Scottish Ambulance Service
Taking Care to the Patient

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NOT PROTECTIVELY MARKED

Public Board Meeting	**May 2018** **Item No 05**

THIS PAPER IS FOR DISCUSSION

TOWARDS 2020: TAKING CARE TO THE PATIENT AND QUALITY IMPROVEMENT

Lead Director **Author**	Pauline Howie, Chief Executive Executive Directors
Action required	The Scottish Ambulance Service Board is asked to **discuss progress** within the 2020 delivery programme and:- 1. **Note** performance against Operational Delivery Plan (ODP) standards for the period to end April 2018. 2. **Discuss** actions being taken to improve performance. 3. **Discuss** actions taken to deliver further improvements in the 3 strategic work streams.
Key points	This paper brings together measurement for improvement with measurement for judgement as highlighted by the Scottish Government's Quality Improvement and Measurement for Non Executives guidance. This paper highlights performance against our Operational Delivery Plan and includes updates from the Clinical Services Transformation Programme, Enabling Technology and Workforce Development strategic work streams. <u>Clinical Services Transformation</u> • Further development and refinement of our New Clinical Response Model continues. Since the introduction of "key phrases" on 9 April, the model has performed as forecast by identifying critically ill patients earlier in the call cycle. This step enables patients to receive life-saving intervention as early as possible. • The positive impact of the introduction of our Trauma desk work has been published this month in Injury, International Journal of the Injured :*Clinician tasking in ambulance control improves the identification of major trauma patients and pre-hospital critical care team tasking* (Sinclair et al, May 2018)

Performance

- VF/VT Return of Spontaneous Circulation has continued to improve and for the last two months is already above our 2018/19 aim of 42%. This means more people reach hospital alive following a cardiac arrest. The monthly median response time for April 2018 was within target at 5 minutes 37 seconds.
- We continue to implement the pre-hospital stroke care bundle to 95% reliability, providing the best pre-hospital care for stroke patients.
- Response to all Immediately Life Threatening incidents for April, was 6 minutes 56 seconds (against a standard of less than 7 minutes). Our 90th percentile measure was 14 minutes 15 seconds (against a standard of less than 15 minutes).

Enabling Technology

- Ambulance Telehealth Programme –The SAS app has been undergoing final integration and testing at Coatbridge Station, feedback to date has been positive. The Team are now confident that they will be able to commence the full roll out in May and complete it in July;
- Emergency Service Network (ESN) Programme – Local programme timescales are still unclear due to significant, timescale slippage in the GB–wide Emergency Service Mobile Communications Programme (ESMCP). The UK Government Full Business Case (FBC) is being refreshed with HM Treasury approval planned for autumn 2018. Scottish Government will be seeking Full Business Case 'assurance' from the Service and the other Scottish emergency services over the summer period;
- Provision of an ESN compatible Integrated Communications Control System (ICCS) - Following a previous Board decision to fully consider the two main options (i.e. to collaborate with Police Scotland and/or the Department of Health), work has been ongoing to produce an appropriate business case. Scottish Government has agreed to fund the capital costs. The revenue costs, while aiming to be minimal, will be subject to a risk share approach with Scottish Government depending on the final level. The business case will be presented at the Board for consideration in September 2018;
- Fleet Replacement Project – The vehicle replacement programme is progressing in line with agreed plans;
- Defibrillator Replacement – Live trials involving devices from two potential suppliers are ongoing. The Defibrillator Replacement Project Outline Business Case (OBC) was approved by the Board in March, it will be considered by the Scottish Government Capital Investment Group (CIG) in June. Once approved a Full Business Case will be developed for Board approval in September.

	Workforce Development • Our Service interim resourcing plan for 2018/19 is now in progress, with continued monitoring to consider the needs for any adjustment arising from the review of our modelling assumptions; • The training prospectus for 2018/19 is now in progress based on regional workforce planning requirements. We continue to progress our overall employee development agenda in line with evolving organisational requirements; • In our employee engagement work, the iMatter single cohort launch commenced as planned in April 2018.
Timing	The key programmes of work for the 2020 Strategy.
Link to Corporate Objectives	The Corporate Objectives this paper relates to are: 1.1 Engage with partners, patients and the public to design and co-produce future service. 1.2 Engaging with patients, carers and other providers of health and care services to deliver outcomes that matter to people. 1.3 Enhance our telephone triage and ability to See and Treat more patients at home through the provision of senior clinical decision support. 2.1 Develop a bespoke ambulance patient safety programme aligned to national priorities. Early priorities are Sepsis and Chest Pain. 2.4 Develop our mobile Telehealth and diagnostic capability. 3.1 Lead a national programme of improvement for out of hospital cardiac arrest. 3.2 Improve outcomes for stroke patients. 3.4 Develop our education model to provide more comprehensive care at the point of contact. 3.5 Offer new role opportunities for our staff within a career framework. 4.1 Develop appropriate alternative care pathways to provide more care safely, closer to home building on the work with frail elderly fallers - early priorities being mental health and COPD. 5.1 Improve our response to patients who are vulnerable in our communities. 6.2 Use continuous improvement methodologies to ensure we work smarter to improve quality, efficiency and effectiveness. 6.3 Invest in technology and advanced clinical skills to deliver the change.
Contribution to the 2020 vision for Health and Social Care	This programme of work underpins the Scottish Government's 2020 Vision. This report highlights the Service's national priority areas and strategy progress to date. These programmes support the delivery of the Service's quality improvement objectives within the Service's annual Operational Delivery Plan.
Benefit to Patients	This 'whole systems' programme of work is designed to support the Scottish Ambulance Service to deliver on the key quality ambitions

	within Scottish Government's 2020 Vision and our internal Strategic Framework "Towards 2020: Taking Care to the Patient", which are to deliver safe, person-centred and effective care for patients, first time, every time. A comprehensive measurement framework underpins the evidence regarding the benefit to patients, staff and partners and supports the Service's transition towards 2020.
Equality and Diversity	This paper highlights progress to date across a number of work streams and programmes. Each individual programme is required to undertake Equality Impact Assessments at appropriate stages throughout the life of that programme. In terms of the overall approach to equality and diversity, key findings and recommendations from the various Equality Impact Assessment work undertaken throughout the implementation of Towards 2020: Taking Care to the Patient are regularly reviewed and utilised to inform the equality and diversity needs.

SECTION 1: PROGRESS WITH OPERATIONAL DELIVERY PLAN (ODP) IMPLEMENTATION - DISCUSSION

RECOMMENDATIONS

The Board is asked to:

1. Feedback on format and design of this area of the paper.
2. Note performance against Health, Efficiency, Access and Treatment (HEAT) standards for the period to end April 2018.
3. Discuss actions being taken to improve performance.

Performance to Date - Key Improvement Highlights

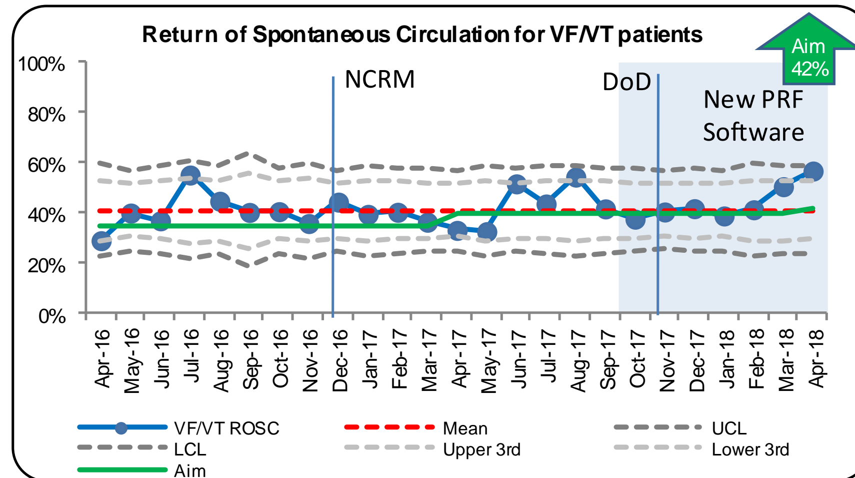
- VF/VT Return of Spontaneous Circulation has continued to improve and for the last two months is already above our 2018/19 aim of 42%. For the first time VF/VT ROSC has been over 50% in two consecutive months. This means more people reach hospital alive following a cardiac arrest. The monthly median response time for April 2018 was within target at 5 minutes 37 seconds.
- We continue to implement the pre-hospital stroke care bundle to 95% reliability, providing the best pre-hospital care for stroke patients. Compliance is statistically stable at 95.6% and we are already meeting 2018/19, 95% aim.
- Response to all Immediately Life Threatening incidents for April, was 6 minutes 56 seconds (against a standard of less than 7 minutes). Our 90th percentile measure was 14 minutes 15 seconds (against a standard of less than 15 minutes).

