

SCOTTISH AMBULANCE SERVICE 2016-17 LOCAL DELIVERY PLAN

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Section 1: Introduction

1.1 Introduction

The Scottish Ambulance Service launched its strategy “Towards 2020: Taking Care to the Patient” in February 2015. This strategy sets out clearly the Service’s commitment to supporting the delivery of person-centred care at home or in a homely setting by 2020.

The Scottish Ambulance Service recognises that it has a significant contribution to make to the effective delivery of this strategy as a frontline service, providing emergency, unscheduled and scheduled care 24/7. Our five-year strategic framework describes how we plan to do that in a way that supports the national quality ambitions for person-centred, safe, and effective care. By 2020 we aim to:

- Improve access to healthcare;
- Improve outcomes for patients – specifically cardiac, trauma, stroke, mental health, respiratory, frailty and falls;
- Evidence a shift in the balance of care by taking more care to the patient;
- Enhance our clinical skills as a key and integral partner working with primary and secondary care;
- Develop our Service as a key partner with newly formed Integration Boards;
- Collaborate with other blue light emergency services as part of a contribution to shared services and public service reform;
- Build and strengthen community resilience;
- Expand our diagnostic capability and use of technology to improve patient care, and;
- Develop a more flexible, responsive and integrated scheduled Patient Transport Service;

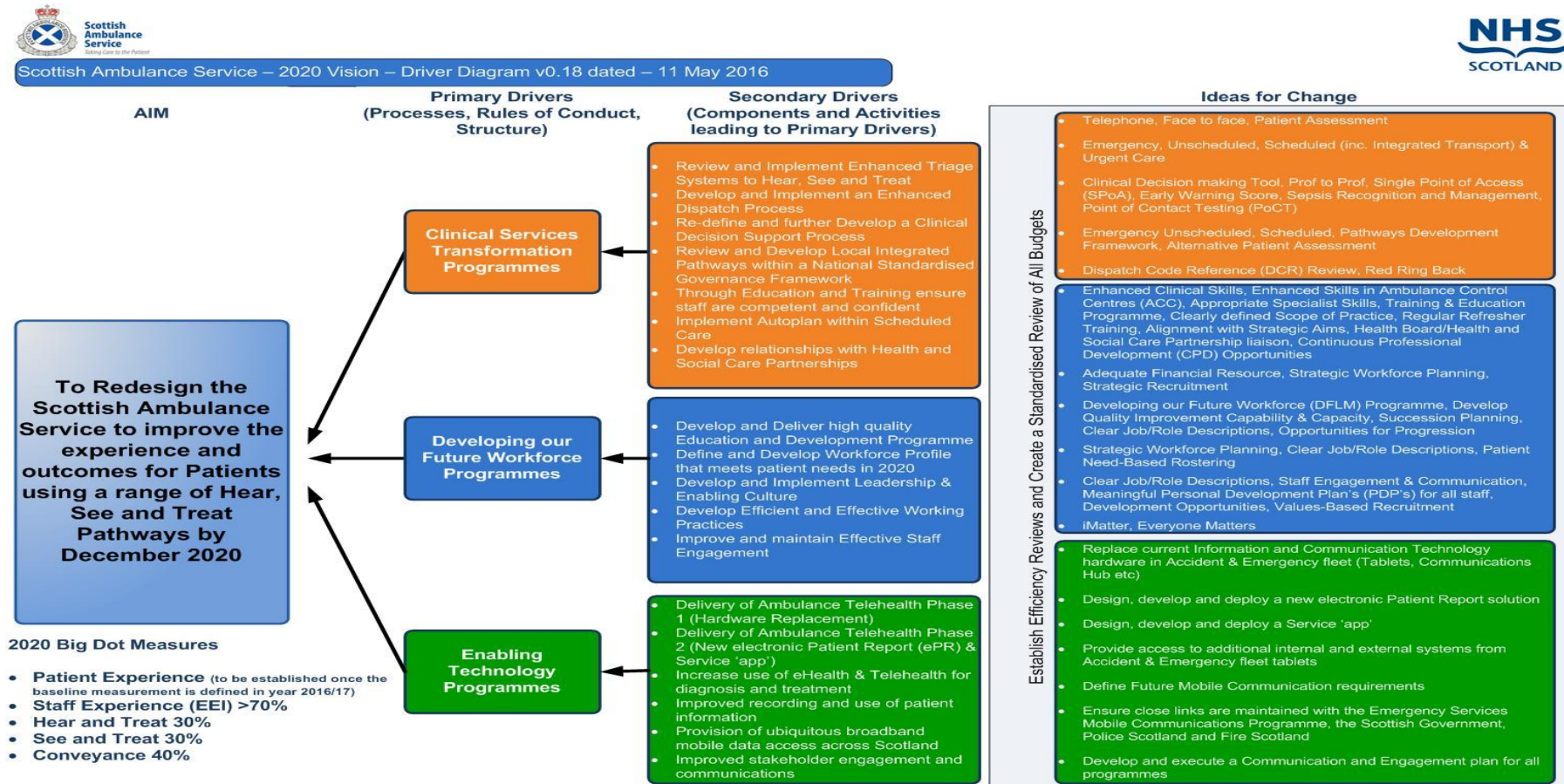
This Local Delivery Plan sets out the key priorities for action in 2016/17 encompassing our Corporate Plan and key performance measures agreed with Scottish Government, and detailing how the Service will work to support NHS Boards and the wider Health and Social Care Partnerships to deliver the 2020 Vision.

The Plan sets out our commitment to deliver against the strategic improvement priorities and how the Scottish Ambulance Service will support the transition to 2020 as we implement our strategy and develop our workforce and operational services going forward, within available resourcing levels.

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1.2 Towards 2020: Taking Care to the Patient

2016/17 will be the second year of our strategy “Towards 2020: Taking Care to the Patient”. Throughout 2015/16, we have significantly progressed our clinical and workforce modelling and tested a number of key elements of both as we begin our transition towards 2020. The driver diagram below sets out our key strategic aims and ambitions for 2016/17 to deliver against this strategy.



1.3 Developing our Clinical Model

Throughout 2016/17, we will continue to build on the work completed in 2015/16 in the development of our new clinical model. We will specifically focus on a number of key areas:

- We will revise our protocols for triage and assessment of patient need both from the public and our partners, building on the work last year with NHS 24, GPs and the Police;
- We will develop the Clinical Hub within our Ambulance Control Centre, to further strengthen clinical decision support, increase hear and treat¹ and access referral to more appropriate pathways and teams;
- We will develop our workforce increasing numbers of specialist and advanced paramedic roles and also developing the skills and roles of our existing workforce to support more effective clinical decision making;
- We will work with our partners in NHS boards and Health and Social Care Partnerships to support the development of new integrated models of unscheduled care both in and out of hours;
- We will continue to work locally with our partners to develop and access appropriate care pathways to reduce avoidable attendances at A&E;
- We will work with NHS boards to support delivery of the 6 essential actions for unscheduled care, notably enhancing our support for effective discharge planning and further development of our low acuity model;
- We will continue to support the development of national trauma system for Scotland, establishing as part of this national programme of work, a 24/7 trauma desk to co-ordinate the flow of patients across this network;
- We will further improve survival from out of hospital cardiac arrest;
- We will strengthen our response to major incidents and co-ordination of pre-hospital major incident management in partnership with NHS boards;
- We will further develop integrated patient transport arrangements with other partners.

