



The Scottish Ambulance Service Board

Health Plan 2008/09 to 2010/11,

(including Local Delivery Plan and Development Programme)

FINAL VERSION

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April 2008

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EXECUTIVE SUMMARY

This Health Plan sets out the Service's performance objectives over the next 3 years - the *Delivery Plan* - together with a strategic development programme showing how we will deliver on the planned performance whilst playing an integral part in the Scottish Government's wider objectives for NHS Scotland. The Delivery Plan comprises the Service's 'HEAT' Targets. The Plan is compiled through a process of engagement with key stakeholders.

The Service's goals with respect to the Delivery Plan can be summarised:

- Save more lives
- Improve health outcomes for patients
- Treat patients more locally to reduce hospital admissions

We provide Accident and Emergency Services and Patient Transport Services, both supported by the Air Ambulance Service. Prioritisation and patient care are fundamental to all our work. The Service is increasingly providing out-of-hours and primary care support as part of a multi-disciplinary team.

A strategic development programme has been in place for several years, progressing a number of major service developments and enhancements in support of *Delivering for Health* designed to help shift the balance of care and contribute to a reduction in health inequalities. The Service will continue to review and revise its development programme, both in terms of its objectives and structure, and particularly in light of the Scottish Government's *Better Health Better Care* Action Plan (published on 12 December 2007).

SECTION 1 - INTRODUCTION

Purpose of Plan

This Health Plan and Delivery Plan sets out the Service's planned objectives and performance targets over the three year period from April 2008 to March 2011. It is designed to:

- Outline our strategic direction
- Identify our contribution towards the *Better Health Better Care* action plan
- Assist the Board in fulfilling its corporate governance role
- Specify our major implementation and development plans for the forthcoming years
- Involve stakeholders, including the wider public, in shaping our strategy through consultation on the plan and strategic planning events
- Promote accountability by setting out measurable targets in key areas of service delivery and performance
- Inform action by staff throughout the organisation

The Scottish Ambulance Service provides Accident and Emergency Services and Patient Transport Services, both supported by the Air Ambulance Service. The Service is increasingly providing out-of-hours and primary care support as part of a multi-disciplinary team. The Service is committed to achieving continuous improvement in each area of service it provides.

Format of Plan

This Health Plan is structured as follows:

- the **Introduction** and general background (Section 1)
- the **Strategic Context** (Section 2) outlining the policy, legislative, regulatory and societal framework under which the Service must operate
- the **Delivery Plan** (Section 3), which sets out what the Service is aiming to achieve in terms of performance over the three year period
- the **Development Programme** (Section 4), which sets out how the Service will develop in order to deliver the planned performance,

including its key contribution to NHS Scotland's *Better Health Better Care* action plan.

- the **Implementation and Control** process (Section 5) outlining how the Service will measure and manage performance against its stated objectives
- the **Financial Plan** (Section 6)

Accident and Emergency Service

In the Accident and Emergency Service, the Service's strategy is predicated upon:

- **Prioritisation**, so that the speed and type of emergency response reflects the clinical condition of the patient
- **Patient care** so that continuous improvement or the maintenance of gold standards is achieved in the intrinsic quality, appropriateness and timeliness of the care received by patients at scene and, if required, during transfer to appropriate care. This includes the patient's own perception of their care gleaned from structured surveys etc.
- **Staff development**, including enhancing skills so that Service staff can play a key role in multidisciplinary healthcare provision within the community and assist NHS Scotland and patients in managing long term chronic conditions out of hospital
- **Efficiency**, so that the best possible use is made of available resources and that value for money is achieved
- **Technology**, so that the advantages of information and clinical technology can contribute to increased effectiveness and efficiency of service delivery and patient care
- **Collaborating closely with our NHS and other partners** – both at an operational level in delivering services 24/7 and at a strategic level in planning and redesigning health and care services. The Service has a wide range of actual and prospective partners, including Local Authorities, voluntary organisations, volunteers, the private sector, patients, carers and the wider community

Patient Transport Service

In the Patient Transport Service, the Service's strategy is predicated upon:

- **Prioritisation**, so that the service provided is tailored to the needs of the patient in terms of the resources used (staff and vehicles) and the punctuality of the service

- **Patient care** so that continuous improvement (or the maintenance of 'gold standards') is achieved in the intrinsic quality and appropriateness of the care received by patients. As with the A&E Service, this includes the patient's own perception of their care gleaned from structured surveys etc.
- **Staff development**, including enhancing skills in areas such as palliative care so that the Service can play a key role in community healthcare provision
- **Technology**, so that the advantages of information and clinical technology can contribute to increased effectiveness and efficiency of service delivery and patient care
- **Collaboration of public, private and voluntary sectors** to connect resources, systems and processes and maximise the efficient use of all the available resources. This is a significant challenge to achieve in practice due to the range of agencies involved in transportation and their varying development plans and priorities. The Service also acknowledges its important role at the interface between social care and health care and will work closely with other service providers to meet the needs of patients and staff
- **Underpinning the A&E Service** so that A&E resources, where possible, are not used to transport non-emergency patients. This is especially important to the Service as it redoubles its efforts on ensuring that Category A performance targets are met

Key Challenges

These strategies and priorities for the A&E service and the Patient Transport Service present the Ambulance Service with some major challenges, including:

- **Clinical developments** - ensuring that staff are appropriately trained and equipped for their newly emerging role, e.g. treatment of minor injuries at scene, management of chronic conditions out of hospital and ensuring appropriate clinical supervision and audit. The Service will promote a co-ordinated approach across NHS Scotland, particularly in relation to complimentary or overlapping roles, e.g. community paramedics, emergency care practitioners, physicians assistants etc. We will also use our research and development capacity to enhance the evidence-base and inform good practice
- **Workforce and resource planning** - determining the numbers, mix and precise roles of staff, vehicles and equipment in each locality; challenges associated with ever growing emergency demand and a changing demand profile for patient transport services; challenges associated with minimising the need to have emergency staff working 'on call' or standby and challenges and opportunities arising from the implementation of Agenda for Change.

- **Service redesign** – early joint planning with NHS Boards is essential to ensure that ambulance services are not adversely affected by changes to the structure and location of A&E and other hospital services and that Boards are effectively engaged with the Service's own redesign plans
- **Health and safety** - minimising and controlling the risks to staff and patients associated with manual handling and stress in a 24/7 shift-working emergency service
- **Infection control** - minimising the risks of infection in a service undertaking around 2 million emergency and non-emergency patient journeys per annum
- **Major incident management** – ensuring that the Service is equipped with the necessary resources, communication systems, skills and leadership to undertake the effective management of major incidents in collaboration with partner agencies
- **Investment decisions** - increases in emergency demand have been rising much faster than all previous expectations over the past few years and this provides a great challenge to the Service. A number of measures are in place to maximise operational performance and ensure efficiently delivered services. Nevertheless, given the scale of the performance challenge ahead, and the tighter financial climate which all NHS Scotland Boards are now in, the Service will have difficult choices to make in order to ensure it delivers on its key priorities
- **Communications** – the Service has been changing rapidly in recent years, harnessing advances in technology, enhancing the clinical skills of its staff and becoming an ever more integral part of the NHS in Scotland. These major changes have occurred in parallel with huge increases in emergency demand. Whilst patient and public opinion would suggest that the Ambulance Service is generally considered in a positive light, the Service recognises a growing need to communicate more effectively with its stakeholders, particularly the public, about its strategies, successes and areas for improvement and to capture their views on these issues more successfully

SECTION 2 – STRATEGIC CONTEXT

A) Compliance and Improvement Context -

i) Government Objectives and Performance Targets

Each NHS Board, including Special Boards such as the Ambulance Service and NHS24 must set out in a Local Delivery Plan (LDP), an annual delivery agreement with the Scottish Government Health Directorate. This is based on key Ministerial objectives known as HEAT targets, under the following headings:

- **Health Improvement** for the People of Scotland – to improve life expectancy and quality of life
- **Efficiency** and Governance – to improve the value-for-money and effectiveness of the NHS
- **Access** to Health Services – to improve the speed and ease with which patients can receive healthcare
- **Treatment** Appropriate to Individuals – to ensure patients receive high quality services that meet their needs.

ii) 'Better Health Better Care' (BHBC)

Our recent Health Plans have outlined strategies in support of *Delivering for Health* (2005), the then Scottish Executive's response to Professor David Kerr's report, the *National Framework for Service Change*. *Delivering for Health* emphasised the need to focus effort on improving health and well-being through preventative medicine, better local services, support for self-care, improving efficiency and targeting of resources on those at greatest risk.

The new Scottish Government have outlined an intention to continue in a broadly similar manner detailed in the *Better Health Better Care* Action Plan on 12 December 2007. The Service has reviewed its strategic plans in light of this document, and consulted on its contribution to BHBC, at a strategic planning event for stakeholders in January 2008.

The table below shows the high-level areas of SAS activity and development which will support the delivery of the BHBC Action Plan.

Scottish Ambulance Service Actions in support of *Better Health Better Care (BHBC)* Action Plan

<i>Better Health Better Care</i> 'Dimension of Quality'	Example Scottish Ambulance Service Actions / Strategies / Evidence Sources in Support
Patient-centredness	<ul style="list-style-type: none"> • Patient Focus Public Involvement (PFPI) programme • Information for patients and carers • Patient experience surveys • Complaints and commendations • Palliative care developments • Patient transport performance
Patient-safety	<ul style="list-style-type: none"> • Health and safety programme • Infection control • Clinical audit • Risk management • Research and development
Effectiveness	<ul style="list-style-type: none"> • Operational performance management • Contribution to national clinical priorities • Contribution to community-based care • Mental health developments
Efficiency	<ul style="list-style-type: none"> • Financial performance • Cash efficiency savings • Sickness absence • Benchmarking systems • 'Efficient Government' initiatives • Implementation of Lean principles • Evidence based clinical practice • Environmental strategy • EHealth and Telehealth developments
Equity	<ul style="list-style-type: none"> • Remote and rural solutions • Equality and diversity programme
Timeliness	<ul style="list-style-type: none"> • Operational performance management • Unscheduled care collaborations

The delivery and monitoring structures which the Scottish Government and NHS Scotland will use to implement the BHBC Action Plan are being agreed with NHS Boards at the time of writing. The Service will review its own development programme structures and connections (see page 57) in light of this to ensure that its contribution to key strategic themes is maximised and is highly transparent, internally and externally. This will ensure that the strategies and actions in the table above can be shown to contribute both to the 'quality dimensions' of BHBC (patient-centredness, efficiency etc) but also to crucial developmental and infrastructure issues such as:

- Service planning
- Managed Clinical Networks
- Workforce planning

- Leadership development
- Long term conditions
- Health inequalities
- Mental health and wellbeing
- Alcohol and drug misuse
- Vulnerability
- Child health
- Anticipatory and preventative care
- Employability
- Carers
- Palliative care
- Transport
- National clinical priorities
- Reducing our carbon footprint
- Unscheduled care
- Planned care
- Remote and rural healthcare

The Service's emerging Better Health Better Care Delivery Framework will also provide clarity on which Executive Directors of the Service will have lead responsibility for delivering which particular aspects of the development programme.

iii) Partnership

It is essential for the effective delivery of care and services to patients that NHS Boards work in partnership with each other, patient representative bodies and other service providers. The Ambulance Service is fully committed to that principle. We believe that early and ongoing engagement with our partners is essential when they, or we, are considering changes to the design, structure and location of services. The Service is also committed to the principle in the Scottish Government's Better Health Better Care Action Plan of developing a more 'mutual' NHS, including the need to engage effectively with patients, carers and the public on major service changes.