IMPROVING CARDIAC ARREST SURVIVAL RATES

SAS H1 Save more lives - Return of Spontaneous Circulation (ROSC) for VF/VT patients

Aim – Working in partnership with organisations and volunteers, as set out in the National Out of Hospital Cardiac Arrest (OHCA) Strategy, increase survival rates after OHCA by 10% across the country within 5 years.

Chart 1 Return of Spontaneous Circulation for VF/VT patients

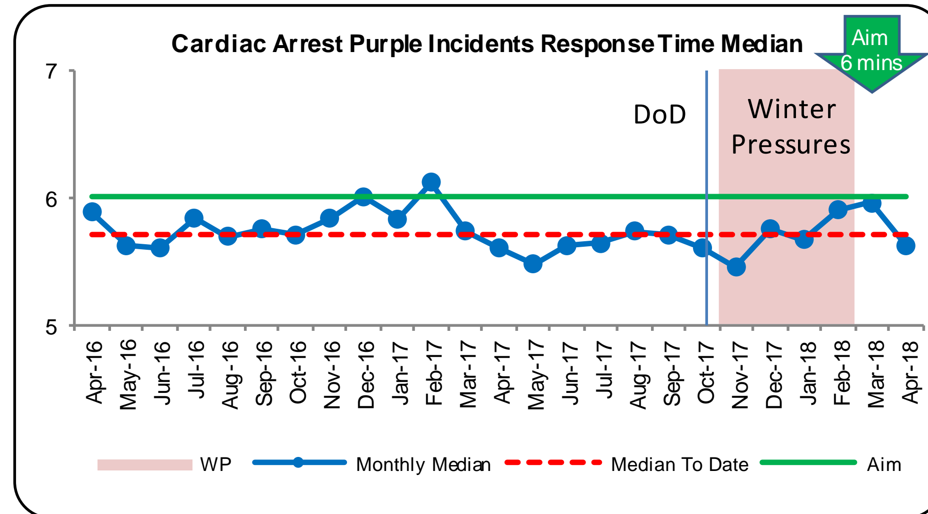


What is the data telling us – We continue to improve with a 6.2% increase in April 18 (56.9%) compared to (50.7%) in March 2018 for VF/VT Return of Spontaneous Circulation (ROSC). This is the third month in a row showing a positive run above the aim.

Why – The Service continues to lead on the Scottish Government Out of Hospital Cardiac Arrest (OHCA) strategy across the whole chain of survival. Many factors such as bystander CPR and the use of Public Access Defibrillators influence ROSC outcome prior to the arrival of the Service, however, early identification of OHCA by the Ambulance Control Centre through the use of Dispatch on Disposition, Pre-Entry Questions and key phrases is a large contributory factor to this success.

SAS H2 Cardiac arrest patients - Cardiac Arrest Purple Incidents Response Time Median

Chart 2 Cardiac Arrest Purple Incidents Response Time Median



What is the data telling us – Incidents coded as Purple represent all patients with the highest risk of actual cardiac arrest or acute risk of deterioration to cardiac arrest. Approximately 50% of patients coded purple are in cardiac arrest. The median response time for Cardiac Arrest purple codes has remained consistently below the 6 minute target.

What are we doing to further improve and by when – On June 6-7 2015, in Norway, 36 Emergency Medical Services (EMS) leaders, researchers, and experts from throughout the world convened to address the challenge of how to increase community cardiac arrest survival and how to achieve implementation of best practices and worthwhile programs. Scotland was fundamental in the establishment of a Global Resuscitation Alliance in order to expand internationally the reach and utility of the Resuscitation Academy concept developed in King County, Seattle since 2008.
In 2018 only four exemplar sites from across the world were chosen to lead on the development of the Resuscitation Quality Initiative developing the quality improvement programme for use globally :-

- Seattle King County
- Melbourne Australia

- Maryland NYC
- Scotland

The Service is taking forward four improvement projects in relation to OHCA as part of the Global Resuscitation Alliance:

- System of Excellence (Complete);
- Telecommunicator CPR (Underway);
- High Quality CPR (Start date October 2018);
- Specialist Response (Start date October 2018);

About the Pilot Programs

- **Cardiac Arrest System Assessment –** Measure your community's capability to manage cardiac arrest using a self-assessment tool to gain a high-level snapshot of performance. Using a maturity model and repeat assessments, communities may track progress over time.
- **Dispatcher Assisted Telephone CPR –** The purpose of this program is to help 999 call takers to rapidly recognise cardiac arrest and effectively coach callers to perform CPR. Individual performances are aggregated into a data analytics package that enables dispatch leaders to visualise trends and opportunities for improvement.
- **Resuscitation Quality Improvement for EMS –** Individual CPR skills decay rapidly and the two-year certification model does not support skills needed for improved patient outcomes. Through their ongoing participation in RQI, individuals achieve a perpetual CPR card – the focus is shifted from course completion to competency in CPR skills.
- **High-Performance CPR for Teams –** This program builds on individual competence towards developing high-performing resuscitation teams. Following a simulation, the team reviews their performance (using video and quality CPR metrics) and conducts a peer-led debriefing. Data from each simulation is aggregated into a data analytics package.

These projects are embedded within the CST programme of work for 2018/19.

Other work streams include:-

- 3RU model implementation in urban areas, where a dedicated Paramedic Response Unit co-responds providing additional decision making support, leadership to resuscitation efforts, and access to mechanical CPR if necessary. This is the national application of the award winning Edinburgh 3RU programme.

In remote and rural communities other solutions are required. Current models in development are the Wildcat Project in rural Aberdeenshire. This is a co-production between the Service and the Sandpiper Trust. In this model over 400 volunteers have been trained in nearly 30 locations, providing a robust response delivering high quality CPR and defibrillation. In Moray, Police Scotland is working in

partnership to respond to OHCA supported by charitable fundraising efforts. Within Ambulance Control Centres, our Additional Response Desk is now implemented with the aim of fully utilising our Community First Responders and other volunteer responders, with early data suggesting a significant increase in co-responder dispatch since its introduction.

We have a real focus within the Ambulance Control Centres on early recognition of patients in cardiac arrest or peri-arrest. This has involved additional training and support, the introduction of Pre-entry Questions and Key Phrases that allows early recognition of the patient in cardiac arrest or peri-arrest even before the triage process has started. This in turn allows dispatchers to reliably dispatch the closest resources as early in the call cycle as possible.

SAS H3 Response to Immediately Life Threatening incidents (ILT) ILT Incident Response Time Median and ILT Incident Response Time 90th Percentile, Emergency Demand

