs. This will help to prevent any increase in demand from having an onward impact on Emergency Departments unless appropriate. We will continue to engage with the public and undertake 'misuse campaigns' in attempt to encourage people not to use emergency services inappropriately, and therefore minimise the risk of any increase in inappropriate demand.
• If competitive tendering results in the loss of services in some areas, SCAS would have reduced scope to make optimal use of the resources in that area or to take advantage of economies of scale. This is most likely to have a detrimental impact in rural drive zones, where there is already a single resource and utilisation rates are already low.	SCAS is actively working to build its bidding capability and capacity to increase the chance of winning and renewing contracts. The strategic plan is also to broaden the range of services offered, so that the risks associated with the loss of any single contract are minimised.
• If SCAS cannot recruit, develop and retain enough clinicians, for either the Clinical Coordination Centres of the mobile healthcare teams, there is a risk that we cannot fulfil our operational commitments.	There is early work to design a new service model and to create the associated workforce.
• There is competition to recruit and retain skilled clinical staff, both in our Clinical Coordination Centres and for our mobile workforce. Without sufficient clinicians, SCAS is at risk of having to	SCAS has a workforce strategy and development plan to ensure that we have the clinical workforce required.

convey more patients to emergency departments instead of assessing clinical needs and directing them to the 'right care, first time'.

1.3 FINANCIAL SUSTAINABILITY

The organisation is financially sustainable in its current configuration and service profile.

However, given the predicted growth in demand and reduction in funding, it is prudent to take action to reinforce the organisation's long term financial sustainability.

The key factors that have changed and risks for the future are:

- Potential loss of Patient Transport contracts and exit costs, or reduced margins if renewed
- Increasing difficulty in delivering year-on-year cost improvements and downside mitigations
- Clinical Commissioning Groups are increasingly challenged
- Increased competition

The strategic plan is designed to address these issues and secure financial sustainability.

1.4 EVIDENCE BASE

Clinical evidence

SCAS is performing well against the majority of clinical indicators and national benchmarking data. It has also achieved a 'clean bill of health' from the Clinical Quality Commission.

There are short term action plans in place to improve performance in some areas, including care for patients suffering from stroke or improving use of analgesia for patients suffering heart attack.

Operational evidence

SCAS is performing well against the majority of indicators.

'Time to treatment'[2] and 'Red 19'[3] have been identified as areas needing improvement and it has long been recognised that these response measures are particularly challenging in rural areas with low demand. The strategy of developing new mobile healthcare services alongside our emergency response service should help to address this.

'Recontact rates' and 'frequent callers' have also been identified as areas for improvement. The move to NHS Pathways as the tool for assessing 999 calls should help to address the telephone recontact rates, as patients will not need to call again whilst waiting to be contacted by a clinician. The introduction of electronic patient records and associated access to the local Directory of Services should enable clinicians to ensure that their response is tailored to patient needs, with improvements in both on scene recontact and frequent caller rates.

Financial evidence

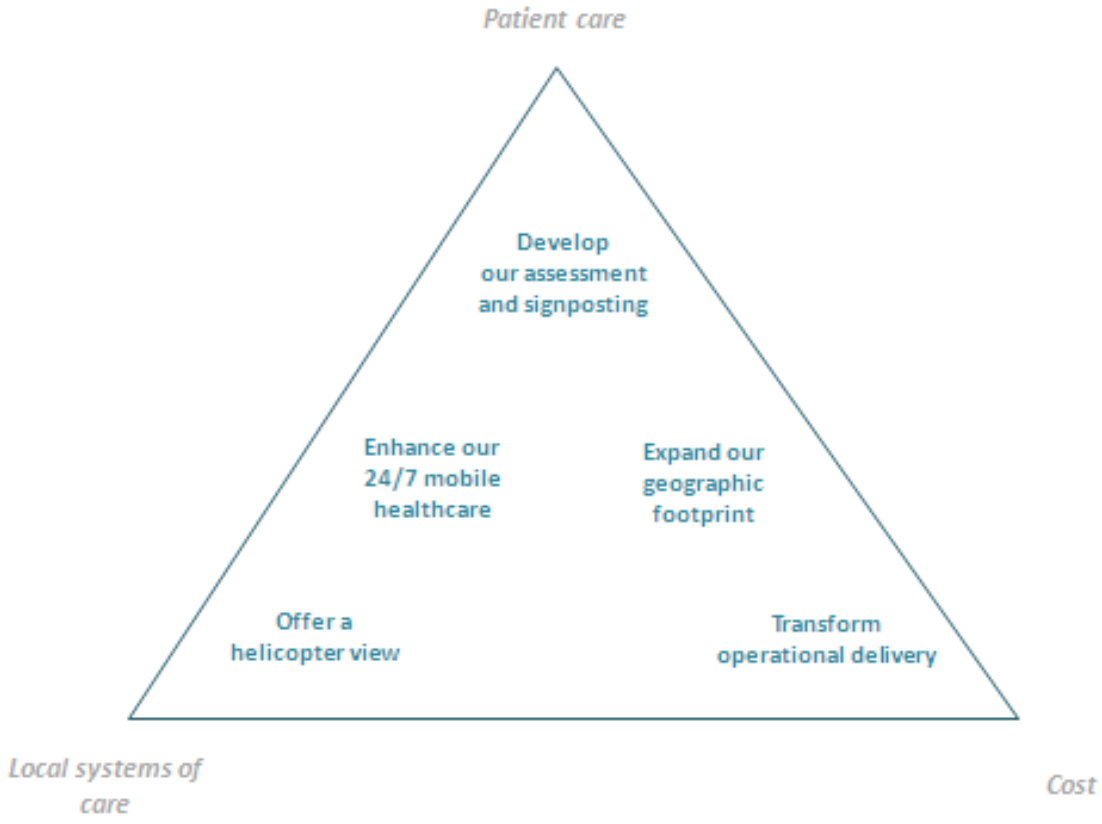
SCAS has an excellent track record in terms of financial performance and is sustainable in its current

[2] Time for first clinician to arrive on scene
[3] Time for conveying vehicle to arrive on scene

configuration and service profile. However, given the predicted growth in demand and reduced funding available, action is required to reinforce the organisation's long term financial sustainability.

1.5 CRITICAL SCHEMES

The key challenges facing SCAS are to improve the quality and effectiveness of patient care and to support local systems to manage rising demand, within the context of tightening finances. The Trust has identified five key strategic schemes, designed both to respond to these challenges and to ensure sustainable high quality services.



The critical enabling schemes to this strategy are outlined below:

- Virtual telephony and resilient technical platform across SCAS
- Ensuring that local Directories of Services are comprehensive, accurate and up-to-date
- Electronic communication and clinical records
- Analytical capability and capacity
- Workforce development (particularly mobile clinicians with advanced skills)
- Technological development (for example tele-monitoring or digital capability)
- Cost transformation programme

2 MARKET ANALYSIS AND CONTEXT

2.1 LOCAL HEALTH ECONOMIES

2.1.1 Current services

SCAS provides a range of clinical telephone assessment and mobile healthcare services across south central England.

These include emergency 999 services in Berkshire, Buckinghamshire, Hampshire and Oxfordshire. We also take referrals from healthcare professionals for urgent clinical transport to and between healthcare settings and, in addition, we hold various contracts for logistics and commercial training services in these counties.

Our urgent NHS111 and non-urgent Patient Transport Services cover a slightly wider geography, including parts of Bedfordshire and Hertfordshire. We have recently taken on some national contracts, including the national resilience for NHS111 during winter 2013-14, the pandemic flu service and managing the legacy organisation for NHS Direct.

2.1.2 Challenges and priorities for each local health economy

We have been working with commissioners and partner agencies to explore the challenges facing each system over the next five years. There are some common themes:

- Manage the growth in demand for unscheduled care
- Integrate services and pathways across health and social care, particularly for the growing frail elderly populations
- Reduce hospital admissions and length of stay, both for patient benefit and in response to tightening finances
- Provide more 24/7 services, with focus on improving the 'out of hours' provision

These priorities have a number of implications for SCAS, and we need to find ways to:

- Enable patients to identify and access the care that they need first time
- Enable more people to stay safely in their own home or community
- Support efficient and effective patient flow around systems of care

We need to redirect 999 and 111 callers to the most appropriate pathway of care, and only to convey patients to emergency departments if it is the best place to respond to their clinical needs.

SCAS is working with local commissioners and other services to ensure that the appropriate pathways of care are in place at the times required. Once developed, it is critical that the various pathways of care are accurately documented and available through the local Directory of Services (DOS), and that SCAS clinicians can refer patients directly onto appropriate pathways.

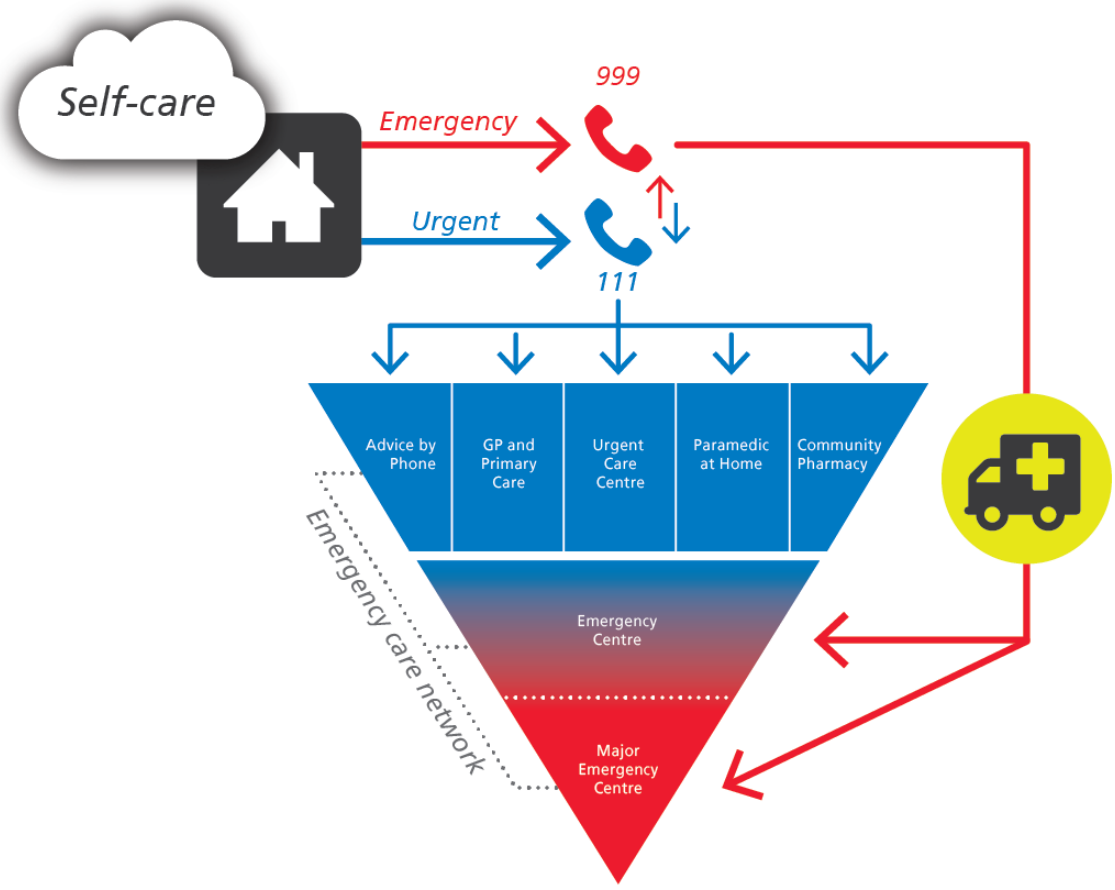
SCAS already has a mobile clinical workforce available on a 24/7 basis. These clinicians are currently available to respond to emergency calls, offering assessment and treatment at scene if this is more appropriate than conveyance to hospital. In response to the challenges facing our local health economies, SCAS is exploring whether this workforce could be utilised to enable more patients to stay at home safely, by offering an assessment and treatment service to urgent calls (not just emergency) and by taking referrals from other health care professionals.

Several health systems in Hampshire are exploring the possibility of 'managed services', adopting a more proactive approach to care for patients identified as being at risk of deterioration or who may benefit from preventative care.

These health systems are also considering a 'lead provider' model, with a single provider commissioned as the lead and others sub-contracted by the lead provider. The aim is to provide more integrated care without necessitating a restructure of provider organisations.

SCAS has recently been awarded the contract to provide Patient Transport Services in the Southampton, Portsmouth and Hampshire areas. This represents a trebling in size of the previous contract held by SCAS in this area. Over the next two years, all other Patient Transport contracts will be subject to competitive tendering. It is also expected that the majority of NHS111 services will be competitively tendered against the new national specification, which is expected in 2014.