The Service will also continue to pursue appropriate opportunities, joint arrangements for co-location and co-ordination of facilities, resources, training and other activities with external partners, e.g. NHS Boards, Fire and Rescue Services, Police and other organisations. The existing guiding principles of fit-for-purpose and value-for-money will continue to govern all supporting strategies and partnership arrangements.

iv) Equality and Diversity

The Ambulance Service believes that the most effective and appropriate services will be delivered within a robust equality and diversity framework which recognises – and strives to exceed wherever possible – statutory and moral obligations on the Service as an employer and as a provider of services. The principles of inclusion, access, opportunity, dignity and fairness are therefore key drivers for strategic planning, operational delivery and organisational development in the Ambulance Service and inform all aspects

of the Delivery Plan and Development Programme, whether in relation to patients or employees. The Service runs a programme of training for managers in Equalities Impact Assessment.

v) Mental Health

The Service also recognises its obligations under Delivering for Mental Health, published by the Scottish Executive in December 2006. We will work in partnership with professionals, service users and carers to ensure appropriate strategies, procedures and resources are in place to enable the development of best-practice in relation to mental health issues and we will contribute to the Audit Scotland report into mental health services. We will also continue to work closely with the Scottish Government in supporting initiatives designed to reduce suicide. The Service is training its trainers to cascade the Applied Suicide Intervention Skills Training (ASIST) programme throughout the organisation and this builds on the successful implementation of the Mental Health First Aid programme we have rolled out to Ambulance Technicians over the past year.

vi) Patient Focus Public Involvement (PFPI)

The Ambulance Service exists to serve its patients through the delivery of high-quality, effective and safe services which are tailored as much as possible to the needs of individuals. Consequently, the Service will continue to develop its PFPI work, particularly to ensure that strategic planning, operational structures and service design and delivery are appropriately informed by the views of patients, carers and the public.

The Service's PFPI strategies, plans and actions are assessed annually by the Scottish Health Council and the Service will use the feedback from that process to ensure continuous improvement in this field. The Service has also commissioned independent patient surveys in previous years and will seek to develop this work further in the next three years, building upon and learning from, the highly positive findings to date around patient satisfaction and experience.

The Scottish Government's Better Health Better Care Action Plan, published in December 2007, contains a long-term commitment to develop an NHS in Scotland which is based on 'mutuality', whereby individuals are not just 'patients' or 'customers' of the NHS, but partners in it as citizens, with rights and responsibilities. Part of this commitment, includes an intention to monitor the performance of NHS Boards more closely in relation to how patients actually experience services provided and to develop a 'HEAT' performance target in this respect. The Service is committed to the appropriate measurement of its performance in this respect.

vii) Emergency Planning / Civil Contingencies

The Service has specific duties in relation to the Civil Contingencies Act and more generally, as a front-line emergency service in relation to planning and

provision around major incidents and continuity of service in unusual or exceptional circumstances. We work closely on these issues with the Scottish and UK Governments and a range of agencies at various levels. We deliver specialised training and guidance, and conduct periodic audits of preparedness.

The Service also has a number of Special Operational Response Teams (SORT) which were established to help manage the consequences of the release of chemical, biological, radioactive, nuclear (CBRN) and explosive substances, whether deliberate or accidental. Their role includes rapid response wherever their special skills, equipment or manpower would assist the care of patients, particularly in major incidents with multiple casualties. The Scottish Executive approved funding in 2007/08 to improve infrastructure, resources and technology required for a 'model' ambulance service responses to such incidents.

viii) Sustainable Development / Environmental Strategy

The Service is committed to meeting its societal obligations in the efficient and safe use of natural and physical resources, and in achieving economic benefits to the organisation from this approach. The Environmental Strategy Group will continue to develop and enhance the organisation's policies and activities in this regard. The Service notes the contribution to sustainable development that the Scottish Government believes NHS Boards can make, outlined in the *Better Health Better Care* Action Plan.

Work was undertaken in 2007/08 on 'travel planning' at a number of key Service sites following consultancy funding from the Energy Saving Trust. This work will be built upon in 2008/09 in order to ensure that the Service does what it can to facilitate its staff using public transport where practicable in the commute to and from work, and for business-related travel.

ix) Health and Safety

Health and Safety considerations for staff and patients are at the forefront of everything the service does. The Service's Health and Safety team, supported by the Health and Safety Committee will continue to work collaboratively with colleagues and all relevant stakeholders to ensure appropriate patient and staff safety and risk management arrangements are in place.

The Service is also rolling out an online incident reporting system to enable faster notification and recording of health and safety related incidents and near-misses and an enhanced ability to analyse trends and issues, in support of ongoing improvement and prevention work and help reduce adverse incidents.

All of the Service's responsibilities and activities in relation to Health and Safety will continue to be underpinned by appropriate training, education and communication, to support the key principle that health and safety is the responsibility of everyone.

x) Infection Control

Minimising the risk of Healthcare Associated Infection (HAI) to patients and staff in a service undertaking around 2 million emergency and non-emergency patient journeys per annum is an important priority for the Service. The annual Infection Control Programme will address the initiatives set out in the Scottish Government Health Directorates HAI Task Force Delivery Plan.

xi) Research and Development

The Service has been working in formal partnership with the University of Stirling since 2005, undertaking key pieces of research in pre-hospital emergency care and developing its own capacity and expertise in clinical research. This work is an important element in supporting the evidence-base for the treatments and interventions we provide for patients and we will continue to develop the research and development strategy in order to strengthen the clinical governance and effectiveness framework within the Service. The Service will continue to develop its alliance with the Nursing, Midwifery and Allied Health Professional Research Unit at Stirling, which is funded by the Chief Scientist's Office for Scotland.

Audits, reviews and evaluations undertaken in connection with Research and Development objectives also bring more immediate benefits, helping for example, to inform and enhance emerging clinical practice in the field.

xii) Skills and Continuous Professional Development

(See also Section 4, Development Programme, p.57) The knowledge and skills of our staff, at all levels, are fundamental to the successful delivery of the Development Programme (and Delivery Plan). The Service therefore affords a high priority to its Education and Training Strategy to ensure appropriate training and Continuous Professional Development processes and resources are in place. This includes skills development for front-line staff, leadership development and capacity building for managers within the Service and the implementation of the Knowledge and Skills Framework of Agenda for Change. (See HEAT Target E5 on p.38)

xiii) Continuous Improvement

The Service will continue to explore the potential of improvement methodologies and techniques from elsewhere in the NHS, the wider public sector and the private sector, both at home and abroad. One potential avenue, which the Service intends to explore, is the 'Lean' systems approach to service delivery, which has its roots in the Toyota production system. It has been adapted and applied successfully in recent years by a growing list of public sector organisations, including various NHS Boards in Scotland and

the Scottish Government has outlined a commitment to its wider implementation in the BHBC action plan.

The driving principles of Lean are based around specifying the 'value' required by the 'customer' (i.e. what service does the patient actually want) and enhancing 'service flow' (i.e. the cohesive way staff and patients actually experience things on the ground) by removing as many wasteful and unnecessary steps as possible in processes, procedures and systems. Evaluations show that successful Lean implementations require key operational processes to be truly owned and designed by the staff who deliver them (as opposed to being designed and implemented 'from afar' by management). The most effective and efficient systems are also those in which performance problems and 'blockages' can largely be identified and rectified in real time.

The Service will explore with stakeholders and partners, appropriate settings for piloting Lean within the Service and seek to evaluate any pilot work, in order to inform longer-term strategies around continuous improvement.

xiv) Remote and Rural Solutions

The Service will continue to work in partnership with all key stakeholders to develop joint solutions to the challenges of providing high quality and timely health care in remote and rural parts of Scotland. We will consider carefully the recommendations in the report of the national Remote and Rural Steering Group to the Cabinet Secretary in December 2007. The remote and rural development team within the Service will devise strategies and action plans, designed to maximise resources for patient benefit, in order to progress this important area of service.

The report recognises the huge challenges to the Service in fulfilling the core A&E response, because of the wide geographical areas to be covered within limited available resource and highlights how we have risen to these challenges by modernising the workforce and technology to improve responsiveness, including new air ambulances, use of digital mapping technology, automated vehicle location systems (AVLS) and enhanced skills and extended roles for staff.

In discussion with key partners, the Service will continue to explore how best it can support the objectives of extended community care teams and work with rural Community Health and Care Partnerships (CHCPs), NHS24 and communities themselves in developing community resilience. The Service will continue to support the development of its voluntary community First Responder schemes and other creative community emergency approaches.

We will also work closely with other transport providers and agencies, including Regional Transport Partnerships, to provide greater co-ordination and integration of existing and proposed transport services. The Service will also engage with the Emergency Medical Retrieval Service (EMRS) pilot initiative in the west of Scotland, and ensure that any lessons learned inform our strategies and actions in the event of a wider national roll-out of EMRS.

xv) Inter Hospital Transfers and National Transport Strategy

In 2005, the Service set out a case to the Scottish Government for investment in a dedicated Inter Hospital Transfer service. The proposal met with support from a number of NHS Boards (including rural, urban and Special Boards), Local Authorities, Royal Colleges and others, whilst other stakeholders were less certain of the value and effectiveness of such a service from their perspective.

The case set out a number of projected benefits, particularly:

- *Strategy* – A dedicated transfer service would support the reconfiguration of health care services at national, regional and local level and would free up paramedics and technicians, enabling them to play an extended role in providing proactive mobile health care in the community.
- *Benefits for Patients* - A high quality transfer service lowers mortality and improves clinical outcomes for critically ill patients. For those patients who are not critically ill (and their relatives / carers), it reduces the stress and anxiety associated with transfer. It also reduces waiting times in hospital A&E departments and waiting times for inpatient treatment by freeing up bed capacity.
- *Benefits for NHS Scotland hospitals* - It would help hospitals operate efficiently, contribute to operational targets, and improve the integration of local, regional and national services.
- *Benefits for SAS and NHS Scotland staff* - It would improve the health and safety of staff and improve job satisfaction.
- *Value for money* - It would improve the efficiency of NHS Scotland and offer value for money
- *Governance* - It would provide robust governance and management over activity that is growing in size and strategic importance

The then Scottish Executive undertook to respond formally by the summer of 2006, but this timetable was delayed. The new Scottish Government formed in 2007, subsequently invited the Service to revisit the proposals with its key partners in the course of 2008/09 in an attempt to discuss and where possible resolve, issues and concerns.

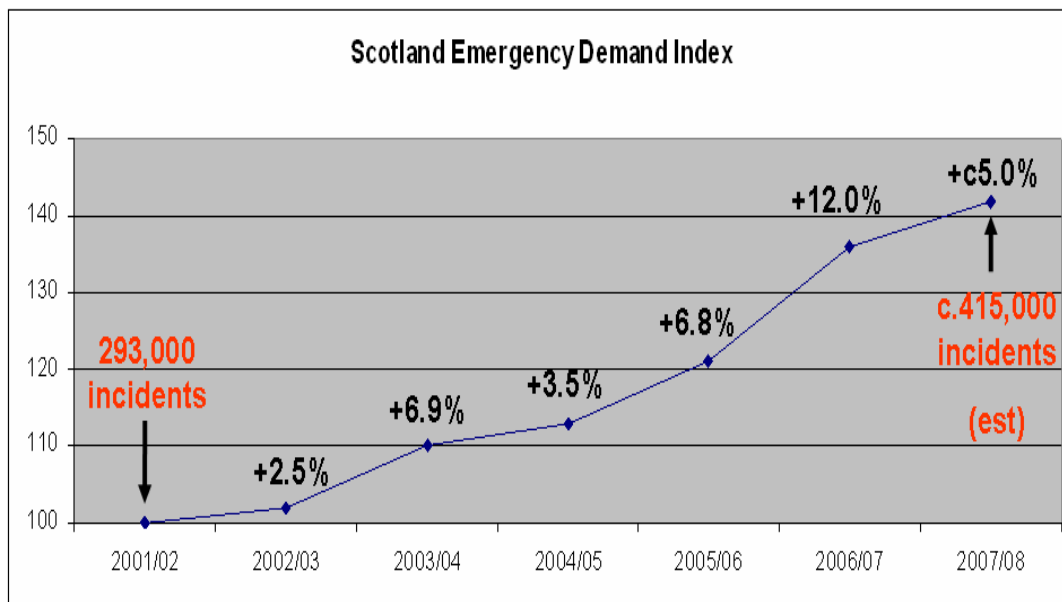
The Service will progress this work with the Scottish Government's support, and will revisit the benefits of the proposal in light of the *Better Health Better Care* Action Plan for NHS Scotland, published in December 2007, which recognises that transport is a key factor in the overall experience of patient care, not least in remote and rural areas. As well as BHBC, this work will require to be integrated with a number of policy areas and service developments, internally, and externally within the wider operational and strategic context of health-related transport, including cognisance of:

