



**Scottish
Ambulance
Service**
Taking Care to the Patient



Strategic Workforce Plan SCOTTISH AMBULANCE SERVICE 2015 – 2020

Introduction

This Strategic Workforce Plan covers the period from 2015-2020. It is expected to deliver a significant shift in the service workforce model based on the Scottish Ambulance Service Strategy Towards 2020: Taking Care to the Patient.

The landscape in which the Scottish Ambulance Service operates is changing and the need for the Scottish Ambulance Service to become a modern, flexible and responsive organisation has never been more acute. The Service must be able to support the wider integration of health and social care and the delivery of the Scottish Government's 2020 Vision where care is increasingly delivered locally, often at home, with pathways for patients being person-centred and appropriate.

Our current workforce will be the basis of our future workforce. Our future workforce will have to be affordable, available and, above all, adaptable. Our aim is to develop the right clinical skills and roles to enhance the treatment we offer and make better decisions for patients every day.

An annual Action Plan is developed, which sets out what we need to do to bring about the future workforce which we require to develop an efficient, high quality service.

This workforce plan is supported by refreshed education, training and organisational development plans which aim to support staff in delivering current high standards of care and move to a future where all decisions are more clearly designed around the needs of the patient and staff feel well supported in making these decisions.

The Service is fully involved in the development of technological advances which will support staff in their decision making, offer better professional support, and enable different treatment options for patients. All of this will be underpinned by robust clinical support and supervision as part of the clinical governance structure.

Pauline Howie
Chief Executive
Date 25 June 2015

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1 Strategic Workforce Plan

1.1 Introduction

This strategic workforce plan describes the framework for the Scottish Ambulance Service in delivering a modernised, flexible, skilled workforce which is capable of supporting the Service's strategic aims and the Scottish Government's 2020 Vision for the NHS in Scotland.

As we move towards 2020, the NHS faces a number of challenges which influence the future workforce required to deliver the 2020 Vision in an integrated health and social care environment. The challenges of providing sustainable services will only be met through increased integration and effective partnership working. As a national service operating 24/7, the Scottish Ambulance Service is ideally positioned to support the necessary change to deliver frontline emergency, unscheduled and scheduled care in an increasingly responsive, person-centred and efficient manner which will assist the wider health and social care system to adapt its current models of service delivery.

In developing this strategic workforce plan, we have sought to align our commitments with those set out in the 2020 Workforce Vision below, and to ensure we develop a workforce capable of delivering the highest levels of quality service and clinical care, in line with the NHS Quality Strategy.

Everyone Matters: 2020 Workforce Vision

“We will respond to the needs of the people we care for, adapt to new, improved ways of working, and work seamlessly with colleagues and partner organisations. We will continue to modernise the way we work and embrace technology. We will do this in a way that lives up to our core values. Together we will create a great place to work and deliver a high quality healthcare service which is among the best in the world.”

Source: Everyone Matters: 2020 Workforce Vision

In taking forward the aims outlined above we are committed to embedding the values of the NHS in Scotland in everything that we do to ensure our service is designed to deliver: care and compassion; dignity, equality and respect; openness, honesty and responsibility, quality and teamwork. To do this we must ensure that our workforce, both current and future, embrace these values from recruitment throughout their careers within the Scottish Ambulance Service. In return the Service needs to demonstrate these values by providing a “just culture” where learning is supported, professionalism is valued and staff are encouraged to be the best they can be.

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Challenges and Opportunities

Scotland faces a demographic challenge in future years with a projected increase in the overall population, which will be significantly higher in those people aged over 60, and virtually double in the over 75 age group. Moreover, by 2035, it is estimated that 24% of the population will be aged over 65.

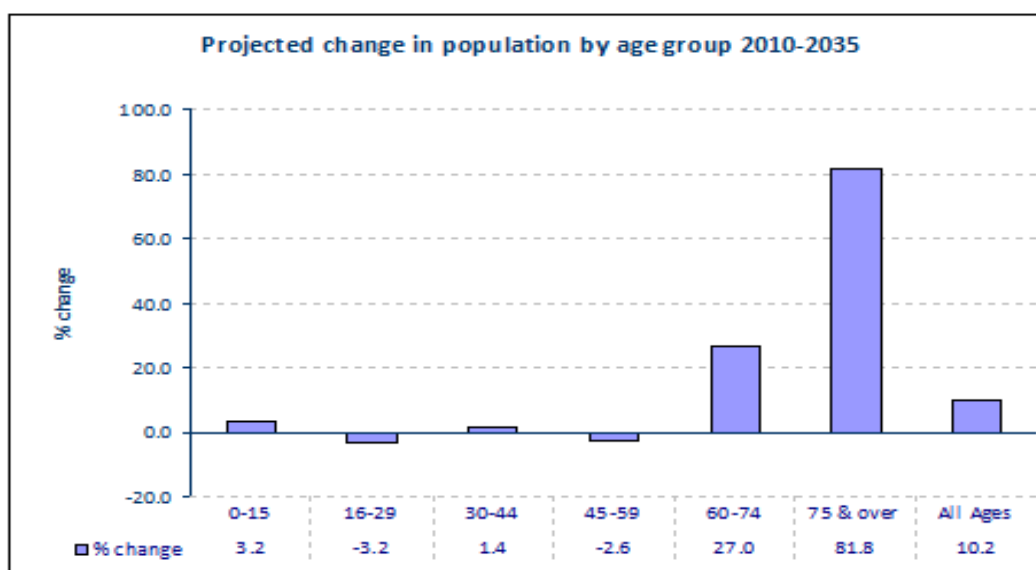
Changing Population

Table 1: Projected changes in population 2010 - 2035

Age Group	Base Year 2010	2015		2020		2035	
	population	population	% change	population	% change	population	% change
0-15	912,000	922,000	1.1	959,000	5.2	941,000	3.2
16-29	975,000	979,000	0.4	920,000	-5.6	944,000	-3.2
30-44	1,036,000	1,017,000	-1.8	1,067,000	3.0	1,051,000	1.4
45-59	1,092,000	1,149,000	5.2	1,117,000	2.3	1,064,000	-2.6
60-74	801,000	851,000	6.2	925,000	15.5	1,017,000	27.0
75 & over	406,000	447,000	10.1	499,000	22.9	738,000	81.8
All Ages	5,222,000	5,365,000	2.7	5,487,000	5.1	5,755,000	10.2

Source: General Registrar for Scotland

Figure 1: Projected changes in population 2010 - 2035



This increase in the elderly population results in increasingly complex presentations for our staff; 65% of the current over 65s registered with a GP have one long-term condition, and 35% have multiple chronic and long-term conditions. Many of these conditions, such as COPD and diabetes, can be, and are being treated effectively at home where the Scottish Ambulance Service has a key role to play in supporting the delivery of effective care within the community.

As a national service, the Scottish Ambulance Service faces the additional challenge of addressing population and demographic changes across all of Scotland, influenced by a range of factors. Whilst the overall trend in our ageing population is clear, this will have varying degrees of impact in different areas of Scotland. Our commitment to delivering an equitable service presents challenges in ensuring an effective response regardless of geography and, in terms of our workforce, ensuring we maintain and develop the skills of staff in areas of low demand.

Equally, our ability to access care pathways and services to enable patients to access more appropriate care is influenced by the availability and sustainability of these services, especially in remote and rural areas. In population terms, Scotland is not a large country, so the increasing provision of specialist services in tertiary centres, such as trauma and optimal reperfusion, is logical. However, this is changing the traditional flow of patients within territorial Health Board boundaries presenting the Scottish Ambulance Service with an additional geographical challenge, and we must ensure we use our resources efficiently to address this requirement

Financial Environment

As with all public services, Scottish Ambulance Service faces significant economic challenges with funding levels unlikely to return to 2009/10 levels before 2025, which is beyond the transition period set out in this workforce plan.

This requires the Scottish Ambulance Service to develop innovative solutions to sustain and improve service delivery and to develop different models of working in partnership across Health, Social and Voluntary Sectors. Our strategy, “Working Together for Better Patient Care” articulates how we have sought to develop that approach and our strategy “Towards 2020: Taking Care to the Patient” builds on this to 2020.

2 Service Change

2.1 Drivers for Change

The Scottish Ambulance Service’s strategy “Towards 2020: Taking care to the Patient” is our response to The Scottish Government’s Route Map to the 2020 Vision for Health and Social Care and provides the framework for this strategic workforce plan.

The operational environment for the Scottish Ambulance Service is changing in response to the wider strategic context in which the Service exists and there are a number of key drivers for change that are determining the shape of the Service in the future, including;

- Demographic challenges of an increasingly elderly and diverse population living at home with multiple chronic conditions;

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- The clearly stated aims of the '2020 Vision' to redesign emergency, unscheduled and scheduled care services across the NHS to shift the balance of care away from traditional acute hospital environment to community based, day case and increasingly planned and anticipatory care;
- The national clinical strategy
- Greater health and social care integration in designing and delivering services that are sustainable and demonstrably person-centred;
- Sustainability of traditional services and operational models, not least GP out of hours, across the NHS, most acutely in rural Health Board areas;
- Development of specialist centres of care for specific clinical conditions, such as stroke, Primary Percutaneous Coronary Intervention (pPCI), and trauma, which affect traditional boundaries and patient flows;
- Public sector reform and the drive for efficient and effective use of NHS resources and sharing services across the public sector;
- The need for a flexible and responsive workforce working across an integrated health and social care environment;
- Developments in technology which facilitate remote diagnostics and enhanced decision support and information-sharing to improve patient care.

2.2

Workforce Implications

Although in recent years the Scottish Ambulance Service has looked to develop new roles and models of working, these have been small-scale and predominantly focussed around local initiatives. To that end, the Scottish Ambulance Service still operates a traditional ambulance service model that favours conveyance to hospital and delivery of response time targets. This existing model does not fully support the Service's strategic vision and emerging clinical and operational models including;

- An aim to increase the level of 'hear and treat' through improved telephone triage, clinical intervention and referral to alternative pathways at the point of the initial telephone call;
- An aim to increase the level of 'see and treat' following face to face assessment by an appropriately skilled paramedic or other healthcare professional with access to enhanced decision support and alternative referral pathways;
- An aim to reduce the level of conveyance to hospital as a consequence of the above and through greater integration of services and access to more appropriate care pathways;
- A commitment to the concept of 'one ambulance service', where our response in terms of skills and resource is appropriate to the clinical needs of the patient. This will ultimately mean that the skill levels of all of our staff will be more appropriately targeted according to the patient, whether this is for unscheduled or scheduled care.

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Model	Current	Future
Hear & Treat	3%	20-30%
See & Treat	17%	35-40%
Conveyance	80%	35-40%

There are a number of projects in train across the Scottish Ambulance Service which are supporting the transition to this new model of working, including;

- The development of enhanced clinical triage, which will improve the assessment of need for patients, facilitate increased hear and treat opportunities, and offer the Scottish Ambulance Service greater access to alternative pathways;
- Following review by a Scottish Ambulance Service-led national task and finish group of professional to professional (P2P) decision support, work is ongoing with NHS Boards to develop an effective infrastructure for P2P across Scotland;
- The development of care pathways, particularly for frail and elderly patients who frequently fall, and suffer from dementia. Developing care pathways for patients with mental health conditions is also a key priority.
- Work to reduce avoidable attendances at Accident and Emergency, admissions to hospital and increase referral to more appropriate alternative services, notably supported by greater integration of health and social care;
- Various local initiatives with NHS Boards to develop different, integrated models, such as the Emergency Responder Model;
- Expansion of clinical adviser capacity in the Ambulance Control Centres both at the point of call handling and dispatch, offering further opportunities to influence assessment of clinical need and appropriateness of response;
- Redesign of scheduled care services to offer greater flexibility and responsiveness to better meet patient requirements;
- Investment in technology, access to telemedicine and telehealth in the Ambulance Control Centres and within ambulances to support better decision making.

It is clear however, that these developments will have limited impact and benefit if the workforce model is not effectively aligned to the service model.

The emerging model described above clearly requires changes in our current workforce. It is also clear that the challenges faced in some areas of Scotland may require the Scottish Ambulance Service to develop a flexible workforce model that reflects those specific needs, for example, different urban and rural services, and that one size may not fit all.