2.1.3 National policy and guidance



NHS England has commissioned Professor Sir Bruce Keogh to review the demands on unscheduled care and to make recommendations about how best to respond. The early findings of the 'Urgent and Emergency Care Review' were published in 2013[4] and concluded that we must:

- Provide better support for people to self-care
- Help people with urgent care needs to get the right advice in the right place, first time
- Provide highly responsive urgent care services outside of hospital
- Ensure that people with more serious or life-threatening emergency care needs, receive treatment in centres with the right facilities and expertise in order to maximise the chances of survival and a good recovery
- Connect all urgent and emergency care services together so the overall system becomes more than just a sum of its parts

Emergency 999 and NHS111 providers play a central part in the proposed systems of care, and SCAS has developed its strategy to align with the findings of the 'Keogh report'.

2.2 NEEDS ASSESSMENT

Demand on all health and social care services is rising, with growing numbers of frail elderly people, populations with more complex health needs and increasing expectations that services are accessible 24/7. These trends will continue across each of our local health economies and we need to find new ways to respond.

People who need health or social care are faced with a complex maze of services. The care available varies from one geographical area to another, by day and by hour. Too often, people find it difficult to identify the services that they need and, even when they know what they need, they find it difficult to access the relevant services.

The emergency 999 and NHS111 services are used as a 24/7 contingency option. However, the ability of SCAS (or other 999/111 providers) to redirect patients effectively relies on a comprehensive range of services being available in each area, and for those services to be identifiable through an up-to-date and accurate local Directory of Services

There are particular challenges for people needing mental health or social care, as these services are not available and accessible on a 24-hour basis in all areas. There is also a particular need to offer well-coordinated care for patients at end of life. Too often, people end up going to emergency departments in the absence of the relevant services being available, identifiable and accessible at the time required.

The complex needs of the frail elderly often require a coordinated and responsive service to support them in their own homes or local communities. Without this, the frail elderly can find themselves transferred between multiple different services, including hospital admission.

The demand trends and predictions used to inform this strategic plan are included in the appendix. Broadly we have predicted that 999 growth will reduce to about 3-4%, as some demand will transfer from 999 to NHS111 as the public become more aware of this service.

[4] Transforming urgent and emergency care services in England, end of phase 1 report, 2013

2.3 CAPACITY ANALYSIS

Workforce

The organisation needs to grow and the workforce needs to expand accordingly, even though some economies of scale are expected.

In particular, there is an intention to expand the Clinical Coordination Centres to become a single integrated assessment and signposting service for all health and social care. This would require more call handlers and potentially more clinicians within our Clinical Coordination Centres.

Our emergency mobile workforce may need to grow a little, but our primary objective is to work with commissioners and other partners to stem the growth in emergency demand. Part of this will involve assessing and treating more people at home, and we expect to need to enhance our mobile workforce to respond to urgent and potentially planned referrals (not just respond to emergency 999 calls). This would require an expansion of our mobile clinical workforce, some of whom would need advanced clinical skills.

The patient transport workforce would need to expand in line with any new contracts secured.

Fleet

Our fleet would need to expand in line with both the mobile healthcare teams and the Patient Transport Services. It is expected that the ratio of cars to ambulances will increase over time.

Estates

The Clinical Coordination Centres would have to expand in size or number with growing call volumes. This needs to be considered as part of any bid for new work.

The resource centres may need to expand with an enhanced mobile healthcare service or expanded Patient Transport Service. Again, this needs to be considered in bids for new work.

2.4 FUNDING ANALYSIS

					5 Year Forecast				
	2009/10 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m
Emergency Services inc HART	111.7	111.1	116.5	121.1	120.1	120.7	123.8	126.1	128.8
111	0.0	0.0	3.8	15.3	15.3	11.2	16.9	18.2	20.7
Commercial Services	22.4	23.3	20.9	22.0	23.7	25.6	30.5	33.9	35.3
Other income	3.8	4.2	3.1	4.1	3.4	3.3	3.4	3.4	3.5
Total Operating Income	**137.9**	**138.1**	**137.7**	**161.2**	**162.3**	**160.9**	**174.6**	**181.7**	**188.3**

Almost all of SCAS income comes from Clinical Commissioning Groups (CCGs). The above table shows the historic and planned funding analysis for SCAS. In 2009-10, £112m out of £138m or 85% of funding relates to the monopoly 999 Emergency services, which is from CCGs. By 2013-14, this reduced to 75% as a result of SCAS winning the NHS111 service (£15m or 9%). 50% of this business (Hampshire) was competitively tendered in 2012-13. The remainder is likely to be tendered by 2015. Commercial services income increases from 16% to 19% by the end of the period. Many commissioners see SCAS providing an integrated 999 and NHS111 service going forward. The challenge to that is the need to competitively tender the business which may result in the NHS111

income reducing.

In addition to funding from these sources, the business has been financed by an £7m capital loan in 2010-11, which has been repaid over between 5 and 10 years. These loans have been funded out of operating spend and the disposal programme. A further loan of £7m is to be taken out in 2014-15 providing financing as the disposal programme is completed.

2.5 COMPETITOR ANALYSIS

Emergency 999 Service

The overall 999 Ambulance Services market has been traditionally dominated by NHS Ambulance Trusts. Health Legislation has in the past presented a barrier to entry for the private sector.

However, there is now an increasing likelihood of competition, especially for segments of the overall market not specifically requiring major emergency service response: for example, the urgent, but not an emergency, transportation of patients following a request from a Health Care Practitioner.

Performance and reputation remain key as barriers to entry. Internal market rivalry between NHS Ambulance Trusts is traditionally low, but could increase in future years. Customer power is affected by the fact that the ease of substitution for commissioners would likely come under political pressure and intense public scrutiny.

Overall competition exists in relation to segmented service supply requirements.

NHS111 Service

This market is relatively young, but based on a mature call centre market operating model. It is currently occupied by a relatively discrete group of NHS and private healthcare providers. Dominant players include Ambulance Trusts, Harmoni (owned by Care UK) and Out of Hours primary care / urgent care service providers.

This is currently a niche market of the call centre industry as entry barriers exist, in terms of the clinical governance requirements, workforce capabilities and technical infrastructure. However, these are relatively easily imitable with sufficient investment and technical know-how. Adjacent market providers e.g. Call Centre operators could enter this market easily.

Customer power is offset by the existence of national oversight by NHS England. The market is anticipated to consolidate in the early years and it remains a market prime for mergers and acquisitions from large private providers, keen to enter the market for the future.

The model for the delivery of NHS111 Services is expected to undergo change in the short to medium term, driven by the national customer requirements. This will put pressure on existing incumbents to change or withdraw from the market.

As the market begins to mature, there may be pressure to drive out inefficiencies, achieve greater value for money and move towards greater integration with other primary care delivery models.

It is also likely that NHS111 will become a gateway into a wider range of services, such as social care. This will raise issue of referral rights into these services.

Patient Transport Service

The UK non-emergency Patient Transport market is characterised by being highly competitive, with both traditional NHS ambulance and private health providers. The market is relatively easy to enter, with few barriers and limited only by investment potential and expertise in health transport.

The provider landscape is expected to continue to change with the ebb and flow of contract awards. Growth is anticipated through integrated solutions, working collaboratively with local authorities and communities supporting a variety of needs.

Differentiation of service lines could become a key feature driven by commissioners' quests to obtain greater value for money with increasing growing demand for services over future years.

Logistics Service

The commercial medical and healthcare logistics sector is made up of a range of niche markets providing capabilities for those gaining entry to tap into a range of adjacent markets.

Current markets are in the collection and delivery of pathology specimens, pharmacy items, medical records and internal mail, internal bulk item transfers between sites and includes transfer of staff across hospital sites. These services require expertise and capabilities in secure transportation, storage and distribution.

Growth is limited to the identification of new requirements from existing and potential customers. There is an exhaustive list of private and NHS providers operating in this market.

Commercial Training

First Aid and other healthcare related training is a highly contestable niche industry sector.

Prior to October 2013, the industry was required to be approved by the Health & Safety Executive for the purposes of providing first aid training. This has changed, with providers now able to provide evidence to potential customers that they can satisfy a key set of criteria and demonstrate competence to deliver first aid training.

With this key barrier to entry relaxed, customer power is now very high and new entrants can be expected to enter the market. Competition is based on price, value for money, capacity and capabilities, and confidence in delivery against the Health & Safety Executive criteria.

This market is heavily occupied by private sector companies, as well as being served by the voluntary sector provision.

Potential competition in future

Various other organisations could become competitors as SCAS seeks to develop new business. These include community providers, third sector and voluntary organisations.

2.6 SWOT ANALYSIS

In our annual review process, we have considered the 'unique selling points', strengths and weaknesses of each service. We have also explored opportunities and threats over five years.

Strengths

- Strong ambulance brand, with high levels of public trust
- Good track record on 111 performance
- SCAS clinicians already situated at standby points 24/7 across Thames Valley and Hampshire
- Clinical Coordination Centres have access to the Directory of Services
- Able to respond to local nuances
- SCAS mobile clinicians less expensive than some of current services (e.g. GPs)
- Motivated staff, working teams and improving outcomes
- Well engaged in local health communities (via Unscheduled Care Boards and Emergency Preparedness, or local equivalents)

Weaknesses

- High reference costs
- Performance is relatively weak against some national benchmarking performance indicators
- Limited availability of suitably qualified clinicians
- Limited flexibility (with Agenda for Change and restrictions to changes in the labour model)
- Limited scope to invest (for example in tele-monitoring or Advanced Paramedics before contracts are awarded)
- Risk that competition law prevents on-going work with local health communities to provide more integrated and seamless care
- Lack of virtual telephony platform (which is currently being addressed)

Opportunities

Helping to prevent avoidable or unnecessary hospital admissions

- Clinical and financial drive across health to increase out of hospital care
- Mobile clinicians with access to Directory of Services and Summary Care Records
- GPs under pressure to provide more out of hours care
  SCAS could offer support: book appointments (in hours as well as out of hours), accept referrals via Directory of Services, and assess patients at home
- Already have mobile clinicians 24/7 across Thames Valley and Hampshire, therefore well-placed to support system in addressing service gaps
- Invest in the development of Advanced Paramedics and/or Emergency Care Practitioners
- Offer enhance Patient Transport Services, for example, supporting people with basic needs in the first few hours after discharge from hospital

Supporting integrated and coordinated care

- Improve patient flow around the system by using synergies between emergency, urgent and planned transport, and tailoring service to meet patient needs regardless of how the need for clinical conveyance or transport is identified
- Provide a technical platform for other services in terms of electronic patient communication and records at scene (potentially GPs, community teams)
- Move to a more proactive service, through tele-monitoring and managed care schemes.
- Offer 111 service as in-hours point of access to GPs (as well as providing this out of hours)

- Offer to manage the Directory of Services

Analytical capability

- Improved data and analytical capabilities with the use of NHS number, Directory of Services and Electronic Patient Records
- Become a commissioning agent, analysing patient flows, service use, capacity constraints and service gaps
- Offer to analyse cost implications of above flows and gaps

System management

- Provide dynamic information about the capacity and flows within a system of care
- Commissioners looking for system and flow management
- Become lead provider or commissioner of unscheduled care in Thames Valley or Hampshire

Step in provision

- Provide step-in 111 services anywhere in the UK
- Ambulance services struggling on our northern and eastern borders, with potential need for step-in providers in the future

Threats

- Risk if the NHS111 service specification changes significantly
- Risk if we lose NHS111 business when services are competitively tendered
- Urgent services are included in Thames Valley PTS bids (currently on hold whilst commissioners review tender requirements)
- Some of Hampshire commissioners are considering lead provider models, with a single organisation commissioned to provide integrated care, with other providers sub-contracted by the lead provider. Risk if SCAS is not proactive in positioning as a lead provider.
- Recruitment and retention of mobile clinicians: some neighbouring ambulance services more advanced in terms of developing enhanced clinical roles and could attract SCAS paramedics
- Lose services or contracts if we have insufficient suitably qualified clinicians
- Highly competitive market, including community providers and other new commercial players in the market
- Increased competition drives down price
- Commercial organisations are able to invest more easily

Unique selling points

Current

- Clinical assessment and prioritisation
- Mobile clinical workforce 24/7 across Thames Valley and Hampshire
- SCAS engaged in clinical networks for better outcomes (e.g. Trauma)
- Only provider to be able to see flows across the whole area (Thames Valley or Hampshire)
- Two site virtual service (with resilience)
- National services: pandemic flu service, legacy organisation for NHS Direct and NHS111 resilience (winter 2013-14)

Potential

- Only provider with 999 and 111 using a common technical platform (CAD and telephony)
- Mobile clinicians have access to view Directory of Services and Summary Care Records (dependent on Electronic Patient Record and visibility of Summary Care Records)
- Integration of 999 and 111 services – potential for 'one number, two services'
- Integration or partnership with community health for better outcomes
- Analysis of patient flows, service use, capacity constraints and service gaps across region (if we invest in analytical capability)
- Analyse cost implications of the above (if we invest in analytical capability and data is shared)

2.7 DO NOTHING SCENARIO

The next table shows the income and surplus 'do nothing' scenario for SCAS. This is the position without the net contribution from the new business. The financial gap position for each health economy has been calculated based on a share of income for each health economy.