- the central role for the Scottish Ambulance Service within any emerging national strategy for health-related transport and its co-ordination at national and regional level
- The Scottish Government's response to the Remote and Rural Steering Group's recommendations on sustainable healthcare provision
- Developments in relation to specialist patient transfer arrangements, for example in relation to neonatal transfers, paediatrics and emergency medical retrieval
- Strategies and policies impinging on transfer arrangements driven by NHS Scotland Regional Planning Groups and individual NHS Boards
- Our revised Patient Transport Strategy which is being developed in the first half of 2008
- Opportunities arising from our Developing Enhanced Skills and Research and Development work, which may offer long-term opportunities in relation to the effective management of inter-hospital transfers
- Issues arising from the improvement of our operational structure and efficiency, including any developments relating to the 'tiering' of ambulance services to ensure the provision of responses, vehicles and clinical skills appropriate to the urgency of the case involved
- An increasing emphasis on effective discharge planning across NHS Scotland, to improve the patient experience, increase operational efficiency and assist NHS Boards in meeting related targets

B) Demand and Performance Context

i) A&E Service

Between 2001 and 2006, emergency demand in Scotland was rising steadily at an average rate of about 5% per annum – a similar trend to the rest of the UK. Then, emergency demand during 2006/07 rose by 12% compared to 2005/06. Although the increase in 2007/08 is projected to be back to about 5%, this is still 5% of a much larger baseline than predicted just a few years ago, given the previous year's unexpectedly large increase. Between 2001/02 and 2007/08 emergency demand has risen by around 42%.



Prior to the unprecedented increases in demand growth, performance on the A&E service's headline measure, *response time to Category A (life-threatening) cases* had been rising - i.e. the Service had substantially improved performance, whilst absorbing increases in demand. In real terms, the Service's performance against Category A and Category B (serious but not-life threatening) response time targets has increased significantly in recent years.

	2004/05	2007/08	%change
Cat A Jobs met within target time	64,592	91,832 (est)	+42.2%
Cat B Jobs met within target time	168,313	215,929 (est)	+28.3%

However, when demand began to outstrip all previous projections, the A&E service's continued percentage-terms performance improvement was affected, posing a significant threat to efforts to achieve the 75% standard for Category A. In response to this, the Service invested in 2006 in 100 additional full-time front-line staff (at a full year cost of c. £5 million), targeting the areas of greatest need.

Additionally, our comprehensive and intensive Operational Performance Improvement Project (OPIP) included detailed work to better understand the impact of demand on performance and ensure the maximum efficiency and effectiveness of available resources. These initiatives combined with close engagement with the Improvement Support Team of the Scottish Government's Health Directorate in 2007/08 has led to a marked improvement in our emergency response time performance over the past 18 months or so.

However, further improvement is necessary and the Service is fully committed to achieving the response time standard for Category A (life-threatening) emergencies of reaching 75% of those incidents within 8 minutes in mainland Scotland, by March 2009. Achieving this within a tighter financial context will be a significant challenge. The Service will receive a 3.15% uplift in funding for 2008/09, in line with wider NHS Scotland as opposed to around 6% in recent years.

The Service will have to build upon its improvement and efficiency focus in a number of key areas, prioritising its operational activities and programmes and explore new ways of working in consultation with its staff, patients and partners. This will include building upon new protocols for the despatch of accident and emergency vehicles, introduced in January 2008, known as the 'front-loaded model' whereby more single-crewed fast response vehicles (FRV) are despatched to certain agreed types of emergency incidents and backed up by a double-crewed ambulance, either automatically for certain cases, or as requested by the FRV crew member.

The Service plans to deliver this in parallel with ongoing development and expansion of 'See and Treat' pathways for patients, helping to reduce unnecessary hospital attendances. This, in turn, should help to reduce pressures on A&E departments and therefore support joint efforts between the Service and NHS Boards to reduce the turnaround time for Service crews at hospitals.

The Service is also pursuing a number of performance management initiatives in areas such as the availability, utility and use of management information, strengthening local management and supervisory structures and procedures, and the efficiency and effectiveness of our Emergency Medical Despatch Centres. A major review has been completed of the roles, locations, functions and wider integration of the EMDCs and the implementation of the recommended options will begin to take place during 2008.

Patient Transport Service

The level of journeys in the Patient Transport Service (PTS) has been declining over the past 5 years, in accordance with the strategy of providing a tailored service, prioritised according to those with greatest need. The PTS nevertheless makes around 1.6 million patient journeys a year. In recent years the Patient Transport Service has focused on improving punctuality performance and service quality for priority patients – cancer, cardiology, mental health and renal patients. The key performance indicators are *punctuality for appointment* and *punctuality for pick-up* for these priority patients and in recent years the Service has made substantial improvements in performance and patient satisfaction levels have been high.

In order to continuously develop PTS services it is proposed to explore further collaborations with NHS Boards, local authorities and voluntary agencies with a view to increasing the cohesion and efficiency of collective health and social care transport resources. There will be more emphasis on discharge planning and services as part of the Planned Care Improvement Programme.

The PTS Strategy will be revised during 2008/09 in light of these achievements and priorities and the wider operational context of the Service. It will also consider issues arising from Scottish Government policies and strategies, including national transport strategies and the *Better Health Better Care* Action Plan which outlines the need for NHS Scotland to engage more effectively with the 7 Regional Transport Partnerships (RTPs), given the statutory duty on RTPs to develop local transport strategies which support the provision of healthcare.

The revised PTS Strategy will also be informed by the work commissioned to the Management Science Department of Stirling University in 2007 to improve our ability to model and plan the location, number and type of vehicle and staff resources we need to meet our patient transport objectives.

Air Ambulance Service

A new air ambulance contract commenced on 1 April 2006 particularly to increase comfort and safety and ensure value for money. The four current aircraft – all specifically designed and built as air ambulances - represents one of the most advanced air ambulance services in Europe, with capacity supplemented when required by resources from HM Coastguard, Ministry of Defence and BP.

Demand in 2006/07 was 3,136 missions, an increase of 4.8% on the previous year. 90% of this activity came from only six of the fourteen territorial Health Boards, with Highland and Argyll the largest user with 45% of the total demand, which in itself saw demand increase by 13% on the previous year. Demand in other areas rose by varying amounts and dropped significantly in some areas such as Greater Glasgow and Clyde and Western Isles. Close monitoring and management of the new contract and ordering system continues to focus on ensuring the appropriate use of the air ambulance service. The average cost of an air ambulance mission is £3600.

Performance in 2006/07 showed significant improvements on the previous year in the four main target areas.

Indicator	05-06	06-07	Variance
To Cover all of Scotland within 60 minutes of take off in 95% of cases	83%	96%	+ 13%
Average Response Time (from take off to arrival at scene)	40mins	30mins	- 10mins
For planned cases to arrive at the patient 95% within time agreed with clinician	87%	95%	+ 8%
Average patient Travel Time (from take off to arrival at hospital)	46mins	40mins	- 6mins

For those Urgent cases where a time factor is agreed with the clinician, average response from time of call to being ready to take the patient improved, from 192 minutes in 2005/06 to 157 minutes in 2006/07. In 2005/06 the average time from time of call to arrival at hospital was 252 minutes; by 2006/07 this had reduced to 231 minutes.

A patient satisfaction survey undertaken in the course of year demonstrated 100% satisfaction levels. A previous survey in 2003 indicated 90% satisfaction.

The biggest challenge for the Air Ambulance Service is to continue to meet performance standards whilst ensuring appropriate and efficient use of resources in a way which continues to support the wider patient care objectives of the Scottish Ambulance Service and NHS Scotland.

SECTION 3, DELIVERY PLAN

Target	Performance				Notes	Lead
	Actual	Planned				
	2007/08	2008/09	2009/10	2010/11		
HEALTH IMPROVEMENT						
H11 Save more lives Rates of survival of cardiac arrest on arrival at hospital	tbc	17-21%	17-21%	17-21%	Survival of cardiac arrest is currently the most reliable indicator of "lives saved". The Service uses the internationally-recognised indicator of 'Return of Spontaneous Circulation (ROSC)' at hospital as the best available proxy for this measure, recognising that it cannot be defined as an exact measure of actual survival. Such clinical indicators are often set to fall within a 'band of reasonableness', recognising natural fluctuations in certain clinical outcomes and which, given the confines of current medical technology and understanding, are not immediately amenable to incremental improvement, in the short-term.	Medical Director
EFFICIENCY AND GOVERNANCE						
E1 Meet financial targets Operate within the revenue & capital resource limits; meet the cash requirement	On target (est)	Meet targets	Meet targets	Meet targets	In line with best practice and Scottish Government requirements	Director of Finance

Target	Performance				Notes	Lead
	Actual	Planned				
	2007/08	2008/09	2009/10	2010/11		
E2 Meet cash efficiency target Cash releasing savings achieved	N/A (new target)	2%	2%	2%	This target supports public sector efficiency through the generation of 2% cash releasing efficiency savings per annum	Director of Finance
E3 Sickness absence Rates of sickness absence	5.6% (est)	5%	5%	5%	The Scottish Government (SG) has set a target of 4% across the public sector by 31 st March 2008. However, given current position and nature of the organization (manual handling/shift working/high stress emergency service), the Service has agreed a stretching target, more realistic and appropriate for an ambulance service. This dialogue has been supported by benchmarking and research work.	Director of Operations / Director of Human Resources
E4 Universal utilisation of Community Health Index (CHI) No of Patient Transport Registrations where CHI number is used	N/A (new measure)	75%	80%	90%	An important measure of the provision of integrated patient care across the NHS. Territorial Boards are assessed based on a sample of laboratory forms. The Service is developing a measure for 2008/09 around Patient Transport Service registrations and will develop the use of CHI further throughout the year within the A&E Service (which may lead to a revised target).	Director of Finance
E5 Implement Knowledge and Skills Framework for Agenda for Change Employees No of available staff covered by AfC with KSF Personal Development Plans	N/A (new measure)	100% by March 2009	100%	100%	Implementing the KSF, and PDPs as a key element will help NHS Scotland and its staff and the SAS achieve the full personal and organisational benefits of Agenda for Change and help ensure the workforce is fit for the future.	Director of Human Resources

Target	Performance				Notes	Lead
	Actual	Planned				
	2007/08	2008/09	2009/10	2010/11		
ACCESS TO HEALTH SERVICES						
A1 Response time to Category A (life threatening) emergency incidents (mainland) Incidents reached within 8 minutes	62.6% (est)	75% by March 2009 (full year tbc)	75% full year	75% full year	Speed of response to life threatening incidents is associated with saving lives and improved health outcomes for patient. Improving Category A performance to the 75% by Mar 2009 is a high priority. In recent years, emergency demand has vastly out-stripped predicted growth and resources. Multi-faceted improvement work to maximise performance within available resources has brought some positive gains. These targets assumes an annual growth in all emergency demand of c.5%	Director of Operations
A2 Response time to Cat B emergency incidents (serious but not life threatening) (mainland) incidents reached within 14/19/21 minutes (depending on population density)	91.3% (est)	95% full year	95% full year	95% full year	Speed of response to emergency incidents is associated with improved health outcomes for patients. Category B standard of 95% within the target time varies by NHS Board according to population density (14/19/21 mins). This target assumes an annual growth in all emergency demand of c.5%.	Director of Operations
A3 Response time to all emergency incidents (island NHS Board areas) Incidents reached within 8 minutes	51% (est)	50% full year	50% full year	50% full year	Speed of response to emergency incidents in associated with improved health outcomes for patients. Standard for islands is 50% within 8 mins.	Director of Operations
A4 - Patient Transport Service Punctuality for Appointment for Priority 1 Patients Patients at hospital 30 minutes or less before appointment time	69.3% (est)	71% full year	71% full year	71% full year	This is agreed headline measure of PTS effectiveness. Helps NHS Scotland operate efficiently and improves the patient experience.	Director of Operations