In terms aligning the workforce model to the clinical strategy, the following transitions will be required;

- Skills sets must be driven by patient need, with a focus on a balance between specialist and generic clinical skills
- All staff, both clinical and non-clinical will work to their full scope of practice, skills, knowledge and experience, supported by Personal Development Plans and enhanced learning opportunities;
- Access to appropriate equipment and medications which allow staff to operate as described above, will need to be improved.
- Delivery of increased levels of specialist paramedics, many of whom will operate as part of an integrated health and social care team, managing patients, primarily with long-term conditions in the community, able to provide treatment at home with direct access to alternative pathways if required. These staff will be able to provide additional face to face assessment for those patients without an immediately life-threatening condition who do not require to go to hospital;
- The development of appropriate numbers of specialist critical care paramedics able to respond to critically ill or injured patients, who can provide support to specialist retrieval teams and seriously unwell patients with a life-threatening condition;
- The development of appropriate numbers of specialist paramedics and support staff able to respond to patients requiring clinical care in hazardous or difficult access environments, including confined spaces, collapsed structures, entrapment; including at height, inland water operations and similar to provide decision making, advice and direct clinical care.
- The development of an appropriate level of conveying resources for emergency and unscheduled care, ensuring the Scottish Ambulance Service is able to convey to hospital when required, meet expectations for planned scheduled work, and manage the increasing demand for transfers and discharge;
- The development of enhanced clinical decision support in the Ambulance Control Centres through increased impact of clinical advisers; for example, rotating specialist paramedic staff through this role; providing access to more senior clinical decision support from medical staff through a professional to professional support network; and through development of the Service's call handlers and dispatchers to make most effective use of triage tools and referral pathways;
- The development of more tailored models, specific to the needs of local communities, such as the Retained and Emergency Responder models, involving the Service, NHS Boards and the voluntary sector supported by appropriate telehealth facilities and decision-support;
- Further skills development of scheduled care staff, within control centres and those delivering care on the frontline;
- The development of corporate and support staff to enable clinical staff to deliver the enhanced clinical model;
- Significant development of leadership and management capability, across all staff groups in the organisation

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- Building on the fostering of a “just culture” where staff feel supported to learn and improve without fear of blame.
- The creation of development opportunities for all staff in line with the career framework, and providing opportunities for development outwith traditional role boundaries, with a view to developing talent and planning succession

The Scottish Ambulance Service’s workforce of the future will be more highly skilled, operating across primary, community and secondary care, accessing improved decision-support, more clinically focussed, but with sufficient capacity to manage the movement and flow of patients through the wider system effectively.

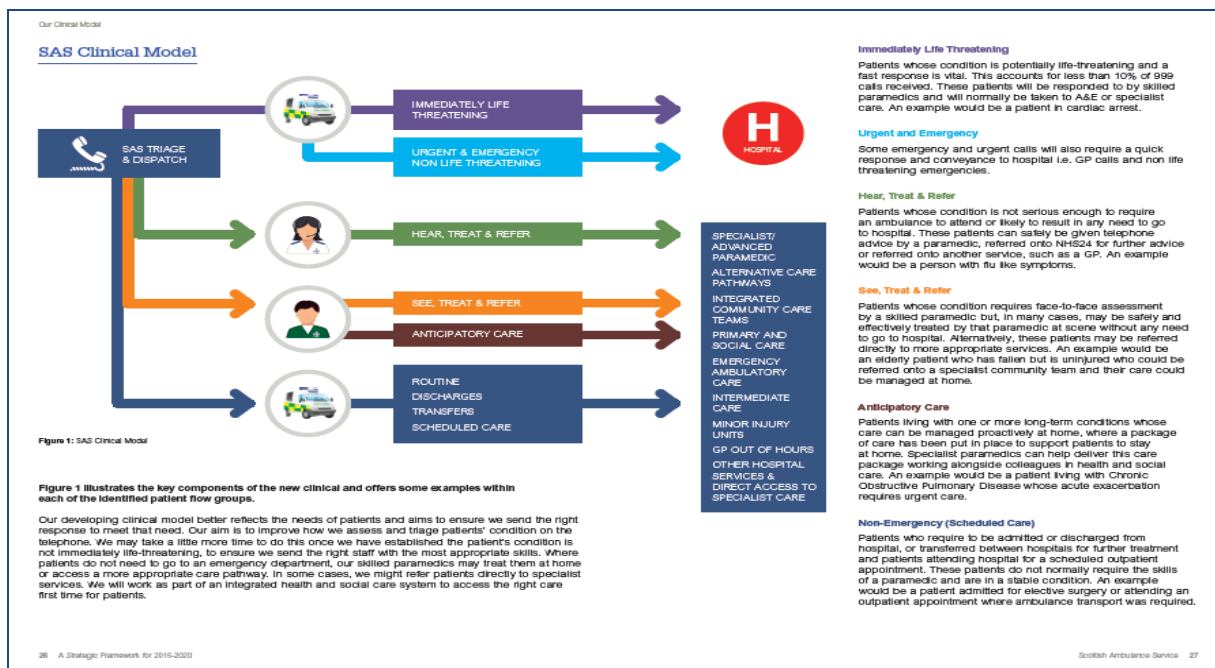
Traditional working practices will need to be reviewed in partnership, to ensure that the most efficient use is made of our people, whilst treating them fairly and consistently in accordance with the NHS Scotland Staff Governance Standards. The scale of change required is significant, affects all staff, and will require effective communication, engagement and partnership working to ensure successful implementation of the strategic objectives.

3 Defining the Required Workforce

3.1 Service & Role Redesign

Revised Service Model

To support the delivery of the 2020 vision, the Service recognises the need to significantly transform its workforce. To deliver our 2020 vision, the Service has developed its clinical service model as shown below:



This model sets out in more detail the core principles described in section 2.2, and aims to deliver;

- Improved and increased clinical triage and clinical decision support within Ambulance Control Centres intended to increase the levels of ‘hear and treat’, This means that where appropriate and safe to do so, instead of sending an ambulance, clinical advice will be offered, patients will be transferred to NHS 24 for further advice, or referred to a more appropriate response, such as a pharmacist or community based team. This will result in fewer ambulances being dispatched for some low acuity calls and more appropriate referral of patients. Critical to the success of ‘hear and treat’ is effective clinical triage and supervision and this will require a higher ratio of clinical staff in the Ambulance Control Centres. Hear and Treat will mean that for those calls that are *not* immediately life threatening calls (ILT), such as a cardiac arrest or a patient stabbed in the torso, an ambulance may not be immediately dispatched, but the caller will be taken through a more detailed telephone assessment by a specialised clinician. Those calls that are deemed as ILT will still require an immediate response by the nearest and most appropriate resource.
- Rapid identification of and response to immediately life-threatening emergencies, increased levels of assess, treat and refer by paramedics on scene where clinically appropriate and safe, reducing avoidable attendances at hospital, and referral to more appropriate pathways where applicable;
- More effective triage of urgent and non-emergency calls, including those for scheduled appointments, building on the concept of ‘one ambulance service’ where the right response based on clinical need is dispatched.
- Development of enhanced skilled Specialist Paramedic and Advanced Paramedic roles supporting greater integration of health and social care, managing patient care at home, supporting anticipatory care planning for patients with long-term conditions and able to prescribe and refer directly to clinical services.

The flow model describes the breakdown of emergency, unscheduled and scheduled care calls received by the Scottish Ambulance Service and the anticipated response ensuring the most appropriate clinical skills to meet the acuity of the call. For each category of call, the roles and skills required to respond to that call have been identified. This may not always be a traditional ambulance for example, where clinically appropriate, the Service may respond with a specialist paramedic who will only request an ambulance to take the patient to hospital if that is required. The percentages against each response type illustrate the proportion of time we will dispatch that response type to that call category. For example, where we have determined the patient’s condition to be immediately life-threatening evidence shows that having three people on scene has a significant impact on patient outcomes so we will endeavour to dispatch an ambulance with a paramedic and paramedic support on board and a specialist paramedic in addition.

The type of response we dispatch would be first and foremost determined by the patient’s condition, but also reflect the likelihood of a patient requiring to be taken to

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hospital. So, for example, where we feel the patient's condition may safely be treated at home we may dispatch a single specialist paramedic to respond. We would also factor in geography to that response decision ensuring where patients do need to be taken to hospital we may dispatch specialist paramedics in an ambulance rather than a car. This assessment is based on clinical triage and we will continue to evaluate the model as we gather evidence through robust clinical governance and audit; at this stage, estimates as to the likelihood of transfer to hospital are conservative as we work with our partners to embed and access alternative care pathways.

Patient Flows	Acuity	Response/skills
<p>Immediately Life Threatening</p> <p>These patients need a rapid paramedic response. We will dispatch an additional paramedic responder and an ambulance to these patients as evidence shows additional support saves lives as does getting to hospital as quickly as possible. An example would be a patient in cardiac arrest. We may also deploy specialist teams to retrieve some patients or deal with major or hazardous incidents.</p>	<p>Immediately life threatening</p> <p>8 minute response</p>	<p>Paramedic/Specialist paramedic</p> <p>Conveying resource</p>
<p>Serious but not Immediately Life-Threatening</p> <p>These patients require a paramedic response and will generally need to go to hospital. We will dispatch an ambulance with a paramedic on board. Whilst their condition is not immediately life-threatening, time can still be important and make a difference to the outcome. An example would be a patient having a hyper-acute stroke who needs to be at a hospital with a CT scanner within an hour.</p>	<p>Time-critical</p> <p>Urgent GP admissions and hospital transfers</p>	<p>Conveying resource</p> <p>Paramedic plus support</p>
<p>See, Treat & Refer</p> <p>These patients require a paramedic response but our aim would be to treat as many of them safely at home as possible. We will dispatch a paramedic, with advanced assessment skills and in some cases a specialist paramedic, able to treat minor injuries and minor illness and if necessary access appropriate care pathways as an alternative to hospital. An example would be a diabetic patient or a patient with an exacerbation of an existing long term condition.</p>	<p>Non time-critical</p> <p>Face-to-face assessment</p>	<p>Specialist paramedic/Paramedic</p> <p>Enhanced minor injury/illness</p>
<p>Hear, Treat & Refer</p> <p>These patients do not require an ambulance to attend and are unlikely to need to go to hospital. We may transfer some patients to NHS24 or to our paramedic clinical advisors who will offer advice, telephone assessment and directly refer patients to a more appropriate service. An example would be a patient with a minor ankle injury which could be seen by their GP. On some occasions, where circumstances or patient vulnerability require it, we may still dispatch an ambulance with a paramedic on board.</p>	<p>Low acuity 999 calls</p> <p>Calls passed to NHS24</p>	<p>Clinical advisor in Ambulance Control Centres</p> <p>Paramedic level</p>
<p>Non-Emergency</p> <p>These patients need to be admitted to, discharged from, or transferred between hospitals. This will also include some scheduled care outpatient and day care activity. These patients do not require a paramedic and will generally be responded to by a scheduled care ambulance.</p>	<p>Scheduled care</p> <p>Low acuity urgent-discharge/transfers</p>	<p>Conveying resource</p> <p>Enhanced Ambulance Care Assistant, Basic Life Support, oxygen, Automated External Defibrillator.</p>

Critical to the effective delivery of this model will be the triage process in Ambulance Control Centres and the need to triage every call. Currently almost 50% of calls to Scottish Ambulance Service are referred by another health care professional or agency and our intention is to increase the level of clinical staff, decision support and supervision within our Ambulance Control Centres. It will be essential to increase the triage of all non ILT calls to fully understand the acuity of the patient's condition and ensure we send the most appropriately skilled response. This will not only support effective treatment for patients but ensure we are better placed to access any supporting information for that patient and any pathways more effectively. It will also

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reduce risk to ambulance staff and other road users by the unnecessary use of blue lights and sirens to attend calls that after triage are not deemed as emergencies.

3.2 Future Workforce

The work being undertaken with operational and staff side colleagues to clarify the future workforce model is based on a number of assumptions;

- that the operational staffing model will be led by patient needs.
- that the first intake of undergraduates for the degree programme for paramedics will start in September 2016, graduating in 2019.
- that the current Diploma in Higher Education for paramedics will continue, transitioning to the undergraduate programme after 2019 for all students.
- the above two assumptions are dependent on the Health Care Professions Council (HCPC) approving both programmes for delivery from 2016.
- that conversion arrangements will be made available for all paramedics and technicians trained in the Certificate, Diploma or IHCD standards over the lifetime of this plan and beyond which appropriately recognise prior learning and experience
- that Vocational Qualifications in 2015 for non-registered ambulance staff will commence, beginning with a pilot project in the North Division.
- that non-clinical staff will be developed, valued and retained alongside the clinical staff cohort, and that this will be critical to the successful implementation of the model.
- that specialist paramedics will rotate into Ambulance Control Centres, Minor Injuries, GP Out of Hours Services, etc.
- that training of Specialist Paramedics will increase significantly from 2015 onwards.
- that advanced Paramedics will clinically supervise/support Specialist Paramedics,
- that Specialist Paramedics will provide supervision and professional advice to paramedics, and paramedics will supervise technicians.
- that the clinical governance of the workforce will be assured via clinical supervision, appraisal and ultimately, revalidation processes which will be developed in line with other professions.
- that the Masters programmes for Advanced Paramedics will commence in the summer of 2015.
- that there will be increased opportunities for protected learning time for all staff to undertake statutory and mandatory training
- that there will be appropriate resourcing and skilling of new roles to implement the clinical model
- that the future workforce model will be funded fully by Scottish Government

Workforce Model

Work is underway within the Service to define the roles required to support the strategy Towards 2020: Taking Care to the Patient. This work sits within the UK context of registration of paramedics by the Health & Care Professions Council. Over the past decade numerous reports have described the changing landscape for the provision of out of hospital health care in the United Kingdom. A number of consistent themes have emerged from these reports, not least the need to ensure that ambulance staffs, systems and processes are aligned to meet growing public expectations to access health care 24/7, against a backdrop of increased demand and reduced capacity from traditional providers including General Practice and Out of Hours. Simultaneously, a number of studies have explored the concept and application of enhanced skills in patient assessment, minor injuries, minor illness and chronic conditions for 'specialist' paramedics. These have demonstrated that paramedics are ideally placed to provide 'first contact' care, seeing, treating, and referring patients into alternative pathways. The benefits of this approach are exemplified by improved patient experience, and improved job satisfaction from the paramedics involved.