Chart 3.1 ILT Incidents Response Time Median

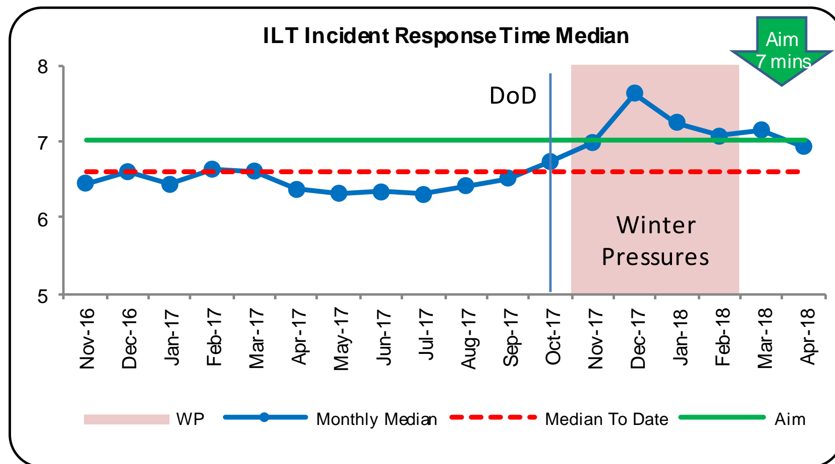


Chart 3.2 ILT Incident Response Time 90th Percentile

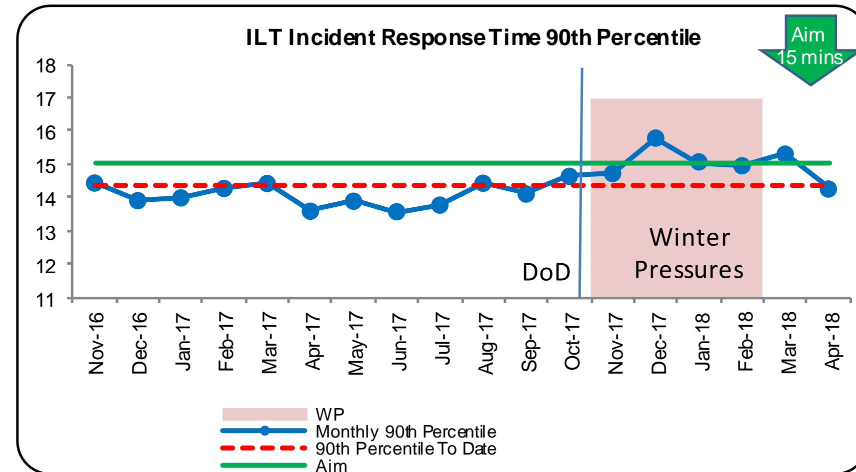


Chart 3.3.1 Emergency Demand

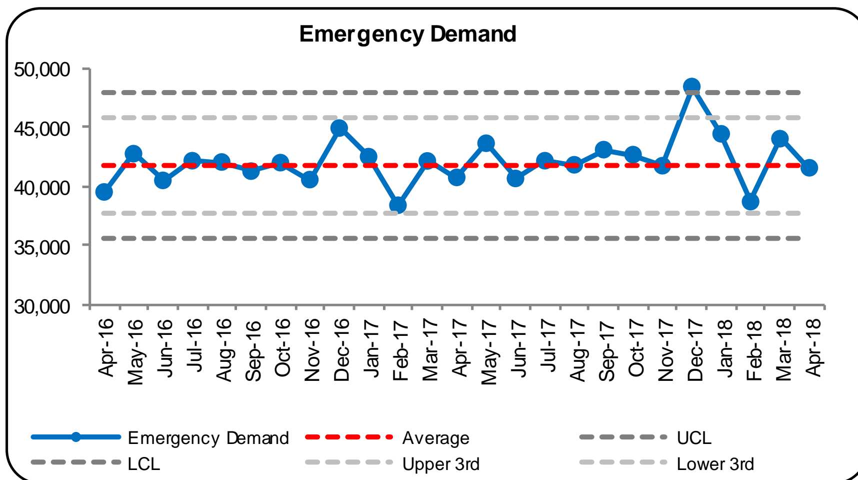
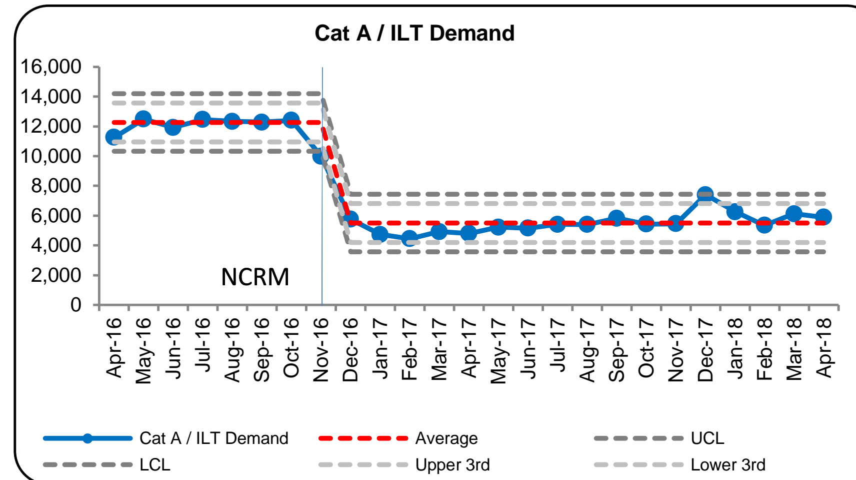


Chart 3.3.2 Cat A / ILT Demand



What is the data telling us - Since Dispatch on Disposition go live in October 2017, we are now reporting on median and 90th percentile ILT performance. For April 2018, performance median was 6 minutes 56 seconds (against a standard of less than 7 minutes), with a 90th percentile of 14 minutes 15 seconds (against a standard of less than 15 minutes).

The demand pressures seen over the winter months have now reduced and are within normal limits, although the volume of immediately life threatening incidents remains higher than expected. In addition, high hospital turnaround times remain across key sites with no signs yet of reducing to pre-winter levels.

Our robust monitoring arrangements for Dispatch on Disposition have enabled our service teams to analyse all areas of the system to identify opportunities to further enhance and improve response and outcomes for patients.

Why - The introduction of Key Phrases has improved the earlier identification of patients who present with life threatening conditions. We have been able to identify 6.6% more ILT calls earlier, enabling quicker dispatch of a resource.

What are we doing and by when - We continue to focus on the pre-positioning of resources when available this reduces the travel time of ambulance resources arriving at the scene.

SAS T1 Reduce hospital admissions - % of unscheduled calls not conveyed

Chart 4.1 % Incidents With a Referral or Discharge Outcome

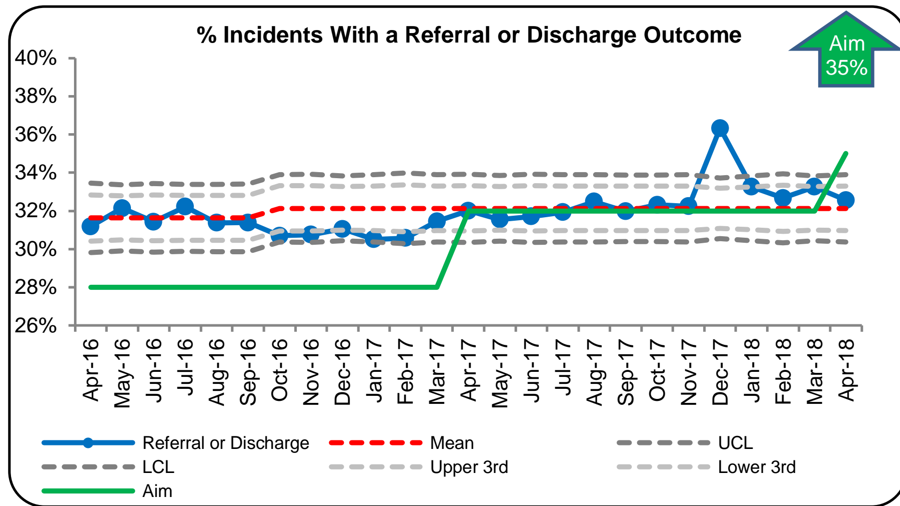


Chart 4.2 % Incidents With a Hear & Treat Referral or Discharge Outcome

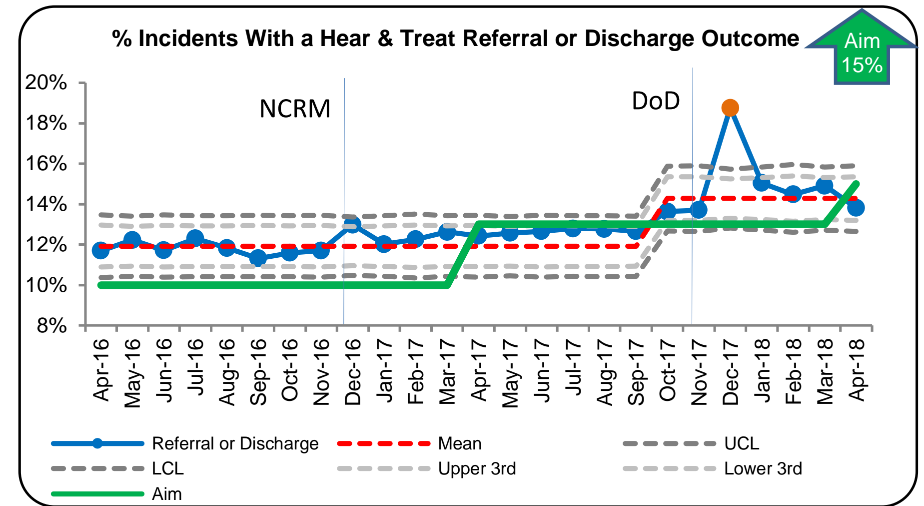
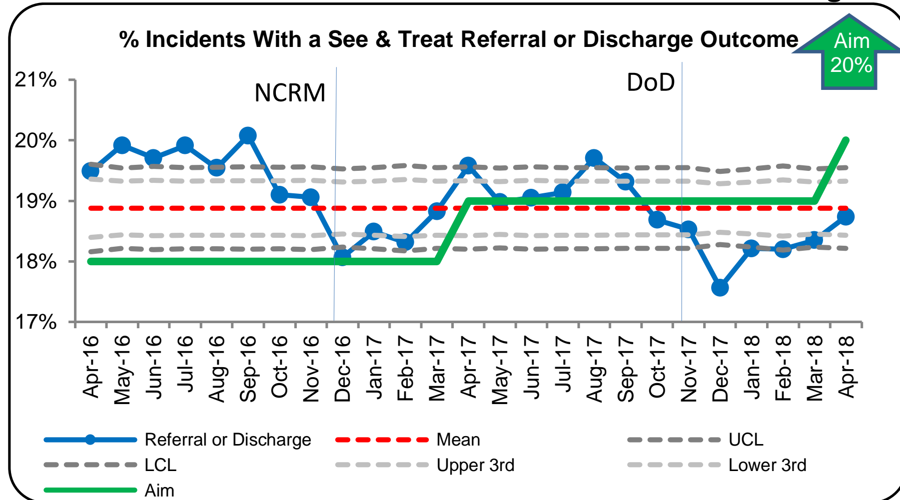