	5 Year Forecast				
	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m
Income	**162.3**	**160.9**	**174.6**	**181.7**	**188.3**
Surplus	**0.4**	**0.4**	**0.3**	**0.5**	**1.0**
Financial gap by LHE:					
Oxfordshire	**0.1**	**0.1**	**0.1**	**0.1**	**0.2**
Berkshire	**0.1**	**0.1**	**0.1**	**0.1**	**0.2**
Buckinghamshire	**0.1**	**0.1**	**0.0**	**0.1**	**0.1**
Milton Keynes	**0.0**	**0.0**	**0.0**	**0.0**	**0.1**
Hampshire	**0.2**	**0.2**	**0.1**	**0.2**	**0.4**

This shows a smaller surplus in each of the years of the plan.

2.8 FINANCIAL GAPS IN LOCAL HEALTH ECONOMIES

The financial gaps in the local health economies are likely to vary over the five year plan period. The current health economies with difficulties in South Central are Oxfordshire, Buckinghamshire and significantly Milton Keynes. SCAS continues to be a small % of the budgets of these areas. As a result to date, whilst the negotiations with these areas have been difficult, the financial difficulties have not stopped SCAS from achieving a reasonable contractual position.

2.9 ALIGNMENT OF MARKET ANALYSIS

We are continually striving to offer the right care, in the right place, at the right time for each patient. Our market analysis has reinforced this as our mission and highlighted that SCAS needs to

focus on improving the following aspects of care:

- Enabling you to identify and access the care you need
- Saving lives
- Enabling you to stay safely in your own home or local community
- Enabling you to travel safely between home and health care settings
- Supporting efficient and effective patient flow around systems of care

Professor Sir Bruce Keogh's review of urgent and emergency care considers the range of issues and challenges faced in this part of the country, as much as any other part of England. The recommendations available so far in the report, at the end of phase 1, are therefore very pertinent to SCAS and we have embraced them as the platform for developing our strategy.

The 'Urgent and Emergency Care Review' concludes that we must:	SCAS's role is critical and our strategic direction is well-aligned with these conclusions
Provide better support for people to self-care	**Enabling you to access the care you need** *SCAS helps you to identify and access appropriate services, by assessing your individual needs and directing you to the most relevant services available, and by coordinating care across agencies*
Help people with urgent care needs to get the right advice in the right place, first time	
Provide highly responsive urgent care services outside of hospital	**Enabling you to stay safely in your own home or local community** *SCAS mobile teams enable you to stay safe in your own home or local community, by taking care to you 24/7* *SCAS will also enable you to travel safely between home and healthcare settings if you are not well enough to make your own way*
Ensure that people with more serious or life-threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery	**Saving lives and improving outcomes** *SCAS save lives, both by dispatching emergency clinicians to treat you on scene if needed, and by providing specialist care during your journey to the most appropriate unit*
Connect all urgent and emergency care services together so the overall system becomes more than just a sum of its parts	**Offering a helicopter view** *SCAS supports the whole system of care, by working with partner organisations to plan care and understand patient flows, both across local communities and for individual patients*

2.10 IMPLICATIONS FOR EACH SERVICE

Our market analysis has identified the need to focus on five key aspects of care. This has been built into the strategic plans for the relevant services.

Service	*SCAS role*	*Strategic objective*
Clinical Coordination Centres	To enable you to identify and access the care you need	To develop our assessment and signposting service To explore ways to share our technical infrastructure with partner agencies, in order to facilitate coordinated care across systems

Mobile Healthcare	To save lives To enable you to stay safely in your own home or local community	To enhance our 24/7 mobile healthcare service
Patient Transport	To enable you to travel safely between home and care settings	To modernise and enhance our patient transport services
Helicopter view	To support efficient and effective flow around systems of care	To transform our analytical capability and capacity To offer a helicopter view
All	To secure our competitive position as provider of choice	To transform our cost base

3 CLINICAL CO-ORDINATION CENTRES

3.1 SERVICE PROVIDED

Current services

Emergency 999 calls

Calls from the public are triaged by our Emergency Operations Centres. Depending on the nature of the call, we may dispatch an emergency response immediately, ask a clinician to assess and treat someone on scene, refer a caller to a more appropriate service or offer telephone clinical advice.

Health care professional calls

GPs and other health care professionals can book emergency or urgent transport for patients who are unable to make their own way to, or between, healthcare facilities.

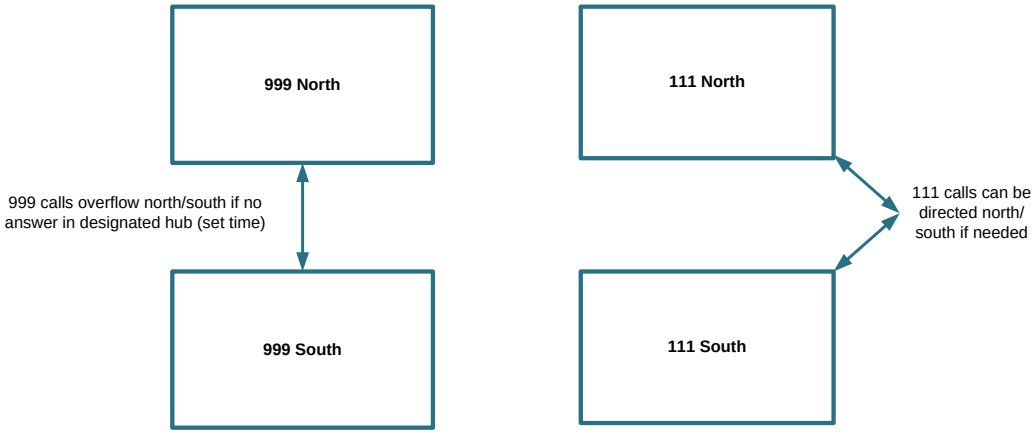
Health care professionals also telephone SCAS NHS111 services to obtain information for alternative care pathways available to patients via the Directory of Services.

NHS111 calls

Calls from the public are assessed through the NHS Pathways system and patients are directed to the most appropriate service available, via the local Directory of Services. Options include dispatch of an emergency ambulance response if clinically necessary, referral to an alternative service or clinical advice on the telephone.

In addition to a range of local contracts, SCAS provided the national resilience service for NHS111 during winter 2013-14, requiring us to take additional calls from other areas during peak demand

Configuration



There is no overflow between 999 and 111

There are currently four parts to our Clinical Coordination Centres. The Emergency Operations Centres for 999 and Contact Centres for NHS111 services are currently run and managed separately. They are also split into two in terms of the geographical areas covered.

3.2 CHANGES IN PROGRESS

Common virtual platform

Technical specification and development work is currently underway to implement a common virtual and resilient telephony platform, across 999 and NHS111 services and across Clinical Coordination Centres in north and south. Once this is achieved, it will be possible to redesign the way that these services are delivered, with potentially economies of scale geographically and between services.

Transition of 999 to NHS Pathways

Work is underway to migrate from the AMPDS[5] triage tool to the NHS Pathways clinical assessment decision support software tool for public 999 calls. This transition will take place during 2014 and, when complete, SCAS will be able to direct patients to the 'right care, first time. This is because:

- NHS Pathways enables and supports non-clinical call takers to resolve calls over the telephone and refer patients to alternative care pathways via the Directory of Services, if clinically safe to do so. This process takes place without the need for intervention by a qualified clinician.
- NHS Pathways enables clinicians to intervene on an emergency call before the pathways assessment is completed, giving greater flexibility and potential scope for dynamic demand management. Currently clinicians are required to wait until an AMPDS code has been assigned to the call before they can have direct dialogue with the patient.
- Unlike AMPDS, NHS Pathways links directly to the Directory of Services, enabling call takers and clinicians visibility of the alternative care pathways commissioned in the wider health care economy and direct access to refer patients.
- NHS number look-up is integrated into the new call handling processes and systems. Use of NHS numbers will enable SCAS to have a better understanding of patient flows and outcomes, which will in turn enable us to identify improvements in the care offered.

With the changes described above, SCAS will be able to increase hear, treat and refer rates for 999 calls. There should also be a reduction in re-contact rates, as clinicians can work more effectively and callers will not have to wait for clinicians to call them back.

Directory of Services

Our Clinical Coordination Centres are reliant on a comprehensive, accurate and up-to-date Directory of Services in each local area when directing patients to the most appropriate care pathway. The Directory of Services is the responsibility of the Clinical Commissioning Groups and SCAS is working with Clinical Commissioning Groups to address any shortfalls.

999 and NHS111 leadership

In order to explore the potential benefits of a common virtual platform, it is proposed that 999 and NHS111 leadership is aligned. Work is also underway to design a potential integrated management structure, ready for consultation during 2014-15.

Virtual 999 call handling

The virtual telephony platform will enable the 999 service to respond more effectively to peaks in

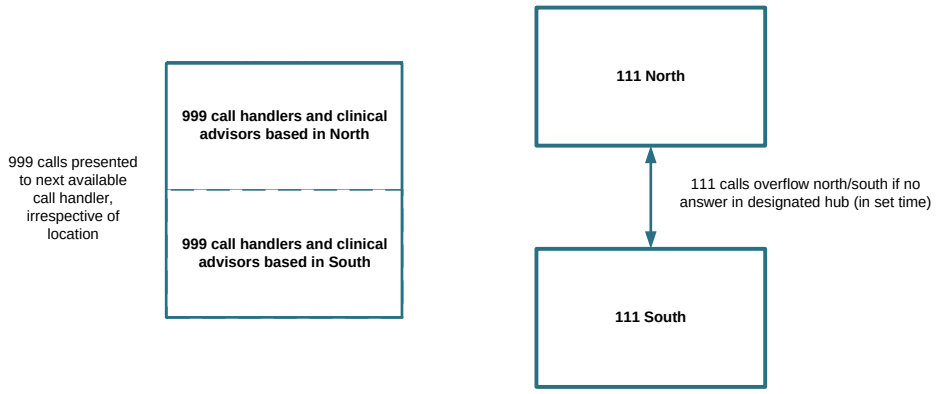
[5] Advanced Medical Priority Dispatch System

demand, with economies of scale across the two geographical bases. Once the virtual platform is fully implemented, the 999 service will move to fully virtual working across the two sites.

Virtual NHS111 call handling

Given that there is currently an array of different performance standards amongst NHS111 contracts held by SCAS, there are no immediate plans to move to a fully virtual NHS111 service.

SCAS is looking at the scope to optimise the benefits of a virtual telephony platform, pending any changes or opportunities when the new national specification for NHS111 services is published.



There is no overflow between 999 and 111 at present

NHS111 resource management

The focus for 2014-15 will be to embed these relatively new services into business as usual and to ensure highly efficient and effective operational delivery. Resource management systems and processes will be redesigned:

1. A tool will be introduced to improve the analysis of demand patterns and design rosters. This will enable better alignment of resource plans with fluctuating demand.
2. Working patterns will be reviewed, in order to create the flexibility to match staff rosters to fluctuating demand patterns.
3. A time and attendance system will be introduced, to record actual rosters allocated to staff and enable improvements in operational efficiency, through better recording of time and attendance, as well as a reduction in manual processes.

3.3 IMPACT OF EXTERNAL CHALLENGE

3.3.1 External challenge

New national specification for NHS111 services

A revised national specification for NHS111 services is expected during 2014.