1.4 Performance Improvement

¹ Reference asterisk comments on page 30

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Our improvements to performance and staffing will continue to focus on the following areas:

- Additional clinical leadership and management presence in our Ambulance Control Centres to provide mentorship and supervision to deal with the volume of higher acuity Category A and B cases at the point of clinical triage. The development of the Clinical Hub will provide an additional skill set within the staff profile to maintain this focus going forward.
- Implementation of workforce plans to enhance frontline staffing in A&E roles and Ambulance Control Centres. To assist with the maintenance of the improvement work, the training prospectus has been reviewed and now provides additional staff to increase relief ratios. This will reduce the impact of training abstractions when developing the workforce and further enhance Service Delivery.
- Support from Hospital Ambulance Liaison Officers to address hospital turnaround time and improve patient flows at key identified locations by acting as an initial point of contact for patient flow/bed managers and A&E staff to deal with issues in real time.
- Continued monitoring, engagement and collaboration with NHS 24 to ensure calls being passed as Category A and Immediately Life Threatening are clinically safe and effective. Dedicated work is being undertaken prior to and in conjunction with the launch of the Futures Programme to maintain clinically safe and effective transfer of calls through the implementation phases.

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Section 2: Strategic Improvement Priorities

2.1 Health Inequalities and Prevention

The Scottish Ambulance Service has over two million patient contacts each year across Scotland. In line with our strategy, we will aim in 2016/17 to increase the percentage of these patients we are able to treat safely and effectively at home. We will engage with Health and Social Care Partnerships to support the delivery of care within communities and increase our cohort of specialist paramedics within the year to strengthen this model.

We will continue to build on our successful working with the voluntary sector to develop and access pathways, which build a network of support for patients within communities. As we complete the implementation of the first phase of our ambulance telehealth programme, we will put in place the infrastructure to facilitate remote diagnostic and near-patient testing helping to reduce further avoidable attendances at hospital. This investment in new technology will also offer crews improved access to patient information to support more effective treatment as well as supporting our aim to share information on ambulance attendances and outcomes with GPs and relevant clinicians to better integrate the care offered to patients. Our directory of services will improve access to care pathways and provide a place for crews to find other local contact information for patients and carers including details of local services.

We will continue to progress implementation of the Out of Hospital Cardiac Arrest Strategy, where already within the first year, we have delivered a marked increase in return of spontaneous circulation (ROSC) rates across Scotland from 33.9% in 2014/15 to 39.0% in 2015/16 for cardiac arrests presenting with a ventricular fibrillation (VF) or ventricular tachycardia (VT) rhythm.

In 2016/17, we will continue to extend the availability and awareness of public access defibrillators, work with partners to raise awareness and develop life-saving skills within communities and further extend our 3RU (rapid resuscitation response) model to out of hospital cardiac arrests.

Having successfully tested the delivery of technician training through the vocational SVQ model in the North of Scotland in 2015/16, we will extend the use of this model in 2016/17 as our primary means of training technicians and ambulance care assistants in the future. This approach offers greater access to the Scottish Ambulance Service as an employer, notably for more remote and rural communities, where training can be delivered locally.

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2.2 Antenatal and Early Years

All children and young people have the right to be cared for and protected from harm and abuse and to grow up in a safe environment in which their rights are respected and their needs met. The Scottish Ambulance Service has continued to improve on early recognition and intervention in relation to children's wellbeing and recognises both its responsibility in the care and protection of children and young people and within the wider context of Getting It Right For Every Child (GIRFEC), the Early Learning Years and the UN Convention on the Rights of the Child and acknowledges that the welfare of the child and young person is paramount.

In September 2015 the Service approved a Public Protection Policy which includes sections on both Child Protection and Child Wellbeing. It is fully engaged and supportive in the introduction of the new Children and Young People (Scotland) Act 2014 and is advised and informed through representation at the Health Board GIRFEC Implementation Change Managers Group (CEL 29) on the requirement to specifically progress parts 4, 5 and 18 (Section 96) of the Act by August 2016. Regular updates on progress within these specific areas are reported through a number of channels within the Service.

Areas of progression towards the GIRFEC delivery plan include:

- Engagement with the national GIRFEC communications team in relation to the provision of 'practice materials' as well as linking into the Partner Communication Toolkit is currently being progressed in order to ensure that the Service can fully support and progress the implementation of parts 4, 5 and 18 of the Act;
- Engagement with NHS Education for Scotland to ensure that the training resource materials are appropriate and relevant for all frontline staff
- Attendance at Master Classes in March 2016 with 3 delegates attending to ensure that training and support will be provided to all front line staff within the Service in preparation for the implementation of both the Primary and Secondary Legislation associated with parts 4, 5 and 18 of the Act in August 2016;
- Engagement and discussion with NHS Borders to address 'information sharing' concerns and explore the possibility of a small test of change in relation to this;

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- Engagement has progressed with the Scottish Care Information Gateway and exploration of the tests that have been progressed within Ayrshire and Arran Health Board in relation to direct access to information;

Internally GIRFEC is being progressed with awareness and training plans for all frontline staff, engagement with PFPI leads which also includes Child Protection and the Ambulance Telehealth Programme around incorporating functionality to assist in secure direct referrals via the new hardware.

The modeling of the draft Service GIRFEC Delivery Plan will be influenced and guided through the work that is currently being progressed by the CEL29 – Health Board Change Managers and the GIRFEC Lead Officers Groups. The final draft of the Statutory Guidance in relation to the implementation of parts 4, 5 and 18, section 96 of the new Children and Young People (Scotland) Act will be highly influential in assisting with the implementation and continuing evaluation of this legislation.

The Service will continue with the implementation of the Paediatric Early Warning System (PEWS) throughout quarters one and two of 2016/17 following national agreement with all Health Boards.

The Neonatal service continues to be a part of ScotSTAR with teams in Glasgow, Edinburgh and Aberdeen. Work continues with Edinburgh and Aberdeen to create a sustainable service with a long term plan is to develop our nursing capability to allow us to safely reduce reliance on consultant cover.

The Perinatal Advisory Service now operates from the West Ambulance Control Centre and retains strong clinical links to the ScotSTAR team for guidance. Working with the Scottish maternity review group, we will develop a strategy to provide this service to the whole of Scotland.

2.3 Safe Care

2016/17 will be the second year of our strategy “Towards 2020: Taking Care to the Patient” and the development of our new clinical model which aims to ensure effective clinical assessment of patient need and appropriate clinical response to meet that need. Throughout 2015/16, we have tested a number

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of key elements of this model, including Hear and Treat² and improved clinical decision making for crews.

In 2016/17, we will further develop this model, notably within our Ambulance Control Centres (Ambulance Control Centre) where we will build on the development of our Clinical Services Desk as a Clinical Hub. This will support our aim to appropriately and safely increase the percentage of patients offered telephone advice or referred onto NHS 24 without the need for ambulance attendance up to 10% in 2016/17. The increase in calls transferred to NHS 24 will be identified and signed off through a joint clinical governance process similar to that for the currently identified call types. These call types include general unwell with no priority symptoms, mild heat or cold injuries/exposure, toothache, splinters and mild bites/stings. To support the development of our Clinical Hub, we will invest in additional clinical advisors within Ambulance Control Centre increasing this cohort to 40 in 2016/17.