There is a clear disparity between the qualification required for entry for paramedics to the register, and those of the other 15 health and care professions that are regulated by the HCPC, all of whom have a minimum requirement for Degree level entry (SCQF 10). Published in 2008, the professional bodies' curriculum guidance suggested that there were key elements missing from the paramedic curriculum to meet the needs of patients. These included many of the areas listed above, and specific conditions including dementia, mental health and well being, and person centredness. In order to address this, guidance has suggested a move to a 3 year programme and degree level entry to the register by 2016.

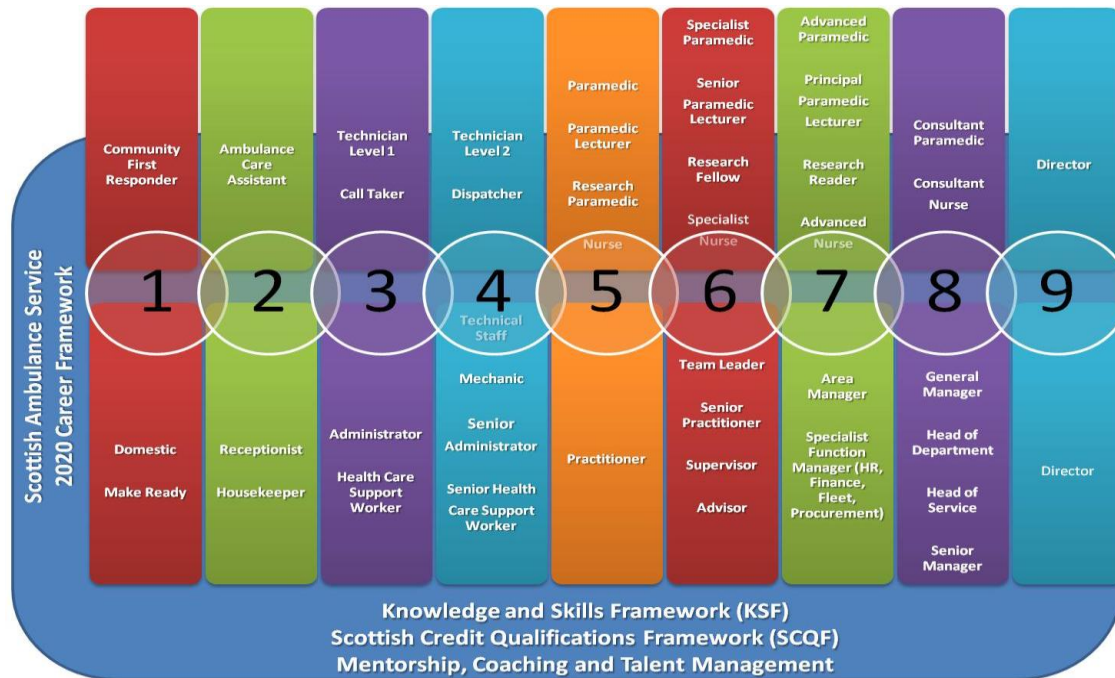
There will be further, wider consultation by the regulator in due course, before any final decision is made on the date at which the entry requirements to the register may change. However, given the extensive lead in times for a 3 year degree programme, accompanied by a requirement to re-validate our paramedic programme in 2016, it is timely that the Scottish Ambulance Service should undertake the degree transition at this time, strategically positioning the profession and service for these developments.

Undergraduate level entry onto the register must also be considered in relation to access to 'specialist' and 'advanced' roles. Currently paramedics may only use specific medications, or those agreed through local Patient Group Directions (PGD). In order to improve patient care, there is recognition that paramedics, alongside other allied health professionals (AHP), should have access to independent prescribing. This will require a further course of study, accessible only by those working in 'advanced' roles, and therefore holding a masters level (SCQF 11) qualification, in parity with other AHPs. This is currently progressing through public consultation, with indications that it may come into law in the next 2 years. The provision of an undergraduate workforce, will therefore provide the foundations from

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which paramedics can progress to undertake further study, and ultimately access independent prescribing.

Figure 3.
Scottish Ambulance Service – 2020 Career Framework



A key assumption of this model is the transition to a graduate paramedic workforce, which therefore requires a review of the level and skills of the support role currently fulfilled by technicians. This will ensure that paramedics operate at their full scope of practice and offer greater scope for treatment at scene. It is assumed that the rate of onward conveyance to hospital following attendance by Scottish Ambulance Service will reduce and, where appropriate, there is likely to be an increase in the number of incidents where there is no immediate threat to life, requiring a paramedic to carry out a face to face clinical assessment, which will likely see more patients being treated safely at home.

Equally, there is greater scope in a ‘one ambulance’ model to enhance the skills of the current cohort of ambulance care assistants to undertake lower acuity urgent and unscheduled work, notably discharge and transfers to facilitate better support flows across the wider system. To support this the Scheduled Care Programme has been undertaking a programme of work to ensure that Patient Transport Service is a flexible and patient-centred service, focused on clinical need. This has been to ensure that the correct support is provided to patients and that the Service is able to respond effectively to demands from NHS Boards linked to discharges, transfers and repatriations.

Work is currently ongoing to refine the scope of practice for our future workforce. Each of the roles required for delivery of the future workforce model is being considered and the scope produced, underpinned by a framework of learning outcomes, to allow for the appropriate delivery of care to the patient. This work is

being conducted in conjunction with the Education Department, the Clinical Directorate, Operations and staff side.

The required scope of practice for each of the roles in the workforce model will reflect the needs of the patient, the needs of the organisation, external drivers (such as guidance from the HCPC, Paramedic Education Evaluation Project) and the wider 2020 vision. The scope of practice and the underpinning qualifications also allow staff to see a clear development pathway from entering the service to specialist and advanced roles. The case studies in Appendix 1 are examples of how this may work in practice.

Ambulance Control Centres

The ACCs are central to ensuring that as the first point of contact to the Service, calls are actively and appropriately triaged to direct patients to the most appropriate care pathway or response, whether emergency, scheduled or otherwise. In the 2020 vision, enhanced clinical triage will be at the core of managing risks effectively. The final model must ensure that different demand management and signposting will not delay response to immediately life threatening calls. In order to deliver this the ACCs will need to ensure that not only are the right staff with the right skills in place at the right times, activity will be underpinned by appropriate ACC estates capacity, skills, systems and processes, including enhanced audit.

Delivery of this will require a different and more thorough clinical intervention (in terms of hear and treat) than at present and this will require a higher skill set and supervision model. There will need to be enhancement to current hear and treat, enhanced triage of PTS calls (most likely through a more clinically focused PNA); all to ensure that we deliver the vision of one ambulance service, with the benefits that that will bring. Any model will require appropriate staffing to deliver the required outputs, including supervisory levels for different disciplines, manageable dispatch/resource and relief ratios, permanent appropriate management (including of PTS, Specialist Services Desk, Major Incident readiness and response) and maintenance and improvement of acceptable standards, such as TAS, especially given the current and predicted CRES requirements. In addition to any workforce changes required, training, development and education of staff and managers will require enhancement from the current model.

The clinical model will inevitably need to change most in order to meet the aspirations of the 2020 vision including linkages to further integration with health and social care systems. This will require a range of changes to the quality of call handling, to dispatch, to training and support and to clinical symptom awareness. This will require Specialist Clinical Advisors with enhanced training in telephone triage and assessment – with staff rotating through hear and treat and see and treat services from an ACC Clinical Hub and operationally. Staff will need to be registered with either the HCPC or NMC and training will need to be further developed, as telephone assessment requires different skills to face to face assessment. A Health Desk Advisor will be required i.e. a function within the ACC specifically to support the specialist services desk and pathways management. This will allow the development of a function to safeguard patients, to support bed management and management of

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frequent users. In addition Clinical advisors, the Special Services Desk and Trauma Desk will all benefit from support to underpin the ongoing and future Control Development programme.

Air Ambulance

Our air ambulance service provides a vital lifeline to the people of Scotland, especially those in remote, rural and island communities. The fleet consists of two purpose built Eurocopter EC135 T2 helicopters based at Glasgow and Inverness along with two KingAir B200C pressurised fixed wing aircraft, again purpose built, which operate out of Glasgow and Aberdeen. This mix and location of fixed and rotary aircraft ensures we are able to provide an air ambulance service which is capable of reaching in excess of 95% of the Scottish population within 1 hour.

In July 2015 the current EC135 T2 helicopters will be replaced with bigger, faster EC145 T2 aircraft which will bring significant improvements to the services we provide. There will be an enhanced and larger interior allowing full access to the patient in flight, increased passenger carrying capacity, increased operational range and the introduction of night vision imaging systems on board will not only improve safety for general night time operations, but also allow the Service to develop and provide emergency responses to incidents during the hours of darkness.

Crewed by a pilot and two paramedics, the two helicopters respond to emergency calls and patient transfer requests from remote, rural or island clinicians to transport patients to mainland health care facilities. Our helicopters can be airborne to an emergency mission in less than two minutes. They seat four persons and carry one stretcher.

The two King Air aircraft mainly respond to medical requests to transfer patients between hospitals. The benefits of having fixed wing aircraft means we can provide quick inter hospital transfer of patients who need to be in specialist units across Scotland and throughout the UK. The aircraft is crewed by two pilots and a paramedic at all times, and the current layout in the aircraft allows us to carry a maximum of three seated passengers along with two stretcher patients.

We carry out around 3,600 missions each year and regularly fly with the ScotSTAR specialist retrieval teams. In addition to our purpose built aircraft we have access to Search and Rescue aircraft of the Ministry of Defence and HM Coastguard to support us during periods when our aircraft are unable to operate due to weather issues, surges in demand or aircraft technical issues.

The role of Air Ambulance paramedic is developing, and a number of existing staff are currently undertaking a BSc in Critical Care. This will allow them to manage patients in flight that previously required the attendance of a doctor or specialist nurse. The workforce model across the Air Ambulance Division is changing, and the co-location of ScotSTAR retrieval teams and Air Ambulance staff in the new Glasgow Airport base from August 2015 will bring further opportunities for closer working and integration.

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It is envisaged that there will be opportunities to review the current workforce model as the role of Air Ambulance Critical Care Paramedics, ScotSTAR Critical Care Paramedics and Specialist Retrieval Nurses will complement each other to deliver enhanced patient care and support Retrieval Consultants where necessary.

ScotSTAR

In April 2014, the Scottish Ambulance Service launched a new specialist retrieval service for Scotland. This brings together a number of specialist teams across Scotland including neonatal, paediatric, trauma and the Emergency Medical Response Service (EMRS) under the central co-ordination of the Scottish Ambulance Service.

The aim for the ScotSTAR workforce is to establish a cohesive, robust and sustainable national team. The future resilience of ScotSTAR will be reliant on a flexible and responsive workforce to meet future demands, while making the most efficient use of resources available. Cross working between the established teams should support this model in the future and will require a varied skill mix of disciplines, specialties and professions including: neonatal, paediatric, adult, Intensive Care Unit, Emergency Medicine and anaesthetic support, across doctors, nurses and paramedics.

The concept of cross cover between teams is untested within NHS Scotland, although has worked elsewhere within the UK (EMBRACE –Paediatric and Neonatal Retrieval service, Sheffield) and internationally but the teams have a solid foundation of many years training both within an acute hospital environment and in transport and retrieval. Issues regarding cross-specialty working for doctors and nurses require further investigation. Identifying competencies and skills rather than posts and titles will support this change to practice.

The requirement for support that is currently provided by the Critical Care Specialist Paramedics, Charge Nurses, Staff Nurses and Transport Nurses will continue, but could be enhanced with the creation of additional Specialist roles (both nurses and paramedics). This role would be provided by experienced nurses and in the longer-term, specialist paramedics. These Specialist Paramedics will have advanced skills, significant experience and ability to undertake autonomous practice, which will be essential to provide support and the ability to lead on some transfers and retrievals of less acuity, not requiring medical input.

It is possible that some of the nurses currently working within the teams who are dual trained (neonates/paediatrics) or (paediatrics/adults), may be keen to enhance their roles through refresher training and further advanced skills. There is also a small cohort of paramedics currently undergoing specialist paramedic training; it will be necessary to increase this cohort of staff to support the ScotSTAR in the first instance and this is included in future workforce projections for the service. In the future this will mean the overall workforce for ScotSTAR will have a greater percentage of non-doctors than doctors, but there will be a continued requirement to have medical staff involved in ScotSTAR to ensure safe and effective transfers of some of the most critically ill patients within NHS Scotland.

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The Specialist Operational Response Division

The Specialist Operational Response Division (SORD) is structured to support a range of specialist corporate level functions which are designed to ensure that the organisation complies with the Civil Contingencies Act (CCA). In addition, SORD developments and capabilities are aligned to support our aspirations towards 2020 by taking care to the patient in a person centred, safe and effective manner.

Risk, Resilience and Business Continuity Management Teams

Regional Resilience Advisors, Resilience Officers and the BC Advisor work across the Service in partnership with Territorial Divisional management teams and the Regional Resilience Partnerships (RRPs) to ensure that the Scottish Ambulance Service assesses, plans, prepares, responds to and recovers from a range of disruptive challenges.

Specialist Operations Response Teams (SORT) and Specialist Training

Due to the complex and challenging environments which SORT Teams may operate within for extended periods of time, and to support our strategic framework “Towards 2020: Taking Care to the Patient” it is imperative that SORT is established with at least Paramedic grade clinical staff who are trained and equipped to respond to immediately life threatening patients requiring advanced care including CBRN medical countermeasures and other advanced life support clinical skills.