Chart 4.3% Incidents with a See & Treat Referral or Discharge Outcome



What is the data telling us - For incidents with a referral or discharge outcome (Chart 4.1) the 2017/18 aim of 32% was met, with 32.7% of incidents achieving a referral or discharge outcome. For 2018/19 the aim has been increased to 35%. Chart 4.1 shows that performance has stabilised following the winter pressures when special cause variation was seen.

Hear and Treat rates have increased since October 2017 (Chart 4.2) with a rise over December and January. The impact of the increased volume of calls may correlate to this change. The rate has been within normal limits during March and April.

See and Treat referral or discharge outcomes have continued to improve over the last 4 months (Chart 4.3). This is the fourth month in a row showing a trend upwards moving towards reaching the new 20% aim.

Why - After the significant winter pressures, the Service has made sustainable improvements in transferring calls to NHS 24 for patients to receive the most appropriate care, as well as creating capacity for clinical advisors to provide clinical assessment by telephone. Additionally, the Service continues to develop the tasking of specialist paramedics in urgent and primary care who have advanced knowledge, skills and access to medicines to treat more people at home or in a homely setting.

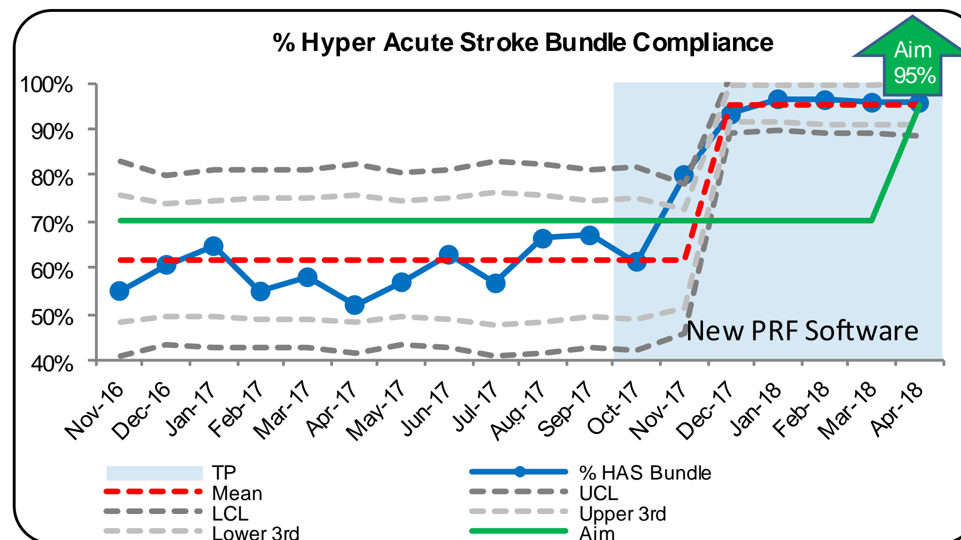
What are we doing and by when - Programmes of improvement are underway for both Hear and Treat and See and Treat outcomes within the Clinical Services Transformation (CST) programme in 2018/19. We are continuing to recruit to our Clinical Hub to create capacity to address more patient incidents with a Hear and Treat Referral or Discharge Outcome. In addition, we use this resource to instigate welfare calls to keep patients safe, identify calls where no ambulance is required and signpost patients to alternative pathways. To learn and improve how we deal with calls staff are testing and developing a real-time feedback and monitoring system for teams and individuals. The system focuses on structured feedback to explore opportunities for improvement using team and individual scorecards. Wider stakeholder engagement is planned aimed at increasing the number of alternative referral options for patients through the Clinical Hub.

An Advanced Practice Strategic Group is now established to explore further opportunities for See and Treat Referral and Discharge Outcomes for patients. The group are reviewing roles and scope of practice for all staff including the job description content to explore every opportunity to safely see, treat, refer and discharge patients and meet their needs in a safe and timely manner. The findings of our recent demand and capacity review by ORH, (presented to the Board in April 2018), will provide a framework for development. This work will form part of both the CST and workforce development programmes in 2018/19.

Patient Safety

SAS T2 Hyper acute stroke - % of hyper acute stroke patients receiving pre-hospital care bundle

Chart 5 % of hyper acute stroke patients receiving pre-hospital care bundle



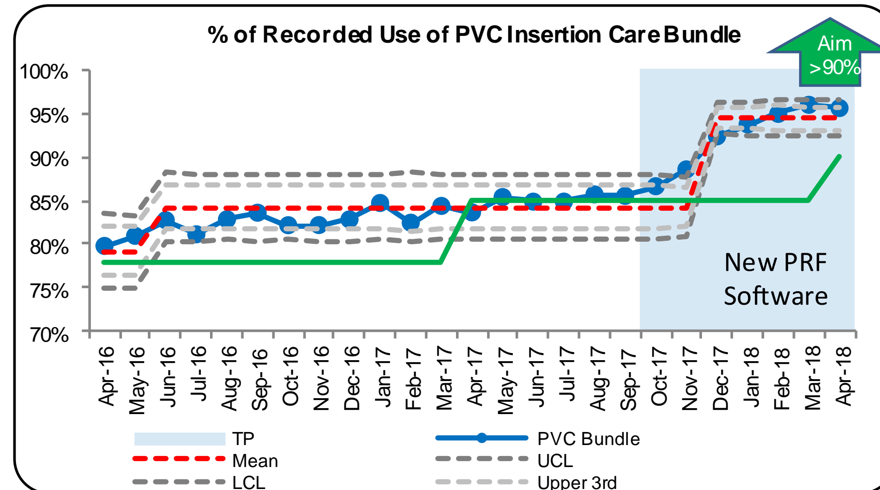
What is the data telling us - We are continuing to improve current compliance for the stroke bundle currently at 95.6% for April 2018. This is the 6th consecutive month we have sustained practice above the 2017/18 70% aim. The data shows a positive shift in practice with staff reliably implementing the pre-hospital care stroke bundle with the new 2018/19 95% aim already being met.

Why - The Service continues to lead on the pre-hospital recognition and intervention for stroke. This includes early recognition of stroke by the Ambulance Control Centre and the New Clinical Response Model approach to tasking resources for stroke patients. Over the past two years, the Service has had a dedicated post to lead our work in improving care for patients with stroke. We commend Craig Henderson for his leadership in this role supporting staff throughout the Service to achieve high reliability in practice.

What are we doing and by when - By 2020, Scottish Government is leading a piece of work to revisit the national stroke pathway to include thrombectomy. The Service will play a key role in this future development, including updating how we measure the components of care for patients with a stroke. This new project will form part of the CST programme of work 2018/19.

SAS T3 Infection control -% of recorded use of PVC insertion care bundle

Chart 6 % of Recorded Use of PVC Insertion Care Bundle



What is the data telling us - The Service target for recording the PVC insertion care bundle has been reviewed and the aim increased from 85% to 90% for 2018/19. Overall compliance for the Service for the last five months has consistently been above the 90% aim with steady improvement since December 2017. Compliance for April 2018 is currently at 95.6%.