Having reviewed and tested our clinical decision support framework for crews to support them to treat patients safely and effectively at home, we will extend the use of this framework in 2016/17 ensuring staff are trained and supported. This moves us away from a condition specific approach towards a more holistic framework to support clinical decision-making. In 2016/17 we will continue to support the Health and Social Care aim to avoid unnecessary attendances and admissions, helping people remain in their own home or homely setting by increasing the percentage of patients safely and effectively treated at scene or at home by our Ambulance Control Centre Clinical Advisors or by frontline crews to 28%.

In 2016/17, we will continue to embed our three-year patient safety programme, focussed on:

- 1) Leadership and culture
- 2) Safe and effective patient care for the deteriorating patient
- 3) Safer medicines management
- 4) Improved outcomes from out of hospital cardiac arrest

We will continue to support the delivery of the national Out of Hospital Cardiac Arrest Strategy in 2016/17 as it moves into its second year. Specifically, we will extend the application of the 3RU model to enhance our response to all cardiac arrests; real-time and follow-up feedback to crews on the effectiveness of CPR; increased availability and awareness of public access defibrillators; and, working with our partners, including Scottish Fire

² Reference asterisk comments on page 30

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and Rescue Service, continue to build a network of first and co-responders across Scotland. During 2016/17, we aim to sustain the improvement in our ROSC rates for patients experiencing a VF/VT rhythm and put systems in place to measure the longer-term survival rates of patients.

We will continue to learn from our programme of patient safety walkround and review of significant and adverse events and to build this learning into on-going staff and policy development. As we complete the first phase of our Developing Future Leaders and Managers (DFLM) programme this year, we will continue to focus and support frontline managers to strengthen clinical leadership and governance across the Service.

We will build on the work already undertaken to ensure further integration and development of the three existing services under the ScotSTAR division. We will continue to work with the North of Scotland planning group to determine requirements for an effective retrieval service.

The three main goals of the ScotSTAR service for 2016/17 are to;

1. Improve coordination and tasking of air and retrieval teams
2. Consolidate and develop the workforce of multi disciplinary teams for the future needs of the patients
3. Work to coordinate and align all data reporting systems from the retrieval teams

We continue to strengthen our quality improvement capacity in 2016/17 to underpin our approach to service delivery and patient safety, notably improving our use of data to proactively identify and manage clinical and operational processes and interventions. This will be achieved through the review and development of our data analysis capability with an aim to provide a “business intelligence” function for the organisation. Additionally, a structured programme of quality improvement learning and development which will engage at Board, divisional management team and frontline staff levels will be developed and introduced.

At Board level we will determine the current breadth & depth of understanding of Improvement Science and develop this capability in line with the guidance described in ‘*Quality Improvement & Measurement for Board Executive & Non Executive Directors*’. This will be an instrumental enabler to the Board to

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positively influence and support Quality Improvement culture across the Scottish Ambulance Service.

We will develop a dedicated learning programme at micro level to build the capacity and capability necessary to deliver our strategic aims. This will enable us, at divisional and frontline levels, to routinely use Quality Improvement methodology to test, implement and spread safe, evidence based service improvements which will be underpinned by the use of data to illustrate and understand gains made and identify further improvement opportunities. Our divisional management and frontline staff will have access to internal and external Quality Improvement learning programmes with content based on existing proven programmes such as the Scottish Improvement Leaders programmes and the NES Quality Improvement Tool Kit.

We will continue to strengthen infection control procedures, including robust audit and monitoring. Our regular audit programme for compliance with standard infection control precautions (SICPs) continues to demonstrate that good compliance is being maintained and this programme will continue throughout 2016/17.

2.4 Person-centred Care

Patients will continue to be involved in the on-going development of our services. As we developed our strategy we engaged with a wide range of stakeholders, and we have continued to build on this approach as we have tested key elements of our new clinical model. In 2016/17, we will evaluate with patients and their representatives the development of our Clinical Hub model within Ambulance Control Centres and as we extend our clinical decision framework to support more effective care at home.

In 2016/17, we will progress refinement of our triage protocols within our Ambulance Control Centres in line with our strategy. This aims to ensure we not only respond effectively to immediately life-threatening incidents, but also that we respond with the most appropriate skills and resources to meet the increasingly complex needs of our patients. This will require us to better understand and clinically assess that need and, in 2016/17, we will implement new triage protocols to facilitate this. This approach to triage will be supported by enhanced clinical capacity within our Ambulance Control Centres and increased levels of specialist roles and clinical decision-making across divisions as previously described as we begin to transition our workforce towards 2020. We will be sharing these changes with patient groups in May and June 2016 to help build understanding of the benefits of enhanced triage arrangements and seek patient stories to build confidence in

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the changes. We will also monitor our feedback channels to track if the changes are delivering the benefits we expect.

We will continue to develop care pathways that are person-centred. In 2015, we developed a framework to support our approach to care pathways and we will work with our partners to embed this framework and approach locally. Throughout 2015, we also reviewed and strengthened our response to hyper-acute stroke patients, notably in the sharing of information directly with GPs and clinics to support more effective treatment and raise awareness of ambulance service interventions. We will continue to build on this in 2016/17 with the development of our new stroke policy and bundle in full partnership with the National Stroke Advisory Group and Managed Clinical Network.

We will also continue to work to support the development of major trauma network for Scotland and we are a significant contributor to the major trauma discussions, in particular developing the proposals for improvements in pre-hospital critical care.

Use of information to deliver more person-centred care is also a key element of our strategy towards 2020. As we roll out the new hardware across our A&E fleet in 2016, crews will also have access electronically to a directory of services, which will offer alternative pathways and information on more appropriate services for patients. Through the improvements being delivered as part of our Enabling Technology programme we will standardise access to the Emergency Care Summary (ECS), electronic Palliative Care Summary (ePCS), electronic Key Information Summary (eKIS), anticipatory care plans and sharing of electronic patient records with GPs and other services. This will play an important role in supporting more effective and joined up person-centred care.

Our staff will be critical to the effective delivery of our strategy and key to that will be their development to support more effective clinical decision-making for patients. Through our DFLM programme, we will strengthen clinical leadership and support for crews and the development of clinical decision-making within our Ambulance Control Centre and divisions with ensure we work towards our 2020 aims of 30% Hear and Treat³, 30% See and Treat⁴ and a reduction to 40% of patients taken to hospital progressing transition to our new clinical and workforce models in 2016/17.

³ Reference asterisk comments on page 30

⁴ Reference asterisk comments on page 30

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We are continuing to work in partnership with patients, carers, the public, staff and other key stakeholders to develop services. This is reflected in the most recent Participation Standard self assessment, where we achieved Level 3 (evaluating) for Patient Focus and Level 2 (implementing) for our Patient Focus Public Involvement (PFPI) Governance Arrangements. We are continuing to build on good practice, through our local Involving people Groups; as well as continued participation in the Person-centred Health and Care Network. This network is helpful for sharing knowledge and ideas.

We have been reviewing good practice across other NHS Boards including the “Must Do With Me” principles. Although these do not readily apply in an ambulance context, we will continue to ensure our focus remains on person centred care.