Environments which SORT operate in are often hazardous or difficult to access, including confined spaces, collapsed structures, entrapments; including at height, inland water operations and similar. In these situations SORT provide decision making, advice and direct clinical care. Given the complexities of these incidents and our desire to “*Improve Access, Improve Care and Improve Outcomes*” with regards to the delivery of enhanced patient care, there is a requirement to develop SORT Team clinical knowledge and skills to a higher level. This is due to, as is often the case at these complex incidents, the need to have enhanced patient assessment and trauma management skills to support multi-system injury and life threatening conditions.

The SORT teams also continue to provide direct support to a range of other key functions such as counter terrorist and protected persons operations, specialist infectious disease patient transfers, bariatric interventions, recruitment fitness testing, specialist services desk and the response to routine 999 emergency calls on a daily basis through the provision of SORT Response Units [SRUs]. Each SORT Team will operate a specialist A&E equipped Ambulance. This resource will provide the specialist response to patients as detailed releasing Divisional Ambulance resources back to support wider Service Delivery activities.

The SORT teams already operate a Response Unit model, this resource could potentially be better used during more day to day routine operations and to assist with the wider development of SORT clinical capabilities which fit with “taking care to the patient”. As a result, discussions are taking place around the structure which

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could better support our strategy of delivering improved patient outcomes by working to shift the balance of care by caring and treating patients in their home or homely setting.

SORT Teams already receive a range of specialist training opportunities; however the academic educational programmes for this cohort of specialists; will be considered alongside the development of the revised Educational Framework.

To support wider organisational preparedness and responsibilities, the SORD team also develop and provide a range of specialist training opportunities for Divisional and corporate level departments in areas such as Risk, Resilience, Business Continuity and Incident Command. Additionally, SORD has employed a Resilience Advisor [training and exercising] to work on a whole-time basis with the Scottish Multi-Agency Resilience Training & Exercising Unit [SMARETU].

Community Resilience

Community Resilience is about communities using local resources and knowledge to help themselves during an emergency in a way that complements the local emergency services. Community First Responders and Co Responders play an important role in responding to targeted emergency calls in local communities across Scotland with back up and support from road and air ambulance crews. An example of this is the 'Chain of Survival'. The 'Chain of Survival' describes the crucial elements that can save a life when someone has an Out of Hospital Cardiac Arrest (OHCA):

'The key factors in determining survival from OHCA are early, high quality cardiopulmonary resuscitation (CPR) and counter-shock therapy (defibrillation). All patients who have a survivable cardiac arrest require CPR and the majority also require defibrillation, both of which must be applied in a matter of minutes in order to be successful. CPR and defibrillation can be performed by ambulance first responders, other first responders in the community, or bystanders (if equipment and instruction are made rapidly available). The interplay of these key elements forms the 'Chain of Survival' which a person must successfully pass through in order to go home from hospital neurologically intact'.

Extract above from Pg 4 Executive Summary. Out of Hospital Cardiac Arrest - A Strategy For Scotland : Scottish Government. March 2015

The Out of Hospital Cardiac Arrest Strategy (OHCA) for Scotland outlines a national commitment to improve survival from cardiac arrest. We will continue to engage with communities, the third sector and partners to look at opportunities to enhance community resilience and improve survival rates from cardiac arrest. Examples of how we are developing these key areas include:

- Continuing to support Community First Responder schemes through the new Scottish Ambulance Service Community First Responder training programme.

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- Continuing to support the development of Co Responder and Emergency Responder service delivery models
- Continuing to developing new volunteering roles which will increase volunteering opportunities and create additional capacity to support the effective delivery of the wider Community Resilience agenda.
- Continuing to train volunteers to deliver CPR and Public Access Defibrillator (PAD) training within local communities to raise awareness and provide the skills and confidence to use CPR and the defibrillator if required

Corporate and Support Services

The front line clinical teams within the Scottish Ambulance Service are supported by numerous corporate and support teams. In order to deliver the objectives of “Taking Care to the Patient”, it will be important for the Human Resources, Finance, e-Health, Procurement, Estates, ICT, Corporate affairs Communications and Fleet teams to align their objectives and resources to support the delivery of “Taking care to the Patient”.

In addition to this, consideration will be given to the impact of shared services projects co-ordinated at NHSScotland level, and the contribution of the Scottish Ambulance Service workforce to these initiatives. The development needs of these groups of staff will be included in organisational development and training plans for each staff group. It will be critical to ensure that members of these teams feel valued and supported during the period of transition until 2020.

Developing our Administrative & Clerical Support Services

A key enabler to the effective implementation of our DFLM programme and the delivery of frontline services is a skilled and knowledgeable admin and clerical function. To create the capacity within our management cohort to undertake their required role we require an admin and clerical support service which is able to absorb much of the administrative activity currently undertaken by our 1st and 2nd level leaders and managers.

Our administrators therefore require to be knowledgeable and skilled in the use of the Service’s systems and processes to effectively support activities such as procurement (PECOS), payroll (SSTS) and the maintenance of personnel information (GRS & eEES). They require to understand key aspects of data and information protection and should be current in terms of making the most effective use of technology. They should also be effectively supporting management colleagues to manage their time efficiently e.g. through diary and appointment management arrangements.

Administrators and teams require to work flexibly across sometimes previously demarcated functions such as payroll or resource planning using standardised rather than individual systems, processes and methods. This will ensure maximum efficiency in the delivery of this support service however it is also recognised that

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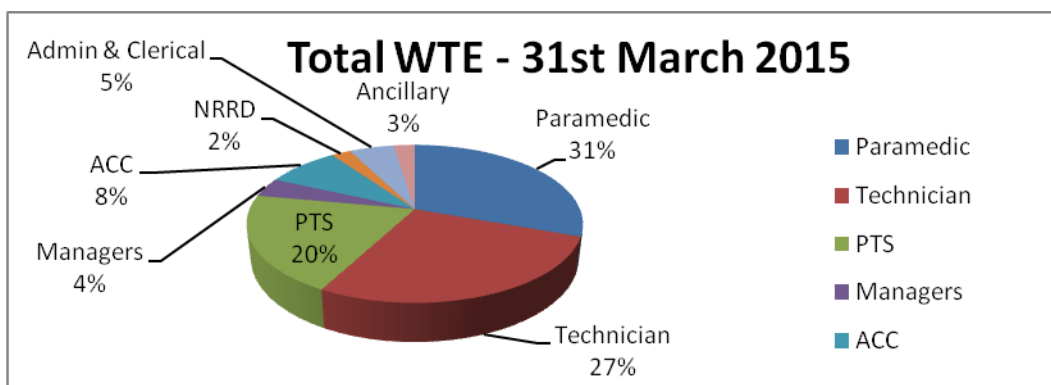
individual areas will have slightly different needs and these will be outlined within local workforce plans.

4 Workforce Capability

4.1 Current Workforce

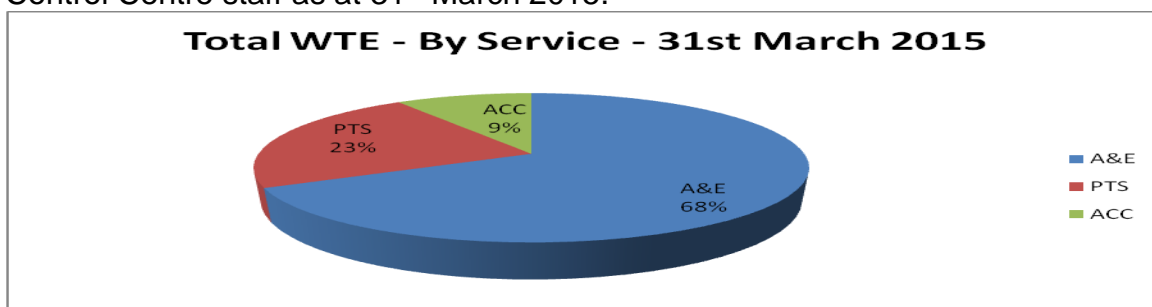
Our People

The staff population decreased overall by 63.7WTE by 31 March 2015 from the 31 March 2014. The chart below illustrates the composition of the total workforce by job category at 31 March 2015.



Turnover for Technicians and Paramedics remains fairly constant at an average of 5.8%. Turnover in our Admin and Clerical function and for our managers has risen. The increased turnover in these areas is largely due to more retirements in these staff groups.

The chart below illustrates the percentage of WTE vehicle crew staff / Ambulance Control Centre staff as at 31st March 2015.



Overall Turnover for the Scottish Ambulance Service for the period 1 April 2014 to 31 March 2015 was 6.74 %. This has increased from an average of 4% in the years spanning from 2008-2012. Years 2013/14 and 2014/15 were over 5 %. This has further increased by almost 1% in 2014/15. This has been a steady increase and this trend appears to be continuing in line with the age profile of staff.

Taking this into account and as detailed in 3.2 above, a number of productivity measures will be considered, including continued development of “leading edge technology”, reviewing patterns of working, service models and review of skills mix as appropriate. Divisional Workforce and delivery plans) outline specific aims within each territorial Division. Different blends of skill-mix will be reviewed in Partnership including the construction of any potential new roles and responsibilities and implementation of plans, based on development and requirements of current workforce matched against requirements of future workforce.

4.2 Affordability

The delivery of Taking Care to the Patient is dependent on a number of critical success factors, particularly the success of this Workforce Plan. This plan will require investment in staff, in education, training and development, and both the Strategy and Workforce plan are underpinned by a five year financial plan. Transitional funding has been provided for year one of the plan from Scottish Government and details of the following four years’ funding requirements will be drawn up over Summer 2015. The Strategy is supported by robust economic appraisal showing a return on investment of £4: £1 for NHS Scotland.

4.3 Availability

In the current political and financial climate there will be increasing pressures on Public sector posts. For some roles we will be competing with the private sector and effectively “fishing in the same waters” for high quality staff e.g. calls taker staff who may choose to go to the private sector. This may also work in our favour in areas where the private sector is having to make cuts in staffing numbers due to financial pressures.

Additionally across the UK there are significant challenges facing all other UK Ambulance Services in terms of recruitment and retention of Paramedics. Across England and Wales alone there are over 2000 Paramedic vacancies with significant competition across regions with high vacancy levels. In turn this has a knock-on effect on our ability to recruit qualified Paramedics from elsewhere in the UK. We are also facing, for the first time, competition with the Private Sector for our highly skilled Paramedic staff (e.g. Oil Industry).

At the same time the demographics of the population are changing with a significant decrease in the proportion entering the labour market and some increase in the proportion leaving the labour market through retirement. This trend may continue with the changes to the pension contributions and legislation.

Recently published figures estimate that by 2033 24% of people will be over 65 and 12% over 75 compared with 17% aged 65 now and 8% over 75 (Source; NRS (2012) 2011 Census: Release 1A). This means that not only is our population ageing but the workforce who are planning to meet the needs of this ageing population are ageing too.

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The analysis carried out by NHS Education for Scotland for the Scottish Ambulance Service shows some very interesting trends and comparisons with the rest of NHS Scotland. The graphs detailed in this section show Individual-level data for non-medical, non-dental staff employed in NHSScotland on September 30th for each year 2007-14 against Scottish Ambulance Service staff for the same period.

These data showed that:

- there were considerable differences between Scottish Ambulance Service and non-Scottish Ambulance Service staff by age, sex and Agenda for Change band.
- the percentage of staff aged 55 and over who left the Scottish Ambulance Service has increased from about 30% in 2007 to about 50% in 2011.
- almost 83% of Scottish Ambulance Service staff employed on September 30th 2007 were employed in each year between 2007 and 2012.
- The headcount of SAS staff increased by about 10% between 2007 and 2014 and most of the inflow consisted of new rather than old staff.

In 2007, of 173 leavers, 30% were 55+. This increased to 50% of 198 leavers being over 55 in 2011 (Figure 1). By 2013 this had reduced slightly to around 50%. This would support the predicted increase in those retiring as we move towards 2015 and the changes in pension legislation.