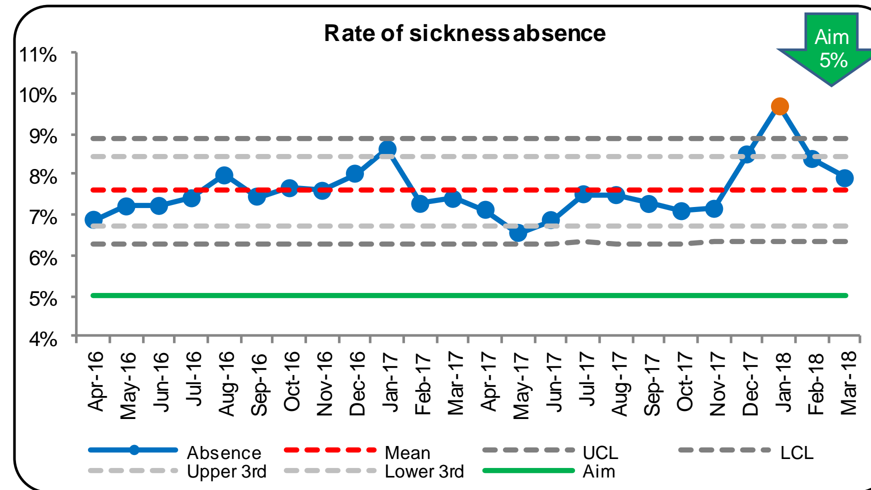
Why - The statistical increase (trend and shift) seen on Chart 6 since December 2017 may be correlated to improved record keeping related to the introduction of new software used on scene by the crews.

What are we doing and by when- It is anticipated that this improvement will be maintained going forward.

Staff Experience

SAS E2 Sickness absence – rate of sickness absence

Chart 7.1 Rate of Sickness Absence



What is the data telling us - Absence level for the 2017/18 performance year was 7.6% (Chart 7.1) the same as in 2016/17.

Why - As previously reported the increase in absence caused by short term absence related to winter illnesses peaked in January 2018 and has subsequently reduced down towards the mean. March 2018 was 7.9%.

What are we doing and by when - Actions introduced to address the absence rise are continuing as we focus on sustained improvement:

- Management focus on early intervention particularly for short term absence with escalation as appropriate.
- Spread of good practice from areas where we have noted better performance.
- Appropriate targets set for all areas to agree relevant improvement levels to support overall trajectory to 5%.
- In depth review of Musculoskeletal absence reasons to identify and tackle root causes.

Section 2 Clinical Services Transformation

1. **Out of Hospital Cardiac Arrest** - Lead a national programme for improvement for Out Of Hospital Cardiac Arrest

Background - Out-of-hospital cardiac arrest (OHCA) remains a significant healthcare challenge in Scotland. Approximately 3,000 patients undergo attempted resuscitation each year after OHCA. The survival rate in Scotland, from this condition, is approximately 6%, which is low compared to the UK average of 9%. Some other European centres best claim to return almost a 25% of all OHCA victims home alive.

Aim - In response to this, the Scottish Ambulance Service chaired a multi partner group hosted by Scottish Government to develop a national Out of Hospital Cardiac Arrest Strategy. Out of Hospital Cardiac Arrest - A Strategy for Scotland (2015) sets out the following high level aims:-

- We aim to increase survival rates after OHCA by 10% across the country within five years. Reaching this level of performance means around 300 more lives will be saved every year compared to recent years. The improvement programme aims to save an additional 1,000 lives by 2020.
- We aim to equip an additional 500,000 people with CPR skills by 2020. Increasing the rate of bystander CPR is the cornerstone of improving outcomes because prompt bystander CPR can increase the likelihood of survival after OHCA by 2 or 3 times.

Status - A programme of work is underway across the following areas:

1. **Cardiac Arrest Registry:** Linking ambulance service data with other datasets to allow patient outcomes to be measured and system performance and service changes to be monitored.

2. **Telephone CPR, telephone dispatch and PAD Utilisation:** The Ambulance Control Centre (ACC) is the hub of the coordination of all the resources involved in the pre-hospital care of Out Of Hospital Cardiac Arrests. ACC call handlers are effectively trained and supported and reliably use the best triage tools available so that they can rapidly identify OHCA, initiate telephone Cardiopulmonary resuscitation (CPR) and task appropriate resources. ACC call handlers require up to date and accurate information regarding available resources to map Community First Responders and defibrillators to the location of the patient.

3. **High performance CPR, Feedback and Second-tier response:** We have developed rapid deployment of responders with the appropriate skills to perform high quality resuscitation. Robust clinical governance and feedback systems to maintain skills, motivation and morale. Introduced the use of second-tier responding by specialist paramedics where appropriate.

4. **PAD programme, Bystander CPR, Community Engagement:** Concerted effort to increase bystander CPR rates is fundamental. We are supporting and strengthening existing community assets including engaging with organisations through a full partnership in

the Save a Life for Scotland (SALFS) initiative. To ensure that best use is made of Public Access Defibrillators (PADs) we are developing a structured approach including: governance for mapping and maintenance, encouraging servicing and maintenance in the community, ensuring PAD mapping is kept up to date, review of public information available about PADs.

5. **Co-responder Model:** We are working with partner organisations such as Police Scotland and the Scottish Fire and Rescue Service (SFRS) to optimise early response to OHCA by using community assets.

6. **Culture of Excellence:** It is essential that we emphasise through our internal communications to all staff that OHCA is a potentially survivable event. We have a whole systems approach to emphasise the continuous improvement of clinical performance and patient outcomes. We have a framework in place for staff to be informed of their own performance and outcomes. Not all patients survive and we recognise the need for staff support and welfare in these circumstances. We have a system in place to ensure that the staff are supported through the challenging experiences they face. Profiling our success is key to achieve the aims we seek and every opportunity is explored to share our success underpinned by data for improvement at both national and international events.

Improvement - Implementation of the Out of Hospital Cardiac Arrest programme will save more lives. For April 2018 the VF/VT ROSC rate is 56.9%, which is more than the 2018-19 aim of 42%.

Planned activities - Our 2018/19 delivery plan is agreed. This includes evaluation of 3RU (Rapid Resuscitation Response Unit) phase one to identify opportunities to test, implement and spread best practice. We are in the process of agreeing the education requirements of the CCP programme in relation to OHCA including: developing a faculty plan for future 3RU training and re-training to ensure a sustainable model and complete the Global Resuscitation Alliance Programme in Perthshire.

- Clinical guidelines are agreed by Cardiac Arrest team. Our Medicines Management team are now developing plans for post ROSC adrenaline administration.
- Following a test of change, Livingston is now confirmed as a training site. Staff are trained and are analysing local data for improvement. Further testing planned in Edinburgh, Paisley and Aberdeen.
- Borders have agreed to test a rural 3RU response. Training will take place in May 2018.

Other considerations - There are a number of inter-dependencies for CST within Enabling Technology programme, particularly the Defibrillator Replacement project. The New Clinical Response Model is also supporting the identification of cardiac arrest patients earlier in the call cycle and dispatching three resources to provide the best pre-hospital care.

2. **Developing a Scottish Trauma Network – Implementation of Scottish Ambulance Service/Pre-hospital minimum requirements** - Support NHS Scotland to deliver a high quality major trauma service.

Background - Trauma remains the fourth leading cause of death in western countries and the leading cause of death for people under 40. Each year in Scotland, around 4000 people are seriously injured, with around 800-1000 cases being defined as 'major trauma'. The Scottish Trauma Network has been established to meet the needs of the population of Scotland. The Service is an essential partner within the Trauma Network. We are responsible for ensuring patients are taken to the most appropriate facility to deal with their injuries and receive the fastest access to expert specialist care and intervention.

Aim - To Improve triage and response to major trauma patients, thereby saving more lives and improving outcomes.

Status - We have undertaken a number of projects funded through the Scottish Trauma Network. These include the implementation of the Trauma Desk, piloting the use of Advanced Paramedics based in Major Trauma Centres and development and testing of a Major Trauma Triage Tool for use by ambulance crews to support decision making on where a patient should be transported to regarding the severity of their injuries.

Improvement - The trauma desk in Ambulance Control is fully operational and has improved the identification of major trauma patients and pre-hospital critical care team tasking. Mr Neil Sinclair one of our Consultant Paramedics has recently published our work in this field (Sinclair *et al*, *Injury*, 2018). Enhanced trauma equipment has been rolled out to all front line crews.

Planned activities:-

- Working group will continue to develop the Advanced Practitioner (critical care) job plan, educational model, clinical supervision system.
- We have commenced recruitment of 6 Advanced Practitioner Trainees to support extension of the Advanced Practitioner trial into the South East Trauma Region.
- Training and awareness of Adult Trauma Triage Tool in Fife/Tayside with a planned roll out in May 2018.
- Established a Trauma Desk Clinical Governance Group.
- Continue to implement an Adult Trauma Triage Tool in North of Scotland Trauma Region ahead of the Major Trauma Centre launch in Autumn 2018.
- Continue options appraisal reviews in partnership with North of Scotland trauma region to determine site of North ScotSTAR Hub.