Plans are in development for improving our governance arrangements in relation to PFPI and we plan to move to a framework which promotes greater diversity within our population of patient and public representatives and makes it easier to participate in involvement activity. For example, we are looking at our digital technology arrangements with a view to improving VC facilities.

A renewed focus on communications and engagement, tailored for and targeted at key audiences will help build greater understanding of the Service’s strategic objectives and the anticipated benefits to patients and to staff. Improved access to involvement opportunities and to feedback mechanisms will help generate more diverse patient and public input and feedback on services. Patient Literature which will be provided to patients who have been seen by ambulance staff, but who are not conveyed to hospital is being developed which highlights to patients and carers how to feed back on their care experience, as well as highlighting advocacy and support services.

2.5 Primary Care

Having participated in the national review of Primary Care Out of Hours, we will progress a number of key recommendations in 2016/17 and support the development of out of hours services. Following engagement with daytime GPs and Out of Hours Groups, a workgroup chaired by our Medical Director has been established and includes representatives from GP Out of Hours and BMA, representing In Hours GPs.

We will increase our cohort of specialist paramedics, working with urgent care providers to establish this role as integral to the delivery of out of hours care.

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We will evidence the benefit and build on the successful work with a number of NHS Boards to date whereby paramedic practitioners operate as part of an integrated team to support in and out of hours primary and urgent care. We will use the Health and Social Care Partnerships network to share evidence and identify areas of commonality and build on these gains.

We will continue to strengthen our relationship with NHS 24, notably in respect of effective triage and access to pathways for patients. In support of this we are currently developing joint governance arrangements with a consolidated report to both clinical governance committees. This is scheduled to commence from August 2016.

We will also look to develop professional-to-professional support for crews and potentially look to develop the role of GPs within our Ambulance Control Centre to strengthen and support clinical decision-making.

We will also look to further extend the sharing of our electronic patient record with GP practices following successful roll out within Glasgow for patients treated at home to ensure awareness for GPs where patients are attended by us but not taken to hospital. We are also working to share patient record documentation with territorial boards. Within information governance parameters this information can be shared with appropriate clinicians whether they be primary, secondary care or mental health. We will explore the opportunities to include multi disciplinary teams such as allied health professionals and specialist nurses.

As we complete the roll out of new hardware across our fleet, we will enhance the access for crews to patient records and care plans to support more effective treatment.

During 2015, we developed our low acuity model to more effectively manage requests from GPs, investing in additional dedicated capacity within divisions and establishing dedicated desks within our East and West Ambulance Control Centres to manage this activity. This model aimed to ensure we fully assessed the requirement for an ambulance response both in terms of timeliness and identifying the most appropriate resource and skillset for that patient. It also strengthened our clinical governance arrangements and increased our direct contact with patients ensuring we were better able to identify earlier where a patient's condition had deteriorated or was of a higher acuity. In 2016/17, following full evaluation of the low acuity model, we will work with our GP colleagues in and out of hours, to fully embed this approach, supported by our additional clinical advisor capacity.

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2.6 Integration

The development of integrated Health and Social Care Partnerships is fully aligned to the aims set out in our 2020 strategy. We will work with Health and Social Care Partnerships as they progress the development and commissioning of services, identifying opportunities to build on our successful partnership working to date to route patients to appropriate community based care.

Clearly, for a national service such as Scottish Ambulance Service, the complexity of this landscape must not be underestimated. However, we will continue to develop an awareness of the role that the Scottish Ambulance Service has to play in supporting new models of service delivery, working as part of integrated teams both in and out of hours.

Building on our success to date, we will continue to work locally to support the development of care pathways, linking in with community based services such as local falls prevention teams, and further embed our increased specialist paramedic cohort and referral processes to and from these new integrated models, such as hospital at home, for example.

Our DFLM programme and our commitment to increasing our Quality Improvement capacity will also strengthen our capacity to effectively engage locally with these partnerships to deliver a national approach tailored to local need by equipping Scottish Ambulance Service managers with the capability and capacity to effectively engage with local partnerships.

Our Clinical Services Transformation group we will develop reporting and governance arrangements to ensure the engagement work with Health and Social Care Partnerships is coordinated and aligned to strategic priorities of each organisation.

2.7 Scheduled Care

We have a key role to play in the redesign of scheduled care services across Scotland and a commitment to ensuring that we support the effective transformation of outpatient activity and the reconfiguration of elective patients across Scotland. We will work with NHS Boards to continue to improve our Scheduled Care Service following our internal redesign, ensuring effective planning, notably in respect of discharge planning, with NHS Boards, and promoting the development of models such as the NHS Lothian Flow Centre.

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As we go through 2016/17 we will further progress key improvement areas to benefit patients and our partners through areas of focused work which include:

- A review of arrangements for patients who do not currently go through our clinical assessment for transport process (e.g. renal dialysis and day hospital patients) to ensure we are supporting these people at the right times in their disease and condition development. This will include consultation and collaboration with Health Boards and other partners to ensure that other transport options and providers are utilised in support of these groups safely, effectively and efficiently.
- We will work with Health Boards utilising the existing liaison structures to fully understand their pressures and priorities and provide scheduled care service support to these areas wherever possible. It is anticipated that priorities will include:
 - Patient transfer activity across Health Board boundaries
 - Patient flow, particularly in relation to discharge activity
- We will realign the day to day work patterns for our scheduled care service to ensure it matches demand utilising data and information from our auto-plan system to support this.
- As part of our continuous improvement process we will undertake a clinically led review of the assessment process used to determine the needs of patients who contact us for transport support in consultation with patients and partners.
- We will continue to work internally to fully define the role of the Scottish Ambulance Service within an integrated transport for health model and with external partners to develop, test and implement this approach wherever possible.

Throughout this activity we will ensure we are fully engaged with patients, the public, health and social care providers and other partners across public, private and the third sector.

2.8 Unscheduled Care

The Scottish Ambulance Service has recognised for a number of years the shift in the clinical profile of our patients resulting in the majority of presentations to our A&E service having a degree of disease, and indeed social complexity previously unknown to us. Our response to this shift was described in our 2010-15 strategy 'Working Together for Better Patient Care' and continues in our current strategy 'Towards 2020 Taking Care to the Patient' but of equal importance is our support for the current government

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programme “6 Essential Actions for Unscheduled Care” and the partnership working opportunities this brings. In the context of 6 Essential Actions we will initiate or continue a number of developments with the key areas as follows:

Clinically focused & empowered management – During 2016/17 our operational and Ambulance Control Centre managers will build on the established networks through the Chief Operating Officers group working closely with hospital colleagues to ensure we collectively understand local system pressures with an aim to minimise bottlenecks and turnaround delays at the hospital front door and discharge issues at the back door. Scottish Ambulance Service and Health Board key contacts were confirmed or established in November 2015 with key focus on the principles detailed Good Practice Guidance – Compliance Checklist.

Hospital capacity & patient flow realignment – we will continue to work with ISD and NHS 24 colleagues to develop reliable data which describes the patient’s journey from community presentation to hospital. This work will not only inform the development of specialty pathways required within the hospital but will assist in identifying opportunities in partnership with Health and Social Care Partnerships for the development of safe community based care delivery as an alternative to A&E.

