NOT PROTECTIVELY MARKED

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

THIS PAPER IS FOR DISCUSSION

TOWARDS 2020: TAKING CARE TO THE PATIENT AND QUALITY IMPROVEMENT

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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 August 2018. 2. **Discuss** actions being taken to make improvements. 3. **Discuss** work being taken to transform the service 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 ODP and includes updates from the Clinical Services Transformation Programme, Enabling Technology and Workforce Development strategic work streams. Each programme has active risk registers which are reviewed at each of the Programme Boards. <u>Clinical Services Transformation</u> • Our work to save more lives from cardiac arrest continues to deliver improved results – for the last six months we have significantly exceeded our aim of 42% of patients in VF/VT arrest arriving at hospital with a pulse – our performance in August 2018 was 56.9%. • Over 33% of patients were managed at home or an alternative to hospital in August 2018. • We continue to reliably implement the pre-hospital stroke bundle, with the data in August 2018 demonstrating 96.5% compliance. This is the eighth consecutive month that we have sustained practice above the 95% aim. • We have successfully recruited 6 Trainee Advanced Practitioners in Critical Care as part of our work to respond to

	patients with major trauma care to improve clinical outcomes. • In addition, we have recruited a further 15 Trainee Specialist Paramedics and 5 new trainee Advanced Practitioners to work in Urgent and Primary Care. These roles are designed to provide person centred care directly with a greater range of treatment and interventions to support comprehensive care at home in a safe and effective manner. <u>Enabling Technology</u> • Ambulance Telehealth Programme – The end-to-end testing of the Content Management System for the SAS app highlighted issues with that element of the system which requires re-working by the supplier. Delivery of the fully tested system is now scheduled for the start of October, after which rollout will commence, with a view to completing it by December 2018. • Specification of the Major Incident module for the ePR (Electronic Patient Report) continues. Simulation with the currently developed software is taking place in October 2018. The final software version is due to be delivered for testing in December 2018 for rollout by March 2019. • Emergency Service Network (ESN) Programme – Local programme timescales are not yet determined due to significant timescale slippage in the GB wide Emergency Service Mobile Communications Programme (ESMCP). The programme has been 'reset' with a new management team and an agreement for a phased incremental approach to delivery of the various ESN products. The UK Government Full Business Case (FBC) is being refreshed. • Provision of an ESN compatible Integrated Communications Control System (ICCS) – ICCS replacement Business Case has been drafted and is being presented to the Board for consideration in September 2018. • Fleet Replacement Project – The vehicle replacement programme is progressing in line with agreed plans. • Defibrillator Replacement – The evaluation of the tender has completed and a preferred bidder identified. The Full Business Case (FBC) has been drafted and is being submitted to the Board in September, if approved this will be submitted to the Capital Investment Group in October 2018. <u>Workforce Development</u> • Our Service resourcing plan for 2018/19 is in progress, with monitoring of our recruitment and training targets to consider any adjustments in planning for 2019-21;

	• The training prospectus for 2018/19 is core to our employee development agenda, with work continuing to identify and deliver on priority development needs; • In our employee engagement work, the transition to the iMatter single organisational cohort has been successfully completed and the action planning submission deadline recently passed, with a great outturn across the organisation showing a further significant increase on our action plan completion rate. • Sickness absence - we aim to sustain improvements through the comprehensive health, safety and wellbeing programme to further reduce absence.
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 paper.
2. Note performance against Health, Efficiency, Access and Treatment (HEAT) standards for the period to end August 2018.
3. Discuss actions being taken to improve performance.

IMPROVING CARDIAC ARREST SURVIVAL RATES

SAS H1 Save more lives and SAS H2 Cardiac arrest patients

Chart 1 Return of Spontaneous Circulation for VF/VT patients

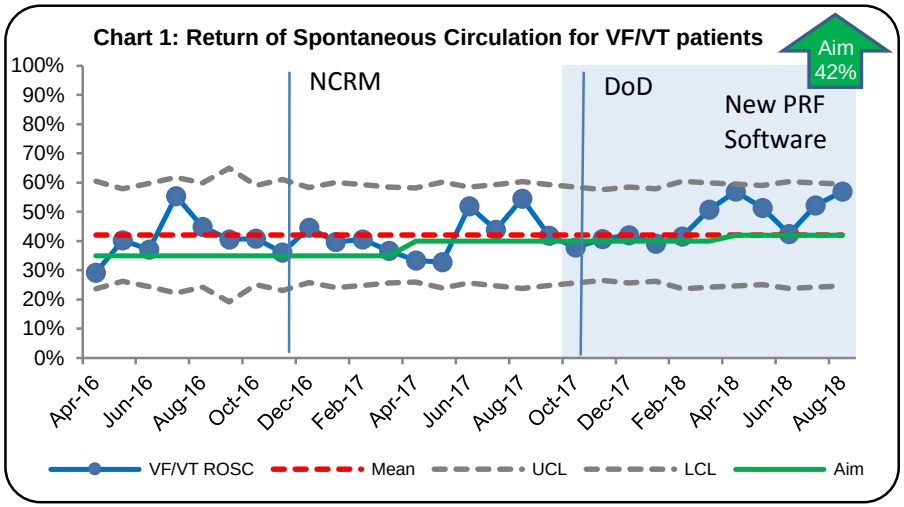
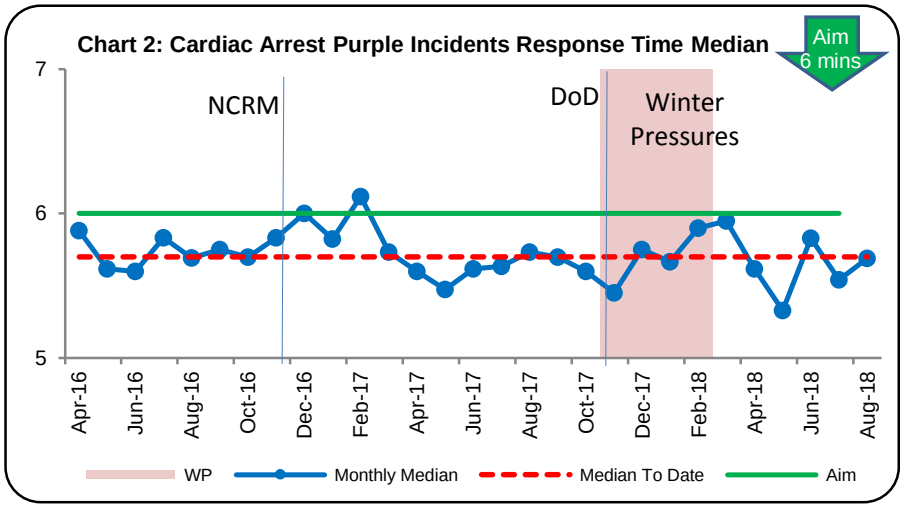


Chart 2 Cardiac Arrest Purple Incidents Response Time Median



NCRM = New clinical Response Model DoD = Dispatch on disposition

What is the data telling us – We continue to perform above our aim with 56.9% of VF/VT patients achieving return of spontaneous circulation (ROSC) in August (Chart 1). We now have 6 data points above the mean. As this is a control chart if maintained above the mean for a further two months this will demonstrate a statistical shift.