Other considerations - We are working closely with the four trauma regions and national co-ordinating team to ensure we provide high quality pre-hospital care for trauma patients. This can be challenging to provide a consistent service approach that meets the needs of all regions.

3. New Clinical Response Model - Invest in technology and advanced clinical skills to deliver the change.

Background - Following a review of nearly 500,000 patient records, a New Clinical Response Model (NCRM) pilot programme was introduced in November 2016. The model focuses on improving patient outcomes, rather than simply measuring the time it takes to respond. Resources are now allocated on confirmation of the severity of the incident, rather than the location of the incident. The model allows us to respond faster to more patients with time critical, immediately life-threatening conditions, such as cardiac arrest. It also supports our call handlers to better understand our patients' health needs in less urgent cases, so that our dispatchers can more effectively send the right resource first time for patients.

Aim - Patients receive the right response first time.

Status - Phase 1 and 2 of the project are complete. 'Dispatch on Disposition' was introduced in October 2017, and subsequently two Pre-Entry Questions were introduced to identify critically ill patients as early as possible. The project is now in phase 3 and the 'Key Phrases' trial to further improve identification of critically ill patients earlier in the call cycle is now live and performing as expected.

Improvement - Dispatch on Disposition, the Pre-Entry Questions and Key Phrases have resulted in improved ability to identify cardiac arrest patients, provide a faster response and access to life-saving CPR.

Planned activities:-

- **We will continue to improve identification of critically ill or injured patients as early as possible in the call cycle in order to dispatch a resource as soon as possible**. Patients that are conscious and breathing but critically ill or injured, for example anaphylaxis, penetrating trauma and childbirth, will not be identified by the pre-entry questions. To address this issue, we have developed a list of 'Key Phrases' linked to the 999 call "what's the problem" field following the initial pre-entry questions to identify these patients. The introduction of 'Key Phrases' aims to provide a further layer of patient safety. We have tested the introduction of 'Key Phrases' over a four week period starting in April 2018 and monitored the outcomes with initial positive results.

- **We are further triaging patients within the yellow response category so that those with the highest clinical acuity receive a response sooner**. The Clinical Response Model is divided into 5 levels of response acuity; purple (Cardiac arrest rate >10%), red (Cardiac arrest rate >1%), amber (acute pathway need), yellow (high acuity yellow response) and green (additional phone triage). Patients coded within the yellow response tier have a range of acuity symptoms, for example abdominal pains, neck injury, back pain and bleeding after falling. We will develop and implement additional triage for this cohort of patients to identify and transport those with the greatest need, to hospital, as soon as possible. Some patient calls coded yellow are benefitting from a referral to an alternative pathway for treatment by an Advanced Practitioner or provision of telephone advice.

- **We are improving the call-handling process for requests from Healthcare Professionals so patients receive a response based on their clinical need**. Currently, calls from Healthcare Professionals are unscripted and taken by non clinical call handlers. We will develop a systems based protocol for call handlers and a standardised approach for Healthcare Professionals to book the most appropriate level of response. We will test and develop the new system throughout 2018/19, and we will engage with Healthcare Professionals over this period to update them on changes to improve booking of transport for their patients. Initially, this is focussed on GP practices and using the most appropriate resource dependent on patient need, be it Emergency Ambulance or Patient Transport, then in the future plan inter-hospital transfers with the same process.

Other considerations – The Clinical Response Model underpins most of our service transformation work. To ensure further development of the model, it is essential that we have alternative pathways available to refer patients for the most appropriate treatment and advice. This includes availability of advanced practitioners in urgent and primary care that can provide more care at home.

4. **Hear and Treat** - Enhance our telephone triage and ability to see and treat more patients at home through the provision of senior clinical decision support.

Background - The Service's Strategy aims to enhance the number of patients that can be safely and appropriately be dealt with by using alternative treatment pathways as an alternative to a traditional ambulance response.

Hear and Treat is defined by the Service as: The number and proportion of emergency incidents that have been resolved by providing advice over the phone, where no physical response arrives at scene.

Aim - To redesign the Service Control Centres Clinical Advisor Hear and Treat outcomes to improve patient experience through effective clinical triage with the view to discharging patients to an alternative care pathway or self-care advice.

Status – Additional Clinical Advisors are operating within the Clinical Hub. A measurement framework is being revised and developed. Discussions continue with NHS 24 to increase the number of calls that are transferred as part of business as usual, building on the work undertaken during the winter pressures.

Improvement - An increase in calls transferred to NHS 24 results in patients with low acuity conditions receiving access to the service they require in a timelier manner, resulting in better clinical outcomes and patient experience. System changes which allow Clinical Advisors to refer to Specialist Paramedics and Advanced Practitioners in urgent and primary care will also provide better clinical outcomes and patient experience.

Planned activities:-

- **Increase the transfer of triaged eligible 999 calls to NHS 24** to support patients to access the service they need in a timely manner. Build on our success during the winter pressures generating an increase of around 0.5% hear and treat calls (around 8 per day). Additionally, a project will be established to develop wider joint working to improve triage and associated processes so that patients receive a seamless service whether they call 111 or 999.
- Establish baseline data set for existing clinical advisors and implement revised measurement framework.

Other considerations - Working with NHS 24 in 2018/19 we will create a seamless experience for patients dialling 111 or 999, and provide access to the service they need in a timely manner.

5. **Specialist and Advanced Practitioners in Urgent and Primary Care** – Develop our education model to provide a more comprehensive care at point of contact.

Background - Towards 2020: 'Taking Care To The Patient' clearly sets out our aims to transform our clinical model to ensure the right resource gets to the right patient at the right time. This has resulted in the development of our out of hospital clinical service where our clinicians are providing more comprehensive care at home, and supporting access to alternative care pathways that are integrated with communities and the wider health and social care service.

We have developed new roles of Specialist Paramedics and Advanced Practitioners in urgent and primary care with an advanced scope of practice to be able to treat more people at home or in a homely setting.

Aim - Our aim by December 2020 is that our Advanced Practitioners in Urgent and primary care are able to work as a key component of integrated multidisciplinary teams within a rotational model across health and care settings as autonomous practitioners and support care in a home or homely setting.

Status - We have around 100 trained Specialist Paramedics in urgent and primary care. One third of them work in primary care multidisciplinary teams within out-of-hours services and GP practices across the country. Our Clinical Advisors ensure patients with low acuity needs are provided with the most appropriate response including advanced practitioners.

Improvement - As well as effectively managing the increasing urgent demand from 999 calls, Advanced Practitioners in urgent and primary care play an important role in the in hours multi disciplinary team. Early data from the pilot underway in Inverclyde has indicated 230,000 hours of GP time could be saved if the model was adopted nationally, 65% of home visits are suitable for Specialist Paramedics and

Advanced Practitioners. This represents improved clinical outcomes and patient experience, as well as a potential financial benefit of circa £56 million per year.

Planned activities:-

- National mapping of predicted locations of highest demand for Specialist Paramedics and Advanced Practitioners in urgent and primary care using MPDS coding and linked to the active tasking data capture.
- National recruitment and selection of 51 Specialist Paramedics and 12 Advanced Practitioners (Urgent and Primary Care).
- Completion of education and competence framework.
- Completed review of Patient Group Directions (PGD).
- Safety thermometer survey /staff experience survey to be developed and tested.
- Specific Clinical Practice Guidelines development to commence.

6. **Scheduled Care Service** - We continue to develop our scheduled care service in partnership, supporting outpatient services and effective discharge and transfer to improve patient flow, and deliver a better experience for patients.

Background - Transformation in health and social care delivery across Scotland aims to reform Scheduled Care by supporting patients to attend the most appropriate centre of care or return home from care centres. The Service plays a fundamental role to achieving improved patient flow and experience. During 2017/18, a wide range of tests of change have provided clear direction in how we respond to requests on the day of travel for urgent admissions to acute hospital sites and urgent transfers between acute hospital sites. Some patients may require a quick response to get to definitive care without necessarily requiring any clinical intervention en route. Therefore, a proportion of these requests could safely be undertaken by the Scheduled Care Service.

Aim - Provide an agile and responsive scheduled care service that makes best use of resources and provides improved patient care and experience.

Status - Renal Dialysis patient reviews continue, with specific focus on Ayrshire and Arran and Lanarkshire. The first phase of reviewing Renal Dialysis patients within Ayrshire and Arran is complete, with engagement being led by NHS Ayrshire and Arran. A review has now taken place with patients attending the Renal Dialysis Units in Lanarkshire.