Patient rather than bed management – ongoing improvement work during 2016/17 in relation to our scheduled care service and Ambulance Control Centre triage processes will compliment the work to improve hospital discharge processes including the use of discharge lounges and provision of transport support for patients where that is clinically required.

Medical & surgical processes arranged to improve flow through the unscheduled care pathway – the Scottish Ambulance Service can offer the wider system a clear support role in the context of developing care plans for patients who present as an unscheduled care case and safely prioritising their need for medical and surgical services as planned presentations. During 2016/17 we will continue to build our clinical capability through our Specialist Paramedic role which offers an opportunity to support patients at home, in collaboration with partners, and plan their onward journey to hospital in a timeframe suitable to the patients need, and the system’s capacity, thereby reducing the risk of delays in the emergency department.

7 day services to reduce variation at weekends and during out of hours – during 2016/17 we will continue to build our clinical capability to offer patients local, community based outcomes in full collaboration with partners

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in health and social care. We will also engage this capability to support the capacity and resilience of partner services in similar ways to those developed in Forth Valley primary care and Hospital at Home in Lanarkshire. We will continue to improve our scheduled care service to ensure patients accessing seven day services but who clinically require transport are supported.

Ensuring patients are optimally cared for in their own homes – throughout this document we have described the development of a number of clinical initiatives aimed at improving our ability to offer the patient an outcome at home on in their community. During 2016/17 we will continue to develop, test and implement a range of improvement initiatives in conjunction with Health and Social Care Partnerships including:

- Improving our understanding of the patients need through triage processes which are more clinically focused within our Ambulance Control Centres
- Redesigning our training, education and career frameworks to maximise delivery of the future roles we require but to also ensure staff are sighted on development and career opportunities.
- Developing our local workforce plans to ensure new roles and skills which will support more patients to remain at home are introduced in a structured way which complements the Services overarching aims.
- Working with staff and their representatives to achieve the cultural shift required to move our current clinical model to one which enables staff to keep patients at home in a way they feel professionally safe and supported.

This will be underpinned by the pre-hospital emergency care group chaired by our Medical Director with representatives from all territorial boards.

2.9 Mental Health

The provision of safe effective care for patients who present to the Scottish Ambulance Service in mental health crisis is a key area for development with our partners. We will continue to work with Scottish Government sponsored strategic groups such as the Suicide Prevention Strategy Group to improve the service we provide to patients in serious crisis.

We are strongly represented at the Mental Health Scottish Patient Safety Programme with a particular emphasis on our work at transitions of care. This

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is of significant importance particularly to island boards and where prolonged transfers are required. We are specifically developing a new consent policy and new guidance documentation for staff working with patients affected by the consequences of severe injuries and wider mental health problems.

We will also continue to work with local community mental health services across both urban and rural Scotland to test the provision of services to patients with an acute exacerbation of their mental health condition which would benefit more from the input of community based mental healthcare professionals. To this end we are developing and testing approaches with colleagues in NHS Highland, NHS Greater Glasgow and Clyde and NHS Ayrshire and Arran to identify the most effective principles which will underpin safe, effective delivery of these services across Scotland.

We are seeking to develop robust links through our operating divisions with the Brief Intervention Programmes being established in territorial boards. We are committed to effective triage of all patients whether they be suffering from physical or psychological illness as part of our holistic programme to review all of our dispatch codes this work is being considered to ensure equity of service provision.

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Section 3: Our Corporate Priorities 2016/17

The tables below sets out the key workstreams and deliverables that will be taken forward in 2016/17 and the benefits these will deliver to patients, staff and partners. These priorities are in line with the Service’s strategy “Towards 2020: Taking Care to the Patient” and form the basis of the Service’s Corporate Plan for 2016/17. Measurement frameworks are being developed to support the delivery of these outcomes to ensure full benefits are realised.

Key Workstreams	What will be different?	Benefits	Outcomes
Clinical Services Transformation			
Clinical Decision Making	<ol style="list-style-type: none"> 1. Review DCR triage process 2. Development of clinical hub within Ambulance Control Centre 3. Piloted and evaluated enhanced clinical decision support tool for front line staff 4. Strengthened professional to professional decision-support through single points of access to care pathways with health and social care 5. Fully embedded Paediatric Early Warning System (PEWS) 6. Increased transfer of appropriate calls to NHS 24 7. Increased hear and treat⁵ for appropriate calls 	<ol style="list-style-type: none"> 1. Safest and most clinically appropriate responses for all users of SAS 2. Single coordinated clinical function to focus on high and low acuity patients 3. Improved, easily accessible decision-support for crews to facilitate safe and effective treatment for patients 4. More effective response to patient need – right response, right time. 5. 6 and 7. Efficient and effective use of SAS and partner resources 	<ol style="list-style-type: none"> 1. A revised performance framework based on clinical outcomes. 2. Patients will receive the response and clinical skills they require to meet their need 3. Staff evaluation of the clinical decision support tool 4. Utilisation of support line and continuous measure of patients referred to pathways based on their clinical need. 5. Early recognition and management of deteriorating children and young people. 6. Measure chief complaint and call volume transferred to NHS

⁵ Reference asterisk comments on page 30

Key Workstreams	What will be different?	Benefits	Outcomes
		appropriate to patient need	24 7. Patients contacting the SAS will be referred to an integrated care pathway or provided self care advice by Ambulance Control Centre Clinical Advisors.
Response	<ol style="list-style-type: none"> 1. Implemented specialist services desk in Ambulance Control Centre to centralise co-ordinations of specialist retrievals 2. Implement new Mass Casualties Guidance and Pre Hospital Medical Response to Major Incidents 3. Embed low acuity model across the Service following the successful pilots 4. Improved discharge planning and support patient flow with NHS Boards 5. Improved co-ordination of air and road retrieval services 	<ol style="list-style-type: none"> 1. Improved co-ordination of specialist response resources 2. Improved specialist response for acutely unwell patients 3. More effective and efficient use of SAS and other agency resources 4. More effective and efficient use of SAS and other agency resources 5. More effective use of specialist retrieval assets in support of patient outcomes. 	<ol style="list-style-type: none"> 1. Continuous evaluation of specialist services desk 2. Guidance issued and exercised with debrief and lessons learned to follow 3. Improved unscheduled care performance 4. Improved scheduled care performance 5. Improved ScotSTAR service delivery evidenced by, for example, improved mortality.
People and Partnership	<ol style="list-style-type: none"> 1. Prepared for the implementation of major trauma proposals in 2016: agreement of triage 	<ol style="list-style-type: none"> 1. Safer care by reducing variation across NHS 	<ol style="list-style-type: none"> 1. Increased survival rates for patients suffering from major