Chart 2 shows the median response time to patients in cardiac arrest coded purple. Our response over the whole system to these patients is consistently faster than the 6 minute target. In August, the median response time to patients in the purple response category was 5 minutes 41 seconds.

Why – The Service continues to be a key partner in the delivery of the Scottish Government Out of Hospital Cardiac Arrest (OHCA) strategy, linking across the whole chain of survival. The main factors which influence ROSC are bystander CPR followed by timely

defibrillation when indicated. However, evidence suggests that early identification of OHCA by the Ambulance Control Centre through the use of Pre-Entry Questions and key phrases, as well as dispatch on disposition, is a large contributory factor to this success.

What are we doing to further improve and by when – The Service is taking forward improvement programmes as part of the Out Of Hospital Cardiac Arrest work. Further details are provided below under the Clinical Services Transformation pages (p17-26)

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

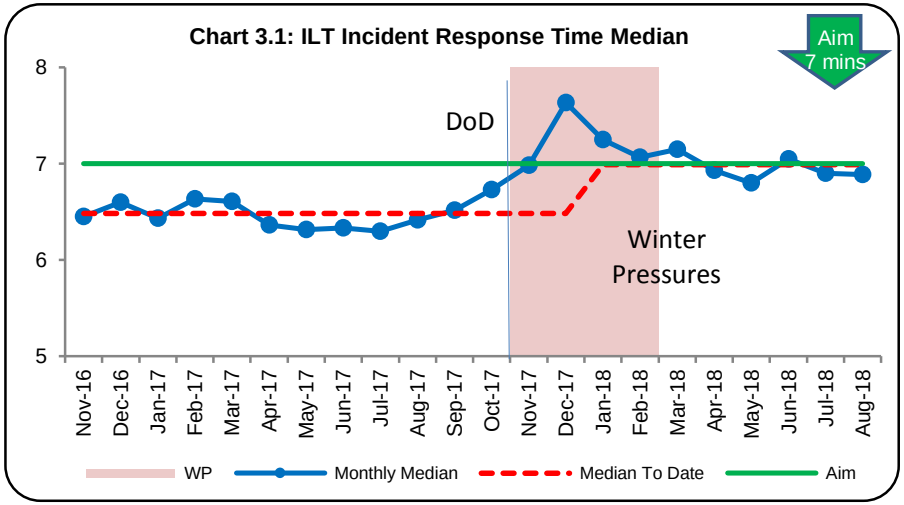


Chart 3.2 ILT Incident Response Time 90th Percentile

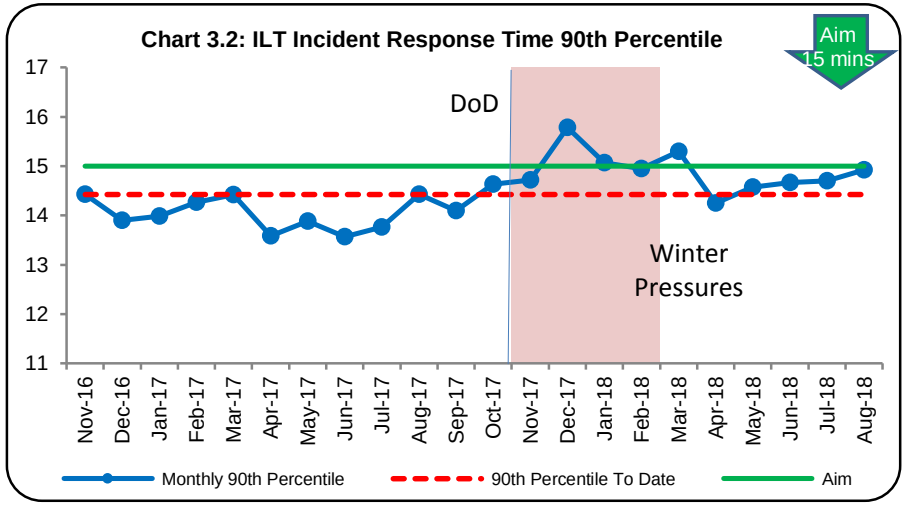


Chart 3.3 Emergency Demand

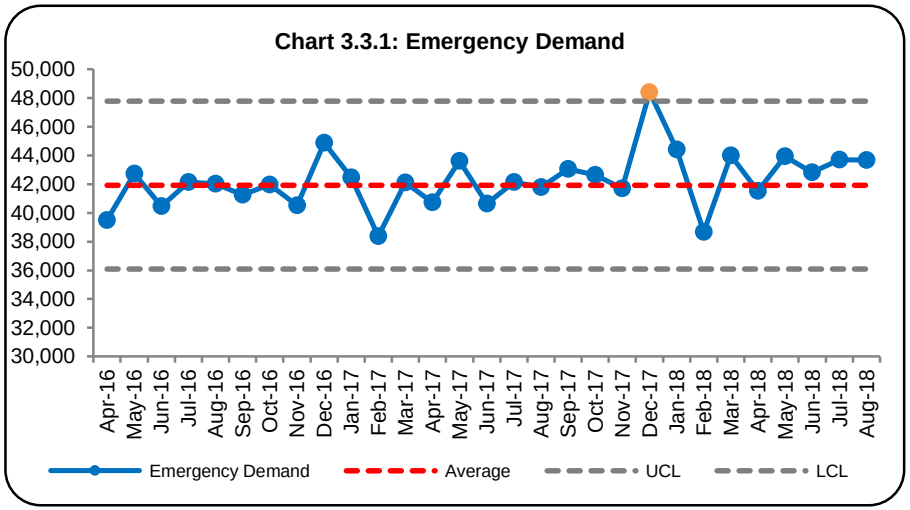
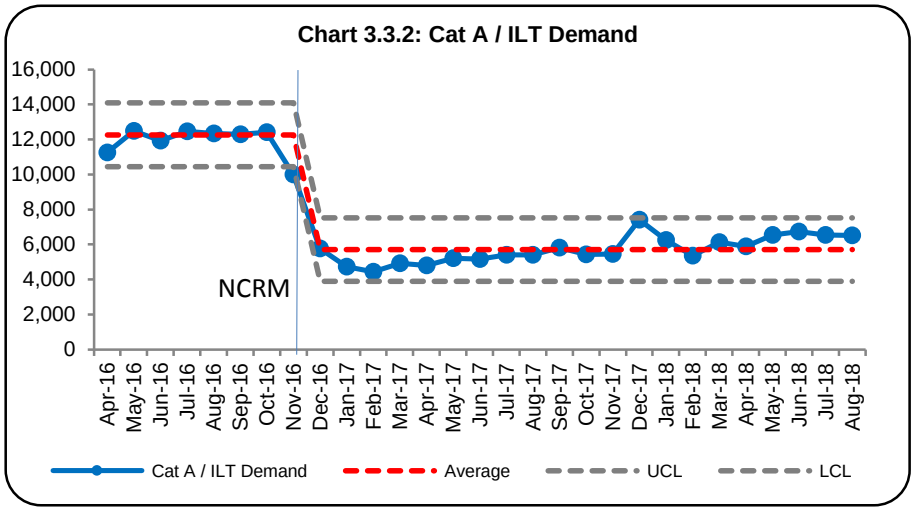


Chart 3.4 Cat A / ILT Demand



What is the data telling us - Since Dispatch on Disposition went live in October 2017, we are now reporting on median (midpoint) and 90th percentile ILT performance (response time for 90% of ILT incidents). For August 2018, performance median was 6 minutes 53 seconds (against a standard of less than 7 minutes), with a 90th percentile of 14 minutes 55 seconds (against a standard of less than 15 minutes). Performance within these areas remains stable.