Target	Performance				Notes	Lead
	Actual	Planned				
	2007/08	2008/09	2009/10	2010/11		
A5 Patient Transport Service: Punctuality for pick-up for Priority 1 patients Patients picked up within 30 mins of agreed time	83.5% (est)	89% full year	89% full year	89% full year	This is agreed secondary measure of PTS effectiveness in terms of ensuring satisfactory patient experience of the service.	Director of Operations
TREATMENT						
T1 Improve Health Outcomes for Patients –NHSQIS standards for patient safety & clinical governance	Score of 10 (Level 3)	No assessment	10 or above	10 or above	Inclusion prescribed by the Scottish Government as headline measure of quality of treatment. Includes root and branch assessment of all clinical activity, including clinical performance indicators. As there is no assessment until 09/10 the Service will review the target in line with all key clinical effectiveness and governance issues and strategies during the course of 2008/09.	Medical Director
T2 Reduce Hospital Admissions Emergency calls treated at scene	9.3% (est)	10-15%	15-20%	20-25%	Anticipated performance will improve as more formal See and Treat conditions are signed-off, Pathfinder training is rolled-out to all paramedics, triggers for unnecessarily risk-averse processes are reduced and the balance of care in the NHS continues to shift out-of-hospital. Supports NHS Boards with target to reduce rates of attendance at A&E and 4 hour wait (A&E) target. The Service will monitor and review this target as the impact of the roll-out of the 'Front Loaded Model' (see pages 38 & 53), is evaluated, and enhance it if appropriate.	Medical Director

The following section takes each of the Delivery Plan objectives and provides some explanatory background on why the objective has been selected, details of the planned investment, an indication of the main actions and projects to realise the objective, and some of the key risks.

HEALTH IMPROVEMENT

“Health Improvement for the people of Scotland – improving life expectancy and healthy life expectancy”

Specific targets for the Scottish Ambulance Service:

- **Target HI1 – Save More Lives** – Rates of survival of cardiac arrest on arrival at hospital

Target HI 1 - Save More Lives

Measure: Rates of survival of cardiac arrest on arrival at hospital

Background

Most of NHS Scotland's health improvement programme is about improving life expectancy, living healthier lives, and reducing health inequalities. The Scottish Ambulance Service's programme for health improvement is primarily about *saving more lives*. It is extremely difficult to quantify "lives saved" as a result of Service intervention, but an internationally recognised indicator is the Return of Spontaneous Circulation (ROSC) rate, for which the World Health Organisation set a standard of 14-18%. Whilst cardiac arrest cases represent only a small portion of the Service's life-threatening workload, this indicator is the most reliable available indicator of "lives saved".

Research has established that the most reliable determinants of survival of cardiac arrest are speed of response by the emergency service and bystander cardio pulmonary resuscitation (CPR) whilst specialist medical care is en-route.

Actions

The Service plans to save more lives by:

- Continuing its operational performance improvement work, thereby responding to more life-threatening incidents within the 8 minute target;
- Increasing the amount of bystander CPR delivered by trained volunteers. The Service will continue to develop and expand this programme in conjunction with organisations such as the British Heart Foundation and First Response.
- The introduction of improved clinical advice within our Emergency Medical Despatch Centre, enhancing the efficient and appropriate allocation of emergency resources on a prioritised basis

It is not feasible to quantify precisely the improvement in survival of cardiac arrest that will flow from these measures, so the planned performance is not based on any analysis of the mathematical relationship between improvement in response time to life-threatening incidents and survival of cardiac arrest. Nevertheless, there is enough clinical evidence available to indicate that we can anticipate maintenance of the rates of survival of cardiac arrest within the 'bands of reasonableness', as the various actions begin to take effect.

The Service also supplements this measure, for the internal monitoring of clinical effectiveness, with additional data on ROSC which can be extracted from its Heartstart programme, run in conjunction with the British Heart Foundation.

In addition, now that the Service has electronic recording of its A&E interventions it will develop its IT systems to pull data from the Emergency

Care Summary and seek to populate patient records to allow more comprehensive and timely information sharing and audit of effectiveness.

Risks

The key risks to delivery are:

- that the Service fails to deliver continued improvement in operational response times
- that not enough new First Response schemes can be created through lack of volunteers or resources, or the existing schemes are unsustainable for similar reasons

Performance

Actual	Planned			
	2007/08	2008/09	2009/10	2010/11
tbc%	17-21%	17-21%	17-21%	17-21%

Finance 2008/09

The Service aims to invest in approximately 30 additional paramedics at an associated cost of £1.2 million together with a move to new EMDC facilities at Cardonald at a revenue cost of £590k in 2008/09 and £1.5 million capital in 2008/09.

Finance 2009 - 2011

The Service aims to invest in approximately 30 additional paramedics each year at an annual cost of £1.2 million, together with enhancements to its North and East EMDC facilities at a revenue cost of £800k.

EFFICIENCY AND GOVERNANCE

“Efficiency and Governance Improvements – continually improving the efficiency and effectiveness of the NHS”

Specific targets for the Scottish Ambulance Service:

- **Target E1 – Meet financial targets** – operate within the revenue and capital resource limits; meet the cash requirement
- **Target E2 – Meet cash efficiency target** – Cash releasing savings per annum
- **Target E3 – Sickness absence** – Rates of sickness absence
- **Target E4 – Universal Utilisation of Community Health Index (CHI)** - No. of Patient Transport Registrations where CHI number is used
- **Target E5 – Implement Knowledge and Skills Framework for Agenda for Change Employees** – No. of AfC Employees with Personal Development Plans

Target E1 - Meet Financial Targets

Measure: Revenue Resource Limit; Capital Resource Limit and Cash Requirement

Background

The Scottish Government's Spending Review of 2007 has led to a smaller increase in funding for the Service, and the NHS as a whole, than in recent years, and efficiency savings targets have also increased. This will make achieving our financial targets a considerable challenge. Nevertheless, the Service has a track record of meeting its financial targets in recent years. Financial planning is rigorous and the Service plans to live within its means over the period of the Delivery Plan.

Actions

Implement robust financial management and audit arrangements.

Risks

Efficiency Savings Realisation

There is a high risk rating regarding the timetable for realising efficiency savings in relation to major reorganisation of operational activities with an associated danger of not releasing funding for identified service developments identified in the Delivery Plan.

Impact of Growth in Demand

There is a high risk that continuing growth in demand compromises service redesign proposals including realisation of efficiencies and contributes to additional operating costs required to satisfy patient services.

Pay Terms and Conditions

There are medium-level risks surrounding negotiation of outstanding terms and conditions issues such as meal break payments and revised unsocial and on-call payment terms. There is also uncertainty regarding the final annual pay award level.

Permanent Injury Benefit Awards

There is an unknown risk level arising from the lack of current information on permanent injury benefit claimants. Estimation of the required provision is impossible to undertake with any accuracy in the absence of detailed information.

Impact of NHSS Service Redesign

There is an unknown risk level associated with NHSS service redesign measures arising from uncertainties in plans of other health boards which could directly impact upon the level and composition of patient services provided by Scottish Ambulance Service. There is also related risk of an unknown level arising from new protocols around the potential for independent scrutiny of major service change proposals, in relation to uncertainties in the internal SAS and joint planning processes arising from territorial board or SAS proposals for change.

Performance

Actual	Planned		
2007/08	2008/09	2009/10	2010/11
On target (est)	Meet targets	Meet targets	Meet targets

Finance

See Section 6 of this document for detailed financial plans.

Target E2 - Meet Cash Efficiency Target

Measure: % Cash Efficiency Savings Achieved Per Annum

Background

This target supports public sector efficiency through the generation of 2% cash releasing savings per annum. This is a new high-level HEAT target for 2008/09.

Actions

Implement robust financial management and efficiency savings strategies, reviewing all pertinent areas of activity as required.

Risks

See target E1 above.

Performance

Actual	Planned		
2007/08	2008/09	2009/10	2010/11
N/A (new target for 2008/09)	2%	2%	2%

Finance

See Section 6 of this document for detailed financial plans.

Target E3 - Reduce sickness absence

Measure: Rates of Sickness Absence

Background

The Service has been running a programme to control sickness absence for a number of years. The programme includes stringent application of the management of sickness absence policy and procedures, together with close monitoring and reporting of the level of sickness absence and of the reasons for sickness absence. That programme has successfully controlled sickness absence for some 5 years at a rate between 5.5% and 6%. Research shows that many other ambulance services in the UK have sickness absence rates which are considerably higher.

The target set by the Scottish Government is 4% across the public sector by 31st March 2008. However, given the current position it would be extremely challenging to reduce the rate to 4% in a manual handling, shift working emergency service, where many of the jobs, by their very nature, incur high levels of stress. The Service therefore agreed with the Scottish Government in 2007 a target of 5% which would still be stretching, but would be more realistic and appropriate for an ambulance service.

Actions

- The Service's strategy will build on the work already completed and underway, targeting the principal causes of sickness absence (manual handling injury and stress) and those geographical areas currently accounting for most of the sickness absence.
- Continue to develop and implement effective human resource management systems centrally and within our operating divisions, including, for example, the timely conduct of structured return-to-work interviews.
- Implement our comprehensive Occupational Health Strategy including provision of fast-track physiotherapy and a confidential employee counselling service.

Risks

Delivery

Target delivery is supported by work to develop an organisational culture where promoting attendance and staff wellbeing are key priorities. There is leadership from the Chief Executive, General Managers and Heads of Department across the organisation.

Risks relate to areas of continuing high absence levels, and may be attributable to:

- Working patterns

- Team culture
- Inconsistent application of absence management policy
- Inconsistent application of work/life balance policies

Each of the above issues are being explored and improvement strategies are being developed.

Workforce

Promoting attendance will be supported by:

- Absence continuing to be a high priority for all managers and lead by the Executive Team.
- Development of a single system for recording and monitoring absence i.e. Workforce Planning System (linked to Thor system)
- Continuing to train managers to deal consistently with absence, including e-learning module, distribution of absence management leaflets to staff and managers
- Consideration of shift pattern redesign
- Continued use of Fast Track Physiotherapy and Employee Counselling services.
- Consideration of dedicated 'phone in sick' line.
- Further development of Case Conference approach in certain cases
- Further development of Occupational Health Service

Finance

Cost pressures will continue in the short-term due to over-time costs to backfill absences and the provision of additional OHS Services will bring additional costs.

Improvement

We need to better understand the reasons why an individual will phone in sick when they could be at work e.g. relating to motivation and workplace issues. Work will be carried out to try and identify the root causes of this.

Performance

Actual	Planned			
	2007/08	2008/09	2009/10	2010/11
5.6% (est)	5%	5%	5%	5%

Finance 2008/09 – 2010/11

The Service plans to invest in additional management development training to ensure sickness absence policies are consistently and robustly applied throughout.

Target E4 - Universal utilisation of Community Health Index (CHI)

Measure: Number of Patient Transport Registrations Where CHI Number is Used

Background

The Community Health Index (CHI) number is the unique patient identifier for NHS Scotland. Ensuring that a patient's CHI number is included on all clinical communications helps reduce clinical risk and contributes to increased patient safety. Patients can be correctly identified more quickly and more easily. A more complete picture of a patient's health care can be accessed by health care professionals, allowing them to make more informed decisions about that patient's care. The risk of erroneously attaching information about one patient to another patient's record is reduced. Universal use of CHI means that a patient's health care information moves through the NHS with the patient. The need to ask patients the same questions or to repeat tests and investigations is reduced.