Figure 1: Percentage outflow by age

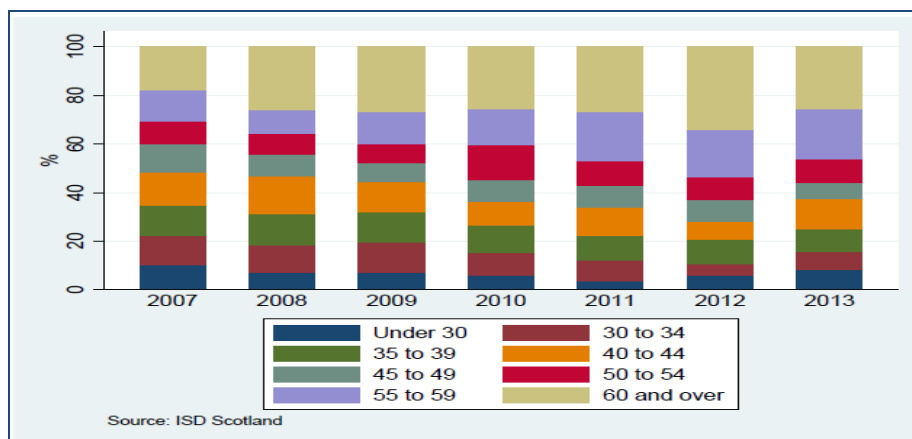
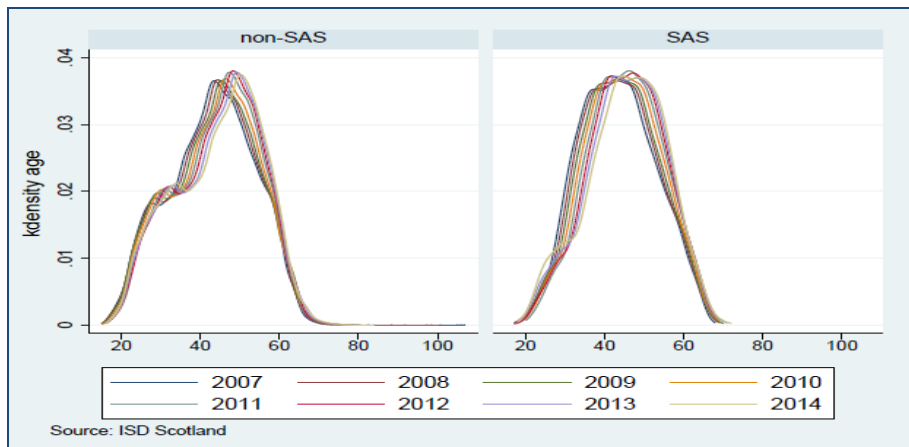
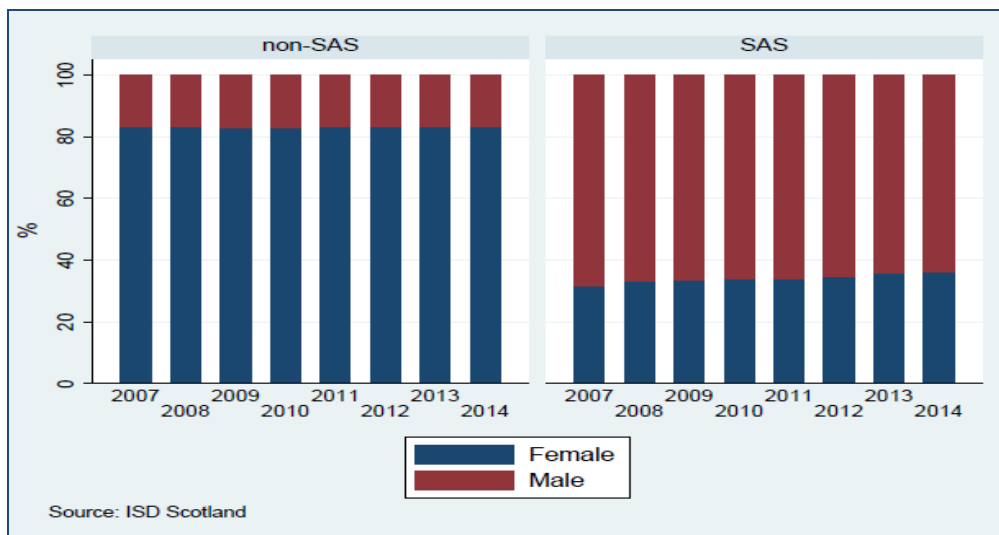


Figure 2: Distribution by age



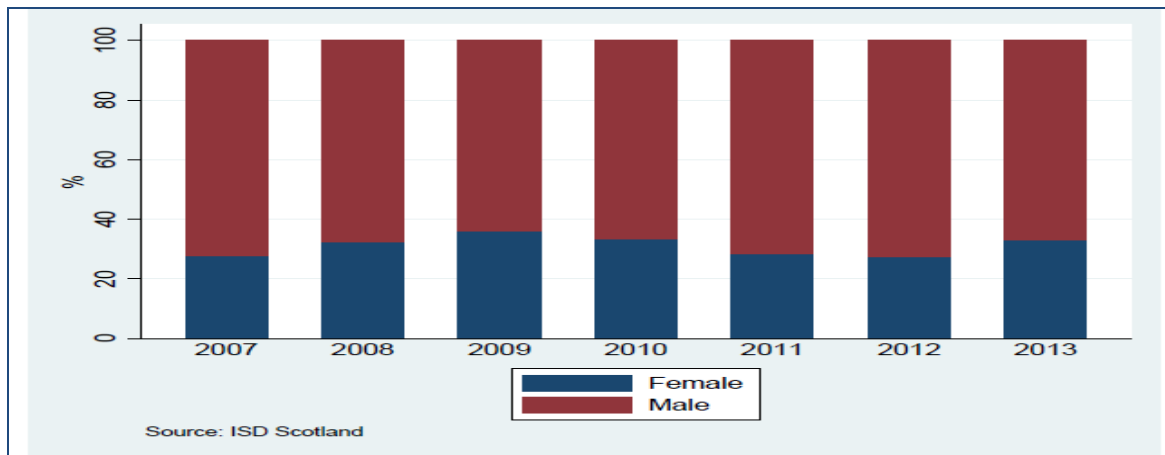
For Non-Scottish Ambulance Service (Territorial Health Boards) there is a trend illustrated by the 2 main peaks of the ageing workforce being replaced by younger new recruits. This is not reflected in the Scottish Ambulance Service’s workforce where the whole workforce is ageing and not being replaced at the same rate. Further work on age profile in each location is required to look at impact in specific areas as well as views and expectations of our staff across all age groups on the changing face of the service. This piece of work will take into account differing views and expectations around learning, development and experience as we progress this challenging agenda. During 2014 this trend showed a slight bulge which reflects the larger intakes in training of technicians with an increase in the younger age groups.

Figure 3: Distribution by sex



The above graph shows marked differences in the gender balance between Scottish Ambulance Service and the rest of NHS Scotland, but a steady slight increase in female staff.

Figure 4: Percentage outflow by sex



As expected the fact that our percentage of male employees is higher than females the outflow is also higher.

Figure 5: Distribution by Agenda for Change band

Our Agenda for Change band distribution in comparison with Territorial Boards shows a marked difference with the bulk of our posts at Bands 3, 4 and 5 which would reflect our current operational profile. Further analysis of this distribution of Band in relation to gender balance (Equality Monitoring Report 2013-14) shows a disproportionate number of males in Bands 6-8a.

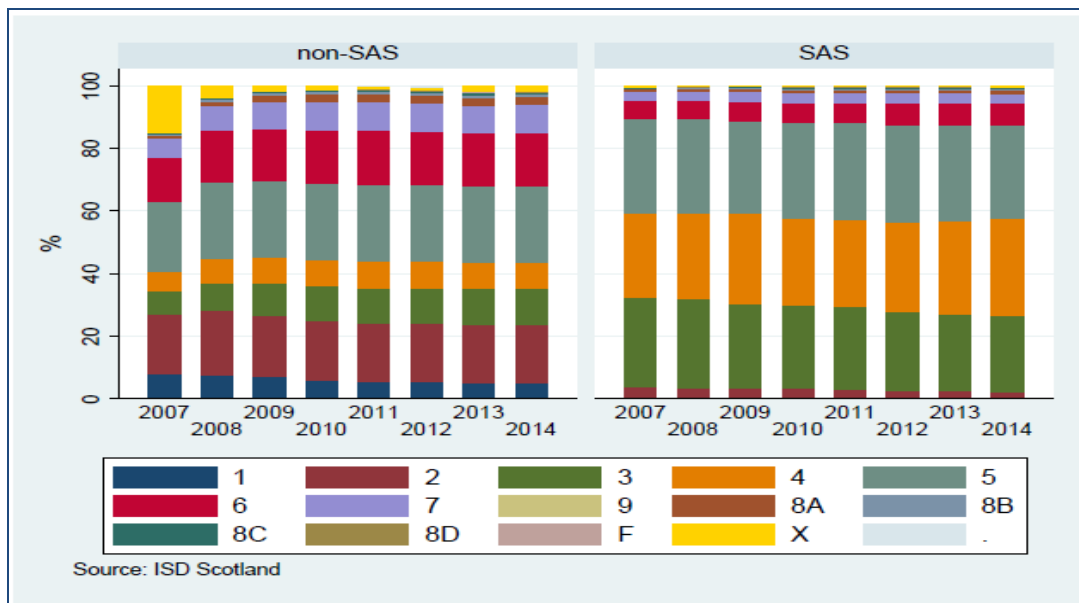
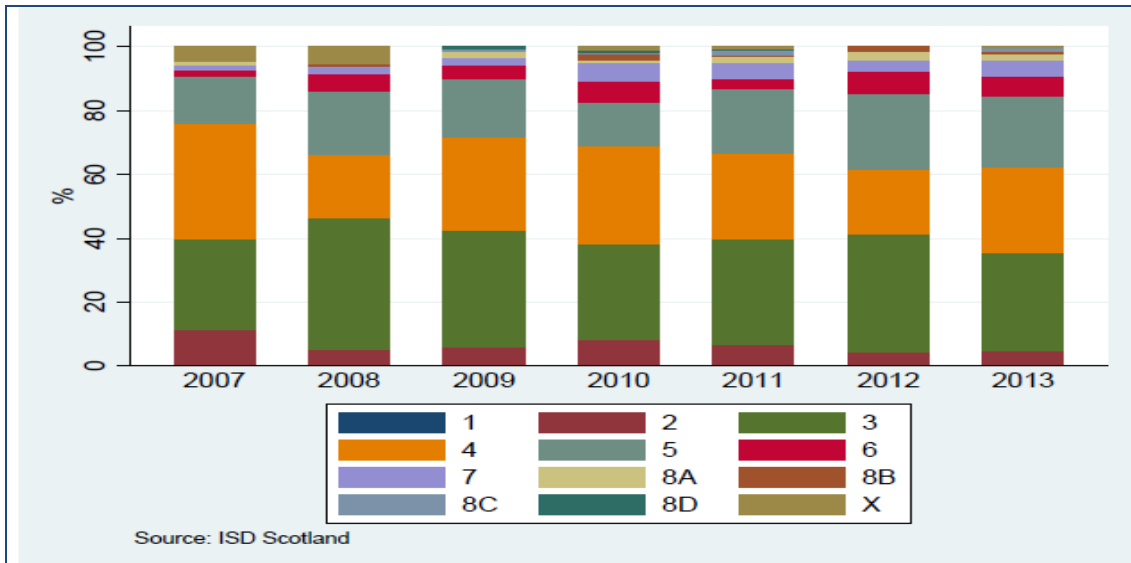
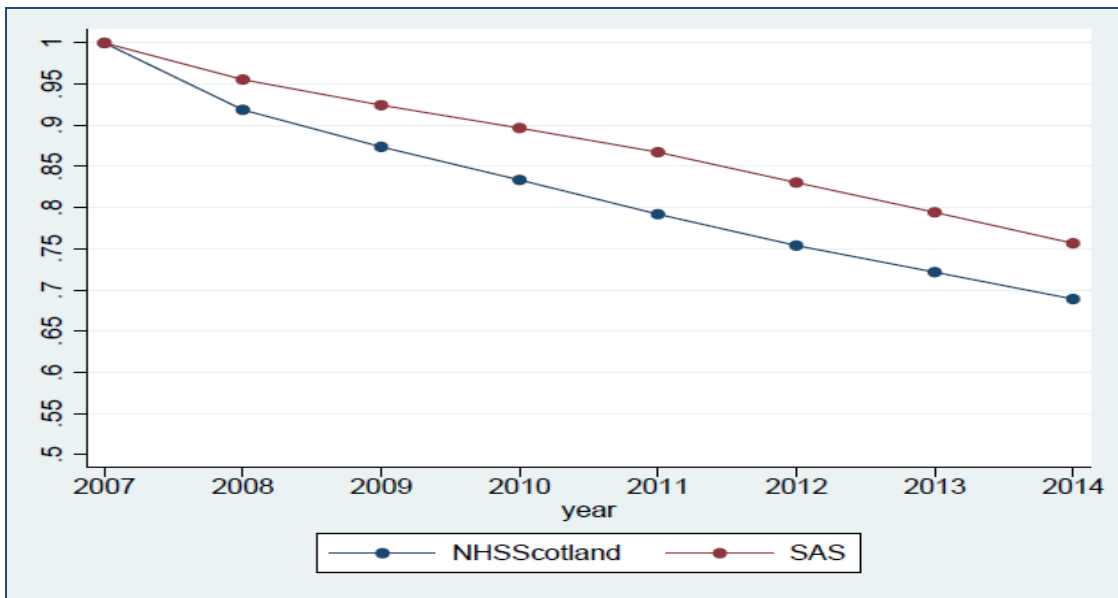


Figure 6: Percentage outflow Agenda for Change band



As above the greatest outflow/turnover is in bands 3, 4 and 5. The highest outflow being from our Band 3 (ACA/PTS) roles which would reflect our projected decrease in workforce numbers in previous years.

Figure 7: Retention rates of staff employed on September 30th 2007



In comparison with the rest of the NHS 80% of staff employed within the Scottish Ambulance Service in 2007 were still employed at 2011, compared with 73% shown by the rest of the NHS. When we are considering role profiles, skills analysis and role development we need also to consider the significant investment required in our current staff, in terms of Education and Development as the bulk of our staff we currently have will remain with as we move towards 2020.

Although our turnover is not as high in comparison with other Health Board areas, we are seeing an increase in experienced staff with long service retiring from age 55. This will have an obvious impact on the availability and supply of experienced mentors to support our emerging models of service delivery. Our Education model will require to be flexible enough to accommodate the needs of our experienced staff's development along with the potential loss of this valuable knowledge and experience.