Chart 3.3 shows demand remains within control limits although is higher in this performance year than last, and the volume of immediately life threatening incidents, chart 3.4, continues to track above the level expected. Hospital turnaround times remain high across the key sites, affecting our capacity to respond to lower acuity incidents as timeously as we would expect.

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. Since their introduction we continue to identify over 6% more ILT calls earlier, enabling quicker dispatch of a resource.

What are we doing and by when - We are reviewing all ILT calls to identify any common or special cause for the increase. We continue to focus on the pre-positioning of resources when available to reduce 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

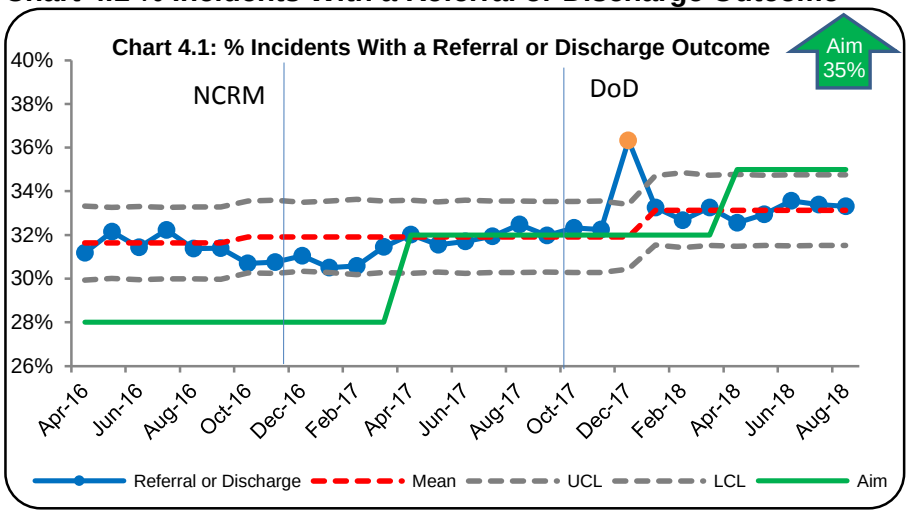


Chart 4.2 % Incidents With a Hear & Treat Referral or Discharge Outcome

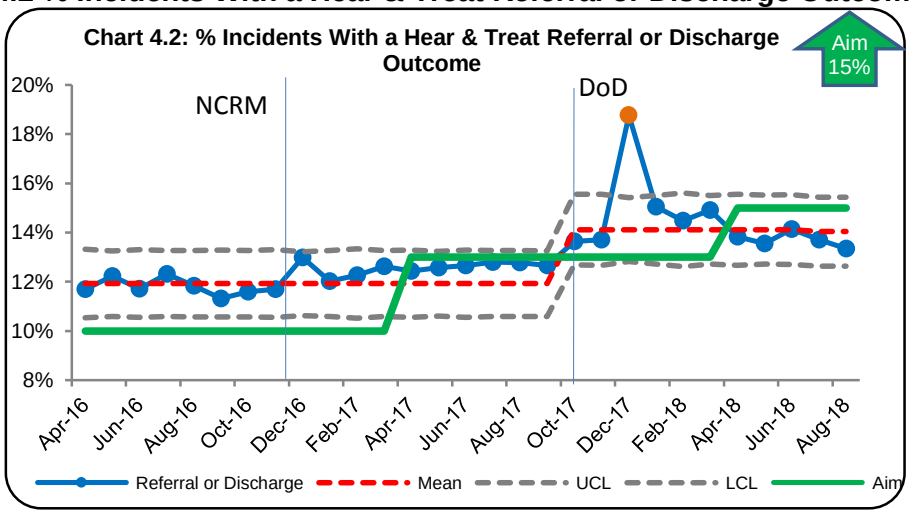
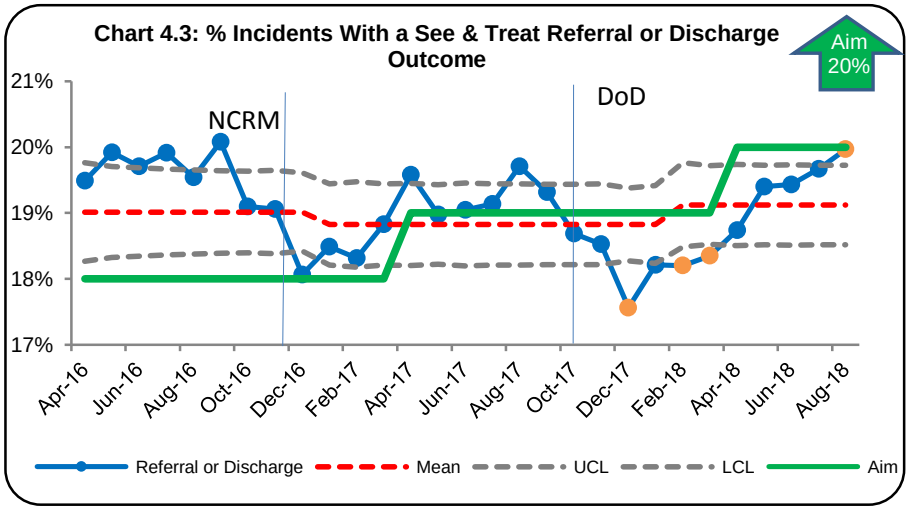


Chart 4.3% Incidents With a See & Treat Referral or Discharge Outcome



NCRM = New clinical Response Model DoD = Dispatch on disposition

What is the data telling us – For incidents with a referral or discharge outcome (Chart 4.1) the data demonstrates that performance has stabilised following the winter when special cause variation was seen and has stabilised.

For incidents with a Hear and Treat referral or discharge outcome (Chart 4.2) the data shows variation within normal limits between January and August. For 2018/19 the aim has been increased from 13% to 15%. In August 13.35% of patients received a Hear and Treat referral or discharge outcome, and although performance has decreased slightly since the winter pressures, performance is still higher than the period of stability seen in summer 2017.

For incidents with a See and Treat referral or discharge outcome (Chart 4.3), the August data of 19.97% exhibits special cause variation as it is outside the control lines. We can also see a positive trend with the six most recent data points going up with the data being variable across the whole time range, and shows an opposing relationship to Chart 4.2.