By ensuring that the CHI number is used on all clinical communications, an essential building block is being put in place with NHS Scotland for the developing Electronic Health Record. The CHI number provides the "glue" that allows a complete record to be constructed for each patient, no matter where the individual pieces of information come from. CHI also provides a safer and more efficient way for health care staff to find the correct patient.

Territorial NHS Boards are assessed based on a sample of laboratory forms. The Ambulance Service proposes to measure Patient Transport Service registrations where CHI is used in 2008/09 and develop the use of CHI internally further throughout the year within the A&E Service, to facilitate longer-term connectivity to our Cab Based Terminals in A&E vehicles and wider national developments such as the Emergency Care Summary and the National Accident and Emergency System.

Actions

- Set-up and implement protocols for data entry, sampling, extraction, analysis and follow-up
- Currently, if the CHI number is unavailable at time of registration, there is little that the Service can do to obtain it so improvement actions will focus on ensuring that there are fewer internal data input errors and omissions and working with partners to increase the availability of the CHI number when booking PTS transport.

Risks

- Key risks are the failure of staff to use the CHI number when available or that ICT or issues in partner organisations make the target beyond our control

- Other risks include the lack of an effective national communications and marketing strategy aimed at raising public, patient and staff awareness of the purpose and benefits of using CHI numbers

Performance

Actual	Planned		
2007/08	2008/09	2009/10	2010/11
N/A (new target)	75%	80%	90%

Retrospective measurement suggests Service performance would have been around 74% in 2007/08 although it was lower than this in some areas. The targets have been set with recognition of the need to ensure the Service has appropriate control and influence over reaching the target and that there are no undue operational risks from introducing the target in a particular way (for example, if the CHI number was to be made a mandatory field in the registration system, this could disadvantage patients who contact the service office direct and who do not know their CHI number).

Finance 2008/09

It is intended to upgrade the PTS system at a cost of c. £200k, together with the development of interfaces with the Emergency Care Summary, at a cost of c. £100k.

Target E5 – Implement Knowledge and Skills Framework for Agenda for Change Employees

Measure: Number of staff covered by AfC with KSF Personal Development Plans

Background

The Knowledge and Skills Framework (KSF) is a key part of the NHS Agenda for Change pay system. It applies to all staff employed on Agenda for Change terms and conditions. The KSF is an organisational tool for describing the knowledge and skills staff need to apply at work in order to deliver high quality services. It includes an annual system of review and development for staff to ensure effective working for patients and the public and provides a single agreed system of pay progression (as such is an integral and mandatory strand of Agenda for Change).

The KSF applies to all staff employed in the NHS across the UK on Agenda for Change terms and conditions, and meets equal pay requirements. It offers development to staff and facilitates career development through post outlines which clearly describe the knowledge and skills that need to be applied in different posts in the NHS. There are also annual development reviews where every member of staff has the opportunity to discuss how they have applied their knowledge and skills and to identify their learning and development needs.

Personal development plans (PDPs) are agreed between each staff member and their reviewer and set out how the learning and development needs will be met. The learning and development opportunities should be focused on the needs of the individual in their post.

Implementing the KSF, and PDPs as a key element, will help the NHS in Scotland and its staff, and the Scottish Ambulance Service achieve the full personal and organisational benefits of Agenda for Change and help ensure the workforce is fit for the future.

Actions

- Implement the KSF Strategy within the Scottish Ambulance Service

Risks

Delivery

The Project Board will be chaired by Director of Human Resources working to support implementation of KSF. Risks relate to ensuring that implementation is carried out in such a way that operational performance is not impacted on as well as ensuring that PDPs are realistic and practical for the Ambulance Service :

Workforce

Implementation is being carried out:

- Through a pilot project in a non-operational area.
- Testing out of all systems and methods prior to impacting on operational staff
- Making best use of e-learning methods of training staff on the new system

Finance

There will be a financial impact to back cover staff whilst they undertake training and take quality time out to agree PDPs etc.

Improvement

With the major focus on improving operational performance there is a likelihood that timescales may slip where staff are needed to undertake operational shifts. There is also a risk that staff may not see KSF as being of value to them so there is a significant challenge of ensuring that management view the implementation of KSF as an essential short-term investment for future gain. Work will be undertaken in this regard.

Performance

Actual	Planned		
2007/08	2008/09	2009/10	2010/11
N/A	100% by March 2009	100%	100%

Finance 2008/09

£50k for implementation costs. The Service plans to continue to invest in its clinical and leadership development. It currently spends 2% of its direct costs on training and education and plans to continue to do so, enhancing this if appropriate.

ACCESS

“Access to Health Services – recognising patients’ need for quicker and easier use of NHS services.”

Specific targets for the Scottish Ambulance Service:

- **Target A1 – Category A (life threatening) Responses** (mainland) increase percentage of incidents reached within the target time of 8 minutes
- **Target A2 – Category B (serious but not life threatening) Responses** (mainland) – increase percentage of incidents reached within the target time of 14/19/21 minutes (depending on population density)
- **Target A3 – Island NHS Board Emergency Responses** – increase percentage of incidents reached within the target time of 8 minutes
- **Target A4 – PTS Punctuality for Appointments for Priority 1 patients**
- **Target A5 – PTS Punctuality for Pick Up for Priority 1 patients**

Target A1 - Response time to Category A (life threatening) emergency incidents (mainland)

Measure: Incidents reached within 8 minutes

Background

Although speed of response to life-threatening cases is not the sole indicator of effective A&E response, it will continue to be a key performance indicator for the foreseeable future. There is a wealth of clinical evidence supporting the link between response within 8 minutes and either saving life or improving health outcomes. The Service plans to respond to a greater proportion of Category A incidents within the 8 minute target and expects to see some improvement in clinical outcomes for patients involved in such incidents, e.g. survival of cardiac arrest (see Objective HI1 above).

Actions

The Service has in place a range of projects and developments designed to have a beneficial impact on Category A performance, the main work streams being:

- Ongoing operational performance improvement projects and initiatives
- Review of management structure
- Leadership development training for managers
- Review of EMDC (Control Room) functions and locations and ongoing EMDC Performance Management Initiatives
- Development of management reporting systems and performance management arrangements
- Revision of Fast Response Vehicles despatch protocols – the ‘Front Loaded Model’
- Work to address hospital turnaround times for A&E crews and support NHS Boards in achieving their 4 hour-wait target at A&E
- Partnership work with NHS24 to ensure best use of joint resources
- Reducing Hospital Admissions Project
- Developing Enhanced Skills Project
- Rural Health Solutions Project
- First Responders Volunteer Initiative
- Information and Communications Technology Strategy

Risks

The main risks to delivery are:

- Annual rate of increase in emergency demand increases at a rate beyond which resources can be increased or realigned effectively
- Service reconfiguration elsewhere in the NHS impacts on the level and pattern of emergency demand
- National strategies to address challenges arising from the provision of ‘out of hours’ care since the new General Medical Services Contract are ineffective

- The Service is unable to underpin the performance of the A&E Service with suitably resourced and prioritised patient transport, urgent and inter-hospital transfer services
- Pace of improvement in larger operating divisions is slower than elsewhere
- Changes in performance management processes and management structure take longer than expected to bring improvements, or else do not work as expected
- Management capacity and competences cannot be developed quickly enough to support necessary pace of change
- Failure to secure internal efficiencies meaning that the necessary investment in improving Category A performance cannot be found
- There is no improvement, or a worsening, in hospital turnaround times for A&E crews
- Developments flowing from the Information and Communications Technology Strategy do not bring expected benefits

Performance

Actual	Planned		
2007/08	2008/09	2009/10	2010/11
62.6% full year (est)	75% by March 2009, Full year target tbc*	75% full year	75% full year

*Will be confirmed as monthly trajectory towards 75% in March 2009 is agreed with the Scottish Government.

Finance 2008/09

New radio system to improve voice clarity	£3.30m
Vehicle cleaning services to improve productivity	£0.35m
Additional costs of fuel	£0.10m
New EMDC facility at Cardonald	£2.10m
Additional clinical advisors, call takers and dispatchers	£0.40m
Additional paramedic fast response vehicles	£1.20m
General Manager EMDC	£0.10m
New estate in West Central Division	£1.60m
New vehicles	£3.00m

Finance 2009/10

Fuel	£0.10m
EMDC – Inverness	£1.70m
EMDC – call takers and dispatchers	£0.30m
Additional paramedic fast response vehicles	£1.20m
Replacement vehicles	£4.50m
Glasgow estates	£1.60m

Finance 2010 / 11

Fuel	£0.10m
EMDC – East	£0.30m
EMDC – call takers and dispatchers	£0.30m
Additional paramedic fast response vehicles	£1.20m
Replacement vehicles	£4.50m
Station refurbishments	£2.00m

Target A2 – Category B (serious but not life-threatening) Responses

Measure: Incidents reached within the target time of 14/19/21 minutes (depending on population density)

Background

Improvement in Category B performance is planned. The Service is performing relatively close to target for Category B patients (95% within the target time), but is planning to secure substantial performance improvement for Category A patients (see Objective A1 above). The Service's priority is therefore to improve performance for Category A life-threatened patients but nevertheless plans to maximise performance for Category B patients.

Actions

As highlighted above in A1, the planned activity in improving operational performance will be targeted primarily at Category A, but should also have a beneficial impact on Category B performance.

Risks

The key risks to delivery are similar as for A1 above.

Performance

Actual	Planned		
2007/08	2008/09	2009/10	2010/11
91.3% (est)	95% full year	95% full year	95% full year

Finance 2008 – 2011

As per Target A1 above (see pages 42 & 43)

Target A3 – Island NHS Board Emergency Responses

Measure: Emergency incidents reached within 8 minutes.

Background

Performance in island NHS Board areas is subject to wide variations over time due to the very low volume of emergency demand. The Service plans to develop better performance via collaboration with public and voluntary sectors, e.g. by extending the use of First Responder volunteer schemes and supporting the building of community resilience.

Performance improvement is likely to be marginal because of the topography and the logistics difficulties of providing rapid response to a very sparse and widely dispersed population. Because of the low level of demand and its widely dispersed pattern, investment in additional “mainstream” A&E vehicles and staff is unlikely to yield performance gain – hence the focus on First Responder schemes and other innovative solutions for providing emergency care to remote and rural locations.

Target levels reflect those previously agreed with the then Scottish Executive Health Department and are in keeping with UK-wide remote and rural ambulance targets. They are designed to strike a very difficult balance between patient need, geographical challenges and inevitable resource limitations. The Standard for island NHS Board areas is to reach 50% of all emergency incidents within 8 mins.

Actions

The key work streams are:

- *Development Programme, Rural Health Solutions Project.* Securing collaboration of other public agencies, the voluntary sector and local communities.

Risks

The main risks to securing delivery are:

- Failure to secure collaboration of other public agencies and the voluntary sector.

Performance

Actual	Planned		
2007/08	2008/09	2009/10	2010/11
51% (est)	50% full year	50% full year	50% full year

Finance 2008 - 2011

Continue to invest in purpose designed Island vehicles at a cost of £60k per vehicles.

Target A4 - Patient Transport Service Punctuality for Appointment for Priority 1 Patients

Measure: Patients at hospital 30 minutes or less before appointment time

Background

The Patient Transport Service strategy (published November 2003) has been focused on improving punctuality for appointment for Priority 1 patients, in alignment with NHS Scotland priorities (cancer, cardiology, mental health and renal patients). Performance has improved from circa 44% to around 70% in recent years. Punctuality for appointment is an appropriate indicator – it shows whether the PTS is delivering effectively and helps NHS Scotland hospitals operate efficiently.