Work continues with the NHS Lothian Flow Centre to establish the next stages of our joint improvement work. Between January and March engagement sessions have taken place with other East of Scotland Health Boards to review the opportunity of the Flow Centre supporting the Flow of patients in and out of Acute Hospital sites within other Health Board areas. Included in this work, there has been agreement to extend the scope of the Flow Centre to include the inward flow of patients to St John's Hospital and inter hospital transfers, which we expect will see a reduction in the displacement of the Service's resources across Lothian.

Improvement - An improved scheduled care service will provide better patient flow across acute hospital sites, support reduced hospital bed days and provide an improved patient experience.

Planned activities:-

- 24 hour Patient Transport System cover in Lothian will be tested from June 2018.
- Launch of the C3 and CLERIC IT interface to improve use of resources and timely response to patients in June 2018.
- Patient zone and Patient experience; We are currently working with CLERIC (our software providers) to introduce a PTS application that patients and/or carers can access, which provide a number of features:-

  - Track their vehicle on a map, with up to date ETA;
  - See a picture of the vehicle they will be travelling in;
  - Know the name of the Ambulance Care Assistants transporting the patient;
  - Provide feedback of their experience;
  - Book transport when they are ready to return home;

Section 3 Enabling Technology

1. Ambulance Telehealth Programme

Aim – The aim of the Ambulance Telehealth Programme is to replace and enhance the cab-based technology in the emergency ambulance fleet. The programme is being delivered over two overlapping phases and will be complete during Q2 or early Q3 2018.

Status - **Ambulance Telehealth Phase 1 (Hardware Replacement) –** Completed – New tablets, communications hubs and printers were installed throughout the emergency ambulance fleet (approx. 525 vehicles) during 2016.

Ambulance Telehealth Phase 2 (Electronic Patient Record & Supporting Software) - Phase 2 involves the procurement and design of a new electronic patient report (ePR) application and other supporting software including a new SAS 'app'. The roll out of the new ePR was completed in December 2017. The Enabling Technology Programme Board has now approved the formal closure of the Electronic Patient Report (ePR) Project following submission of a comprehensive 'End of Project' Report. A limited SAS 'app' pilot is ongoing at Coatbridge Station, feedback to date has been positive. There has been some real positive progress regarding the two main technical issues that are preventing the full SAS app roll out. These issues relate to updating app content and the network connectivity required. The Team are now confident that they will be able to commence the full rollout in May and complete it in June or July. The Programme Team are planning to formally close the Telehealth Programme during Q2 or early Q3 2018.

Improvement - Improved ease of use, additional functionality, increased clinical data collection and data quality, ready access to additional relevant information, increased productivity, improved patient care and experience. Ease of use is being measured through surveying users before and after the new tablets and ePR are rolled out. Data collection quantity and quality is being measured through a combination of automated and manual ePR database analysis. Feedback has been received to advise there has been an increase in reporting of PVR bundles and pre-hospital stroke compliance.

Planned Activities - Complete the SAS app pilot and roll out during Q2/Q3 2018 and then formally close the Programme.

Other Considerations - Work continues with colleagues from the Clinical Services Transformation Programme (and others) to further develop the content for the new SAS app and to develop the care pathways required to take full advantage of the new capabilities delivered through the Telehealth Programme. Ubiquitous access to mobile broadband data (as will be delivered by the Emergency Service Network Programme) will be a key enabler for maximising the benefits derived from the Ambulance Telehealth Programme.

Benefit Realisation / Return on Investment - Delivery of the expected benefits from the Ambulance Telehealth Programme is overseen by the Enabling Technology Programme Board. Benefits include lower like for like costs, improved electronic patient record completion rates and data quality, as well as timeous and efficient mapping updates. A comprehensive benefits realisation plan is in place and the

delivery of key benefits is being actively progressed by the Programme Business Change Manager.

2. Emergency Service Network Programme

Background - Radio and Short Data Communications are provided to the Service, and all other GB Emergency Services through the Airwave network. The original Airwave contracts were due to expire on a phased basis from 2016 to 2020; however, a National Shutdown Date of 31 December 2019 was negotiated for all Airwave customers. The UK Government established the Emergency Service Mobile Communications Programme (ESMCP) in 2011 to identify a replacement for Airwave. The programme will deliver a voice and broadband data network that will be known as the Emergency Services Network (ESN). The main ESMCP contracts were awarded in 2015. The Service was due to transition to the ESN from late 2018 through to late 2019 but this timescale has slipped due to wider ESMCP slippage.

Aim - The Emergency Service Network Programme aims to deliver a mobile communications capability that will, as a minimum, match Airwave in terms of functionality, availability and geographic coverage. It also aims to provide a very significantly enhanced mobile broadband capability.

Status - Bryan Clark has taken over from Gordon Shipley as ESMCP Programme Director. Programme timescales are still under review by senior UK government civil servants and their specialist advisors. Current indications are that transition to ESN will not start until autumn 2021 with Service transition unlikely to start until at last 2022. The ESMCP Team are working towards developing a Full Business Case (FBC) by the end of June and gaining HM Treasury approval during September. Prior to Scottish Government (SG) giving their approval to the revised FBC, the Service will again be asked to provide assurance to SG that the ESN will meet Service requirements. This assurance is likely to be sought during late summer 2018. Information provided by the ESMCP Team suggests that the Scottish share of ESMCP costs for 2018-19 will be £39M. A Scottish Finance Sub-Group has been established with representation from SG, SAS, Police and Fire. The potential financial pressures presented by ESMCP have been acknowledged by SG but no firm funding decisions have been made. It is now clear that, due to ESMCP slippage, Airwave contract extensions will be longer than first thought, the national (GB) or local implications of this are not yet clear. The ESMCP Team are leading on negotiations with Motorola (Airwave owners) on behalf of the UK Government. Local discussions have also started with Airwave regarding extensions relating to the Integrated Communications Control System (ICCS), Terminals etc. Initial discussions suggest that there may be scope to use the current ICCS for a further 6 or perhaps even 12 months beyond December 2019 with little or no capital investment, however using it beyond this is likely to require costly hardware and software upgrades. Work therefore continues on developing an ICCS replacement business case. A meeting has taken place with Scottish Government who confirmed there is no requirement to submit this Business Case to the Capital Investment Group. The capital costs are below the Service £1m delegated limit. In addition, Scottish Government has agreed to fund the capital costs. The revenue costs, whilst aiming to be minimal, will be subject to a risk share approach with Scottish Government depending on the final level, these will be described in detail within the business case. It will be presented at the Board for consideration in September 2018. Discussions with Police Scotland have indicated that it is not feasible to progress a joint ICCS procurement as it will compromise their timescales and will not match the

Service's 'ideal' timescales. We are now working with police colleagues to explore all potential courses of action before finally deciding if this option can be discounted in the business case. Given the risks associated with relying on the current Bundle 2 ICCS managed service beyond 31/12/2019, it is essential that a way forward is agreed as timeously as possible. The strategic risks relating to ESMCP are increasing as senior government level scrutiny increases and timescales slip. This includes financial, commercial and technical risks. From a Service perspective, these risks are being managed through the Scottish Government (SG) Strategic Group, the 2020 Steering Group and the Enabling Technology Board.

Improvement - Reduced like for like costs, ubiquitous access to mobile broadband data to support the effective and efficient delivery of clinical services out with the hospital environment. Improvements will be measured through *'before and after'* data analysis and through the use of user surveys.

Planned Activities – Collaboration and liaison with Police Scotland, Scottish Fire & Rescue, the Scottish Government and the ESMCP Programme Team regarding ESN transition planning. Communication and collaboration with the Ambulance Radio Programme Team and Police Scotland staff regarding the two main ICCS replacement options.

Other Considerations - It is worthy of note that the delivery of the internal ESN Programme relies on the corresponding delivery of the risky and highly complex GB-wide Emergency Service Mobile Communications Programme.

3. Fleet Projects

Background - Three fleet related projects are currently being governed through the Enabling Technology Programme; they are the Fleet Replacement Project, the Telematics Project and the Fleet Management System Replacement Project.

Aim – The Fleet Projects aim to manage the annual fleet replacement activities in line with the approved Fleet Replacement Business Case. They also aim to take advantage of technology to improve the operation and management of the Service fleet.

Status - The 2017/18 fleet replacement programme was managed by the Fleet Department and delivered in line with the final agreed plan. The 2018/19 programme has now commenced and is progressing to plan, despite a number of challenging external factors e.g. the supplier T.O.M. has gone into administration. In terms of the Fleet Management System Replacement Project, the Enabling Technology Board has agreed that the project scope will be scaled back and that the current system will be retained albeit with an upgraded server platform. From an Enabling Technology Programme perspective, the Telematics Project has been placed 'on-hold' until a viable 'business case' is established and funding has been identified.