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.

Further work is currently underway to understand the recent decrease in the Clinical Services Desk hear and treat outcomes as no further system changes have been made in this period.

What are we doing and by when - Programmes of improvement and transformation are underway for both Hear and Treat and See and Treat outcomes through the Clinical Services Transformation (CST) programme in 2018/19.

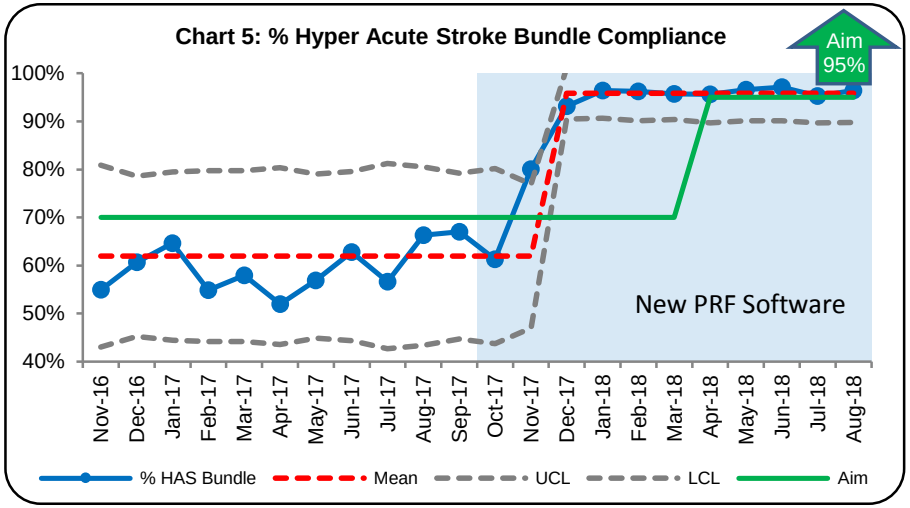
A test of change targeting Specialist Paramedics to patients with low acuity illness and injury, that are likely to be able to be safely treated at home or in the community, has been underway since 17 July 2018. Specialist Paramedics are being deployed to “green – low acuity” category incidents that have been triaged by a Clinical Advisor and are not suitable for a Hear and Treat outcome. Initial data shows further work is required to improve the visibility of Specialist Paramedic resources at the dispatch desk to support effective deployment.

We have recently recruited 15 new trainee Specialist Paramedic posts and 5 new trainee Advanced Practitioners (Urgent and Primary Care) to begin training in September 2018. These roles can offer a range of treatment and interventions directly to patients to support the provision of more comprehensive care at home in a safe and effective manner. As a Service we aim to enhance our support to access alternative care pathways that are integrated with local communities and the wider health and social care service. We believe that working and developing these enhanced roles will improve patient care and experience and ensure more efficient and effective clinical services. In addition over 70% of staff have now completed their learning in practice annual training which this year includes development in clinical decision making.

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



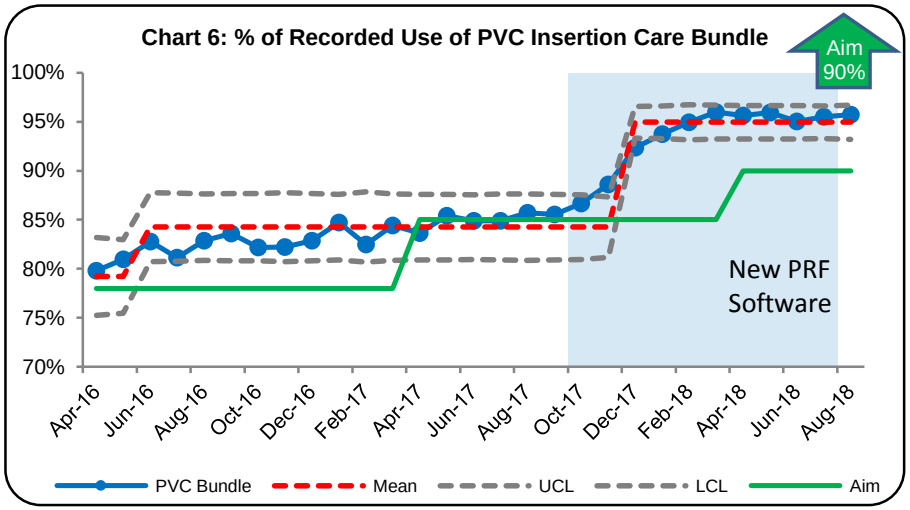
What is the data telling us - We are continuing to reliably implement the pre-hospital stroke bundle, with the data in August demonstrating 96.5%compliance.

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 for stroke patients. Additionally, a dedicated post was in place previously to lead our work in improving care for patients with stroke. The introduction of the new PRF software has made it easier for crews to accurately record when they are providing the stroke pre-hospital care bundle.

What are we doing to sustain this level of implementation – Implementation of the stroke pre-hospital care bundle will continue to be measured. A feedback system for crews and stations is being tested to support continuous improvement. Scottish Government is leading a piece of work to revisit the national stroke pathway to include thrombectomy and 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.

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 - Compliance for recording application of the PVC insertion bundle has been maintained above the 90% target at around 95% for the last 6 month period, with compliance for August at 95.7%.

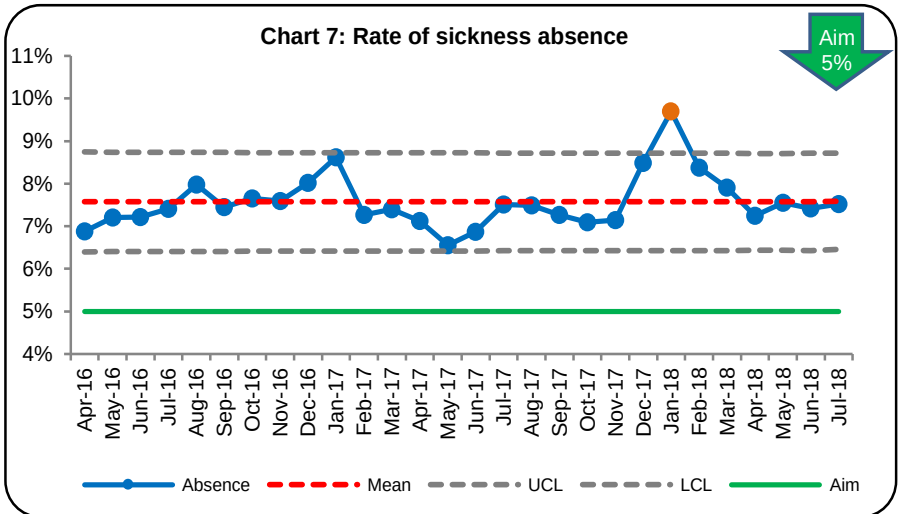
Why - The introduction of new software used by the crews has continued to improve recording of compliance with the PVC bundle.

What are we doing and by when - Continue to monitor compliance across all Regions to ensure this improvement is maintained.