Key Workstreams	What will be different?	Benefits	Outcomes
	<ul style="list-style-type: none"> tool, by-pass protocols and tasking and co-ordination in Ambulance Control Centre 2. Developed and delivered services and pathways working with new Health and Social Care Partnerships, such as for frail and elderly patients 3. With communities, developed effective integrated response models, particularly supporting sustainable services in remote and rural communities 	<ul style="list-style-type: none"> Boards 2. Improved partnership working with other agencies and volunteers and greater integration across health and social care 3. Enhanced community resilience and engagement 	<ul style="list-style-type: none"> trauma 2. Increase in the number of patients following the correct pathway for their clinical need 3. Increase in the number of the CFR schemes and the number of volunteers
Clinical Practice	<ul style="list-style-type: none"> 1. Delivered year two of national Out of Hospital Cardiac Arrest strategy, extended 3RU response model, strengthened community resilience, increased access and mapping of public access defibrillators and co-responder model with SFRU 2. Improved national and local pathways for hyper-acute stroke 3. Ensure skills and roles are linked to workforce model 	<ul style="list-style-type: none"> 1. Increased survival rates for cardiac arrest 2. Increased survival rates stroke 3. Support and training for staff 	<ul style="list-style-type: none"> 1. Increase in Return of Spontaneous Circulation (ROSC) particularly for patients who suffer a ventricular fibrillation or ventricular tachycardia cardiac arrest 2. Early recognition of patients suffering hyper acute stroke 3. Increased number of advanced and specialist paramedics deployed appropriately
Developing our Future Workforce			
Education and Training	<ul style="list-style-type: none"> 1. Obtain HCPC re-approval for mode of delivery of paramedic training. 	<ul style="list-style-type: none"> 1. Assurance of quality of training; regulated and 	<ul style="list-style-type: none"> 1. Approval received by June 2016 2. Fewer technician and ACA

Key Workstreams	What will be different?	Benefits	Outcomes
	<ol style="list-style-type: none"> 2. Extend VQ training model for technicians and ACAs 3. Commence first intake of postgraduate programme for specialist and advanced paramedics 4. Restructure emergency driver training 	<ol style="list-style-type: none"> transferable qualifications to enable direct recruitment 2. Enhance recruitment by delivering training locally; increase capacity for centralised paramedic training 3. Enable paramedics to work to an evolving scope of practice creating capacity and capability to deliver enhanced care models and increase see and treat⁶ 4. Enhance clinical supervision for improving clinical practice through decision support 5. Improve efficiency of student flow to release capacity for clinical training 	<ol style="list-style-type: none"> vacancies; more paramedics able to be trained through Academy 3. In 2016/17, uptake of paramedics on Masters programme 4. Fewer delays in completing emergency driver training, faster completion of technician qualification, more paramedics trained
Workforce Planning	<ol style="list-style-type: none"> 1. From engagement work in 2015/16, role profiles and job descriptions will be updated and confirmed for all operational roles 2. A process for implementing and monitoring transitional planning will be embedded across all 5 operational divisions building on work to 	<ol style="list-style-type: none"> 1. Clarity of operational and clinical requirements for all roles 2. More responsive workforce planning, greater governance of workforce 	<ol style="list-style-type: none"> 1. Increased staff satisfaction as measured through iMatter; identification of specific local/regional roles for career progression 2. Fewer days lost to vacancies;

⁶ Reference asterisk comments on page 30

Key Workstreams	What will be different?	Benefits	Outcomes
	<p>identify workforce requirements in each year to 2020.</p> <p>3. Targeted recruitment and training for all roles required in 2020 will have commenced</p>	<p>requirements through improved management information; sustainability of recruitment and training models.</p> <p>3. Creating capacity and skill set to deliver enhanced care models</p>	<p>reduced overtime spend</p> <p>3. Increased capacity and capability within frontline roles; improved pass rates on training courses; fewer drop outs from training</p>
<p>Leadership & Enabling Culture</p>	<p>1. Continue delivery of agreed frontline management development modules in line with PDPs.</p> <p>2. Complete transition to 20% of frontline managers' time protected for management duties and clinical leadership</p> <p>3. Development plans in place for all other operational managers, fully utilising programmes available through NES and HIS.</p> <p>4. Strategy to develop Quality Improvement capability and capacity, with first cohorts of staff completing dedicated QI training</p> <p>5. Progressed implementation of talent management and succession planning across the Service</p>	<p>1. Enhanced management and leadership capacity; improved clinical supervision</p> <p>2. More visible leadership; staff will have greater access to frontline manager</p> <p>3. Career progression and development opportunities for staff;</p> <p>4. Greater capacity to implement and accelerate change</p> <p>5. Staff offered more targeted career development support and better informed workforce planning.</p>	<p>1. Evaluation of effectiveness of the DFLM programme in delivering enhanced management practice.</p> <p>2. Proportion of managers with 20% protected time for team leaders; increased staff satisfaction; fewer disciplinary procedures</p> <p>3. Improved completion rate of PDPs/e-KSF</p> <p>4. Staff completing QI development activity and change initiatives supporting progression to 2020 workforce profile</p> <p>5. Talent management and succession planning outputs built into workforce planning assumptions.</p>

Key Workstreams	What will be different?	Benefits	Outcomes
<p align="center">Develop Efficient and Effective Working Practices</p>	<ol style="list-style-type: none"> 1. Evaluate effectiveness of current operational model 2. Review existing recruitment and retention plans 3. Review the existing scheduled care service capacity matched against projected demand 	<ol style="list-style-type: none"> 1. Improve safety, effectiveness and quality of care by identifying areas for improvement towards 2020 2. Improve effectiveness of recruitment and reduce turnover of staff 3. Improve the efficiency of the service and align clearly to the patient and partner requirement 	<ol style="list-style-type: none"> 1. Improved operational performance; increased staff satisfaction 2. Reduction in overtime spend as a result of fewer days lost to unfulfilled vacancies 3. Improved resource utilisation and patient/partner satisfaction of service provision.
<p align="center">Staff Engagement</p>	<ol style="list-style-type: none"> 1. Progressed Everyone Matters action plan 2. Implemented iMatter staff engagement framework 3. Development of performance management with clearer links to development activity. 	<ol style="list-style-type: none"> 1. Increased staff engagement and satisfaction 2. A more engaged and motivated workforce 3. Proactive development of staff; Career progression and development opportunities for all staff 	<ol style="list-style-type: none"> 1. Staff engagement and satisfaction levels as measured by iMatter 2. iMatter implementation extended across the Service providing positive influence to more staff. 3. Annual review of succession plan outputs 4. 80% of staff will receive a personal development review (PDR); improved access to development for all staff.

Enabling Technology			
Ambulance Telehealth	<ol style="list-style-type: none"> 1. Delivery of new ambulance hardware 2. Delivery of a new electronic patient report form 3. Delivery of an internal Scottish Ambulance Service Directory of Services application (app) to run on the new hardware 4. Access to back office systems and approved websites from the vehicle 5. Delivery of multi-SIM mobile data access across Scotland. 	<ol style="list-style-type: none"> 1. and 5. Enhanced resilience across Scotland for accessing and transferring data and information 2. Improved recording and use of patient data and information 3. and 4. Improved decision support for crews; better outcomes for patients, access and referral to care pathways more appropriate to patient need 4. and 3. Clinically driven technology solution 	<ol style="list-style-type: none"> 1. 100% of new hardware installed in vehicles 2. Increased completion of ePR 3. and 4. Increased app and system utilisation rates 5. Improved Mobile data coverage
eHealth	<ol style="list-style-type: none"> 1. Delivery of an interface to facilitate the transfer of electronic patient information gathered by ambulance clinicians to appropriate healthcare professionals in other organisations. 2. Delivery of an interface to allow Ambulance Control Centre staff appropriate seamless access to the Emergency Care Summary (ECS) and Key Information Summary (KIS) information via the Command and Control System 3. Deliver a 2-way interface between the Service and Northern Ireland Ambulance Service to 	<ol style="list-style-type: none"> 1. Shared emergency information will improve the quality of patient care and enhance ambulance referral information for improved clinical decision-making 2. Improved patient care through effective information sharing between healthcare providers 3. Reduce the risk of delayed 	<ol style="list-style-type: none"> 1. Provide the capability to electronically pass patient information to 100% of territorial health boards in Scotland 2. Improve the efficiency and effectiveness in healthcare provision by providing clinicians with additional relevant information to enhance their decision making