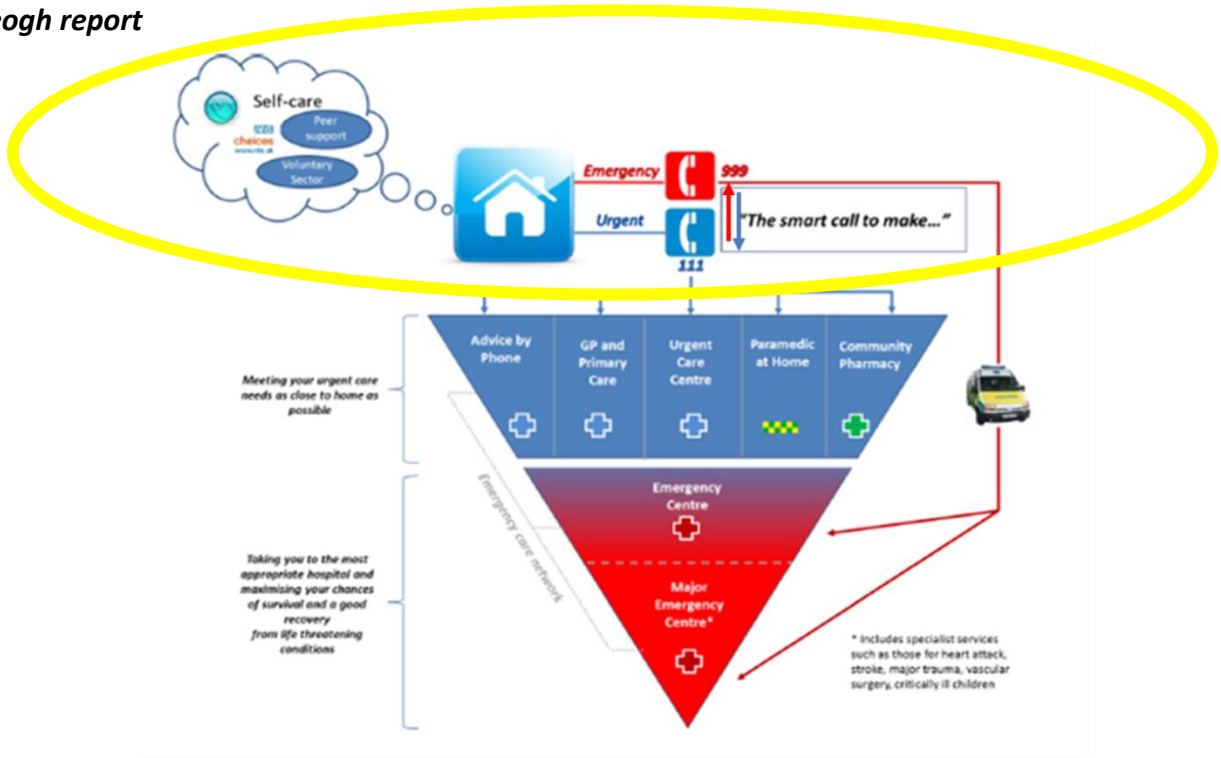
SCAS hopes that this will facilitate greater standardisation between contracts, which in turn will enable us to realise some of our potential economies of scale in NHS111 services.

It is predicted that this specification will require a virtual telephony platform. It is also envisaged that there may need to be some redesign of our current NHS111 services in order to accommodate the other changes to requirements.

It is expected that various NHS111 contracts will be subject to competitive tendering once the new specification is available, and this process may commence in Autumn 2014. This could present risks in terms of some of our current contracts, as well as the opportunity to expand our NHS111 service.

There may be a drive to reduce the number of contracts across the country, with a rationalisation of existing contracts into fewer regions. Again, this could present both risks and opportunities.

Keogh report



The Keogh report[6] places 999 and NHS111 services at centre stage in terms of navigating patients around emergency and urgent care services.

This is consistent with SCAS's strategic direction and, as the provider of both 999 and NHS111 services in Thames Valley, much of Wessex and some of Hertfordshire & South Midlands areas, we need to rise to this challenge.

3.3.2 Sustainability risks

The key uncertainties are:	*Mitigation*
• If increased competition drives down income for NHS111 services, it may bring the financial sustainability of these services into question.	We are focussing on operational efficiency and effectiveness, in order to maintain our good track record for performance and to minimise costs.

[6] Transforming urgent and emergency care services in England, end of phase 1 report, 2013

• Telephone access to our services may become out-dated, for example with increasing expectation that we should respond to email, text messages, images or other digital options.	We are continually reviewing our technology strategy and need to explore options as part of our strategy. As part of this, we need to consider the differing preferences and needs of various groups of users.
• There are sometimes discussions about merging the control centres for 999 with other emergency services (police, fire, ambulance). If so, this could fragment SCAS's current assessment and signposting services, as well as increasing the range of competition.	SCAS has a very clinical model of telephone assessment and is able to explain the benefits of this approach.

3.3.3 SCAS role in the future

On the basis of this analysis, it is clear that SCAS has a pivotal and growing role within the health system, in terms of enabling people to identify and access the care that they need.

3.4 STRATEGIC OPTIONS CONSIDERED

We have explored a wide range of options for our Clinical Coordination Centres:

- Adopting a more proactive approach to care (not simply reacting to calls for help)
- Offering a wider range of services
- Exploring the opportunities through developments in communication technology
- Reconfiguring Clinical Coordination Centres, exploring virtual and integrated options
- Transforming our cost base
- Shrinking this part of our business
- Expanding our geographic footprint

3.4.1 Proactive approach to care

Self-care

Our Clinical Coordination Centres could support people who are caring for themselves, especially those with diagnosed long terms conditions. SCAS could provide 24/7 telephone advice, access to various on-line support tools and facilitation 'virtual consultations' with specialist advisors.

Managed care

SCAS could offer a more proactive service, perhaps telephoning people rather than only reacting when called. For example, we could make welfare checks in the following circumstances:

- At regular intervals for people who are in virtual wards, alerting the local integrated care team if they do not answer or report a deterioration in their health
- A few hours after a frail elderly person is discharged from hospital
- The day after someone has been treated on scene after an emergency call

This approach benefits from working with the GPs or relevant agency to identify patients at risk.

Tele-monitoring

SCAS could offer the telephone aspect of a tele-monitoring service, working with a partner company to provide the technology. This service would be particularly relevant for patients with

long term conditions or anxiety-related disorders.

This service would need to be linked to community-based teams who could respond to patients whose monitoring indicates deterioration. Section 4 explores the potential role of SCAS mobile healthcare teams.

3.4.2 Range of services

Planned care
SCAS has the infrastructure to respond to emergency and urgent calls 24/7. We have the systems in place to book GP appointments out-of-hours. We could use this infrastructure to respond to non-urgent enquiries as well, and to book appointments for other services.

Social care
We need to improve the pathways for 999 and NHS111 callers who need social care services. We will work with social services to provide direct access to relevant services, as a way of avoiding inappropriate conveyance to emergency departments.

Once these arrangements are in place, it may be sensible to offer a single point of access for social care, not just for those who call 999 or NHS111.

Voluntary sector / specialist advice lines
SCAS has the infrastructure to provide 24/7 telephone access. We are using this to host a team of midwives who provide an advice line, with advantages for 999, NHS111 and the midwifery teams in being co-located. We could adopt a similar approach for other specialist teams and voluntary sector groups, for example a mental health help line.

3.4.3 Developments in communication technology

On-line services
SCAS has developed on-line options for healthcare professionals who need to book transport for their patients. However, we currently offer telephone access only for members of the public who are injured or concerned about their health. We could start to explore alternative options.

For example, we could take the example of the former NHS Direct symptom checker and set up arrangements whereby answers are automatically downloaded into our system if someone subsequently contacts the 999 or NHS111 service. This would be more efficient operationally, as well as being more user-friendly.

Other possibilities are to develop an 'app' or explore working in partnership with another company such as Circle, who have recently developed the 'Babylon' app. We could also facilitate access to specialist self-care tools.

Image transfer and video links
Many people have the facilities to take and send images of injuries. We could set facilities for people to send these images to us or use video links, in order to minimise the need for an on-scene assessment.

3.4.4 Configuration of the Clinical Coordination Centres

Virtual services
With a virtual telephony platform, one option is to run the services in North and South as a single service, with the call answered by the next available call handler irrespective of location.

Emergency responders would continue to be dispatched by geographically focussed teams.

There are a number of options for a virtual approach, as it could be applied to 999 and/or NHS111.

The concept of 'virtual services' could also be extended beyond the current Clinical Coordination Centres. For example, the Clinical Coordination Centres may be able to transfer a caller for a virtual consultation with a specialist clinician, who could be located in a hospital or even their own home. Another example would be a virtual transfer to an advisor in social services, who may be located in another building.

Integrated services

Another option would be to integrate the provision of 999 and 111 telephone assessment and signposting services. For example, the call handlers based in the North could be trained and equipped to handle either 999 or 111 calls, with a combined call queue irrespective of whether the caller dialled 999 or 111.

Again, there are a number of options for an integrated service, as it could be applied to the Clinical Coordination Centre in either the North and/or South. With this approach, we would also need to explore options around prioritising 999 calls within the joint queue.

Mirrored services

Instead of fully integrated services, another option is to align the systems and processes across the Clinical Coordination Centres, so that staff are able to work shifts in another section to help with peaks in demand.

In theory, this could apply across all four parts of our Clinical Coordination Centres. In practice, staff are more likely to be willing to work additional shifts in the same geographical base as their usual place of work.

Fully integrated virtual services

With a fully virtual and fully integrated service, calls would go to the next available call handler irrespective of location. Any call handler would be expected to answer 999 and 111 calls.

Within this option, there may be scope to prioritise 999 calls within the joint call queue. This would need to be explored further.

Combination of virtual and mirrored services

There are numerous options available by combining the options outlined so far. For example, 999 services could be provided through a virtual Clinical Coordination Centre, using systems and processes that are aligned with the 111 services, so that some staff can work in both 999 and 111.

NB Initial assessment suggests that it is not possible to integrate 999 and 111 services if one is operating virtually and the other is not.

Single site service

Another option is to consolidate all assessment and signposting services onto a single site and to manage them as either integrated or mirrored services.

When SCAS was established in 2006, it was decided that there should continue to be at least two Emergency Operations Centres in order to provide resilience. Experience to date has confirmed the need for two-site resilience; therefore, this option has not been considered in detail at this stage.

3.4.5 Cost transformation

All services within SCAS are exploring options to transform their cost base, in order to secure their competitive position as the provider of choice.

Within the Clinical Coordination Centres, the options being explored relate to improving the alignment of resources to fluctuating demand, and the potential economies of scale through virtual or integrated services.

Clinical redesign	Use the opportunities presented by the NHS Pathways tool to redesign dispatch processes, with the aim of matching the skill and vehicle dispatched to the needs of the patient, in line with 'right care, first time'
Partnerships	Work with both commissioner, to ensure that the Directory of Services is comprehensive, accurate and up-to-date, and GPs, to ensure that individual patient care plans are accurate, up-to-date and visible to relevant parties, in order to support 'right care, first time' and prevent unnecessary conveyance to emergency departments
Volunteers	Offer to host charity helplines within our Clinical Coordination Centres, for example a mental health crisis line, in order to increase the scope to offer the 'right care, first time' without defaulting to emergency dispatch
Technology	Use the virtual telephony platform to realise the potential economies of scale in both the NHS111 and 999 services. Explore ways of using other aspects of our technology (such as mobile data transfer, electronic patient records, access to directory of services) in order to support partner organisations with mobile clinicians and facilitate more integrated and coordinated care across systems
Scheduling	Improve our capability to predict demand and introduce greater flexibility to match the workforce to demand, including consideration of the benefits of combining some or all or the 999 and NHS111 workforce capacity
Cost base	Only bid for contracts where costs are comfortably covered by income. Explore options such as home-working and virtual-working from other health-settings, in order to find cost-effective ways of securing the clinical input and expertise required to assess and advise callers.

3.4.6 Shrink

As NHS111 services are retendered, SCAS needs to assess each opportunity in terms of clinical, operational and financial sustainability. There may well be situations where the income is not sufficient to fund a high-quality clinical service.

In these circumstances, SCAS may need to consider withdrawing from some aspects of the NHS111 service. These decisions need to be balanced against the long-term strategy of providing two numbers, one service.

3.4.7 Grow

We have already started to develop some national services and to provide step-in 111 services in neighbouring areas. Over the next few years, it is likely that a number of services will be competitively tendered and SCAS could aim to expand its geographical footprint for telephone

assessment and signposting services.

In readiness for this, SCAS is exploring options for expanding the capacity of its Clinical Coordination Centres, potentially at very short notice.

3.5 ASSESSMENT OF STRATEGIC OPTIONS

The strategic options identified above have been assessed against the following criteria:

- Benefit to patient care
- Benefit to local systems of care
- Strategic fit
- Investment required to achieve strategic option
- Risks during change
- Impact on SCAS clinical sustainability
- Impact on SCAS operational sustainability
- Impact on SCAS financial sustainability

3.6 STRATEGIC OPTION SELECTED

Strategic direction

The Board has considered the various options available to SCAS and concluded that we need to develop a bigger and more comprehensive assessment and signposting service.

Our strategic intention is to handle a wider range of enquiries including social care, as well as health, and planned care, and as well as urgent and emergency. We will also seek opportunities to expand and cover a wider geographical footprint.