Actions

The PTS strategy will be revised during 2007/08 and the associated action plans will set out how performance is to be maintained and developed.

The PTS strategy will compliment work which the Service will take forward under the *Better Health Better Care* banner and through its Reducing Health Inequalities project work. The service will continue to develop its engagement with the Efficient Government Programme, through which it has been engaged with 5 local authority partners on pilot work in support of patient transport improvements and efficiencies.

Risks

The key risks to delivery are:

- Failure to secure adequate collaboration between public, private and voluntary sectors.
- Focus on Category A performance improvement distracts / detracts from development of patient transport services

Performance

Actual	Planned			
	2007/08	2008/09	2009/10	2010/11
69.3% full year (est)	71% full year	71% full year	71% full year	71% full year

Finance 2008/09

£185k reflecting better targeting of resources to those with clinical need for transport.

Finance 2009 - 2011

£2.7m reflecting better targeting of resources to those with clinical need for transport.

Target A5 - Patient Transport Service Punctuality for Pick Up for Priority 1 Patients

Measure: Patients picked up within 30 minutes of agreed time

Background

Punctuality for pick up is becoming increasingly important in the Patient Transport Service. Patients appreciate being picked up from hospital in line with the scheduled time and this also assists NHS Scotland hospitals operate efficiently.

Actions

The main actions are as per target A4 above.

Risks

The key risks to delivery are as per target A4 above.

Performance

Actual	Planned		
2007/08	2008/09	2009/10	2010/11
83.5% full year (est)	89% full year	89% full year	89% full year

Finance 2008/09

As per target A4 above.

Finance 2009 - 2011

As per target A4 above.

TREATMENT

“Treatment appropriate to individuals – ensure patients receive high quality services that meet their needs.”

Specific targets for the Scottish Ambulance Service:

- **Target T1 – Improve Health Outcomes for Patients** – NHS Quality Improvement Scotland (QIS) Standards for Patient Safety & Clinical Governance
- **Target T2 – Reduce Hospital Admissions** – reduce unnecessary transport to hospital by increasing percentage of patients treated at scene or treated and referred to appropriate service

Target T1 – Improve Health Outcomes for Patients

Measure: NHS Quality Improvement Scotland Assessment for patient safety, clinical governance, and risk management.

Background

The NHS Quality Improvement Scotland (QIS) standards for clinical governance, patient safety, and risk management cover the full range of standards in the field. Performance against the standards is measured via self-assessment (with a portfolio of evidence) plus inspection and peer review. The Service received the best score in NHS Scotland in 2007, achieving a 10, with the next best score recorded being an 8.

Although the next formal assessment of the Service is scheduled for 2009/10, work will continue apace before then to develop and maintain our standards in this crucial area. The Service is continually reviewing its suite of clinical indicators and enhancing the reporting and analysis capabilities as part of a major overhaul of our management reporting systems. This compliments the introduction of 'cab based (computer) terminals' into our A&E vehicles and the subsequent roll-out of electronic patient report forms, which adds significantly to the richness of the clinical information the Service holds.

It is intended to recruit a new Medical Director in 2008 as part of a strengthening of our directorate structure and this will help to enhance the governance and accountability arrangements in relation to patient safety and clinical effectiveness.

In addition to reporting against HEAT targets the Service also monitors a wider range of Clinical Indicators and reports on these to the Clinical Governance Committee and Board on a regular basis. These are reviewed on a regular basis, most recently in November 2007 and were benchmarked by our auditors in 2007/08. Measures planned in 2008/09 include:

Chest Pain of Cardiac Origin; % of eligible patients:

- receiving oxygen therapy or entonox
- receiving nitrates
- receiving aspirin
- thrombolysed with a call-to-needle time of less than 60 minutes
- arrived at a primary angioplasty (pPCI) centre within specified time

Stroke; % of eligible hyper-acute patients:

- arrived at point-of-care within 3 hours of symptom onset

Fracture; % of eligible patients:

patients with suspected neck of femur fracture who receive oxygen in transit

Risks

Delivery

Target delivery is supported by work to develop organisational culture where promoting patient safety, clinical governance, and risk management are key priorities. There is leadership from Chief Executive and directors and across the organisation.

Risks relate to patient safety, clinical governance, and risk management and may be attributable to:

- Maintaining the Service Risk Register
- Risk logs for projects
- Failure of inclusion in the Scottish Patient Safety Program
- Under-reporting of incidents.
- Investigating adverse incidents and near misses
- Sharing lessons learned

Workforce

Promoting patient safety, clinical governance, and risk management will be supported by:

- Chief Executive and Director level involvement
- Training of managers (including a line managers' support programme)
- Consideration of new best practice guidelines
- Dedicated support services will be allocated to enable improvements

Finance

Funding has been made available to improve patient safety, clinical governance, and risk management.

Improvement

The Service aims to improve on the score of 10 for the NHS Quality Improvement Scotland Assessment for patient safety, clinical governance, and risk management standards.

Performance

The next formal assessment will take place in 2009 and planned performance will be specified in the next Health Plan.

Actual	Planned		
2007/08	2008/09	2009/10	2010/11
Score of 10 (Level 3)	No assessment	10 or above	10 or above

*As there is no assessment until 10/11 the Service will review the target in line with all key clinical effectiveness and governance issues and strategies during the course of 2008/09.

Finance 2008/09

£400k for e-Health Strategy.

Finance 2009 - 2011

£400k each year for e-Health Strategy.

Target T2 – Reduce Hospital Admissions

Measure: Emergency calls treated at scene

Background

Reducing hospital admissions and securing more locally delivered healthcare is a key goal for NHS Scotland. The Kerr Report highlighted that NHS Scotland needed to get better at managing long term, chronic conditions out of hospital – it is better for the patient and for helping hospitals to operate efficiently. The then Scottish Executive responded with *Delivering for Health* as a de-facto strategy for the NHS in Scotland. The new Scottish Government have developed this vision with the *Better Health Better Care* Action Plan, published in December 2007.

Preventing unnecessary emergency transport to hospital also releases ambulances for front line response to life-threatening incidents and helps prevent hospital A&E departments from being swamped with inappropriate cases. As such, this target supports NHS Boards in the achievement of their HEAT target on reductions in the rates of attendance at A&E and the A&E 4-hour wait target.

The Service's strategy is built on widening the role of paramedics and enhancing their training appropriately – hence the Service's ongoing investment in training 'pathfinder' paramedics, including plans to roll this training out to all paramedics over the next two years. It is the longer-term aim of the Service that extended skills for paramedics continue to be developed and utilised effectively in the community.

Clinical indicators such as this are often designed to fall within a gold standard 'band of reasonableness', recognising inevitable natural fluctuations in certain clinical outcomes and which, given the confines of current medical technology and understanding, are not naturally amenable to continuous incremental improvement, in percentage terms. However, it is anticipated that performance could improve as more 'See and Treat' conditions are rolled-out, pathfinder training is provided to all paramedics and the balance of care in NHS Scotland continues to shift out-of-hospital.

The Service's Research and Development Team, working in partnership with the Nursing, Midwifery and Allied Health Professions Research Unit at Stirling University, have undertaken research into the effectiveness and management of 'see and treat' procedures from a staff and patient perspective, and will continue to build upon this work in conjunction with our Training Department to ensure that patient safety and staff development are paramount in work on reducing hospital admissions. From a governance perspective, activity and developments in support of this HEAT target are reported to the Clinical Governance Committee of the Board.

Actions

The main work streams are:

- Reducing Hospital Admissions and Developing Enhanced Skills Project Work, particularly work to improve triage in control rooms to minimise inappropriate ambulance responses to patients and improving triage and clinical skills in the field to minimise emergency transport to hospital.
- The ongoing roll-out of the new protocols for the despatch of accident and emergency vehicles, introduced in January 2008, known as the 'front-loaded model' whereby more single-crewed fast response vehicles (FRV) are despatched to certain agreed types of emergency incidents and backed up by a double-crewed ambulance, either automatically for certain cases, or as requested by the FRV crew member.
- The Training, Education and Development Strategy

Risks

The main risks to delivery are:

- Failure to secure adequate numbers of suitably trained/equipped paramedics.
- Risk-averse behaviour by paramedics, which can be defined as the taking of unnecessary (albeit benign) clinical steps when providing care to a patient, often based on a learned response of 'playing it safe', even where clinically-proven algorithms and protocols may demonstrate that the risk of omitting a particular element of treatment are negligible or effectively non-existent. This can be partially mitigated by the continued use and development of clear, clinically-approved protocols backed by robust, evidence-based training, education and development, and robust internal communication and clinical support systems.

Performance

Actual	Planned		
2007/08	2008/09	2009/10	2010/11
9.3% (est)	10-15%*	15-20%*	20-25%*

* The Service will monitor and review this HEAT target as the impact of the roll-out of the front-loaded model is evaluated, and enhance it if appropriate.

Finance 2008/09

Clinical advisers	£0.40m
Additional front-loaded model paramedics	£1.20m
Additional paramedic fast response vehicles	£3.00m

Finance 2009/10

Additional paramedic fast response vehicles	£1.20m
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Finance 2010 / 11

Additional paramedic fast response vehicles

£1.20m

SECTION 4, DEVELOPMENT PROGRAMME – SUPPORTING *BETTER HEALTH BETTER CARE*

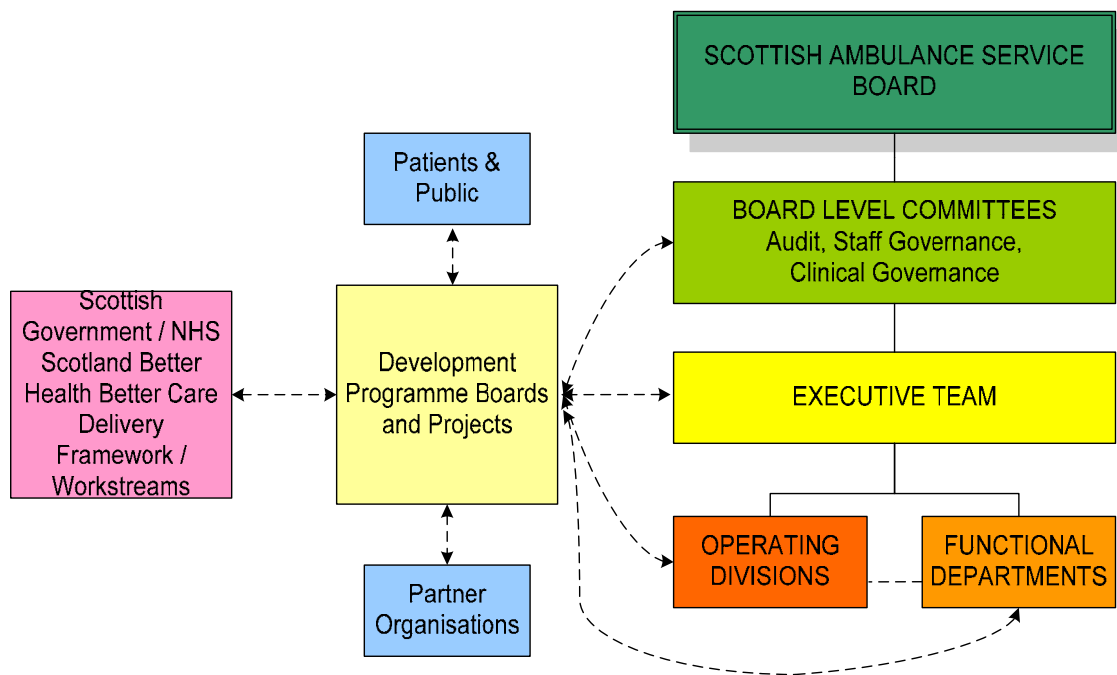
Background

As part of the planning process to develop a strategic response to the Kerr Report and *Delivering for Health*, the Service established a Development Programme of key service redesign projects to plan the implementation of Delivering for Health objectives in an Ambulance Service context. High level objectives included:

- Reducing Hospital Admissions
- Developing Enhanced Skills
- Developing Rural Health Solutions
- Rationalising Inter Hospital Transfers
- Enhancing Information and Communications Technology
- Reducing Health Inequalities
- Developing Patient Transport Services

A partnership approach has been taken to the Development Programme and many key stakeholders – including external partners, patients and public representatives - have been closely involved in shaping priorities and work plans. Considerable progress has been made in the past few years against each of these objectives and the myriad connections between them has become increasingly clear. In order to build upon success to date, reduce duplication (and hence, increase efficiency) and create flexibility to adapt the Programme towards the objectives of the new Scottish Government's Better Health Better Care Action Plan (published in December 2007) the Service will review the precise format of the Development Programme. A generic structure is below, showing how these are likely to fit into the wider corporate governance and operational structure of the Service.