	<p>electronically transfer incident details of calls received from the corresponding area</p> <p>4. Install dual mode tablets into a selection of scheduled care vehicles so that they can be used as an unscheduled care resource for low acuity incidents</p>	<p>response times due to a critical loss of ability to handle 999 calls effectively.</p> <p>4. The installation of dual mode tablets will allow the vehicle and crew to deal with low acuity unscheduled care patients where appropriate, thereby reducing demand on unscheduled care resources</p>	<p>3. Implement a solution that will enable the Service and Northern Ireland Ambulance Service to receive an overflow call from the other organisation, triage the call and electronically transfer the incident details into the dispatch queue of the 'home' service command and control system</p> <p>4. Implement a solution which will allow the use of scheduled care ambulances to carry out GP routine calls for patients that require hospital treatment not considered life-threatening or requiring an A&E ambulance</p>
Future Mobile Communications	<p>1. Future Mobile Communications Programme Manager identified and appointed</p> <p>2. Future Mobile Communications Programme - programme management arrangements reviewed and enhanced for programme delivery</p> <p>3. National (Scotland) Tri-Service and Government Strategic Assurance Group fully established</p> <p>4. National (Scotland) Tri-Service and Government Tactical Group fully established</p> <p>5. Maintain and enhance links with the UK Government Emergency Service Mobile</p>	<p>1. and 2. Reduced programme risk and increased delivery confidence</p> <p>3. and 4. and 5. Scottish Ambulance Service interests appropriately represented at Scottish and GB level</p> <p>3. and 4. and 5. Interoperability with other emergency services and external partners maintained</p>	<p>1. Appropriate programme governance arrangements in place</p> <p>2. Appropriate programme documentation set in place</p> <p>6. Appropriate programme communications and engagement plan in place</p>

	<p>Communications Programme</p> <p>6. Review and enhance stakeholder engagement and communications</p>	<p>6. Increased staff awareness of Future Mobile Communications Programme</p>	
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Section 4: Key Performance Measures

As the Service introduces its new more clinically focused response model, its performance framework will be developed to track progress. It is expected that there will be greater focus on clinical outcomes and patient and staff experience. The draft set of metrics below are intended to promote further improvement in line with our strategic aims:

Performance Indicator	2016/17 Full Year Targets
SAS H1 Save More Lives ROSC Return of Spontaneous Circulation for VF/VT patients	>35%
SAS H2 Cat A Cardiac Arrest Patients % of cardiac arrest patients responded to within 8 minutes	80%*
SAS H3 Response to Cat A Incidents % of Cat A incidents responded to within 8 minutes	75%*
SAS H4 Response to Cat B Incidents % of Cat B incidents responded to within 19 minutes	95%**
NHSS E1 Meet Financial Targets Operate within revenue and capital limits; meet the cash requirements	Meet target
SAS T1 Reduce Hospital Attendances % of unscheduled cases managed by telephone or face-to-face assessment	28%***
SAS T2 Hyper Acute Stroke % of hyper acute stroke patients who receive the pre hospital care bundle.	90%
SAS T3 Infection Control % of recorded use of PVC insertion care bundle	78%
SAS Staff Experience % Employee Engagement Score	60%****
SAS Patient Experience Gather baseline data to enhance our use of Patient Opinion	Determine Baseline

* These response related targets currently reflect historical aims which are challenging to achieve within our existing resourcing and response models. Consequently, discussions are underway regarding the development of a response model in line with our strategy Towards 2020 – Taking care to the Patient. As part of our strategic development we are investing in additional skilled staff and new clinical triage arrangements. Our assumption is that these will be implemented by Quarter 3 of 2016/17 and significant improvements will be recorded thereafter.

** The relevance of the Cat B target will be significantly influenced by the emerging clinical response model set out in our strategy. This new model will be supported by an appropriate performance framework that reflects improved clinical outcomes for patients in line with the national clinical Strategy and the SG 2020 Vision. Consequently we will continue to work with the Scottish Government to review the reporting requirement for Cat B as we develop the model and performance framework over the coming year.

*** Assuming development of alternative service provision & associated care pathways with Health and Social Care Partnerships

**** iMatter in process of being rolled out and indicator will be adjusted when overall score for organisation is established at end of roll out.

These measures reflect the overall aims of our 2020 strategy and our increasing focus on clinical effectiveness and patient outcomes. It should be noted however that the achievement of our SAS T1 aim will be dependent on the clinical development of our workforce and the emergence of alternative community services and associated care pathways. Consequently we envisage this target to be reached through an incremental trajectory across 2016/17 rather than a single step achievement. We are working to develop shared data sets, through the unscheduled care datamart and Public Health Intelligence. This will allow us to better understand and evaluate our clinical effectiveness, such as longer term survival for out of hospital cardiac arrest or trauma patients, but also to effectively evaluate our own decision-making, for instance in respect of re-presentation by patients following hear and treat or treatment at home. This will be reported on throughout the year as these data links develop.

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Section 5: Financial Plans

Although 2016/17 will be a challenging year for the Service Scottish Government investment in the services' strategy instils a level of confidence that will support the delivery of financial targets.

Our opening base line has now been confirmed at £223.541m as follows:

SCOTTISH GOVERNMENT
HEALTH AND SOCIAL CARE DIRECTORATES
Territorial Boards and Special Health Boards Funding Uplifts 2016-17

Board	2015/16 Baseline £000	Recurring Allocations (1.0% Uplift) £000	Adjusted Baseline £000	2015/16 Baseline (1.7% Uplift) £000	Strategy £000	Total 2016/17 Budget £000
Scottish Ambulance Service	212,066	2,822	214,888	3,653	5,000	223,541

In addition to the usual pay and inflation pressures the Service faces a significant financial pressure arising from revised employer contributions to the national insurance contributions scheme of £3.36m and the continued commitment to paying the Scottish Living Wage and Guaranteeing a minimum increase of £400 for staff earning less than £22,000.

There are also a number of operational pressures identified during 2015/16 that will continue into financial year 2016/17. There is a great deal of similarity across divisions, with all reporting the main pressure being excess costs arising from the utilisation of overtime to provide relief cover, primarily in unscheduled care but there are also instances in scheduled care. These pressures will need to be addressed in order to maintain our current delivery model.

The additional investment in staffing will help address the pressure of excess costs arising from the utilisation of overtime to provide relief cover. However, any benefit will not be fully realised until the training programme is completed beyond 2016/17. Detailed implementation plans are being compiled to ensure the Service fully understands and addresses the current pressures within the Unscheduled Care Service.

The Service has received an additional recurring allocation of £5 million for 2016/17 to facilitate the implementation of our 'Towards 2020: Taking Care to the Patient Strategy'.