SCAS role in the future

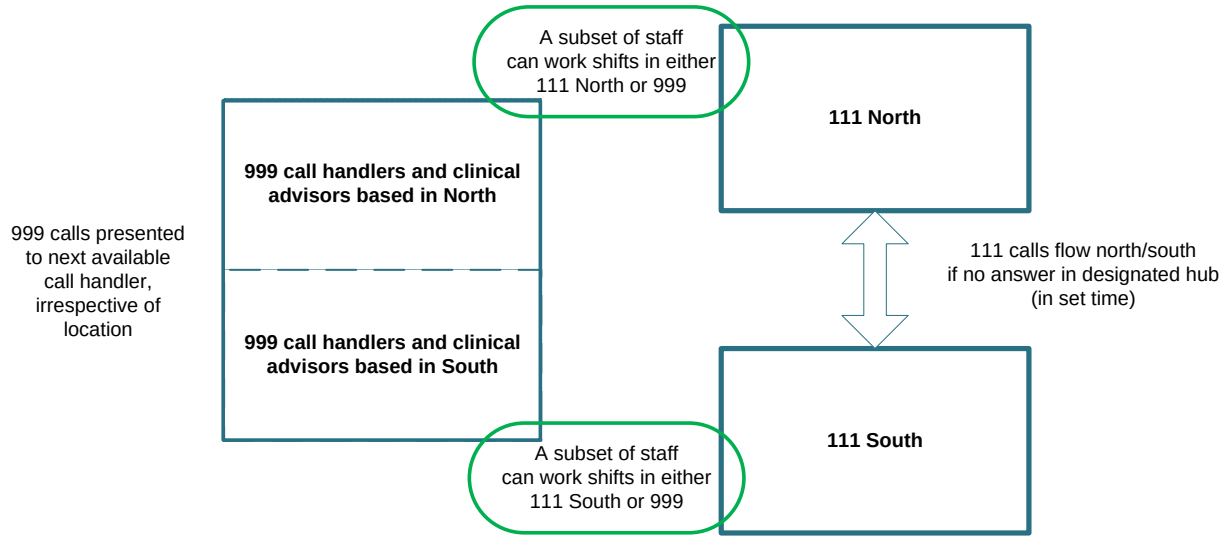
To enable you to identify and access the care that you need.

Vision

- 24/7 telephone and digital services
- Two numbers, one services (i.e. it does not matter whether someone calls 999 or 111)
- Comprehensive and up-to-date Directory of Services for each local area
- Seamless access to services via the local Directory of Services
- High quality clinical assessment, advice and signposting
- Hosting arrangements for specialist advice lines and voluntary sector help lines
- Single point of access to health and social care
- Planned, urgent and emergency services
- Proactive welfare calls to people at home who are at risk of deterioration in health
- Visibility of Summary Care Records, so that care can be tailored to individual needs

Configuration

For the time-being, SCAS will move towards mirrored 999 and NHS111 services, so that a sub-set of staff can work across both services and help to accommodate fluctuating demand.



Our intention is that the 999 service will make use of the virtual platform to improve resilience and realise economies of scale.

If the various NHS111 contracts adopt a common performance framework, we may consider running the NHS111 service as a virtual two-site hub in the future as well. However, pending publication of this specification and subsequent tender documents from Clinical Commissioning Groups, the NHS111 service will continue to run separately between the North and South Clinical Coordination Centres, with some flow of calls during peak periods.

3.7 REASONS

Patient benefits

Members of the public will be offered simplified access to health and social care.

Improvements in local Directory of Services and visibility of Summary Care Records will enable SCAS to identify the 'right care, at the right time, in the right place' to meet individual patient needs.

More people will be supported in their own homes or local communities, with a combination of proactive monitoring and easy access to help or advice when needed.

The plans to host specialist advice and voluntary help lines will improve SCAS's scope to address the people's needs, particularly those who need mental health or social care advice out of hours.

With simplified access, improved assessment of individual needs, shared clinical information about care plans, and up-to-date information about the local services available, SCAS will be well positioned to minimise the number of people who need to be taken to emergency departments.

Impact on service

There will be an expansion in both incoming and outgoing call volumes, with associated implications for workforce, technical and estates capacity.

More enquires will be handled on the telephone or on-line. This has implications for clinical risk management and governance arrangements within the Clinical Coordination Centres.

Our Clinical Coordination Centres will be handling a far wider range of enquiries, with implications for workforce skills and development.

The successful development of improved assessment and signposting services should result in reduced growth in demand for emergency responses to scene.

Impact on local health economies

Improved access, assessment and signposting will reduce the duplication of activity across health and social care, as more patients will be directed to the 'right care, in the right place, at the right time' in the first instance.

There will be a corresponding reduction in attendances at emergency departments (or at least reduction in growth of demand) and there may be an associated reduction in hospital admissions (although this is outside SCAS control).

The 24/7 telephone and on-line services could be made available for use by other providers, and provide the platform to provide coordinated and integrated care across local communities.

Alignment with local health economy requirements

This strategy is extremely well-aligned to the vision of many of our local health economies and discussions about longer-term transformation programmes. The key challenges are:

- To position SCAS as the organisation that is commissioned to provide of these services
- To make the necessary investment within SCAS and across the local health economies to achieve these longer term goals.

4 MOBILE HEALTHCARE

4.1 CURRENT SERVICE

SCAS provides a wide range of responders across Berkshire, Buckinghamshire, Hampshire and Oxfordshire, which enables us to tailor our mobile healthcare response to meet individual needs.

At present, SCAS mobile healthcare teams are only commissioned to provide on-scene assessment and treatment to people who have called 999.

Saving lives

Emergency response service	For patients with a life-threatening condition, we will immediately dispatch a clinician and an emergency ambulance to the scene.
Health care professional service	Depending on patient's needs, we can provide specialist clinical teams to convey patients in an emergency ambulance or someone to drive the patient in a car. Options for the new service model include closer working with the Patient Transport Service, in order to utilise the most appropriate response to meet individual needs.
Trauma networks	We work with the Thames Valley and Wessex Trauma Networks to ensure the patients who have suffered major trauma are provided with effective pre-hospital care and transferred safely to the appropriate trauma unit. This includes running Specialist Incident Desks within our Emergency Operations Centres.
Clinical networks	We also work with cardiac, stroke and vascular networks, and plan to work with future Urgent Care Networks.
Air ambulance	We work with local charities to provide air ambulance services in both the Hampshire and Thames Valley areas.
Co responders	We have a variety of schemes working with local fire and military teams to provide a speedier response in rural areas.
Community first responders	We also work with local members of the community, offering the necessary training and support, to provide speedier responses in some rural communities.
Emergency preparedness	We work closely with other agencies, including the Fire and Police Services, Local Authorities and other Ambulance Services, to ensure that we are prepared for any major incidents.
Hazardous area response teams	Some of our clinicians are specially trained and equipped to respond to incidents in hazardous areas, for example following a fire, flood, contamination or terrorist attack. This includes scope to care for mass casualties.

Enabling you to stay safely in your own home or local community

See and treat service

Some people who call 999 can be treated on scene, and we dispatch appropriately trained staff for these calls. There are various schemes to support this approach, including:

Falls Referral scheme – if someone is not injured after a fall, but is assessed as being at risk of a repeat fall, SCAS clinicians refer the patient to the local Falls Assessment Team

GP Triage scheme – SCAS clinicians ask a local GP to assess a patient who does not need to be taken to an emergency department, but who needs either a medical assessment or GP referral to access the relevant pathways of care.

In some city areas, we provide temporary first-aid facilities whilst clubs and pubs are open. This helps to accommodate the peaks in demand and to prevent the need for people to go to emergency departments for relatively minor injuries.

4.2 CHANGES IN PROGRESS

Several change initiatives are underway to develop and improve our mobile healthcare, including:

- Improve care of patients who suffer stroke or heart attack[7]
- Align staff and vehicle capacity with demand fluctuations
- Introduce electronic patient records
- Improve the service for patients assessed by a GP or healthcare professional as needing emergency or urgent conveyance to or between health units

4.3 IMPACT OF EXTERNAL CHALLENGE

4.3.1 External challenge

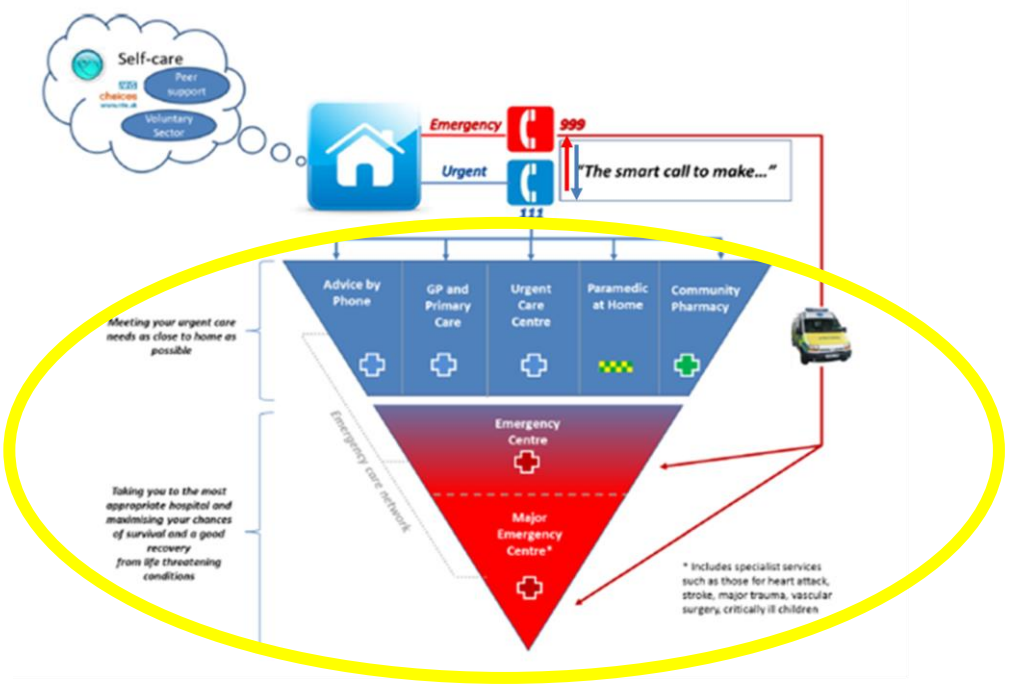
Keogh report

The Keogh report gives ambulance services a pivotal role in urgent and emergency care systems, especially the proposed 'paramedic at home' service. SCAS's ability to respond to this challenge is dependent on our scope to invest in developing a mobile workforce with advanced clinical skills.

Recruitment and retention of clinicians

Mobile clinicians (such as paramedics) are increasingly recognised as having skills required by other organisations, and SCAS needs to work hard to articulate an attractive vision and to recruit, develop and retain the workforce required to deliver the vision for the future.

[7] STEMI (ST segment elevation myocardial infarction, a type of heart attack)



Competitive tendering

Commissioners are required to competitively tender all services. This is already starting to have implications for our services for health care professional (which have been included in some tenders for patient transport services).

We predict that all aspects of the mobile healthcare service, including the emergency component, will be subject to competitive tendering over the next few years.

Community providers

Our market analysis suggests that community providers are likely to plan expansion in this area. They are currently providing support to people in the community during core hours and likely to seek funding through Better Care Funds to expand the hours of this provision.

SCAS is currently providing 24/7 mobile healthcare and seeking to protect its income by using these teams to provide out-of-hours assessments in response to urgent and planned referrals, as well as emergency 999 calls.

Collaboration and competition

This competitive context makes it increasingly challenging to collaborate with partner agencies to find ways to provide integrated pathways and seamless packages of care.

Local nuance

There is significant activity within local communities to encourage health and social care partners to work more collaboratively and to create innovative ways to support more people in the community. This requires a high level of investment in managerial time to engage in this activity and to find ways to respond to the local nuances required in order to work collaboratively with local partners.

Electronic communication and records

The adoption of electronic communication and record keeping present enormous opportunities to the mobile healthcare teams in SCAS, as they will be able to access information about an individual

patient's condition, care plan and the services available in the local area. We are working with local GPs and other stakeholders to encourage adoption of Summary Care Records and to ensure visibility by SCAS clinicians.

Investment

SCAS needs to invest in developing the workforce and technology required to achieve its ambitions as a mobile healthcare provider. Commercial organisations are better able to make these kinds of investment.

4.3.2 Sustainability risks

The key uncertainties are:	*Mitigation*
• If increased competition drives down income for mobile healthcare services, there is a risk that it may bring the financial sustainability of these services into question.	We are focussing on operational efficiency and effectiveness, in order both to maintain our good track record for performance and to minimise costs.
• If competitive tendering results in the fragmentation of mobile healthcare services within a geographical patch, there is a risk that it may bring the operational sustainability of these services into question. This is a particular risk in rural areas, where there is lower demand for any particular service and efficient use of resources is reliant on multiple services sharing the use of a Mobile Team.	SCAS is working hard to articulate and make optimal use of the synergies between various mobile services.
• If the lead provider concept is taken forward by some commissioners, this may create a risk in terms of the geographical fragmentation of SCAS, with services in the relevant areas sub-contracted by the lead provider.	SCAS is working with partners to integrate service delivery at local level, whilst balancing the benefits of standardisation and economies of scale across a wider geography.

4.3.3 SCAS role in future

It is clear that SCAS continues to have a critical role in saving lives. In future, our mobile healthcare teams will also be pivotal in supporting people at home and local communities.