Improvement - Reduced running costs, improved reliability and vehicle availability, improved vehicle specifications, improved management information. Improvements will be measured through 'before and after' data analysis and through the use of user surveys.

Planned Activities – From an Enabling Technology perspective the main activities around the three fleet projects relate to project management support and benefits realisation.

Other Considerations – There are a number of inter-dependencies between the Fleet Projects and other Service Programmes e.g. Clinical Service Transformation, Defibrillator Replacement Project and the ESN Programme.

4. Defibrillator Replacement

Background – The current Philips MRX defibrillators are nearing the end of their serviceable life. A Project is now underway to replace them with new Advanced Life Support (ALS) monitor/defibrillator units. The aim being to improve patient care and staff experience.

Aim – The objective of the Defibrillator Replacement Project is to manage and deliver the replacement of defibrillators used by Scottish Ambulance Service clinicians. The aims being to improve patient care through innovation and clinical transformation, enable the delivery of the Out-Of-Hospital Cardiac Arrest Strategy for Scotland (2015) and to deliver better care to patients wherever they may be.

Status – Procurement of the replacement defibrillators is now underway. Live trials involving equipment from the two preferred suppliers are ongoing at number of stations throughout Scotland. The Outline Business Case (OBC) for the defibrillator replacement will be presented to the Board for approval in July and by the SG Capital Investment Group (CIG) in September.

Improvement – Implementation of new defibrillators will deliver various benefits including enhanced clinical care for patients and improved staff experience through full integration with the new ePR.

Planned Activities – Finalise OBC approval during summer 2018 before completing the procurement and developing the FBC during Q3/4 2018. The current plan is to complete the roll out during 2019.

Other Considerations – There are a number of inter dependencies between the Fleet Projects and other Service Programmes e.g. Clinical Service Transformation, Defibrillator Replacement Project and the ESN Programme.

5. Enabling Technology – Other Projects

The scope of the Enabling Technology Programme currently extends beyond the programmes and projects already covered in this section. It also includes a number of projects related to the delivery of the Service eHealth Strategy, Cyber Resilience and renewing or re-procuring a number of key ICT related contracts. Further details regarding these additional projects and initiatives are available via the Enabling Technology Programme Team as required.

Section 3 - Workforce Development

1. Employee Resourcing

Aim – To recruit and retain staff to ensure the Service has the necessary skills to deliver its 2020 workforce profile and improve staff experience.

Status – Implementation - progressing with 2018/19 intake plans based on continuing strategic direction of travel.

Improvement – We have a sustainable Technician Pipeline given high levels of interest in joining the Service (over 3000 applications from our last advertising campaign). Our continuing challenge is ensuring the translation rate for staff progressing on to Paramedic training. A number of improvement projects are being progressed in 2018/19 to support both higher Paramedic Training numbers and recruitment of qualified staff. This includes recruitment of additional staff numbers from the first full time degree programme commenced in Scotland (first graduates in 2020). Although this position supports our workforce trajectory we will continue to monitor turnover at individual skill set level to ensure workforce forecast numbers do not require additional adjustment.

Planned Activities Include – Continuing delivery of the Technician VQ model with focus shifting to next July intake. The April intake of 59 represents the first of present interim target of 188 for 2018/19. Work continues on delivering the other targets within our resourcing plan which include an additional 200 Paramedics including 51 Advanced Paramedics and 75 Ambulance Care Assistants (all subject to possible revision in light of modelling and intakes achieved to date). Paramedic intakes commence in August with Regional Workforce Leads encouraging staff applications. The Workforce Development Group is monitoring the position to consider the best options for maximising intakes. Workforce re-modelling (incorporating Clinical Response Model developments and Demand & Capacity Review) will inform any further adjustments for this and future year targets.

Other Considerations – The development of the employee resourcing model continues to mitigate the risk associated with maintaining a pipeline to support the continued high volume Paramedic recruitment training through to 2020. Recruitment process improvement work arising from review of the Service's 2017/18 plan are progressing and will aim to maximise the opportunities arising from increased interest in the Service for both qualified and unqualified staff.

Benefit Realisation/Return on Investment – ensuring the Service has the right mix of skill and resources will enable it to effectively contribute in an integrated health and social care system.

2. Employee Development

The Scope of Practice framework document has been developed which defines how all of the Service's frontline roles will operate to support our 2020 Strategy. The initial focus was on the development and deployment of the Service's new Specialist Paramedic role in Urgent & Emergency Care, but planning for 2018/19 will review needs across all areas, incorporating the development of advanced paramedic practice, reflecting re-banding implications and incorporating major trauma, national operations (Ambulance Control Centres, National Risk & Resilience Department, ScotSTAR and Air Ambulance) and support/corporate functions.

Aim - To identify the employee development requirements arising from the workforce modelling activity which will underpin the delivery of our Workforce Plan and achievement of 2020 target numbers.

Status – Planning (review of work to date and response to workforce re-modelling activity).

Improvement – Career Framework underpins and directs staff advancement with the Learning & Development policy (approval confirmed in December 2017) and underpinning processes ensuring there is a framework for the identification and prioritisation of resources to support our 2020 strategy. Educational Governance improvements are being led by the Capable Workforce Group (reporting to the Workforce Development Steering Group), which aims to bring key stakeholders together to take and organisational view of our dispersed training delivery model and advise on improvements to the identification, delivery and reporting on key development priorities.

Planned Activities Include – Modelling activity to inform employee development requirements. Learning & Development infrastructure development. Career framework model developed to align and incorporate pathways for all clinical, operational and management requirements. The implementation of Turas Appraisal as replacement for the eKSF system commenced with the launch from 1 April 2018. The Turas Appraisal system is also designed to support the recording of Executive Performance Management. Leadership development needs assessment and progression of national board collaborative activity aligned to national NHS Scotland Leadership Framework will support new 2018/19 delivery arrangements. Agreement of key metrics to measure progression will support these changes.

Other Considerations – The Clinical Service Transformation (CST) programme leads on developing advanced practice within the Service, so close working arrangements between CST and Workforce Development are required to manage interdependencies.

Benefit Realisation/Return on Investment – To support the delivery of the Service's See and Treat and Hear and Treat targets, with greater integration of health and social care, managing patient care at home, supporting anticipatory care planning for patients with long-term conditions, prescribing and referring directly to clinical services. This work will also ensure that support function needs are incorporated into our development planning, ensuring that priority development needs are identified and supported.

3 Employee Experience

The main focus for employee experience work over the last three years has been the implementation of iMatter, the continuous improvement tool designed to improve staff experience. The tool encourages dialogue between teams and their managers, and encourages discussion on how to improve communication and engagement at local level.

Aim – to improve staff engagement in the Service. Measured by employee engagement index (EEI) of 70 by 2020. 2018/19 milestone is 62.

Status – Consolidation – Next test of change commenced in April with our move to single cohort, after our completion of full Board roll out in 2017/18.

Improvement – The iMatter Board response rate for 2017 is 64% (compared with 63% NHS Scotland) with an employee engagement index (EEI) score of 67.

The Service moved to one cohort run in April 2018. This will allow year on year comparisons to be made as the whole of the Service will be going through the process at the same time.

Planned Activity – The team confirmation stage of the iMatter process commenced as planned in April 2018. As this work progress the continued focus remains on developing local action plans to concentrate on the areas where changes can be made at team level. Our aim is to sustain the significant improvement achieved in 2017/18.

Emerging themes from action plans have been discussed at the Executive Team and iMatter Implementation Group, where representatives across each business area share good practice. Improvement examples featured in the National Scottish Government report from iMatter team work actions are being considered for further spread:

- Improving training and simulation from work in the East;
- Using mindfulness programme which has been rolled out in ACC and East;
- Creating time for reflection and change which has been tested in the West;
- Building in time for action planning from work in the North;

The recent results from the Health and Social Care Staff Experience Report 2017 identified three themes requiring most attention are consistent with those arising across NHS Scotland; confidence in performance management across the organisation, visibility of management and involvement in organisational decisions. The Staff Governance Committee considered the draft OD Plan for 2018/19 in April which will incorporate activity to address these key themes.

Other Considerations - Employee Experience reporting will be extended into new areas of activity in 2018, which reflect the wider Organisational Development agenda.

Benefits Realisation/Return of Investment - There is a clear evidence based link between high levels of staff engagement and improved staff experience, which in turn leads to improved patient experience.