Once the Scottish Government has agreed with NHS Board's the exact structure and format of the national Better Health Better Care implementation and monitoring framework, the Service will shape the delivery structure of its own development programme accordingly to ensure it can demonstrate its contribution clearly and logically. This will include clear accountability of specific Executive Directors in the Service in relation to the delivery of particular aspects of the development programme.



Skills and Continuous Professional Development

The knowledge and skills of our staff, at all levels, are fundamental to the successful delivery of the Development Programme and Delivery Plan. The Service therefore affords a high priority to its Education and Training Strategy to ensure appropriate training and Continuous Professional Development processes and resources are in place. This includes leadership development and skills development for front-line staff and implementation of the Knowledge and Skills Framework under Agenda for Change.

Our Development Programme will enable us to help meet the commitment in *Better Health Better Care* of ensuring patients receive timely and appropriate care as locally as possible. For example, our 'Pathfinder' Paramedic training has enabled paramedics to undertake a range of clinically-approved 'See and Treat' interventions with patients which mean they do not have to go to hospital unnecessarily but can safely and appropriately be left at home with self-care instructions or referred to another health or care professional for follow-up care, and so forth. All paramedics are being trained in the pathfinder programme over the next two years.

Deliverables

Although the precise structure and format of the Development Programme and its constituent projects is under review, it is likely that high level deliverables will include the following.

Reducing Hospital Admissions

- Audit and evaluate current 'See and Treat' (S&T) conditions

- Use clinical indicators to monitor effectiveness and identify issues for development
- Complete 'feedback loop' connecting research and development work with training requirements in relation to See and Treat
- Identify additional range of conditions appropriate for S&T
- Increase range of conditions for S&T within current range of skills
- Increase range of conditions for S&T with additional range of skills
- Develop and roll out the range of Out of Hours Community Paramedic skills (prescribing etc) for utilisation in core operational environment
- Continue to ensure the safety and efficacy of all clinical interventions – and the appropriateness and availability of accompanying guidelines and protocols

Enhanced Skills

- Drive accreditation of competencies and skills for SAS staff, through NHS Education for Scotland (NES)
- Implement the Knowledge and Skills Framework of Agenda for Change
- Ensure appropriate connections to UK-wide skills development issues via Skills for Health and other ambulance services.

Rural Health

- Building upon the recommendations in the national Remote and Rural Steering Group's report to the Cabinet Secretary in December 2007
- Support the establishment and development of rural health community resilience systems
- Extend role and number of First Responder volunteer schemes
- Develop SAS role in light of NHS 'rural practitioner' – under auspices of NHS Education for Scotland (NES)
- Assess and develop SAS inclusion in rural resource centres
- Revisit all viable models of SAS contribution to rural health solutions and develop consultations, evidence-base and communications strategy around options
- Develop partnerships with other professions, agencies and sectors, including primary care and also the wider community as essential to effective rural health solutions.

Information and Communications Technology

- Continue with ICT strategy – ensuring alignment with NHS Scotland strategies, particularly around e-Health, in partnership with NHS National Services Scotland and others
- Continue to develop effective telephone system of clinical advice, working in close association with NHS 24 and other partners
- Roll-out the enhanced Airwave digital radio network (£50m investment) providing greater coverage and reliability
- Continue to develop the Cab Based Terminals project (£10m investment) – bringing state-of-the-art computer technology to front-line ambulances, and empowering staff with more sophisticated tools, information and resources with which to deliver patient care

- Continue to rationalise IT systems, platforms and management reporting tools in support of organisational objectives

Health Inequalities

- Develop wider national focus for clinical health mapping work initiated with NHS Highland
- Engage with Social Inclusion Partnership (SIPS) and voluntary and community organisations to pursue shared objectives around reducing health inequalities
- Engage in national work programme of new Equality and Diversity Directorate at NHS Health Scotland as appropriate
- Continue to work closely with Scottish Health Council to develop and enhance patient focus and public involvement (PFPI) work, ensuring it informs policy and strategy in relation to health inequalities

Patient Transport

- Review and update Patient Transport Strategy to ensure service develops in line with key principles, including:
 - NHS Scotland strategies and policies
 - Quality improvement
 - Prioritisation
 - Patient need
 - Partnership working and communication
 - Value for money
 - Technology
 - Staff skills development

Air Ambulance

- Emergency Medical Retrieval Service development
- Retrieval Service development

Clinical

- Primary Angioplasty (PPCI) developments
- Developments in the management of hyper-acute stroke patients
- Implementation of mental health and other clinical support strategies
- Procurement of new defibrillators in 2009/10

SECTION 5, IMPLEMENTATION & CONTROL

Development Programme

The delivery of the Development Programme is co-ordinated by Executive Directors who are accountable to the Chief Executive and, in turn, to the Board. The Board is responsible for approving overall strategy and ensuring that governance arrangements are robust and appropriate.

Each high-level project within the Development Programme, e.g. Rural Health Solutions is normally overseen by a nominated Executive Director, who chairs the Project Board and acts as the high-level Project Sponsor. They are usually supported by a Project Director, selected from the ranks of the Service's Senior Management. The Project Director tends to oversee the project's general progress against agreed objectives and provides advice and guidance on strategies and risks to the Project Board and ongoing support to the Project Team. The more 'hands-on' day-to-day management of each project is delegated to a Project Manager, who co-ordinates the activities of the Project Team, which comprises staff members with skills and remits which are particularly relevant to the project objectives. The Project Manager will be someone with appropriate overarching skills and knowledge for the issues and themes involved. Sometimes they will also continue in their substantive post within the Service, or for bigger and more complex pieces of work, may be seconded full-time to the Project for a specified period.

Non-executives and external stakeholders, such as other health professionals, government officials, NHS Board managers and patient representatives also sit on Project Boards as appropriate, which helps to facilitate consultative and accountability principles.

The Service's emerging Better Health Better Care Delivery Framework will also provide clarity on which Executive Directors of the Service will have lead responsibility for delivering which particular aspects of the development programme. (See page 11)

Delivery Plan

The Service Board also monitors performance against the HEAT targets in the Delivery Plan and receives monthly progress reports at Board meetings via the Chief Executive and Executive Directors. Each of the six Divisional General Managers attends at least one Board meeting per year to provide an update on progress, issues and challenges and respond to questions from the Board.

The Service has been reviewing its internal structures and performance management arrangements. The Chief Executive will lead bi-monthly performance management reviews with individual Divisional General Managers. This will be complimented by ongoing and ad-hoc performance management arrangements led by the Executive Directors, which will be both pro-active (forestalling problems and building on successes) – and re-active

(dealing with 'blockages' and 'hot-spots' in performance, quickly and effectively). This process mirrors the performance management arrangements within each operating Division, whereby local management teams will use local knowledge and centrally-collated data and intelligence to manage and improve performance at every level:- individual staff, stations, sub-divisions and division-wide.

The Service is working to greatly enhance the quality, availability and utility of management information available to all managers in the service, including the development of real-time 'dashboard' information to aid collective understanding of problems and barriers and facilitate prompt preventative or remedial action. This information will be available to all operational managers and within our EMDCs (Control Rooms), where effective real-time allocation and monitoring of resources is crucial to the success of our operations. The Service is reviewing, in consultation, the most effective accountability and line-management arrangements for the EMDCs as part of a wider review of their structure, location, function and integration with wider systems. The recommendations will begin to be implemented during 2008.

The performance objectives of the Delivery Plan are not the only indicators of performance of the Service. The Scottish Ambulance Service is a large, complex organisation, and the performance of such an organisation is multi-faceted. Although some key performance objectives and indicators have been identified to represent a summary of the Service performance to the 'outside world', there are many other aspects of performance that will be measured and managed internally – to combat the risk of over-reliance on a narrow range of performance indicators and ensure appropriate Board and management stewardship of resources.

Performance management is ultimately the responsibility of all service staff, from front-line crews through to the Chief Executive and Board. The Service recognises the importance of leadership development for its managers to empower and skill them in monitoring and motivating their staff and the crucial role this plays is developing a positive ethos and strong performance management culture. The Service also recognises the importance of managers having the necessary capacity to deliver on their performance management objectives without avoidable distraction to other duties, and will continue to develop structures and processes to support this.

Board-Level Reporting

The table below sets out the arrangements for reporting performance against the high level HEAT (Health, Efficiency, Access and Treatment) targets of the Service's Delivery Plan. In addition, the service has many responsibilities for which it is accountable which are not specified within the Delivery Plan. The reporting of these to relevant stakeholders, including the Board, will continue as now.

HEAT REPORTING ARRANGEMENTS FOR 2008/09

HEAT target	Measure	Frequency	Style of Reporting	Lead Dir
HI1 Save More Lives	Rates of survival of cardiac arrest on arrival at hospital	Monthly	Graph of actual performance over last three years to date and planned performance for year plus supporting narrative	Medical
E1 Meet Financial Targets	Revenue, capital and cash expenditure	Monthly	Narrative and tables showing year to date and planned positions plus supporting narrative	Finance
E2 Cash Efficiency Target	Cash releasing savings achieved	Monthly	Narrative and tables showing year to date and planned positions plus supporting narrative	Finance
E3 Reduce Sickness Absence	Rates of sickness absence	Monthly	Graph of actual performance over last three years to date and planned performance for year plus supporting narrative	Operations / Human Res
E4 Universal Utilisation of CHI	PTS registrations where CHI is used	Quarterly	Graph of actual performance over year to date and planned performance for year plus supporting narrative	Finance
E5 Knowledge & Skills Framework	AfC staff with Personal Development Plans	Quarterly	Graph of actual performance over year to date and planned performance for year plus supporting narrative	Human Resources
A1 Response Time to Category A incidents (mainland)	Incidents reached within 8 minutes	Monthly	Graph of actual performance over last three years to date and planned performance for year plus supporting narrative	Operations
A2 Response Time Category B incidents	Incidents reached within 19 minutes	Monthly	Graph of actual performance over last three years to date and planned performance for year plus supporting narrative	Operations
A3 Response Times - Island NHS Boards	Incidents reached within 8 minutes	Monthly	Graph of actual performance over last three years to date and planned performance for year plus supporting narrative	Operations
A4 PTS Punctuality for Appointment for Priority Patients	Patients arriving at hospital within 30 minutes or less before appointment	Quarterly	Graph of actual performance over last three years to date and planned performance for year plus supporting narrative	Operations
A5 PTS Punctuality for Pick Up for Priority 1 Patients	Patients picked up within 30 minutes of agreed time	Quarterly	Graph of actual performance over last three years to date and planned performance for year plus supporting narrative	Operations
A6 Reduce Hospital Admissions	Emergency calls treated at scene	Quarterly	Graph of actual performance over the last year to date and planned performance for the year plus supporting narrative	Medical
T1 Improve Health Outcomes for Patients	NHS QIS review of Clinical Governance and Risk Management standards	No review in 2008/09	NHS QIS report	Medical