Staff Experience

SAS E2 Sickness absence – rate of sickness absence

Chart 7 Rate of Sickness Absence



What is the data telling us - Absence level for the 2017/18 performance year was 7.6% (Chart 7) the same as in 2016/17.

Why - Although not yet achieving the aim, the July figure of 7.5% remains slightly below the mean.

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

- Weekly Executive team monitoring of vector of measures for regions and sub regions and review of causes of absence for areas with the highest absence levels.
- Action Plan to review working practices which are impacting on staff health, wellbeing and motivation.
- Continuous review of musculoskeletal absence reasons to identify and tackle root causes.

Patient Transport Services (PTS) Punctuality

Chart 8 % of PTS Punctuality Inward Journey

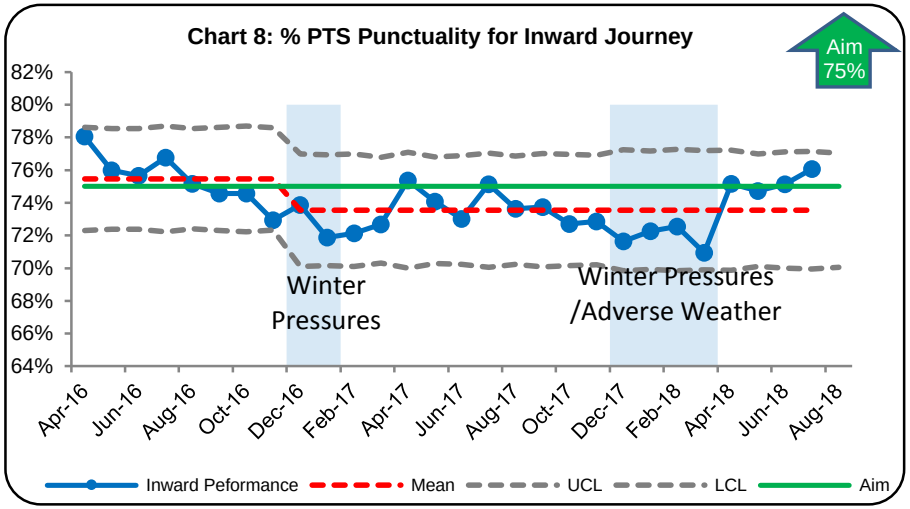


Chart 9 % of PTS Punctuality for Pickup After Appointment

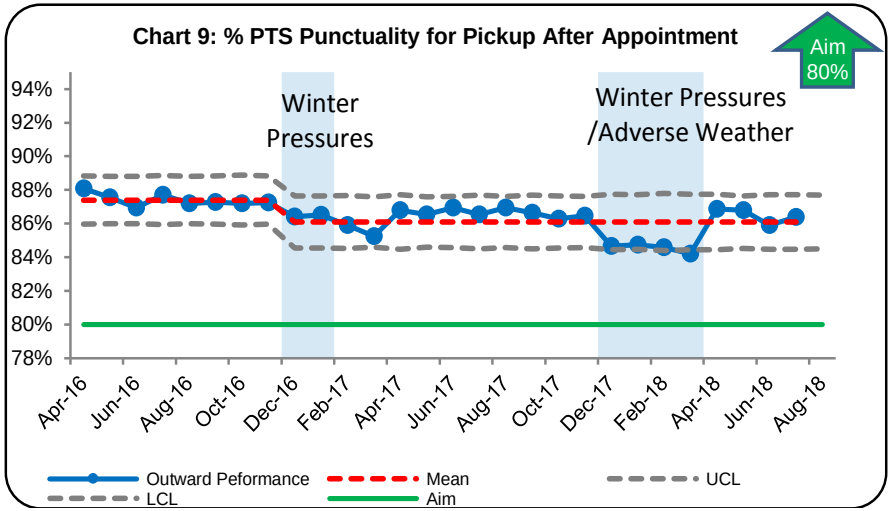
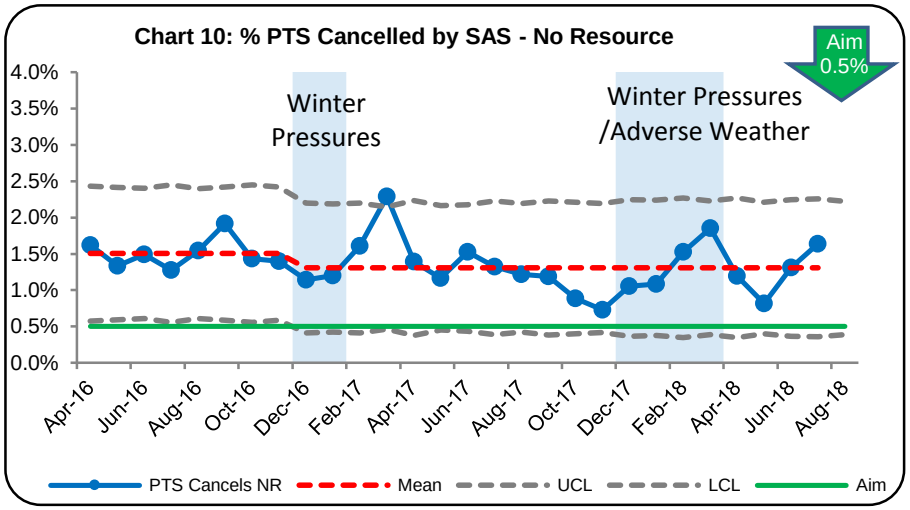


Chart 10 % PTS Cancelled by SAS – No Resource



What is the data telling us - Punctuality for Inward Journey (Chart 8) at 77.2% is now above the mean and the 75% target.
Punctuality for Pickup after Appointment (Chart 9) has returned to the mean following the easing of winter pressures.
Cancelled by SAS – No resource (Chart 10) remains above target, the numbers are close to the mean and within normal variation.

Why - Punctuality for Inward Journey (Chart 8) has improved since winter pressures in March.
Performance for Punctuality for Pickup after Appointment (Chart 9) has been stable over the past year excluding the winter period, and remains above target at 86.1%. PTS crews are often tasked with additional patients (such as discharges as well as other inward journeys) in the time between inward and outward out-patient journeys, which can impact on punctuality of pick-up after appointment.
Cancelled by SAS – No resource figure sits at 1.6% (Chart 10) and represent a small proportion of the total and includes factors such as high abstractions including short notice staff call-offs.

What are we doing and by when - A number of new PTS staff have been recruited and trained across the Service in the early part of the year which has improved resource availability over recent months.

Improvement in this area is a point of focus for the Scheduled Care Advisory Group in order to reduce cancellations towards the target of 0.5%. Performance is reviewed monthly by the Executive team and regions have local improvement plans which are being progressed and tracked.

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 8%, compared to the UK average of 9%, with some other European centres claiming to return almost a quarter of all OHCA victims home alive.

Aim - In response to this, the 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 was published in 2015 and 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 would mean around 300 more lives being saved every year compared to recent years, with a 1,000 additional lives saved 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 co-ordination of all the resources involved in the pre-hospital care of out of hospital cardiac arrests. ACC call handlers need to be effectively trained and supported and then 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 also need up to date and accurate information about available resources requiring the mapping of community first responders and defibrillators.