In addition, we will need to ensure that any future education and training model takes into account the challenges we face in terms of filling vacancies. This is a particular concern in remote and rural areas and areas in which there is still an On Call element of working in operation (e.g. North and South West Scotland).

Skills for Health are currently working with NHSS to review and update the Labour Market Information. This work has also involved some scenario planning with the aim of supporting the overall aim of working towards the 2020 Workforce Vision and an integrated approach to health and social care.

Figure 8 – Higher Education Statistics Agency Statistics

- mean age 33
- 57% male
- 96% Scottish-domiciled
- 37% reported having dependants
- almost all were of white ethnicity
- 3% reported having a disability

- **Scottish Index of Multiple Deprivation (SIMD) quintiles**
- Q5 { least deprived: 20%
- Q4: 23%
- Q3: 28%
- Q2: 20%
- Q1 { most deprived: 10%

- **level of qualification on entry:**
- Degree: 31%
- HNC or HND: 22%
- SVQ or NVQ: 20%

The information detailed above highlights some interesting trend relating to the intake of students. The Gender balance for the Service is currently 36/64. The information detailed above indicates and increase in female students with 57% male and 43% female.

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Equality & Diversity

Our five year strategic framework "Towards 2020: Taking Care to the Patient" describes how we plan to deliver our frontline service providing emergency, unscheduled and scheduled care 24 / 7. Our mission is to deliver the best ambulance services for every person, every time. Our goals to improve access to healthcare, evidence a shift in the balance of care by taking more care to the patient and improving outcomes for patients cannot be achieved without a firm commitment to continue to progress our equalities work now and in the future.

Our equality outcomes were published for the first time in April 2013. These were developed with input across a number of sources including our patients, members of the public, senior managers, staff and staff side colleagues. These set out our focus for equality and diversity work between 2013 – 2017. An update on progress against these outcomes was published in April 2015.

In keeping with the requirements of the Equality Act 2010 and Equality Act (Specific Duties) (Scotland) Regulations 2012 we also published our second mainstreaming report in April 2015. This report highlights some of our equalities work and outlines the actions we are taking to progress this further in order to meet the need to have due regard to eliminating discrimination, advancing equality of opportunity and fostering good relations. This work is key as we strive to deliver better person-centred care and contribute to the reduction of health inequalities.

The Equality Monitoring Report 2013 – 14 can be seen at Appendix (ii). This illustrates the workforce profile for the Service and provides the key actions to be taken forward to improve equality monitoring in future. The information contained in this report in conjunction with the above data will further inform action plans around the following:

- Increasing numbers of younger people joining the Scottish Ambulance Service via the Modern Apprenticeships Scheme (see also section 5)
- Improving access across communities through the introduction of the Vocational Qualification route which would support a broader spectrum of people from across all educational, age and social groups.
- Improving the gender balance across Bands 6-8a.

We continue to monitor the Service Anti-Bullying and Harassment Campaign. The aim of this campaign is to raise awareness of unacceptable behaviour and encourage staff to raise any concerns / issues at the earliest opportunity in order to resolve problems as soon as possible.

EQUALITY IMPACT ASSESSMENT

The equality impact assessment has been developed which, along with taking into account the Protected Groups and General Duties, also reviewed our data on trends in our workforce to better inform this process. Specifically, some of the issues we have identified from discussions with staff and Partnership colleagues include:

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- The implications for different age groups due to the fact that we want to develop all of our staff.
- The need for clear pathways for the development of different levels of staff which are accessible to all.
- The implications for all administration staff and the gains so far from the Administration Learn & Improve programme.
- Progress we have made so far in increasing the proportion of female paramedics in various roles as the Service has attracted more females into operational roles.
- The implications of turnover both currently and in the future.
- The accessibility of the vocational qualification route versus the current Glasgow Caledonian University (GCU) based model.
- The potential for developing further apprenticeships.
- Being aware of health inequalities and ways to improve health & wellbeing in new workforce model.

The Equality and Diversity Steering Group continues to meet bi-monthly to take the key areas of work forward. Membership includes representatives from across the Divisions.

4.4 Adaptability

Resource Modelling and workforce planning

A detailed resource modelling exercise is underway, using the assumptions about future clinical service delivery set out in section 2. The exercise is designed to derive the numbers and skill levels of operational staff required to support the clinical model set out in "Taking Care to the Patient". This exercise is anticipated to conclude by the autumn of 2015. Initial indications are that there will be a requirement to recruit and train additional specialist paramedics, and additional care assistants to support the changes to service delivery set out in the strategy. It is also anticipated that, as health and social care partnerships are established, there will be further developments of specialist paramedic roles to support local initiatives and integrated community teams.

Further work is underway to determine the workforce model within the ACC, which will be critical to the effective delivery of our strategy, not least the level of clinical staff and supervision to support increased hear and treat.

To support the operational cohort of staff, the DFLM programme will develop approximately 150 team leaders across the Service to deliver supervision, personal development and local leadership. The development programme for team leaders commenced in 2014.

Modelling for administrative and clerical support will need to reflect the need for team leaders to be released to perform these duties. It is essential that the skills and

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processes required to improve the efficiency of the administrative service are further developed to ensure the full effectiveness of the DFLM programme.

A review of senior management portfolios and skills to align resources correctly to deliver the strategy will take place. This will allow a robust and resilient workforce to be developed and maintained across all staff groups.

As detailed transition plans are developed, further refinement of resource requirements will be required year on year.

5.0 Action Plan

5.1 Introduction

Throughout development and delivery of our previous strategy and, as we refresh the strategy towards 2020, the Scottish Ambulance Service has engaged with a wide range of stakeholders and partners and demonstrated a commitment to working in partnership to develop and improve the quality and contribution of our service.

The Scottish Ambulance Service has developed a specific plan to take forward implementation of the 5 key priorities set out in the 2020 Workforce Implementation Framework and Plan 2014-15 which will be monitored by the Staff Governance Committee. Key actions include;

- Embedding the NHS Scotland values as part of ongoing organisational development programme;
- Developing Frontline Leadership and Management capacity and capability across the Service;
- Developing talent management and effective succession planning;
- Ensuring the Service has the right mix of skills and resources to effectively contribute in an integrated health and social care system;
- Robust staff governance and Partnership arrangements
- Consultation with Key Stakeholders (internal and external).

The Scottish Ambulance Service will also undertake staff governance audits; develop and deliver a staff governance action plan; and take forward actions and recommendations arising from the NHS Staff Survey at a national and local level. We will continue with our programme of workforce modernisation and will continue to implement our action programme to improve attendance (Scottish Ambulance Service Local Delivery Plan 2014-15).

- Following the NHSScotland Staff Survey in 2014 our Service has committed to having a renewed focus on some targeted actions as detailed below:

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- Investment in ACCs, communication and engagement with ACC front line staff.
- i-Matter continuous improvement model (teams), in tandem with renewed effort in meaningful individual appraisal.
- Leadership and Management Development programmes at all levels.
- Focus on welfare and wellbeing, linked to attendance management plans.
- Promotion and adoption of NHS values, with particular focus on healthy organisational culture.
- Further developing partnership working to continue making progress.

This follows on from the work done following the 2013 Staff Survey results, championing a shift in our culture around how we monitor and evaluate our performance. Rather than always focussing on what staff could do better, we have shifted focus to building a high performance culture and managing staff performance in a positive and productive way in order to build on our strengths. When performance management is appropriate, it can mean higher levels of engagement with staff, retention and organisational performance – with our colleagues working together to ensure that all of our staff can reach their potential.

To ensure that the Service is performing at its best, we want to ensure staff at every level throughout the Service understand what performance standards are expected and to support this with regular and consistent feedback from our management teams.

This section will also focus on action planning and how education and other strategies support service redesign and role development as we develop and implement this plan. We will also demonstrate how we plan to ensure that the workforce as a whole develops effectively and we encourage and promote equality agenda across the Service and continue to mainstream this in all that we do.

5.2 Education & Development

Education and Professional Development – Learning Strategy

In 2009, the Scottish Ambulance Service published “Realising Our Potential: The Learning Strategy, which was fully aligned to the delivery of the 5 year strategic framework “Working Together for Better Patient Care”. The learning strategy provided the blue print for learning and development, and established both the Scottish Ambulance Academy and our relationship with Glasgow Caledonian University.

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We have built on this relationship to deliver a Cert HE in Ambulance Studies, DipHE in Paramedic Practice and BSc in Paramedic Practice, with in excess of 600 students accessing programmes in the past 3 years. We have also achieved UK recognition for our collaborative delivery arrangements, which ensure that students are not only 'fit for practice', but also 'fit for purpose.'

The delivery of our learning strategy will require that we build on our experiences within both higher and further education, to deliver new programmes that meet the requirements of the Health Care Professions Council and other regulatory bodies. We have also achieved recognition for the development of clinical simulation and human factors education in out of hospital care, working with both the Scottish Clinical Skills Network, and the Association for Simulated Practice in Healthcare.

We will take our experience of technology enhanced learning, to further develop a virtual Scotland wide foot print, that provides equity of access, and opportunity for all staff. Our learning strategy supports our new strategic framework "Towards 2020: Taking Care to the Patient", it provides the mechanism by which our staff will access learning opportunities that deliver real outcomes for patients, for staff and for the organisation.

The Scottish Ambulance Service recognises the fundamental role of its workforce in delivering safe, effective, patient centred care, within the context of a more integrated approach to health and social care provision. Central to the delivery of our educational model, is our clinical career framework (page number required), which provides parity with other Allied Health Professionals, links career progression to educational award, and maintains the opportunity for advancement through a vocational pathway.

The implementation of the educational infrastructure to deliver our new Clinical Career Framework will require transformational change, not only in the way that education is delivered, but also in the way that it is funded. The transition to vocational awards linked to the SCQF, for our non-registered clinical staff, will require our education department to realign current structures, to provide the quality and assurance framework for the delivery of new awards. The increased flexibility of the vocational awards, will allow for the delivery of the programme across Scotland, promoting more accessible, inclusive, opportunities for people within local communities to join the service. Building on the success of our partnership model for paramedic education at Glasgow Caledonian University, we will seek out the opportunity to develop relationships within the Further Education Sector, for the delivery of the vocational awards programme.

The transition to an undergraduate BSc (Hons) programme, that will meet the aspirations of the 2020 vision, will require the validation and approval of a new 3 year programme in June 2016, with the first intake of students planned for September 2016. A 3 year honours programme, will provide parity with paramedic

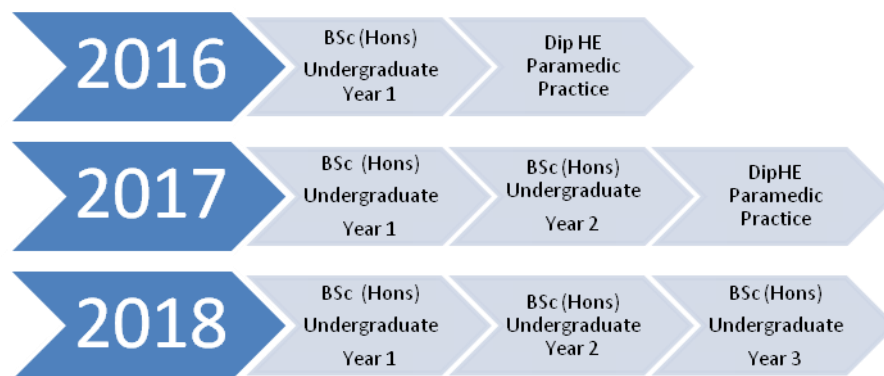
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registration programmes across the UK, and will also be unique within the Scottish Education System.

This programme will require validation for delivery not only on campus in Glasgow, but also for off campus delivery, using technology to link remote and rural students with their cohort. This model is utilised successfully on other programmes, and will provide the basis for widening access and participation to paramedic education across Scotland.

It is envisaged that ultimately, all full time undergraduate students, will be funded through the Scottish Funding Council. However, this is unlikely to be available until 2018, requiring that in the interim the Scottish Ambulance Service, fund bursaries for these students.

In order to prevent 'fallow' years, there will still be a requirement for the delivery of a 1 year Diploma of Higher Education award, leading to eligibility for registration with the HCPC, during 2016 and 2017.



There will also continue to be a requirement for the delivery of the current BSc pathway through Glasgow Caledonian University, to allow both DipHE and IHCD qualified paramedics, the educational pathway to access Masters level qualifications leading to Specialist and Advanced Paramedic roles. The delivery of our Specialist and Advanced Paramedic programmes provides the basis for inter-professional education with other Allied Health Professionals and nurses. Working in collaboration with the Higher Education sector, we will seek to develop specialist pathways as part of existing Advanced Practice Masters level programmes. These programmes will be delivered in conjunction with several universities, further enriching the learning and development opportunities for staff.

In summary we aim to:

2015

- Obtain approval for the delivery of Vocational Awards.
- Level Vocational Awards against the SCQF.

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- Deliver and evaluate a pilot Vocational Award for Technician level 1.
- Develop the BSc (Hons) programme content for approval.
- Work in collaboration with NHS Education Scotland and the Scottish Funding Council to seek undergraduate funding for Paramedics.
- Commission a pilot cohort of Advanced Paramedics at 3 Universities across Scotland.
- Transition current CertHE programmes to Vocational Awards.
- Secure GCU validation and HCPC Approval for the delivery of the BSc (Hons) programme
- Secure GCU validation and HCPC Approval for the continued delivery of the DipHE programme.
- Determine funding arrangements for the first fulltime undergraduate student cohort on the BSc (Hons) programme.
- Continue the delivery of the BSc Paramedic Practice (part time) degree.