4.4 STRATEGIC OPTIONS CONSIDERED

Again, we have explored a wide range of options for our mobile healthcare teams:

- Using our infrastructure in new ways
- Using our Mobile Teams in new ways
- Developing a new approach to care offered
- Transforming our cost base
- Expanding geographically
- Shrink this aspect of our business

4.4.1 Using our infrastructure in new ways

Electronic records and communication

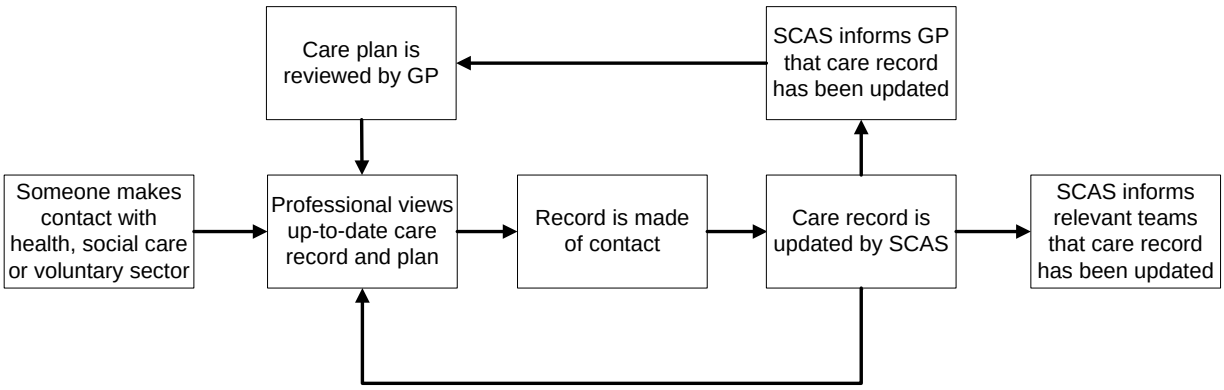
We are currently implementing systems within SCAS to enable our mobile clinicians to use Electronic Patient Records and to see Summary Care Records.

Once these systems are in place, we could offer the facilities to other services. For example, we could provide the facilities for out-of-hours GPs and community teams to be able to use Summary Care Records and Electronic Patient Record whilst on scene.

Integrated Alert System

SCAS could use its tools and infrastructure, particularly NHS number, Electronic Patient Record and visibility of Summary Care Records, to provide an integrated alert system for teams providing care across a local system of care.

The overall concept is simple:



4.4.2 Using our mobile teams in new ways

Pathway on Directory of Services

Our mobile clinicians currently undertake clinical assessments and provide treatment on scene for people who have called 999. If commissioned, we could offer 'SCAS mobile healthcare teams' as a pathway on the Directory of Services, so that SCAS clinicians can receive referrals for people who need urgent or planned assessment or treatment on scene.

Home visits for GPs

We could also take referrals from GPs and do 'home visits' on their behalf, reporting back as the 'eyes and ears' of a practice-based GP.

Emergency Care Practitioner nursing homes

We have a number of Emergency Care Practitioners, whose advanced paramedic skills could be used in a liaison capacity with residential and nursing homes. This may help to ensure that appropriate plans are in place before a crisis situation, and potentially to prevent some crisis situations. The Emergency Care Practitioners would be expected to liaise closely with the GP covering the home.

Falls service

Nearly a fifth of 999 incidents relate to a fall. Some are uninjured and simply need help to get off the floor. Others are in life-threatening situations.

We know that people who are over 65 years who have fallen more than once in a year are at high risk of repeat fall. In view of this, we have set up a scheme to refer people at risk of a repeat fall to the local falls assessment service.

We could develop our services beyond this and offer an assessment before the next fall, also avoiding the need for another clinician to be called to the patient.

Liaison with Integrated Care Teams
Our senior clinicians (perhaps Team Leaders) could work with Integrated Care Teams to ensure that care is coordinated and seamless in the relevant patch. This could involve participation in multi-disciplinary team meetings, along with support within SCAS to take forward innovative ideas.

Tele-monitoring
Many local health communities are exploring the possibility of tele-monitoring, and SCAS hopes to become a key provider of this service (see section 3).

Whichever organisation(s) provide the technical platform and telephone service for tele-monitoring, SCAS mobile healthcare teams could provide a mobile response service for those patients who are flagged as needing an on-scene assessment.

Direct access to community and specialist services
SCAS mobile clinicians could be given direct access to refer patients to community and specialist services, according to the services available on the local Directory of Services and the plans in the patient's Summary Care Record. This would enable SCAS to prevent some unnecessary attendances in emergency departments.

4.4.3 New approach

GP out-of-hours provider
SCAS could incorporate the provision of GP out-of-hours services into its core services. This would mean that we have GP skills within our portfolio of mobile healthcare responses.

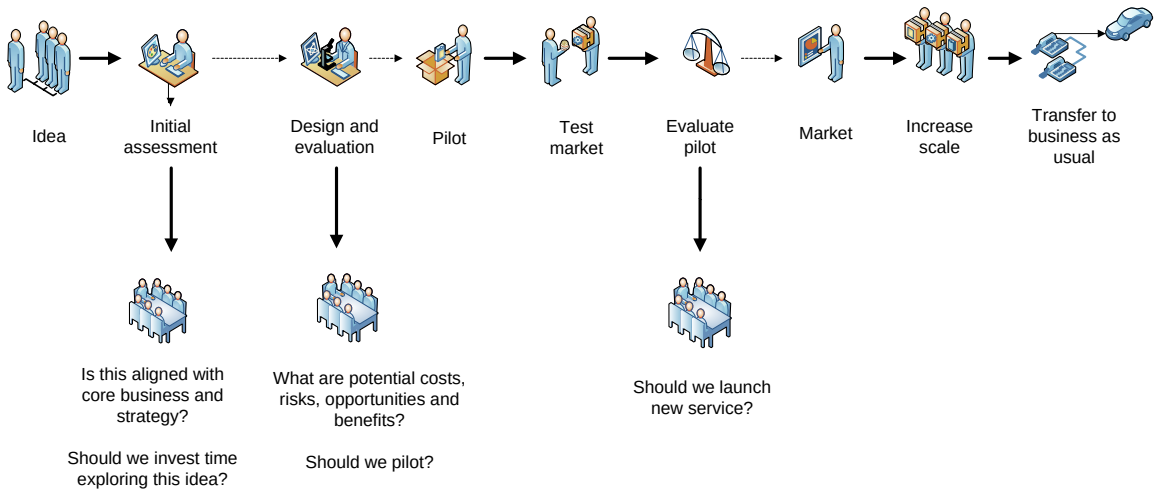
At home diagnostics
We could explore technological developments in terms of mobile diagnostic equipment, and consider offering an 'at home diagnostics service'. We would need to explore the skills required to use the equipment, as well as likely demand, cost and transportability.

Voluntary sector
We already have a number of Community First Responders, Co-Responders (e.g. from the Fire Service) and Staff Responders (who are clinically trained but do not respond as part of their normal day to day duties). We are looking at options for improving our engagement with and utilisation of the voluntary sector.

Prevention
SCAS has considered ways of helping to prevent health emergencies, and looked for ways of learning from the approach adopted by Fire and Rescue Services.

Set up transformation and innovation hub
In response to the small local nature of the innovations in mobile healthcare, we could set up a process designed to nurture innovative ideas, pilot potential solutions on a small scale and to roll out across a wider geography once developed.

Innovation and incubation hub



4.4.4 Develop our mobile workforce at risk

There are very long lead-in times to develop mobile clinicians, especially those with advanced skills. SCAS needs to consider developing the workforce based on predicted requirements, well ahead of any contracts. If not, there is a risk that SCAS is not in a position to bid for the work as and when opportunities arise.

Paramedic development
SCAS could develop and diversify its paramedic workforce, including the development paramedics with primary care or urgent care expertise, and critical care paramedics.

Other healthcare professionals
SCAS needs to work with, and potentially employ, a wider range of healthcare professionals. For example GPs, mental health specialists, midwives, occupational therapists or physiotherapists could all be engaged in order to respond to suitable patients. Their contribution could either be through dispatch to scene or virtual consultations via the Clinical Coordination Centres.

Deployment model
A predicted deployment model is needed to inform the nature and size of the future workforce. For example, some deployment models would include the requirement for a technician (or equivalent level), whereas other models would preclude this option.

4.4.5 Geographic expansion

Other options include geographic expansion of either our existing emergency service or redesigned mobile healthcare teams.

Ambulances services on our northern and eastern borders are struggling to provide financially sustainable high-quality services or to achieve Foundation Trust status. This could provide an opportunity for SCAS to expand as a step-in provider.

4.4.6 Cost transformation

All services within SCAS are exploring options to transform their cost base, in order to secure their competitive position as the provider of choice.

For mobile healthcare services, the options being explored relate to improving the alignment of resources to fluctuating demand, and the potential to improve utilisation of resources through greater synergies between our various field operations: emergency operations, urgent mobile healthcare, urgent conveyance to or between health settings, and planned patient transport.

Clinical redesign	Review the deployment model, to ensure that the skills and vehicle required are matched to the needs of the patient 'right time, first time', reducing the need for more than one response to be dispatched
Partnerships	Work with GPs and integrated care teams in each local system to ensure that people are supported in their own homes and local communities, reducing the need for inappropriate conveyance to hospital
Volunteers	Expand our indirect resourcing scheme, ensuring consistent and fast responses to emergency calls without significant additional investment
Technology	Give mobile clinicians access to the local Directory of Services, for both SCAS clinicians and partner agencies, reducing the need for inappropriate conveyance to hospital
Scheduling	Improve our capability to predict demand and introduce greater flexibility to match the workforce to demand, including consideration of the benefits of sharing the workforce and fleet resources between emergency responders, healthcare professional and patient transport services
Cost base	Reduce reliance on private providers by forecasting requirements, and then recruiting, developing and retaining the workforce accordingly.

4.4.7 Shrink

Rather than expand its mobile healthcare service, SCAS could shrink this aspect of its business.

SCAS plans, and is expected, to support commissioners in identifying gaps on the Directory of Services. If gaps are successfully addressed, the activity of emergency ambulance services should reduce, or at the very least growth should be minimised. The remaining activity would be focussed on those patients who are in life-threatening situations and need emergency conveyance.

SCAS could off-set this reduction in emergency activity by offering to provide mobile healthcare services that help to address the service gaps in the first place. Many of the strategic options considered earlier in this section have been developed on this basis.

Alternatively, SCAS could work with commissioners to identify shortfalls and gaps in services across local systems of care, but not play a part in providing the services to address them. This would result in shrinkage of the mobile healthcare service (or at least prevent the predicted growth).

The risk of shrinking the mobile healthcare service is that this may compromise the sustainability of the remaining emergency service. A critical mass of emergency resources would still be required, particularly in rural areas, despite the loss of activity and income.

4.5 ASSESSMENT OF STRATEGIC OPTIONS

The strategic options identified above have been assessed against the following criteria:

- Benefit to patient care
- Benefit to local systems of care
- Strategic fit
- Investment required to achieve strategic option
- Risks during change
- Impact on SCAS clinical sustainability
- Impact on SCAS operational sustainability
- Impact on SCAS financial sustainability

4.6 STRATEGIC OPTION SELECTED

Strategic direction

The Board has concluded that we should work with local partners to find new and innovative ways to support people in their own homes or local communities.

We will prioritise the larger scale technical developments, exploring ways to enable partner organisations to make use of our technical infrastructure, so that patients benefit from the increased integration and communication between the various organisations involved in their care.

Where there are opportunities to do so, we will enhance our mobile healthcare services. For example, where there is a gap in the service provision in a local community, our mobile clinicians could be available to offer clinical assessments on scene for urgent or planned care. These developments are only envisaged within the area where SCAS provides emergency 999 services.

SCAS role in future

- To save lives
- To facilitate efficient and effective flow of patients around local systems of care
- To enable you to stay safely in your own home or local community

Vision

- 24/7 mobile clinical workforce
- Streamlined and fast processes
- Electronic communication and patient records
- Response tailored to needs of the patient and the incident
- Strong clinical links with trauma and other networks
- Specialist care during journey to the most appropriate unit
- Resilient services, prepared for any eventuality
- Close liaison with GPs, virtual wards, community and integrated care teams
- SCAS integrated alert system
- Services commissioned and available via the local Directory of Services
- Urgent and planned assessment and treatment (as well as emergency responses)
- Mobile response service linked to tele-monitoring

4.7 **REASONS**

Patient benefit

Patients will be supported in their homes or local communities, with 24/7 mobile clinical teams available to respond day or night, and working closely with the patient's GP and other care teams.

Good electronic communication and record keeping will enable better coordination of care.

This should reduce the risk of patient requiring an emergency admission and facilitate speedier discharge from hospital following any admission.

Impact on service

SCAS needs to redesign its service model and develop the workforce required to support people at home and in local communities.

There is scope to review the divide between emergency response teams and patient transport, as there is an overlap in the clinical needs of patients utilising these services. Some patients requiring planned transport have high levels of clinical need, whereas some patients requiring emergency conveyance to hospital could be taken in a car. We need to find ways of tailoring our response to meet individual needs and making optimal use of the resources available.

The new model is also needed to inform our fleet strategy.

Impact on local health economies

Coordinated and responsive support at home should reduce the growth in demand for 999 calls and emergency admissions. It should also facilitate timely discharge from hospital, reducing the overall growth in demand for emergency bed capacity in the acute sector.