3. **High performance CPR, Feedback and Second-tier response**. 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. 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 by supporting and strengthening existing community assets. Engaging with partner organisations through a full partnership in the Save a Life for Scotland (SALFS) initiative. Developing systems to ensure that best use is made of Public Access Defibrillators (PADs) 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.** 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 potentially survivable and that we need to focus on continuous improvement of clinical performance and patient outcomes.

Through the above actions we are optimising our process to provide highly reliable care. We are embedding practice to ensure that SAS staff are supported through the challenging experiences they face. Feedback communications are key. Therefore we have implemented a system to continuously inform and support staff regarding their own performance and outcomes achieved for patients. Communication and recognition of our improvement and achievements are being highlighted through national and international forums.

Improvement - Implementation of the Out of Hospital Cardiac Arrest programme will save more lives. As reported in Chart 1, we continue to perform above the 42% aim with 56.9% of VF/VT patients achieving return of spontaneous circulation in August. We now have 6 data points above the mean. As this is a control chart, if maintained above the mean for a further two months this will demonstrate a statistical shift.

Planned activities –

- Further evaluation of 3RU (Rapid Resuscitation Response Unit) phase one to identify and agree key actions before spread including: the education requirements of the CCP programme in relation to OHCA, plan to develop a faculty for future 3RU training and re-training to ensure a sustainable model and complete the Global Resuscitation Alliance Programme in Perthshire.
- Complete the SAS contributions to the review of the Pre-Hospital UK Resuscitation / JRCALC Guidelines as part of the AACE / NASMED Lead Paramedic Group.
- Begin testing with British Heart Foundation for the National Defibrillator Network.
- Continue background work with Scottish Fire and Rescue Service with the aim of co-responding, and re-engage with Police Scotland to further develop co-responding models.

Other considerations - There are a number of inter-dependencies with the Enabling Technology programme, particularly the Defibrillator Replacement project, and the New Clinical Response Model which are supporting 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 a crucial partner of the Trauma Network and responsible for ensuring patients are taken to the most appropriate facility for their injuries and receive quicker access to expert specialist care and intervention.

Aim - 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 Practitioners 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 go depending on 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 (data published, Sinclair et al, Injury, 2018). Enhanced trauma equipment has been rolled out to all front line crews. We have provided all our operational staff with ATMIST aide memoire cards to record information and support standardisation of the format in which clinical reports are passed to Trauma desk and hospitals within the trauma network. We have successfully recruited to 6 new Advanced Practitioners in Critical Care to the South East Trauma Region, with the intention of further improving outcomes for patients requiring critical care.

Planned activities -

- Continue roll out of Adult Trauma Triage Tool in the North Trauma Region ahead of go-live on 1 October 2018.
- Trial of single point of contact using Specialist Services Desk (SSD) for Remote and Rural Obstetric emergencies to commence in September.
- Trial of using SSD as a single point of contact for HM Coastguard for non-emergency transfers commenced in August.
- Begin planning for North ScotSTAR hub to go live in April 2019 following agreement of location in Aberdeen.
- We are continuing to work with the Scottish Trauma Audit Group (STAG) to ensure data linkage between eSTAG and SAS data warehouse via Information Services Division Unscheduled Care Database, is in place for "go live" of North Major Trauma Centre and trauma triage tool to assess the specificity and sensitivity of the tool.
- Induction for the 6 new Trainee Advanced Practitioners (Critical Care) in the South East Trauma Region.

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 –

- More accurately identify patients with immediately life threatening symptoms to ensure the most rapid dispatch of resource, resulting in more lives saved
- Safely and more effectively identify and send the right resource first time for patients, for example dispatching a conveying resource first time to chest pain and stroke patients, resulting in better overall clinical outcomes

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 'key phrases' was successfully implemented in April 2018 to further improve identification of critically ill patients earlier in the call cycle.

Improvement - We have more accurately identified patients with immediately life threatening symptoms, with a number of patient groups being re-triaged to the highest priority purple response category based on the high probability that resuscitation will be required. We have also improved identification of critically ill or injured patients as early as possible in the call cycle in order to dispatch a resource as quickly as possible by introduction of two pre-entry questions and a list of 'key phrases'.

The new clinical response model supports the dispatch of multiple responses to patients in the highest priority purple response category; the closest resource will be dispatched as well as ensuring the response includes a double crewed emergency ambulance to ensure an effective resuscitation team ('triple response') and if required the ability to transport to hospital. Over the NCRM pilot period we have seen an almost 100% increase in patients receiving a multi-resource/clinician response in our highest priority response category, providing a greater chance of survival.

The response model focuses on improving patient outcomes rather than simply measuring the time it takes to respond. We have demonstrated that response times have been maintained to our most acutely unwell patients who require a time-critical response. However, for the majority of patients requiring an emergency response the most important factor in effective care is the ability to target clinical skills to provide treatment and/or refer the patient to the most appropriate care provide for further assessment and treatment – providing the right response first time. While there has been a slight increase in response times to patients that are less acutely unwell, there has been no increase in clinical deterioration of these patients and the outcomes for these patients have remained stable.

Over the course of the pilot we have consistently identified patients within our amber response category who have a low identified need for resuscitation but a defined and identified need for specific acute pathway care, for example ST Elevation Myocardial Infarction (STEMI) and hyper acute strokes. These patients still require an emergency response and are likely to be transported to the Emergency Department, therefore a response with an emergency ambulance that can transport the patient to hospital is crucial. Over the first year of the NCRM pilot this was achieved for more than 90% of our patients, providing the right response first time.

Planned activities:-

- **We will continue to develop the Healthcare Professional (HCP) call process 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 consistent approach for Healthcare Professionals to arrange the most appropriate level of response.
- **Improve our management of patients within the "yellow" response category so patients receive a response sooner**. 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, and identify those who would benefit from referral to an alternative pathway.
- Production of both a comprehensive internal evaluation of NCRM and the commissioned external review by the University of Stirling in the near future.

Other considerations – NCRM underpins most of our service transformation work. To ensure further development of the model it is essential we have alternative pathways available that we can refer for the most appropriate treatment and advice. This includes availability of Specialist Paramedics and 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 dealt with by using alternate treatment pathways as an alternative to a traditional ambulance response.

Hear & 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 & 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 – The Clinical Hub has been strengthened with additional Clinical Advisors – currently we have 26.9wte Clinical Advisors with further recruitment planned. A measurement framework has been developed to support improvement. 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 months. It has been agreed with NHS 24 to establish a project group to take forward a number of joint activities aiming to improve the continuity of care provided to patients by phone whether they call 111 or 999.

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 which will support patients to access the service they need in a timely manner. This is being progressed through the current proposal building on the process implemented during the winter months with an anticipated increase of 0.8% hear and treat (around 12 calls a day).
- We can positively report that an average of 81% of calls requiring NHS 24 response are now transferred. Improvement work will take place to understand the remaining 19% of calls and how we can further improve the transfer of these calls.
- Development of the joint NHS 24/SAS project group.