As we complete our workforce modelling in 2015/16, we will finalise the level of support required to transition our current and future workforce and embed

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our clinical model and we recognise that this will require new ways of working in partnership.

This investment will be utilised to continue the investments awarded in 2015/16 to support development of our Ambulance Control Centre, divisional low acuity support models and continued focus to develop our front line leaders and managers which will be vital in delivering integration and shifting the balance of care.

The investment will also be utilised to support the implementation of our strategy, to provide additional accident and emergency support in the North of the country, to support further development of our Ambulance Control Centre, to commence the training of Specialist paramedics, to commence Telehealth Phase II and continue to support Out of Hospital Cardiac Arrest.

The forthcoming five years will be challenging from a financial perspective. However, we have in place sound systems of governance. These provide a platform to enable the Service's strategy to be progressed in the knowledge that redesign will produce efficiencies that can be reinvested in shaping a modern ambulance service.

A detailed financial plan and trajectories against NHS HEAT targets to deliver within budget and identify cash releasing efficiency savings are submitted as an appendix to the LDP. Break even position is dependent upon cash releasing efficiency of £9.897m representing 4.53% of our core revenue position. Plans have been identified if subsequently delivered upon will achieve the full savings target of £9.897m. Of this target 41% is already banked. The remaining balance is currently categorised as medium risk but a significant dependency on reduced overtime still exists.

Section 6: Workforce

Throughout 2015/16 we have undertaken significant workforce planning as we begin to transition to our future workforce, which will be the key enabler in the delivery of our 2020 strategy. In addition to modelling the workforce required to meet the increasingly complex demand we respond to and support our strategic aims to treat more patients safely and effectively at home, we have reviewed the scope of practice of new and existing roles and reviewed the model of education and on-going development for staff to deliver against this requirement.

In comparing the baseline position for our current workforce and our proposed workforce numbers to deliver our 2020 strategy, we have identified the need

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for a significant increase in recruitment activity for our frontline staff groups. As we plan the delivery of our recruitment targets, we will need to accommodate and sustain much higher volume recruitment over the period of the strategy implementation. Our recruitment strategy has been reviewed and a range of actions are being progressed to expand our capacity and develop a sustainable resourcing model. Our 2016/17 plan will inform the basis of additional changes to ensure we can meet ongoing organisational needs.

The workforce planning phase has been used to inform the development of our Training & Education delivery model. Following a successful pilot in 2015/16, we will adopt a VQ delivery model nationally in 2016/17 to increase capacity for Technician training. This will also allow us to increase our capacity for Paramedic training through our Academy at Glasgow Caledonian University, and to accommodate further training of Specialist and Advanced Paramedics.

The resourcing and training changes which we have undertaken will allow us to provide staff with clear pathways for career enhancement. Our workforce plans will inform our local recruitment and training delivery plans to better match our employee resourcing efforts with the evolution of our service delivery model.

This work will be coupled with our review and revision of working practices to ensure our staff are able to contribute most effectively to the needs of the service. Through this work we intend to better harness the potential of individual staff members and provide ongoing opportunity to the benefit of staff retention levels.

Workforce requirements arising from our 2020 strategy have been directed by the Developing our Future Workforce workstream. As part of our governance around delivery of the programme, a full risk assessment has been conducted and informed the development of the programme risk register.

Workforce planning risks have been mitigated by initial modelling work which has been conducted using our Optima planning tool. From this we have built a range of underpinning workforce assumptions into our workforce projections which include staff turnover and internal progression.

Our workforce demographic profile informs our forecasting assumptions, to ensure that we anticipate the impact on workforce targets and adjust accordingly. With present recruitment changes and retirement patterns, we anticipate a reducing average age and shift of our workforce profile to lower age ranges. We will monitor the actual position as part of our ongoing review,

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and consider local variations and potential impact. Our baseline workforce demographics are contained within the Equality Monitoring Report 2014-15.

Forecasts will continue to be reviewed to ensure that our assumptions relating to workforce changes are accurate, and in-year adjustments will feed in to our year on year recruitment and training targets. This will allow us to prioritise areas of higher staffing requirements to minimise the risk of any service gaps

In 2016/17 we will progress a number of key elements of that transition plan, specifically:

- We will further increase the number of specialist paramedics across the Service to support integrated working with primary and unscheduled care, provide enhanced decision support and increase the level of safe and effective treatment of patients at home. We will test and evaluate the rotation of these specialists through our Ambulance Control Centre to provide additional clinical advice for patients and crews and to more effectively target the skills of these specialists to patient need;
- We will increase the number of clinical advisors working in our Ambulance Control Centres by up to 40 to develop our Clinical hub model and support increased levels of hear and treat and onward referral for patients;
- We will embed a VQ level 3 and level 4 qualification for technicians and ACAs, following the successful pilot in the North of Scotland, expanding access to the Scottish Ambulance Service as an employer and ensuring we are able to invest in a growing number of frontline staff over the next year;
- We will progress implementation of divisional transitional workforce plans towards 2020 ensuring the right mix of skills and roles are in place to deliver our new clinical model ensuring alignment with our clinical services transformation programme. A key component in support of this will be delivery of our 2016/17 training plan which will include the training of 233 Ambulance Technicians and 187 Paramedics. Our workforce planning process will be embedded within Divisions to allow ongoing monitoring of workforce targets. This will allow tracking against new strategy role target numbers and staff establishment vacancy rate measures.

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- We will continue to develop our low acuity model for urgent and routine work with dedicated ACA staff delivering this with additional training; continuing to shift towards a 'one ambulance' workforce model.
- We will support the development of a major trauma network for Scotland ensuring our staff are fully trained and supported to effectively triage trauma patients to the right hospital, co-ordinate and manage flows through a 24/7 trauma desk operating as part of the specialist services desk within Ambulance Control Centre, and developing a cohort of critical care paramedics to support effective primary and secondary retrieval;
- We will finalise our educational model to deliver a significantly increased workforce in 2016/17, including use of the SVQ model for technician and ACA training and access to graduate paramedic programmes going forward;
- We will begin delivery of a Masters programme for advanced paramedics able to provide clinical leadership for our specialist paramedic staff;
- We will continue to implement our Developing Future Leaders and Managers programme as a key enabler in developing leadership capacity across the organisation which will be critical in embedding our new clinical model, transitioning our workforce and engaging effectively at a local level in the integration agenda. Throughout 2016/17, we aim to increase capacity for leadership and management within this role by protecting 20% of team leader time for leadership activities;
- We will continue to develop our capacity for management of major incidents and lead the national work on pre-hospital major incident management in partnership with NHS Boards and Scottish Government;
- We will continue to roll out iMatter across the Service in 2016/17, establish a measure of staff engagement and develop plans in response to improve this as an ongoing measure of organisational effectiveness.
- We will progress the Scottish Ambulance Service implementation plan for Everyone Matters (2020 Workforce Vision) in line with the five strategic priorities outlined in CEL 20 (2014);

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- Healthy Organisational Culture
 - Sustainable Workforce
 - Capable Workforce
 - Integrated workforce
 - Effective leadership and Management
-
- Core to developing our Organisational Culture will be understanding the key messages from iMatter and staff survey outputs to direct our efforts on improving overall staff experience. Work on our Wellbeing Strategy, Communications & Engagement Plan and Just Culture initiatives will all combine to support progression of our Healthy Organisational Culture.

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