Alignment with local health economy requirements

This strategy is extremely well-aligned to the vision of many of our local health economies and discussions about longer term transformation required in relation to Better Care Funds.

The key challenges are:

- To position SCAS as the organisation that is commissioned to provide additional mobile health care services
- To make the investment in our workforce development necessary to achieve these longer term goals

5 PATIENT TRANSPORT

5.1 CURRENT SERVICE

GPs and other healthcare professionals can book transport for patients who are either unable to make their own way to health service appointments, or eligible for NHS transport. Transport is mainly booked by on-line, supported by access to a call centre for enquiries or changes to bookings.

5.2 CHANGES IN PROGRESS

IT strategy

Work is underway to transform the IT infrastructure for Patient Transport and Logistics services

The Patient Transport services hubs are moving onto a common computer system, enabling virtual and streamlined services across the two communication centres.

There have pilots to assess the benefits of both on-line bookings and electronic communication devices for road staff. These schemes have been successful and are being rolled out across Patient Transport services.

The new IT systems will fit GPS tracking capability, which will enable dynamic scheduling of vehicles and communication updates to patients. This will support more efficient use of resources, better accommodate traffic issues, improve communications and customer care.

Competitive tendering

SCAS has recently won the Patient Transport contract for the Southampton, Portsmouth and Hampshire area. Contracts were previously held by a variety of provider and the award of this combined contract represents a tripling of the previous business in this area.

SCAS is in the process of tendering for several other Patient Transport Service bids. If these are successful, SCAS will substantially expand its Patient Transport Service. If unsuccessful, significant services and income could be lost.

Resettlement service

The Patient Transport Service in the Southampton, Portsmouth and Hampshire area will include a new 'resettlement service', and SCAS will offer a service to check on the welfare of patients shortly after discharge from hospital.

Partnership approach

SCAS is developing partnerships with the voluntary, third sector and local authority organisations, in order to offer a more cost-effective service.

5.3 IMPACT OF EXTERNAL CHALLENGE

5.3.1 External challenge

All of SCAS Patient Transport Service business will be subject to competitive tendering over the next two years.

Impact on income

Whether or not SCAS win these bids, the process of competitive tendering is likely to have a detrimental impact on our income and also creates a cost pressure in terms of bid teams. We need to balance the risks of either losing contracts to lower bidders, or reducing our own prices in order to retain the contracts.

Healthcare professional requests for transport

Some commissioners are exploring the option of incorporating of urgent transport requests from GPs or other healthcare professionals in their Patient Transport Service tendering processes.

In areas where SCAS provides emergency 999 services, the potential loss of these services to more successful competitive bidders presents a risk as SCAS currently uses a combined workforce to respond to both emergency 999 and healthcare professional calls.

In areas where SCAS does not provide 999 services, this presents the opposite risks. Without the synergies between 999 and healthcare professional services, it is much more challenging to develop a clinically, operationally and financially viable proposal for tender submissions.

5.3.2 Sustainability risks

We have recently transformed the cost base within Patient Transport Service and they are currently clinically, operationally and financially sustainable. This balance will need to be brought into question for each tender submission and contract negotiation.

If a suitable balance cannot be struck, SCAS will not bid for the relevant Patient Transport Service business. This presents the risk of significant exit costs.

5.3.3 SCAS role in future

The Trust Board has concluded that Patient Transport Service is a key part of our business and pivotal in terms of SCAS's role in both transporting people safely between home and healthcare settings, and in facilitating good patient flow around local systems of care.

5.4 STRATEGIC OPTIONS CONSIDERED

5.4.1 New roles

SCAS could develop new offers as part of the Patient Transport Service. For example, we could offer the 'resettlement service' (which is being developed in the Southampton, Portsmouth and Hampshire area) when bidding for other contracts.

5.4.2 Shrink

The Trust Board has debated whether Patient Transport Service is a core part of SCAS business, whether it is financially and operationally viable, or whether it would be better for the organisation to focus on other services.

The conclusion is that there are potential synergies between our various 'field operations' and that we should optimise these, rather than lose Patient Transport Service . Therefore, as long as contracts can be negotiated that are financially, operationally and clinically sustainable, Patient Transport Service forms a very important part of the portfolio of services offered by SCAS.

5.4.3 Grow

SCAS seeks to grow its geographical footprint and will look at options to expand the Patient Transport Service into neighbouring areas, as long as contracts can be negotiated that are financially, operationally and clinically sustainable.

5.4.4 Cost transformation

All services within SCAS are exploring options to transform their cost base, in order to secure their competitive position as the provider of choice.

For Patient Transport Services, the options being explored relate to transforming the use of communication technology and exploring the potential to improve utilisation of resources through greater synergies between our various field operations (emergency operations, urgent mobile healthcare, urgent conveyance to or between health settings, and planned patient transport).

Partnerships / volunteers	Develop partnerships with the voluntary, third sector and local authority organisations, in order to offer a more cost-effective service.
Technology	Common computer system, enabling virtual and streamlined services across the two communication centres. On -line bookings and electronic communication devices for road staff, in order to minimise reliance on the communication centre staff.
Scheduling	GPS tracking capability, which will enable dynamic scheduling of vehicles and support more efficient use of resources.

5.5 ASSESSMENT OF STRATEGIC OPTIONS

The strategic options identified above have been assessed against the following criteria:

- Benefit to patient care
- Benefit to local systems of care
- Strategic fit
- Investment required to achieve strategic option
- Risk of change
- Impact on SCAS clinical sustainability
- Impact on SCAS operational sustainability
- Impact on SCAS financial sustainability

5.6 STRATEGIC OPTION SELECTED

Strategic direction

SCAS will review all opportunities for Patient Transport Service in the areas covered by the emergency 999 service and in neighbouring areas. SCAS will seek to be Patient Transport Service provider in all of these regions, as long as clinically, operationally and financially sustainable contracts can be negotiated.

SCAS role in future

- To enable you to travel safely between home and healthcare settings
- To support efficient and effective patient flow around local systems of care

Vision

- Expanded service
- Responses tailored to meet individual needs
- Utilise the most appropriate vehicle and staff to meet patient needs
- Close working between mobile health care and Patient Transport Services
- Timely discharge from hospital
- Resettlement service following discharge from hospital
- Efficient and effective patient flow around systems of care
- Core part of the range of services offered by SCAS

5.7 REASONS

Patient benefit

Patients benefit from better scheduling of transport, reduced journey times and improved communication. They also benefit if the type of transport can be tailored to meet individual needs.

Impact on service

The new IT infrastructure will increase operational efficiency through improved scheduling of resources.

Depending on whether contracts are won and the nature of any contracts, this could have profound implications for the Patient Transport Service.

Impact on local health economies

SCAS is working to facilitate efficient and effective patient flow around local systems of care.

Synergies between emergency response teams, mobile healthcare teams and patient transport services offer significant opportunities for local health systems in terms of support people in their own homes and coordinating care. SCAS will endeavour to take these opportunities forward in areas where it wins contracts.

Alignment with local health economy requirements

Local health economy requirements are being articulated through the tender documents and the alignment of SCAS Patient Transport Service with specified requirements is being tested through the bidding processes.

6 HELICOPTER VIEW

6.1 CURRENT SITUATION

SCAS collects a significant amount of data about local health economies through the provision of 999 and NHS111 services. We propose to analyse this data and 'offer a helicopter view' of local systems. This service does not exist at present.

Analytical capability and capacity

SCAS has the capability to analyse data related to activity numbers and sub-process times on an incident basis. It also has some limited capability to analyse clinical performance.

The Performance Information Team sets up and produces routine performance reports. It also provides ad-hoc analysis, although the demand for analysis continually outstrips the capacity of this team. This demand is coming from both internal SCAS personnel and, increasingly, commissioners who are seeking to understand demand trends and patient flows.

Data is also made accessible to managers via a QlikView platform. The Performance Information Team is in the process of building 'scorecards' to help managers analyse the data that they need.

Data structure and storage

SCAS uses a huge array of software systems, some of which interface with one another on a point-to-point basis, and some which do not interface effectively. The data needs to be structured and stored in a way that enables it to be viewed and analysed via QlikView.

The data warehouse is out-dated and SCAS is currently investing in improved infrastructure.

Analytical requirements

As mentioned above, the internal demand for analysis continually outstrips the capacity of the Performance Information Team. Commissioners are also requesting analysis, some of which SCAS can provide, and some of which SCAS has difficulty providing.

The development of this strategic plan has thrown a spotlight on the deficiencies in terms of our analytical capability and capacity. SCAS has a wealth of data, but we have not been able to effectively access or use this data to inform the development of this strategic plan.

As a consequence of our regional role, SCAS is the only organisation to have oversight of local health systems across the Thames Valley and Wessex areas. We need to be able to access and analyse this data, in order to understand demand trends, patient flow, clinical outcomes, service gaps and the implications of change. Commissioners also need this information and seek it from SCAS.

NHS number

The use of the NHS number as a unique identifier gives us an opportunity to analyse patient basis data, as well as incident based data. This will enable SCAS to analyse and better understand demand trends, patient flow, clinical outcomes, service gaps and the implications of system redesign.

It would also enable us to evaluate the cost of care by patient, highlight exceptionally high-intensity users and help to identify scope for more effective and efficient care.

6.2 IMPACT OF EXTERNAL CHALLENGE

6.2.1 External challenge

Commissioners recognise that SCAS has a wealth of data. They are asking for analysis of demand on our services, and we need to be able to respond.

As for all health services, SCAS is under increasing scrutiny in terms of service delivery, effectiveness of care, patient safety and clinical outcomes. We need to ensure that our clinical performance data is robust and utilise it to drive improvements in care.

One of the challenges faced in our strategic planning process has been the absence of analysis about patient flows, available either internally or externally. SCAS has visibility of patient flows on a day to day basis. Therefore, the challenge for us is to transform this wealth of data into useful information.

6.2.2 Sustainability risks

There are no risks to sustainability of our analytical service, because it does not exist as yet.

The sustainability of other services depends on our ability to drive improvements in terms of efficiency and effectiveness, in terms of clinical, operational and financial performance. We are reliant on analysis to understand performance, identify areas of risk and drive improvements.

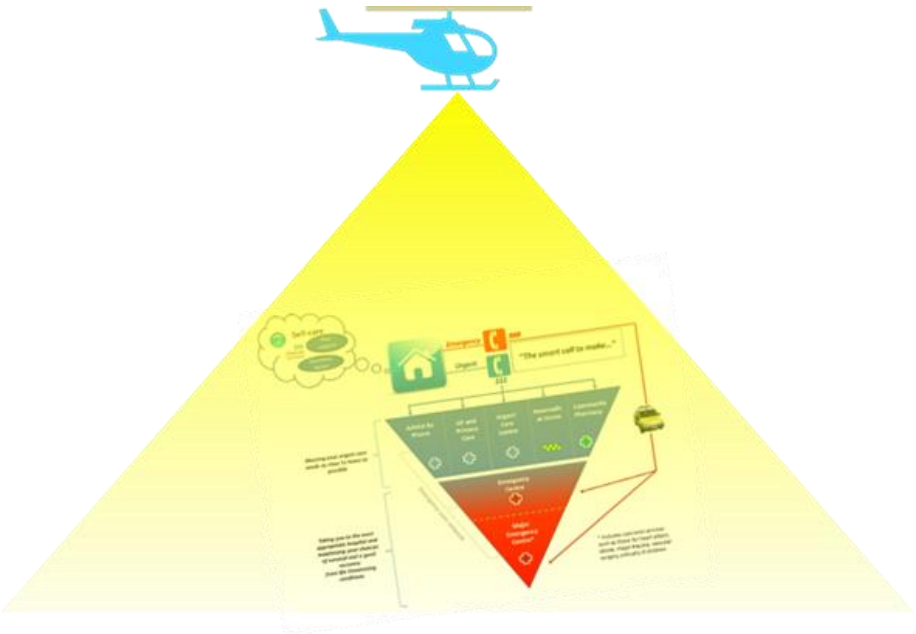
There is a risk if the current investment in infrastructure does not yield the benefits expected.

6.2.3 SCAS role in future

We have a key role in supporting efficient and effective patient flow around systems of care.

We need to transform our analytical capability and capacity in order to underpin this system role with a robust understanding of demand trends, patient flow, clinical outcomes, service gaps and implication of system redesign.

Once we have addressed the current shortfall in analytical capability and capacity, we could offer a 'helicopter view' of systems of care to local commissioners, and potentially other providers.