Other considerations - We already work closely with NHS 24 and this will increase over 2018/19 as we seek to create a seamless experience for patients whether they dial 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 more comprehensive care at point of contact, and enhance our ability to see and treat more patients at home through the provision of senior clinical decision support.

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 Specialist and 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 approximately 100 Specialist Paramedics in urgent and emergency care. One third of them work in primary care multidisciplinary teams within out of hour's services and GP practices across the country. We have successfully recruited 15 additional Specialist Paramedics and 5 new Advanced Practitioners (Urgent and Primary Care) to begin training in September 2018.

Improvement - As well as effectively managing the increasing urgent demand from 999 calls, Specialist Paramedics and Advanced Practitioners in urgent and primary care can play an important role in the Primary Care in hour's multi-disciplinary team. 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 up to around £56 million per year.

Planned activities:-

- Completion of education and competence framework.
- Continue to improve dispatch of Specialist Paramedics to patients with low acuity illness and injury that are likely to be able to be safely treated at home or in the community. An initial test has been in place since 17 July for a subset of patients within the yellow and green response categories. Further work is planned to improve the visibility of Specialist Paramedics at the dispatch test.
- Specific Clinical Practice Guidelines development underway to support the safe and effective care of patients that are treated at home
- Continue to develop the joint test of change with NHS24 in primary care in Musselburgh.

Other considerations - Specialist Paramedics and Advanced Practitioners in urgent and primary care are crucial to achieve further development through the New Clinical Response Model, so that patients with lower acuity needs are provided with the right response and are treated at home where safe and appropriate to do so.

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 - Work is continuing to review the use of PTS and Low Acuity resources to handle same day requests for admission. A short life Focus Group, led by a Clinical Governance Manager, is reviewing the process including the scope of practice of PTS staff and its match to the patient profile.

Another group, chaired by the ACC Head of Operational Delivery is reviewing the ACC aspects of the process including how patients are identified as suitable for PTS and how the calls are received and allocated by Control.

Work has also been done to measure the volume of calls deemed suitable for PTS and the proportion of this demand actually handled by such resources. This has revealed wide variation in how the process is used and how productive Low Acuity resources are in different areas. This has highlighted the need to identify the reasons for this variation and take steps to promote best practice and increase utilisation. This will remove some of this workload from A&E crews, reducing lengthy delays on non-ILT emergency calls, improve compliance with rest breaks and reduce the number of shift over-runs, thus improving both staff and patient experience.

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:-

The C3/Cleric interface has been installed and a short test took place in the first week of September of the process of transferring calls from the A&E CAD to Cleric rather than the current practice of using paper. This highlighted some minor issues, which have been referred to IT to resolve before a further test is carried out.

The Scheduled Care Advisory Group will consider putting in place improvement programmes to understand the complex issues relating to PTS and to put in place change ideas to achieve the aims.

6. Clinical Data Set Development

Background - All UK ambulance services have traditional performance measures predominantly based on time based response. This approach has limitations as it does not reflect the clinical abilities of the modern ambulance clinician workforce or provide a framework for the measurement of best clinical practice across the entire patient pathway. There is now a need and opportunity to re-design this measurement framework and shift the culture from historic time targets to optimal patient care.

Aim - To re-design how the service uses clinical and operational data to allow for the measurement of clinical effectiveness across the entire patient pathway of different clinical acuities.

Status

- Clinical Data Group formed and has met twice.
- Clinical effectiveness group to meet for the first time in September.
- Development of clinical data sets aligned to key areas of practice and strategy – in final testing.
- Electronic Patient Report completion quality framework in final testing.

Improvement – this will allow us to understand the quality of care we provide to patients, alongside the time it takes us to respond. It will also support feedback to frontline staff on the care they provided and any areas where improvements could be made.

Planned Activities - Development of a national clinical effectiveness implementation plan. A key element of measurement of clinical practice is to have the ability to feedback areas of success and areas of improvement. At present there is an opportunity to develop the service systems so this could be delivered, identifying resource and structures to take ownership of this information.

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 Q4 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 approved the formal closure of the t (ePR) Project following submission of a comprehensive End of Project Report. A SAS 'app' pilot has completed at Coatbridge Station with positive results. The issue relating to the network connectivity has been resolved and the Virtual Private Network (VPN) connectivity that is required before app rollout has now been made available across the emergency fleet. End-to-end testing highlighted fundamental issues with the Content Management System (which updates the app) and this has now gone for re-development by the supplier. This is due to be delivered in early October. SAS testing will then commence, with the intention of roll out being completed by the end of November 2018. The Programme Team are planning to formally close the Telehealth Programme during Q1 2019.

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 PVC bundles and pre-hospital stroke compliance.

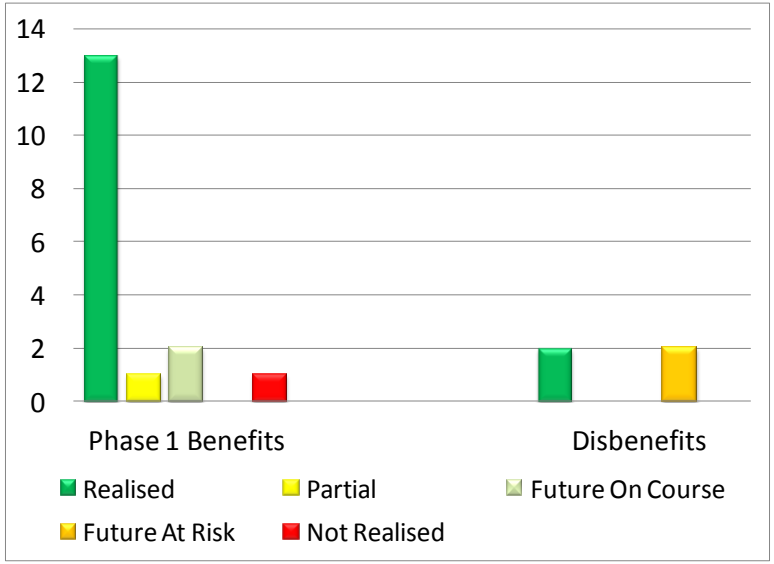
Planned Activities - Complete the SAS app development work and roll out during Q4 2018 and then formally close the Programme.