2017-2020

Operationalise the delivery, funding and evaluation of both vocational qualifications and higher education awards, to meet workforce demands.

Aligning the career framework to the national framework in place across the wider NHS provides scope for understanding the roles of other clinical staff within the delivery of the 2020 Vision, providing an opportunity for a richer mix of clinical skills. It will develop a workforce, educated, trained and enabled to deliver more comprehensive care at the point of contact for our patients, and offer new role opportunities for our staff alongside other Allied Health Professionals and nurses.

In developing a workforce to deliver 2020 Vision, we recognise that the delivery of qualifications linked to an academic career pathway, is only one part of developing our people. Our aim is that by 2020, the workforce within the Scottish Ambulance Service will provide all staff working to their full scope of practice, skills, knowledge and experience, supported by Personal Development Plans and enhanced learning opportunities. This will require that we change the emphasis on learning as being delivered to staff, to that of a learning partnership, in which opportunities are jointly developed, owned and achieved by both the individual and the organisation.

Fundamentally, learning cannot be considered in isolation, and therefore we will continue to strengthen the link between learning and safe, effective practice. We will utilise the opportunities provided through the service wide roll out of WiFi access, to provide tailored, targeted e-learning and blended learning programmes for all staff. This will ensure that all learning activity is accurately captured, and will allow for data transfer directly into staff records, providing organisational assurance, and individualised learning records for professional development and registration purposes.

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Using a joint e-learning platform with other health boards, will not only realise financial savings, but also provide potential access to the NHS Scotland repository of over 10,000, e-learning modules. Learning activities will also be linked to a decision making application available to staff on personal smart phones and tablets, and ultimately via the Ambulance of 2020.

We recognise the importance of learning and development, and we will work to provide protected learning time for all staff to enable them to undertake face-to-face, e-learning and blended learning activities, that are reflected in their Personal Development Plans.

In order to provide enhanced levels of clinical care, we will develop a modular educational programme for current paramedics and technicians to enhance their clinical decision making, and support the further introduction of clinical decision making tools, that will enhance the level of care provided to our patients.

In summary we aim to:

- Develop our e-learning platform to enhance access to statutory, mandatory and professional development programmes, for all staff.
- Link e-learning records into our human resource system, and utilise our resource planning system to facilitate protected learning time for the abstraction of staff.
- Develop our decision support application, linked to our e-learning materials.
- Develop a modular educational programme to enhance the clinical decision making skills of current paramedics and technicians.
- Link our learning activities to Personal Development Plans.

This will provide the following benefits:

It will support an aim to increase the level of 'treat and refer' following face-to-face assessment by an appropriately skilled paramedic with access to enhanced decision support and alternative pathways.

It will provide enhanced skills and development of scheduled care staff, within our control centres and those delivering care on the frontline, as well as corporate and support staff.

Learning Governance

Our staff are vital to our success, and it is clear that we cannot meet the challenges we face without a professional, competent and confident workforce. Learning governance and a learning and development policy will provide guidance regarding

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education, professional development and learning access that will enable us to realise our potential.

The purpose of learning governance is to provide consistent, clear and transparent guidelines for all staff participating in learning and development opportunities across the Scottish Ambulance Service. It also seeks to align learning and development opportunities with the strategic objectives of the Directorates and the Service. A Learning and Development policy will set out the guidance for staff members and managers that enable decisions to be made regarding access to learning and development opportunities, making links to the Knowledge and Skills Framework (KSF) where post outlines exist for roles.

The guidance will make reference to relevance, methods of development, resources, roles and responsibilities, effectiveness and equality of access. It also supports the Service requirement to evidence that we meet the Staff Governance Standard that staff are Appropriately Trained.

Learning and development opportunities will be focused on:

- Statutory/Mandatory Training
- Knowledge and Skills Framework (KSF) development
- Continuing Professional Development (CPD)
- Career development

Priority will always be given to learning and development activities that relate to the individual's KSF needs and strategic organisational Service needs.

The scope of learning governance will apply to all staff of the Scottish Ambulance Service completing the following activities:

- Undertaking appraisal and performance reviews.
- Devising Personal Development Plans (PDP).
- Setting personal objectives.
- Planning learning and development activities to meet Knowledge and Skills Framework (KSF) post outline requirements, including agreeing objectives for those activities.
- Providing a portfolio of evidence of achievement against KSF requirements.
- Applying for and approving study leave and/funding.
- Allocating/prioritising resources for learning and development activities.
- Constructing annual organisational learning and development plans.
- Evaluation of learning and development.

Access to Learning and Equality of Opportunity

The Service is committed to:

- Ensuring that learning and development opportunities are provided for all staff, as published on the Service's intranet site, @SAS.

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- Ensuring that resources for learning and development are distributed fairly, appropriately, timely and in a cost effective manner.
- Widening learning and development opportunities for staff requiring assistance with core skills, including literacy, numeracy and Information and Communication Technology (ICT) skills.
- Meeting differing learning styles and needs of staff.

Those commitments must be balanced by the requirements of the Service to meet its strategic objectives and to mitigate risk. Access to learning must take into account funding that is available, the delivery of priority organisational learning and development initiatives and the ability to release staff from roles with the minimum cost and impact to the Service and patients. Priorities will be influenced by statute, legislation, and professional bodies' codes of conduct and CDP requirements, Service and staff members' needs.

NHS Education Scotland

The Service continues to develop its relationship with NHS Education Scotland (NES) and to maximise its allocation of places within the National Leadership Unit's (NLU) Leadership & Management Development programmes. By providing facilitator resource the Service has managed to increase the number of delegates to the NLU's Leading for the Future programme from two to six per year and in 2013 applications were oversubscribed for this programme. Working in collaboration with NHS Education Scotland we are looking at supplementing existing opportunities by co-producing and delivering a further programme aimed at those with responsibilities of managing change.

Additionally and in line with the Scottish Government's Everyone Matters priority workstream – Capable Workforce; the Service has been working with NES Educational Projects department to develop resources aimed at widening access to learning and development across all roles, but in particular to support the learning needs of support staff in three key areas:

- Clinical healthcare support roles
- Administrative services
- Estates and facilities services.

This work has focused, primarily, on the learning needs of staff at Career Framework levels 1-4 who, in the main, are covered by the current Scottish Government definition of Healthcare Support Worker (HCSW). This also includes some staff in non-clinical roles working at higher levels.

Work will continue in 2014 in implementing and embedding a learning and development framework that maximises opportunities for all staff and leverages our relationship with key partners and stakeholders.

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Organisational Development

Organisational Development is aligned to our Strategic Workforce Plan and supports the delivery of 'Taking care to the patient' and the 2020 Workforce Vision by involving, engaging and developing our people.

There are a number of workstreams that will enable us to involve, engage and develop our people that can be categorised into four broad themes of leadership and management development (see section 3), talent management and succession planning, culture and values and building organisational development (OD) capacity and capability. Much of the activity however is cross cutting and interlinked across the workstreams.

Leadership & Management Development

The Service's strategic aims described in our 'Taking Care to the Patient' document describes a future where our leaders and managers are operating in an increasingly complex and challenging environment within tighter financial parameters and greater expectation to continually improve service provision. They therefore have to continue to adapt and improve their skills and competencies in order to operate efficiently and effectively in their rapidly changing environment.

The Service is committed to enable our leaders and managers to achieve their full potential and will do this in a planned and phased approach which will support the delivery of the overarching strategy.

Our primary focus is on implementing our 'Delivering Future Leaders and Managers' (DFLM) programme that is aimed at developing our 1st and 2nd level managers. Learning and development pathways comprised of a range of development modules have been designed to equip and enable this cohort of managers to continually improve their performance and potential.

As we move towards 2020, in addition to DFLM we will also identify, plan and deliver development for other leaders and managers in the Service from the Board, Executive and Non Executive Directors to senior managers and other managers in support departments and services.

The 'Delivering Future Leaders and Managers programme of work has a major part to play in supporting the ongoing delivery of our refreshed strategy. We also have a number of other leaders and managers out with the DFLM programme that play a pivotal role in delivering our strategy and developing our workforce. Identifying and addressing their development needs whilst ensuring that the approach dovetails with the DFLM programme will be key in enabling this to happen. One of the routes to leadership and management development throughout Scotland is through the National Leadership Unit in NHS Education Scotland that we have very strong links with and we shall continue to maximise the uptake of opportunities available through them.

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Talent Management & Succession Planning

Our talent management approach will be guided and driven by the strategic imperatives of this Strategic Workforce Plan and our corporate objectives.

We are clear as an organisation that talent development is for everyone in the organisation, not just a special few and our working definition of talent management for the Scottish Ambulance Service is:

“planning, managing and developing the current and long term potential of our workforce to achieve our organisational vision through a co-ordinated and systematic approach”

Our ultimate aim for our talent management approach is to have the right people, in the right place, at the right time, with the right skills. In order to achieve this our approach will be more planned, co-ordinated and consistent across the Service that anticipates future demand and requirements with clear focus and direction.

Our talent management approach is comprised of four key elements that are highlighted below:

Talent Management - Right people, right place, right time, right skills

Recruitment & Selection	Learning, Career Planning & Development	Performance Management	Succession Planning
<ul style="list-style-type: none"> • Establishing job requirements • Forward planning according to Strategic Workforce Plan requirements • Values based recruitment • Psychometrics • Assessment Centres 	<ul style="list-style-type: none"> • Induction & prep for new roles • Learning & development opportunities e.g. leadership courses, shadowing, secondment, project team • Personal Development Plans • Mentoring • Coaching 	<ul style="list-style-type: none"> • Setting expectations of job performance • Evaluating performance & potential • Providing feedback • Managing and improving performance 	<ul style="list-style-type: none"> • Identifying critical posts • Planning succession for critical posts • Forward planning and development initiated according to the Strategic Workforce Plan requirements

Culture & Values

The culture of our organisation is evolving over time but the NHS Scotland values we have adopted remain constant throughout. When we were developing our last HR/OD strategy “Doing the Right Thing” we undertook considerable work in partnership with our staff to determine what we wanted to have more of and what we wanted to have less of in regard to our cultural shift as highlighted in the table below.

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More of	Less of
Enabled & supported	Command & control
Involved & engaged	Told & instructed
Learning culture	Blame culture
Constructive feedback	Critical
Accountability & responsibility	Avoiding difficult conversations
One service	Silo working
Proactive	Reactive
Looking at Service holistically	Focus on one target
Trust & empowerment	Micromanagement

We will continue to build on the work to date to enable our cultural shift and further embed our values through development activity such as i-matter, the staff experience programme, leadership & management development, progression of initial 'Flying Lessons' work, team development, development of an internal coach team and development of an internal coach team.

Building OD Capacity & Capability

Our current OD resource is very limited given the challenging agenda ahead. In order to maximise the use of this resource and expand it further plans are being developed to progress two initiatives:

- The development of an internal coaching team
- Up skilling a cohort of staff with an OD skill set

Coaching is known to increase confidence, enhance individual performance and decision making and improve interpersonal effectiveness and has been used to great effect for leadership development and career planning for a number of individuals in the Service. We believe this should be extended to more individuals within the Service and developing our own internal coaching team will enable this to happen.

Likewise, OD interventions and activity will have little impact moving forward towards 2020 if we do not place further investment to increase the capacity and capability of this limited resource. Developing a cohort of staff from across the Service with key OD skills such as effective facilitation and presentation skills, how to take an effective brief and designing and delivering OD interventions will achieve this. This will initially be progressed through the development of an in house delivery team for the progression of the Flying Lessons work. It will also enable a more co-ordinated approach to our OD activity that gains traction and contributes to the delivery of our Strategic Workforce Plan and Corporate Objectives.

5.3 Recruitment & Retention

Recruitment

A recent review and internal audit of current recruitment practice across the Service was undertaken in conjunction with our internal auditors. This included an audit of local recruitment and selection procedures to establish where these were legally compliant and to identify where there was any variation against Service agreed policies. As a result of the outcome of this audit and review, work was undertaken to update the content of the Recruitment and Selection Manual with a view to unifying processes across the Service and introduce a more consistent approach.

Also as part of the National Project to implement the National HR (eESS) system, we are working with the eESS Recruitment Workflow Group to ensure there is a more effective computer based recruitment system (iRec) across the Service and NHS in Scotland. The group has developed a common set of guidance, forms and letters which will support the implementation of iRec. This in turn will support significant organisational change to align with a move towards shared HR services over the next few years. The success of the whole integration agenda is inextricably linked with the success of the use of a common system. This will also support the improvement of the quality of our people data and equality monitoring ability, supporting robust data management throughout the Service.

In addition, a number of other initiatives are being developed in conjunction with Job Centre Plus, Skills Development Scotland and collaboration with universities and Colleges, to address the growing concern about lack of job opportunities and employment for people in the 18-24 age range. We are also engaging with other emergency services in terms of sharing good practice around the whole Equalities agenda.

We are also looking to expand the number of young people employed through the Modern Apprenticeship scheme. We are currently exploring the possibility of including other support staff roles, in addition to our current fleet apprenticeships, such as administrative and control room staff.

In considering all of the actions outlined it is essential that in order to ensure a “Healthy organisational culture” (Everyone Matters: 2020 Workforce Vision Implementation framework and plan 2014-15) we must also ensure that the NHSScotland values are embedded in everything we do to allow us to develop and maintain an engaged and empowered workforce. In essence our recruitment and induction processes become the essential tools and gateways to allow this to happen.