6.3 STRATEGIC OPTIONS CONSIDERED

SCAS has considered a wide range of options:

- Do nothing
- Develop analytical capability and capacity within SCAS
- Develop capability and capacity in partnership with an academic organisation
- Develop capability and capacity in partnership with a commercial organisation
- Use analysis to understand SCAS demand trends and service delivery
- Offer analysis to commissioners in order to drive system-wide improvements
- Become a 'system manager' or lead provider, on behalf of commissioners
- Become an agent of Clinical Commissioning Groups in overseeing the local systems of care

6.4 ASSESSMENT OF STRATEGIC OPTIONS

The strategic options identified above have been assessed against the following criteria:

- Benefit to patient care
- Benefit to local systems of care
- Strategic fit
- Investment required to achieve strategic option
- Risks of change
- Impact on SCAS clinical sustainability
- Impact on SCAS operational sustainability
- Impact on SCAS financial sustainability

6.5 STRATEGIC OPTION SELECTED

Strategic direction

The Board is currently reviewing options for our informatics and business intelligence strategy and this section will be updated once this work is completed. The likely path is for SCAS to develop capability and capacity in partnership with an academic organisation.

SCAS role in future

- To offer a helicopter view of local systems of care
- To facilitate efficient and effective patient flow around local systems of care

Vision

- SCAS is a credible voice regarding local systems of care, particularly for unscheduled care
- Solid understanding of demands on SCAS services and opportunities for improvement
- High quality analysis of demand trends, patient flows, clinical outcomes, service gaps, capacity constraints, cost pressures and implications of proposed changes
- Able to identify service gaps and provide evidence to inform system redesign, capacity reviews or new pathways
- SCAS is (and is seen to be) an intelligent partner to commissioners
- Become an agent of local commissioners regarding system analysis and monitoring

6.6 **REASONS**

Patient benefit

High quality analysis would enable SCAS to drive improvements in patient care.

The use of NHS numbers across the NHS offers an amazing opportunity to start to analyse data at patient level, and even to identify patients who would benefit from specific care plans.

For example, it would automate the identification of people who are calling emergency 999 on a frequent basis and who may not be receiving the package of care that they need. Currently manual processes are in place for the very frequent callers, but automated systems might help to identify other people who are also at risk of health deterioration.

Impact on service

High quality analysis would also enable SCAS to identify improvements in the efficiency and effectiveness of care.

With a robust understanding of the demand on our services and effectiveness of care, we would be better placed to drive improvements in our service model, capacity plans, processes and performance.

We need to gain a better understanding of demand trends in terms of patient groups and clinical conditions (rather than just incident-level activity). This would enable us to predict future trends and plan for them.

Impact on local health economies

There is scope to analyse patient flows and service gaps from the data gathered in NHS Pathways and the Directory of Services. This analysis would enable SCAS to identify service gaps or capacity issues across the whole system of care, and work with commissioners to improve the services available to patients.

Alignment with local health economy requirements

The strategic objective is to be able to offer commissioners and other partners in the local health economies the information that they need to support delivery of their strategies.

7 OTHER SERVICES

7.1 CURRENT SERVICES

Logistics

SCAS provides non-emergency non-patient transport services, such as samples, in some areas. The contract for the Berkshire area is currently subject to competitive tendering.

Commercial training

SCAS provides some first-aid training. This is on a relatively small scale and subject to ad-hoc contracts for specific training programmes.

National pandemic flu helpline

In the case of a pandemic flu, SCAS is responsible for setting up the national helpline service. SCAS is providing this service as the step-in provider following the closure of NHS Direct. The contract is expected to be subject to competitive tendering within the next two years.

NHS Direct Legacy organisation

From April 2014, SCAS is the legacy organisation for NHS Direct. We are responsible for overseeing the final stages of transfer or redundancy for former staff. We are also responsible for storing historical data.

National NHS111 resilience provider

During the winter of 2013/14, SCAS was the national resilience provider for NHS111 services. This contract ended in March 2014. SCAS would be interested in tendering for any similar contract in the future.

7.2 STRATEGIC PLAN

For these types of service, SCAS does not have a proactive strategy. We are assessing opportunities as and when they arise.

It is essential that these services (or any opportunity for new services) are complementary to our existing core business, they fit with our clinical and operational service models, they are profitable, and they support our long-term sustainability.

8 STRATEGIC PLANS

8.1 SCAS IN THE FUTURE

Services

Simplified access to health and social care (planned, urgent and emergency).

Emergency teams for patients with life-threatening condition, with specialist skills and clinical equipment to treat and convey patients as needed.

SCAS mobile healthcare teams continue to save lives, and also support people to stay safely in their own homes, by offering on-scene assessment and treatment.

Proactive welfare calls to people at home who are at risk of deterioration or recently discharged from hospital.

SCAS integrated alert system (updating Summary Care Records and alerting community teams 24/7).

Analysis of 'helicopter view of local system' offered to commissioners.

Processes

24/7 telephone, on-line and digital services.

High quality clinical assessment, advice and signposting.

Rapid assessment and dispatch to people with life-threatening conditions.

Response tailored to individual needs, using information from the patient's Summary Care Record to inform clinical assessment and care plans.

Seamless access to services available via the local Directory of Services.

SCAS 24/7 Mobile Teams included as a service option on the Directory of Services.

Organisation

Virtual Clinical Coordination Centres, with a subset of staff shared between the EOC999 and NHS111.

24/7 Mobile Teams include advanced clinical practitioners, who work closely with the GPs and integrated care teams within local systems of care.

Close working between SCAS emergency, urgent and planned services, so that the type of response dispatched to the patient can be tailored to individual needs.

Flexible working to enable alignment of capacity with fluctuating demand.

24/7 fleet workshops to ensure that time off road is minimised.

Hosting arrangements for specialist advice lines and voluntary sector help lines.

GPs working within, or very closely with, the Clinical Coordination Centres.

Tools

Single virtual telephony platform across SCAS.

Comprehensive and up-to-date Directory of Services for each local area.

Electronic communications, including Electronic Patient Records and visibility of Summary Care Records for mobile clinicians.

Systems and processes in place to predict demand, plan capacity and schedule staff/vehicles in line with predicted demand.

	Electronic (rather than paper-based) processes across the organisation. Tele-monitoring capability, linking patient, SCAS Clinical Coordination Centres, SCAS Mobile Teams, GPs and other relevant care teams.
Information	All data linked to NHS number as a common identifier. Improved performance scorecards for each service, with drill down to individual / team performance, and incorporating data from all relevant systems. Analysis of demand on services, performance against contracts, patient flows, clinical outcomes, service gaps and cost implications. Live information, retrospective analysis and predictions based on trends.
Contracts	Wider geographical footprint than former 'south central'. Standard contracts across 111 services, with scope for local nuance. SCAS 24/7 Mobile Teams commissioned for planned and urgent assessment and treatment in people's home (as well as response to emergency 999 calls).

8.2 STRATEGIC PRIORITIES

Priorities 2014-15

Clinical Coordination Centres	Complete implementation of resilient virtual telephony platform. Complete transition of 999 services to NHS Pathways. Align management structure of 111 and 999. Review of working patterns in 111 to better align capacity to demand. Implement time and attendance system and redesign processes in 111, in order to improve operational efficiency and remove manual processes. Set up direct booking of GP appointments out-of-hours. Introduce mental health advice and support line within Clinical Coordination Centres. Improve access to social care services for 999 and 111 callers.
Mobile healthcare	Improved alignment of resources (both staff and vehicles) with fluctuating demand. Cost improvement programme for emergency field operations. Implementation of Electronic Patient Records across SCAS. Implementation of new service model for healthcare professional service. Redesign of the service model for mobile healthcare. Workforce development strategy to support the new service model. Redesign of fleet maintenance and workshops.
Patient Transport	Implementation of a virtual platform, including a CAD system across Patient Transport services. Implementation of an upgraded time and attendance system across Patient

	Transport Services. Implementation of mobile communication devices for road staff. Bids for contracts in the Thames Valley, Wessex and neighbouring areas. Mobilisation of contracts if bids are successful.
Helicopter View	Implement a more resilient informatics infrastructure. Redesign the use of QlikView to enable enhanced reporting. Increase the analytical capability and capacity of SCAS. Incorporate NHS number look up into the call handling process. Implement Electronic Patient Records across mobile healthcare teams. Performance scorecard in place for Patient Transport Services.

Plans 2015-16

Clinical Coordination Centres	Move to mirrored 999 and 111 services, so that a subset of staff can work across both services and help to accommodate fluctuating demand. Redesign services if required in response to new national specification. Bid to renew existing 111 contracts and secure new contracts (competitive tendering expected to follow publication of new national specification). Gain visibility of Summary Care Records for staff within Clinical Coordination Centres. Undertake feasibility assessment of tele-monitoring.
Mobile Healthcare	Visibility of Summary Care Records by mobile clinicians. Implementation of changes to the service model for mobile healthcare.
Patient Transport	Bids for contracts in the Thames Valley, Wessex and neighbouring areas Mobilisation of contracts if bids are successful.
Helicopter View	Enable SCAS clinicians to be able to see Summary Care Records. Agree data sharing arrangements with partner providers, so that we can analyse clinical outcomes. Analyse demand patterns, patient flows, clinical outcomes and service gaps. Use high-quality analysis of data to drive further efficiencies within the business.

Strategic intentions 2016-19

Clinical Coordination Centres	On-line services, image transfer and video links. Booking of planned GP appointments. Single point of access for social care. Booking of planned care (e.g. appointments line for choose and book).

Mobile Healthcare	Work with local partners to find new and innovative ways to support people in their own homes or local communities. Explore ways to enable partner organisations to make use of our technical infrastructure, so that patients benefit from the increased integration and communication between the various organisations involved in their care. Where there are opportunities to do so, we will enhance our mobile healthcare services.
Patient Transport	The on-going strategy is subject to the outcome of the tender processes.
Helicopter View	This section will be updated once strategic options have been reviewed by the Board.

8.3 RESOURCE REQUIREMENTS

£0.4m of additional resource has been included in the 2014-15 plan.
This increases to £0.8m by year 5. In addition we have start-up costs relating to each new contract.

8.4 DEPENDENCIES

The critical enabling schemes to this strategy are outlined below:

- Virtual telephony and resilient technical platform across SCAS
- Ensuring that local Directories of Services are comprehensive, accurate and up-to-date
- Electronic communication and records (Electronic Patient Record and Summary Care Records)
- Analytical capability and capacity to provide the 'helicopter view'
- Workforce development (particularly mobile clinicians with advanced skills)
- Technological development (for example tele-monitoring or digital capability)
- Cost transformation programme

8.5 COMMUNICATION PLAN

This strategy has been developed in conjunction with SCAS governors, and is built on strategic engagement discussions with commissioners. Both of these groups will continue to be engaged in further development of the strategy and the associated transformation programme.

Health and Well-being Boards have not been directly engaged in development of this strategy. However, discussions with commissioners were about SCAS's role in supporting local systems in delivering the transformation programmes associated with Better Care Funds.

SCAS leaders were engaged in the development of the strategy, and will continue to be involved as it is developed in greater detail. They are also continually engaged in the transformation programme and there is a specific communication plan for each change initiative during the relevant period of delivery.

We have a team structure, which is critical in terms of engaging the 'hearts and minds' of our staff.

We will ask Team Leaders to discuss relevant sections of the strategy with staff during team meetings. To support this, we will produce a two or three page summary and slide pack. Area Managers and Heads of EOC/111/Patient Transport Service will be given detailed briefings on the strategy and encouraged to support Team Leaders to find innovative and engaging ways to communicate relevant sections of the strategy to their teams.

Summaries of the five-year Strategic Plan and two-year Operational Plan will be made available to all SCAS staff via the intranet.

Again, summaries of the Strategic Plan and Operational Plan will be made available to the public and patients via the internet. They will also be discussed at public Board meetings.

8.6 MONITORING DELIVERY OF STRATEGIC PLAN

SCAS has adopted a portfolio management approach to the design, prioritisation and delivery of the transformation programme required to deliver this strategy.

There is a virtual 'Portfolio Office', operating according to best practice PRINCE2®, MSP®, MoP® and P3O® methodology[8]. Projects report to the Portfolio Office on at least a monthly basis.

The Executive Team meet as a 'Transformation Board' every two months, in order to prioritise projects and resources, oversee the delivery of the transformation programme, and to manage major risks or issues facing projects.

Leaders of the various teams[9] involved in delivering change meet as a Project Advisory Board (PAB) each month. This group reviews business cases and project plans to ensure that the resource requirements and implications of change have been thought through properly. The PAB advises the Transformation Board on the validity of business cases, and makes recommendations about the inter-dependencies between projects, phasing of change activities, and the prioritisation and coordination of specialist resources required to deliver change.

The Service Development Team operates like an internal consultancy, offering project management and other change management skills. The team manages the design and delivery of the most complex cross-directorate or risky projects, and offers advice to the managers implementing smaller change initiatives within directorates.

Risks are identified and managed within each project. Major risks are escalated to the Transformation Board and, if appropriate, incorporated into the Corporate Risk Register.

[8] Cabinet Office guidance: Projects in a Controlled Environment (PRINCE2), Managing Successful Programmes (MSP), Management of Portfolios (MoP) and Portfolio, Programme and Project Offices (P3O)

[9] The PAB includes senior representatives from Finance, HR, IT, Performance Information, Procurement, Service Development and the Portfolio Office