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

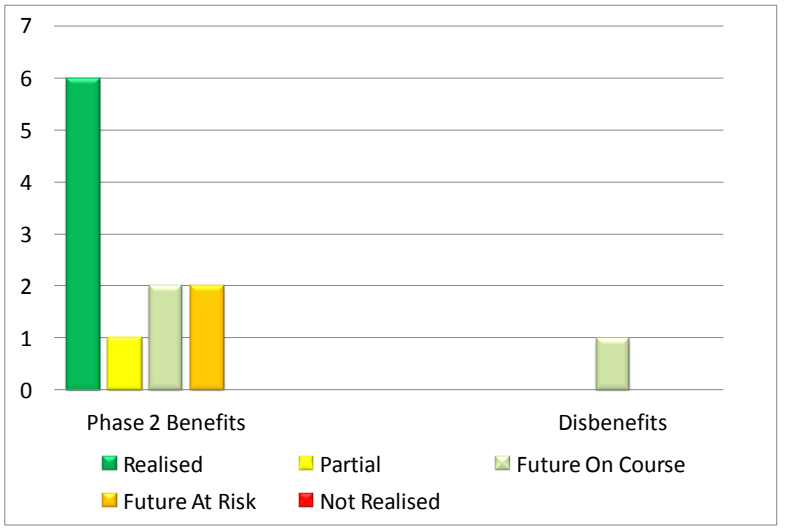
rates and data quality. A comprehensive benefits realisation plan is in place and the delivery of key benefits is being actively progressed by the Programme Business Change Manager. The one risk that is listed as 'Not Realised' during Phase 1 relates to the interim ePR which was implemented on the new hardware while a completely new ePR was being developed. It was anticipated that the interim ePR would deliver a benefit in terms of the user interface and ease of use. Feedback from staff was less positive than anticipated so this benefit was formally recorded as not realised. The interim ePR has now been replaced by the new ePR.

Ambulance Telehealth Phase 1 benefits



1

Ambulance Telehealth Phase 2 (ePR) benefits



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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 there is now unlikely to be a 'big bang' approach to ESN transition; the emerging preference being a phased incremental approach. The ESMCP Team had planned to submit the revised FBC for HM Treasury approval during September 2018, however the latest information received suggests that approval for an 'interim' business case will be sought later this year with FBC approval deferred into mid-2019. The Scottish Government had planned to seek FBC 'assurance' from the Service and the other Scottish emergency services over the summer of 2018 but it is now unclear what assurances will be requested or when. 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. A proposal in relation to phased delivery was submitted for consideration, Scottish Leads submitted a response to advise 'in principle' there was potential for this delivery method to achieve some of the benefits earlier than would have been possible with a 'big bang' approach. However, more detailed information will be required before any decision is reached on whether this is an acceptable way forward. 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 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 the current ICCS beyond this is likely to require costly hardware and software upgrades. Work therefore continues on developing an ICCS replacement Business Case. Scottish Government has agreed to fund the capital costs. The revenue costs, are unlikely to be significantly more than current ICCS costs, however, we are progressing a 'risk share' approach with Scottish Government to mitigate any risk to significant cost pressure. This will be outlined within the ICCS Business Case which will be presented at the Board for consideration in September 2018. Discussions with Police Scotland indicated that it was not feasible to progress a joint ICCS procurement as it would have compromised their timescales, Police Scotland have now progressed their procurement and have issued an invitation to tender (ITT). Therefore, there is now no opportunity for SAS to progress a joint ICCS procurement with Police Scotland. 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 regarding ICCS replacement. Completion of ICCS Business Case.

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. Initial discussions around production of the next Fleet Business Case will also be undertaken.

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 and scoring has now been undertaken on the equipment provided by the two potential suppliers. The Outline Business Case (OBC) for the defibrillator replacement was approved by the Board in March and submitted to the SG Capital Investment Group (CIG). The Full Business Case (FBC) is being submitted to the Board in September and if approved the aim will be for the FBC to be submitted to CIG in October.

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 by September 2018 before completing the procurement and developing the FBC during Q3/4 2018. The rollout plan is currently being developed.

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 4 - 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 sustainable Ambulance Care Assistant and Technician recruitment pipelines given high levels of interest in joining the Service. Our continuing challenge is ensuring the translation rate of staff progressing on to Paramedic training (and to Specialist/Advanced Paramedic roles). A number of improvement projects are being progressed in 2018/19 to support both higher Paramedic Training numbers and recruitment of qualified staff. We continue to monitor turnover at individual skill set level to ensure workforce forecast numbers do not require additional adjustment.

Planned Activities Include – Work continues on delivering the targets within our resourcing plan which include an additional 75 Ambulance Care Assistants, 160 Technicians, 200 Paramedics (including 51 Specialist and 12 Advanced Paramedics). Paramedic intakes commenced in July with a further September and October group. The Workforce Development Group is monitoring the position to consider the best options for maximising recruitment, following the earlier decision to shift the balance to recruiting a Trainee Paramedic intake of 48 in September (47 appointed). Although the focus is on maximising our present training groups, the work has commenced to identify the prospectus schedule for 2019-2021 to support delivery of our workforce targets. 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 high volume Paramedic recruitment and training required as part of our strategy. This work aims to support continuing target delivery over the next three years as we prepare for changes to the Educational Model to align with the introduction of degree level HCPC registration requirements in 2021. This will build on the external pipeline which was expanded last year with commencement of the first full time degree programme in Scotland (first graduates in 2020).

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 has been developed which defines how all of the Service's frontline roles will operate to support our 2020 Strategy. This framework continues to evolve to align with transformational organisational change. From an initial focus on the development and deployment of the Specialist Paramedic role in Urgent & Emergency Care, 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 workforce modelling which will underpin the delivery of our Workforce Plan and ensure we have developed a workforce capable of delivering our strategic aims.

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 and underpinning processes approved and adopted to ensure 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 is a current priority. Learning & Development infrastructure development is focusing on both the development of processes connecting personal development planning and access to learning delivery, and on the development of supporting IT systems for development activity recording and supporting online learning access. The career framework model will evolve to align and incorporate pathways for all clinical, operational and management requirements.

The roll out of Turas Appraisal continues after its launch on 2nd April 2018 as replacement for the eKSF system. We are still awaiting the next national functionality update to allow the reporting of present organisational activity levels. The Turas Appraisal system now supports the recording of Executive Performance Management and the first use of the system is in process for the 2018/19 objective setting cycle. This is one element of Project Lift, the new national level Executive level talent management and succession planning framework, which launched at the end of May 2018. Engagement in the roll out of Project Lift has been undertaken at Executive and Senior Leadership Team level. At the service level we are completing a leadership development needs assessment and progression of national board collaborative

activity aligned to national NHS Scotland Leadership Framework will. 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, and close working arrangements between Clinical Services Transformation and Workforce Development are required and in place 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 was set at 62 (based on anticipated potential drop during our second phase).

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 was 64% (compared with 63% NHS Scotland) with an employee engagement index (EEI) score of 67 (75 for NHS Scotland).

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. The response rate achieved was 64% with a Board EEI score of 67, maintaining our position from the initial implementation phase.

Planned Activity – iMatter action planning phase commenced in June 2018 and the deadline for action plan responses was 10th September 2018. The Service achieved an excellent outcome, with the percentage of action plans completed by the end of the 12 week period at 86%. This achieved our aim of sustaining the significant improvement in 2017/18 with a 73% completion rate, placing the Service within the higher performing Boards with the NHS Scotland average at 43%.

The 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 approved the Organisational Development (OD) Plan for 2018/19 in June which incorporates activity to address these key themes. With the action plan submission phase of iMatter completed, the next phase of work is to develop tests of change for improvement across the organisation and work with iMatter Leads to share these activities and promote positive change to support employee engagement.

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.