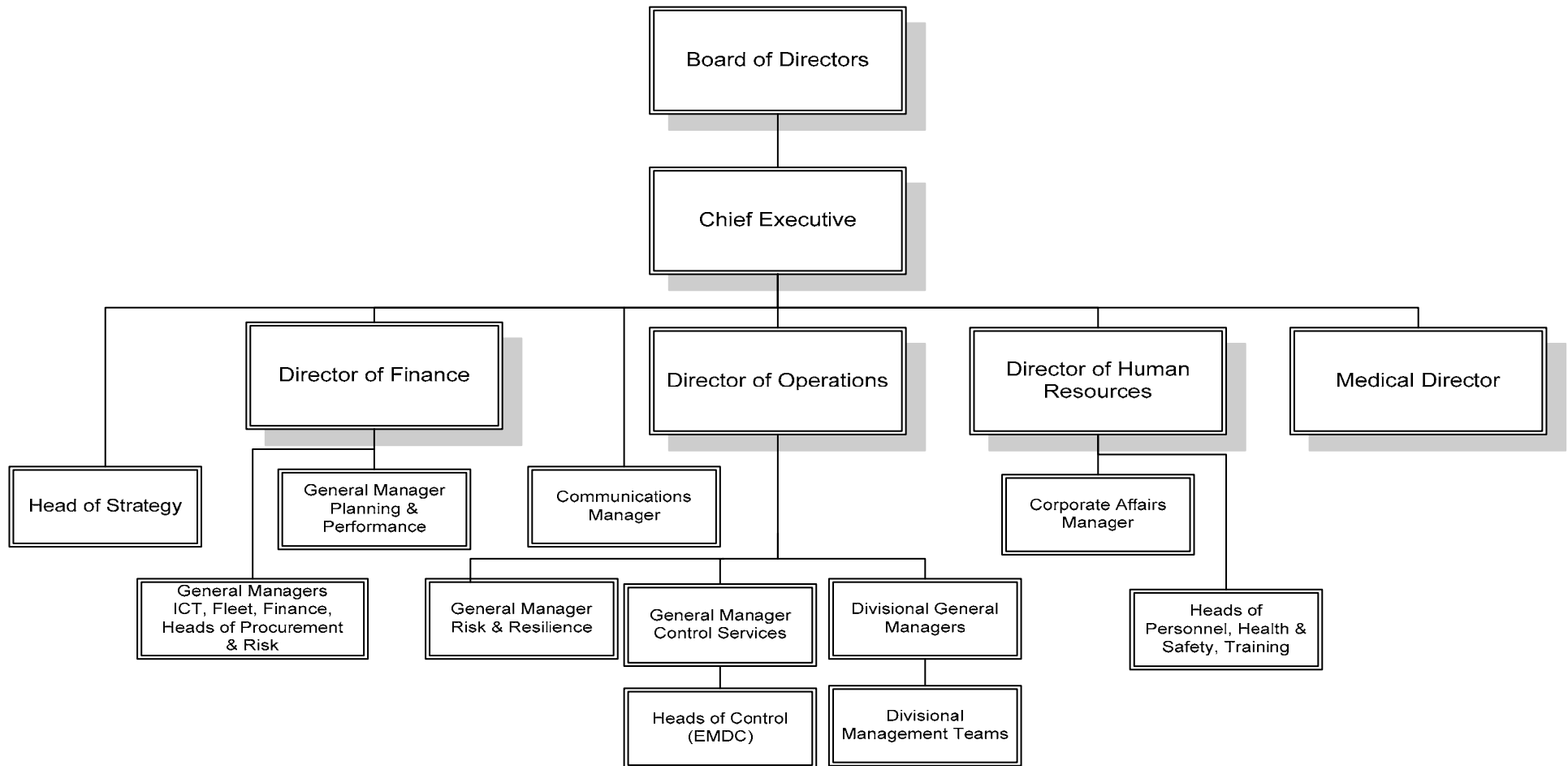
Other Service Accountabilities

In addition to the schedule above the Service Board will gain assurance on the delivery of its responsibilities from the following:

- Updates as required from the Chief Executive (or delegated Executive Directors) on key issues and developments within the service e.g. emergency preparedness, health and safety, capital projects etc.
- Annual summary update from Chief Executive on progress in implementing key strategies and performance against targets
- Minutes of Board Committees (Audit, Clinical Governance and Staff Governance) and verbal update from specified Non-Executive lead
- Internal audit reports
- Annual report from Audit Scotland, which sets out the external audit assessment of the Board's governance arrangements.
- Compliance statements and reports (e.g. to NHS QIS on Information Governance, Scottish Health Council on PFPI etc), position papers, briefings and action plans as required, in response to pertinent matters arising in relation to matters of corporate governance

Papers and minutes of public Board Meetings shall always be made available on the Service's website and internal intranet as soon as possible.

Proposed Organisational Structure



SECTION 6, FINANCIAL PLAN

SCOTTISH AMBULANCE SERVICE

SUMMARISED OPERATING COST STATEMENT

2007-08 £000s		2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s
126,250	Clinical Service - Pay	130,800	134,500	140,000	0	0
54,597	Clinical Service - Non Pay	55,396	57,509	57,776	0	0
2,600	Non-Clinical Service - Pay	5,150	5,800	6,000	0	0
800	Non-Clinical Service - Non Pay	2,280	2,274	1,300	0	0
184,247	<i>Total Gross Expenditure</i>	193,626	200,083	205,076	0	0
5,100	Less Operating Income	6,201	6,400	6,400	0	0
179,147	<i>Net Operating Costs</i>	187,425	193,683	198,676	0	0
	Less FHS Non-Discretionary	0	0	0	0	0
179,147	<i>Net Resource Outturn</i>	187,425	193,683	198,676	0	0
179,147	Revenue Resource Limit (RRL)	187,425	193,683	198,676	0	0
0	Saving/(Excess) against RRL	0	0	0	0	0

SCOTTISH AMBULANCE SERVICE

RECURRING AND NON-RECURRING REVENUE PROJECTION

	Rec £000s	2008-09 Non-Rec £000s	TOTAL	Rec £000s	2009-10 Non-Rec £000s	TOTAL	Rec £000s	2010-11 Non-Rec £000s	TOTAL	Rec £000s
Clinical Service - Pay	129,500	1,300	130,800	134,500		134,500	140,000		140,000	
Clinical Service - Non Pay	54,896	500	55,396	56,509	1,000	57,509	57,776		57,776	
Non-Clinical Service - Pay	5,150		5,150	5,800		5,800	6,000		6,000	
Non-Clinical Service - Non Pay	1,100	1,180	2,280	1,200	1,074	2,274	1,300		1,300	
<i>Total Gross Expenditure</i>	<i>190,646</i>	<i>2,980</i>	<i>193,626</i>	<i>198,009</i>	<i>2,074</i>	<i>200,083</i>	<i>205,076</i>	<i>0</i>	<i>205,076</i>	<i>0</i>
Less Operating Income	6,201		6,201	6,400		6,400	6,400		6,400	
<i>Net Operating Costs</i>	<i>184,445</i>	<i>2,980</i>	<i>187,425</i>	<i>191,609</i>	<i>2,074</i>	<i>193,683</i>	<i>198,676</i>	<i>0</i>	<i>198,676</i>	<i>0</i>
Less FHS Non-Discretionary			0			0			0	
<i>Net Resource Outturn</i>	<i>184,445</i>	<i>2,980</i>	<i>187,425</i>	<i>191,609</i>	<i>2,074</i>	<i>193,683</i>	<i>198,676</i>	<i>0</i>	<i>198,676</i>	<i>0</i>
<u>Revenue Resource Limit (RRL)</u>										
Initial Allocation	183,395		183,395	192,009		192,009	198,676		198,676	
Anticipated Allocations (list below)										
Model Response	2,750	1,180	3,930	600	1,074	1,674			0	
EMDC Review		60	60			0			0	
Infection Control		40	40			0			0	
			0			0			0	
			0			0			0	
			0			0			0	
			0			0			0	
<i>Total RRL</i>	<i>186,145</i>	<i>1,280</i>	<i>187,425</i>	<i>192,609</i>	<i>1,074</i>	<i>193,683</i>	<i>198,676</i>	<i>0</i>	<i>198,676</i>	<i>0</i>
Saving/(Excess) against RRL	1,700	(1,700)	0	1,000	(1,000)	0	0	0	0	0

SCOTTISH AMBULANCE SERVICE						
INFRASTRUCTURE INVESTMENT PROGRAMME						
2007-08 £000s		2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s
	Capital Expenditure					
	<i>New Developments</i>					
	a) Property (list below)					
	New Build					
1,028	West Central Property	2,367	1,500			
786	Ambulance Stations	684	2,862			
979	EMDC Estate	543	1,305	1,500	1,600	2,100
	SORT Bases	885	300			
64	Model Response	412				
	b) Equipment (list below)					
	Medical Equipment					
245	Defibrillators		5,000			
44	Other		100	100	100	
29	Model Response	1,937	647			
	c) IM & T (list below)					
897	Comms & IT	600	1,627	1,600	1,600	1,600
	EMDC Comms & IT	1,044	190	1,265	400	
	d) Capital Grants (list below)					
	<i>Rolling Programmes</i>					
	a) Property					
9,092	b) Vehicles	8,000	8,000	8,000	8,000	8,000
	c) IM & T					
	d) Donated Assets					
	e) Intangible Assets					
13,164	Total Expenditure	16,472	22,647	12,465	11,700	11,700
2,200	Less Capital Income	723	3,900	865	100	100
10,964	Net Capital Expenditure	15,749	18,747	11,600	11,600	11,600
	Capital Resource Limit (CRL)					
3,500	SEHD Formula Allocation	3,600	3,600	3,600	3,600	3,600
9,249	Other Centrally Provided capital funding	10,349	15,147	8,000	8,000	8,000
15	Prior Year Saving/(Excess) b/f	0	0	0	0	0
(1,800)	Net Advances/Banked Funds	1,800				
	Repayment of Advances/Banked Funds					
10,964	Donated Assets					
	Total Capital Resource Limit	15,749	18,747	11,600	11,600	11,600
0	Saving/(Excess) against CRL	0	0	0	0	0

Revenue Supported Developments						
2007-08 £000s		2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s
	Capital Expenditure					
	Existing PPP Unitary Charges					

SCOTTISH AMBULANCE SERVICE

FINANCIAL PLANNING ASSUMPTIONS

2007-08	<u>Assumptions - uplift (%)</u>	2008-09	2009-10	2010-11	2011-12	2012-13
6.00%	Resources	3.15%	3.15%	3.15%		
2.60%	Pay	2.50%	2.50%	2.50%		
3.50%	Prices	2.50%	2.50%	2.50%		
	GP prescribing					
	Hospital Drugs					
	Other FHS uplift					

FINANCIAL PLANNING ASSUMPTIONS

2007-08	<u>£000's</u>	2008-09	2009-10	2010-11	2011-12	2012-13
15,091	Capital Charges	13,950	14,500	15,500		
	Impairments	11,653	3,178	381		
442	Accelerated Depreciation	442	442			

RISK ASSESSMENT

Key Assumptions/Risks	Risk rating/Impact/£
Efficiency Savings Realisation	High risk rating regarding the timetable for realising efficiency savings in relation to major reorganisation of operational activities with an associated danger of not releasing funding for identified service developments identified in the local Delivery Plan.
Impact of Growth in Demand	High risk that continuing growth in demand compromises service redesign proposals including realisation of efficiencies and contributes to additional operating costs required to satisfy patient services.
Pay Terms and Conditions	Medium level risks surrounding negotiation of outstanding terms and conditions issues such as meal break payments and revised unsocial and on-call payment terms. Uncertainty regarding final annual pay award level.

Permanent Injury Benefit Awards	Unknown risk level arising from lack of current information on permanent injury benefit claimants estimation of required provision impossible to undertake with any accuracy in the absence of detailed information.
Impact of NHSS Service Redesign	Unknown risk level associated with NHSS service redesign measures arising from uncertainties in plans of other health boards which could directly impact upon the level and composition of patient services provided by Scottish Ambulance Service.

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