In line with the above and the changes proposed within this Strategic Workforce Plan, consideration is being given to the processes, assessments, systems, training and procedural requirements to meet future needs. This will include a comprehensive review of the Fitness test and other selection tools which are tailored

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to our specific requirements. New recruitment processes are currently being developed for the assessment process for new managers as part of the Delivering Future Leaders and Managers Programme detailed above. The aim of all of this will be to ensure that our core values are incorporated into all of our behavioural competencies within our recruitment, induction and development reviews/appraisal processes.

This also forms part of our Person-centredness programme of work which sets out to ensure that all of our staff have the appropriate level of skills and knowledge to deliver person-centred care. We plan to involve patients in the Recruitment and Induction process with the longer term aim of improving services and standards of care of our staff in delivering person-centred care.

Another significant challenge we will face as we move towards 2020 is that of recruitment and retention in remote and rural Scotland. A number of initiatives have been looked at over the years to improve recruitment and retention rates in these areas with some success. We will continue to work with Territorial Boards, Voluntary sector and other agencies to improve the situation in these areas and support the wider integration agenda.

As detailed in Section 4, the development and introduction of the vocational qualifications route will improve access across communities which would support a broader spectrum of people from across all educational, age and social groups.

6.0 Implementation

6.1 Implementation, monitoring and refreshing

The development and implementation of this strategic workforce plan will require considerable discussion, consultation and a structured approach. This work will continue to be developed in partnership with staff through our Developing our Future Workforce Group and, additionally, supported by Skills for Health who have worked with the Service in 2013/14 to strengthen workforce planning capacity and skills and explore key roles requiring development across the Service. Whilst the specific number of staff is not yet fully modelled, there are a number of key assumptions set out, which will be progressed in this transition year 2015/16

- Review the role of frontline paramedics and support staff to ensure that those dealing with patients are able to operate effectively in an integrated model with access to alternative pathways, remote diagnostic capability and increased treatment at home and in the community;
- Develop the role of specialist paramedic to support both the integration of health and social care and provide additional critical care capability;
- Review the education and training model for frontline staff to ensure that staff continue to be appropriately trained for the roles they are performing;

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- Strengthen leadership and management capability implementing Scottish Ambulance Service's Developing Frontline Leaders and Managers programme and creating capacity for managers;
- Enhance education and clinical supervision in the Ambulance Control Centres to ensure more effective triage and dispatch of appropriate response to patients;
- Development of a 'one ambulance service' model reviewing and developing the role of the scheduled care service particularly to better support a more clinically focussed non-emergency service and management of flows across the wider NHS system.

Following on from the programme of work we have undertaken with the support of Skills for Health, the Scottish Ambulance Service will further develop workforce capabilities and move towards more dynamic workforce planning, including more effective horizon scanning, scenario planning based on projected patient needs and improved use of evidence, data and available tools and techniques to provide better-planned and delivered services for patients.

We will review the delivery of the national workforce plan annually to ensure it achieves what it set out to do. The Divisional and Departmental Plans will be reviewed on a regular basis (bi-monthly) via the local and national partnership forums. This will ensure that any planned outcomes and unintended consequences are continually measured and problems addressed.

In 2013, over a hundred managers across the Service, from the Executive and Senior management teams to staff on the road and support staff, were trained in the Six Steps Methodology. The '6 Steps' approach has been developed by the Workforce Projects Team at Skills for Health¹. By providing this training for specific managers on what workforce planning is and how it underpins the delivery of divisional and departmental delivery plans we will ensure that managers understand their responsibility to develop and monitor the delivery of this plan as part of their objectives. By reviewing this process we will ensure that the Service has the right people with the right skills and abilities available at the right time to play their part in delivering the highest possible standard of patient care and provide us with a sustainable workforce for 2020 and beyond.

RISK ASSESSMENT

A number of risks have been identified through the widespread consultation on the potential workforce model as detailed below:

- Insufficient funding to take forward the workforce model at pace
- Lack of engagement from both internal and external stakeholders
- Modelling assumptions could be wrong

¹ http://www.healthcareworkforce.nhs.uk/resources/latest_resources/six_steps_refresh.html and <http://www.skillsforhealth.org.uk>

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- Changes elsewhere in the system have a knock on effect on our assumptions and modelling.
- We do not effectively engage with all appropriate stakeholders.
- Development and implementation is delayed due to discussions, disagreements, negotiation or interdependencies.
- Not enough resource to carry out planning process to timescales.
- Structure of our Support and Administrative functions is not robust enough to ensure our Strategy is adequately supported.
- Sufficient resources are not available by way of skill, finance, technology, within our support services, to ensure our clinical function is developed and maintained going forward.

Mitigating actions are already being taken forward for most of these risks. In addition the Corporate Risk Register has identified the following areas as high risk for the Service:

- “There is a risk to patient care and staff welfare if we do not modernise skills and working practices quickly enough, for example, relief working, inappropriate working patterns...” (Risk CRR1, Corporate Risk Register)
- “There is a risk that limitations on operational and organisational capacity and resources may prevent SAS from delivering its workforce plan.” (Risk New (SAS Board 2014 1).

Control measures will be fully outlined as we develop our transitional plans to take forward the implementation of this strategic workforce plan. They will be progressed and monitored through the Developing Future Workforce Steering Group.

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*SCQF – Scottish Curriculum and Qualifications Framework, AHP – Allied Health Professional

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Appendix 1

Case Studies

Case Studies

John joined the Service as an Ambulance Care Assistant 10 years ago after being made redundant from his previous employment as a joiner. He had always wanted to progress onto A&E duties but had been held back by his lack of qualifications meaning he couldn't apply directly for the Cert HE. He had considered going back to college but had always been inhibited by his busy work and family life. John applied for a role as a Technician 1 with the Service and was successful in being offered a post. As the training for the role was a Vocational Qualification at Level 3 there were no formal entry requirements. John completed his VQ Level 3 over a 9 month period qualifying at a Technician 1 and then he moved onto the VQ Level 4 programme. After a further 9 months John qualified as a Technician 2. During his Technician 1 and Technician 2 training John had been working alongside a Paramedic and this had sparked his interest in undertaking further education. John Applied for a student Paramedic vacancy on a nearby station and was accepted as a direct entrant onto year two of the BSc programme at GCU. The students on year one had covered the same content at John had on his VQ Level 3 and Level 4 and he was able to slot right in to the programme. After the 2 years on the GCU programme, spending most of his time out on placement in division, John qualified with a BSc (Hons) and was able to register with the HCPC as a Paramedic.

Jenny was an IHCD Technician who had undertaken the programme at Barony in 2005. She had always wanted to build up experience before applying for her Paramedic training, but had reached that point where she at last felt she was ready. Jenny had completed the bridging module to allow her to apply for the programme and was a cleanliness champion on her station having done the NES programme online. Jenny applied for a student Paramedic vacancy that came up on her station and was offered the post. Jenny had been nervous about undertaking academic study, but the bridging module had helped settle some of those fears and colleagues that had attended GCU before reassured her there was lots of support from the Academy team and the university academic developers. Jenny was able to join the BSc programme directly into year 2 and she found her 10 years of experience on A&E really helped her with the practical work. Jenny was able to share her experience with some of the other students that had been through year 1 of the programme and they helped her with some of the academic work. As Jenny had been operational for over 5 years some of her practice placement was working and some was allocated to supernumerary time. When Jenny was supernumerary she was able to get fully involved in all aspects of delivering patient care, even when they had a really poorly patient – Jenny didn't need to step out the saloon to drive to hospital. Jenny completed year 2 and year 3 of the programme and graduated from GCU with a BSc (Hons) in Paramedic Practice, allowing her to register with the HCPC as a Paramedic.

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Arthur had always wanted to be a Paramedic for as long as he could remember. His uncle was in the ambulance service and he had a good idea of what the role entailed. He had spent time talking to other staff in the Service, had visited the local station and spoken with a line manager and had done lots of research about career progression in the Service. Arthur knew it wasn't all like "Casualty". Arthur had left school after his Higher and worked in the local NHS hospital as a Healthcare Support Worker. He had applied to GCU for the BSc in Paramedic Practice and although he had been unsuccessful on his first attempted he had finally got in. Arthur progressed through three years of the programme at the Ambulance Academy, spending time in the classroom learning theory, time in the simulation centre undertaking practical and time out on placement with the ambulance service. Arthur really enjoyed his time on placement; he had spent time on a PRU, with a double crew, with PTS, in the control room, in A&E, in theatres, working with mental health and community teams, and had especially enjoyed the week he spent with the ASSET team in Lanarkshire. When Arthur was on placement he had been supernumerary meaning he could make the most of his time with a mentor. As he had progressed through the three year programme he had been given more and more responsibility but knew there was always someone there to support him. After three years on the programme Arthur qualified with a BSc (Hons) in Paramedic Practice and was able to register with the HCPC as a Paramedic. He then applied for a job with the Scottish Ambulance Service as a Paramedic and was able to start work days after registering.

Heather had been in the Service for over 15 years, starting on PTS and then progressing onto A&E as a Technician. She had qualified as a Paramedic in 2004 after completing the IHCD course at Barony. She had never really thought about furthering her career and had no desire to become a manager. When the Specialist Paramedic (Urgent and Emergency Care) posts were advertised in her division she was keen to find out more and had spoken to her line manager about the new role. Heather felt the idea of seeing people and treating them in a homelike environment was right up her street. She had often felt that there were patients that didn't need to attend A&E but she didn't have the skills or pharmacological interventions to manage them at home. After successfully being recruited for a Specialist Paramedic post she was signed up to a BSc programme at GCU. The course was 2 years long and was completed part time alongside working. The course covered academic study techniques as well as human factors and education specific to the role of the Specialist Paramedic. Heather enjoyed studying alongside nursing students and qualified nurses and found the practice placement embedded the classroom learning. On qualifying Heather was awarded a BSc in Paramedic Practice (Urgent and Emergency Care) and took on the role of a Specialist Paramedic. She knew that the journey didn't stop there as the Service wanted all the Specialist Paramedics to continue study at Post Graduate level as per the recommendations of the College of Paramedics career framework but that suited Heather as she saw the benefits of this in terms of the parity with other Health Care Professionals.

Derrick had worked as a Paramedic Practitioner for the Service for the last 4 years. He had completed a number of modules at a local university and had been awarded a degree, although it was in Professional Practice as the university didn't award named Paramedic awards at the time. He had worked in his local area providing cover for the ambulance service and assisting with 'Out of Hours' cover for the local GP surgery. When the Paramedic Post Graduate programme at his local university started he was keen to apply and his line manager had supported the application as part of his development. The course allowed him to study at Masters level and he could step off with a Post Graduate Diploma (at Specialist Paramedic level) or stay on the programme and achieve a Masters. Derrick knew that the Service was developing Advanced Paramedic roles and these staff would need to be educated at Masters level so he saw the benefit of undertaking the programme. He was keen to be an Advanced Paramedic as this would allow him access to prescribing rights when the law was changed, he could supervise and provide advice to the other Specialist Paramedics in his division and he would be able to provide more care for the patients in his locality in their homes. Derrick was also able to work closer with the local GPs and other Health Care Professionals to provide anticipatory care services, reducing the emergency demand on the ambulance service.

Hilary had been a Paramedic in the Service for over 20 years. She had started her career on PTS and had worked as a Technician for 5 years before undertaking her Paramedic training. She had worked on the same station for most of her career and was really settled in the local community, even giving up her own time to attend the local school and youth groups to give talks about the role of the ambulance service. Hilary had kept abreast of the Service's new strategy and knew that in the future there would be more emphasis on providing care in the patients' home or a homely setting. This was reflected in the desire of the Service to be able to manage more of their patient group without them having to go to A&E. When the Service changed the scope of practice for Paramedics Hilary was keen not to be left behind the newer Paramedics qualifying through the university. She signed up to undertake the conversion course offered by the Service which allowed her to develop new skills in the assessment of minor illness and the management of minor injuries as well as allowing her to learn more about human factors (and the impact of that on patient safety) and evidenced based practice. The programme was assessed with written work and completion of OSCEs where she had to demonstrate some of her new assessment and management skills. Hilary was offered the opportunity to undertake some academic work alongside the skills teaching and assessment but she decided that it wasn't for her at this stage of her career; some of the others in her cohort were going to submit assignments to the university and come away with academic credits they could put towards a BSc. Hilary couldn't wait to use the new skills she had learnt to benefit the patients in her local area. She felt more confident to assess patients and make decisions about their disposition and she was able to provide more appropriate care for people in their own homes, something that supported the 2020 vision of the NHS and also suited people that didn't want the long journey to their nearest hospital when they could be safely treated in their homes.

Adrian had been a Nurse for 7 years before joining the ambulance service. He had worked in a variety of settings including A&E and the community. He hadn't really planned to join the ambulance service when he had first qualified as a Nurse but had been really interested when the Service had started to expand the range of health professionals it employed. Adrian had initially joined the Service to work in the Ambulance Control Centre as a Clinical Advisor and had enjoyed the challenge of managing patients through hear and treat rather than face-to-face. He was able to intervene in calls and avoid an emergency ambulance having to travel on blue lights to the patient, often being able to manage the callers medical problem over the phone. Sometimes he would give advice and sometimes he would signpost the caller to the appropriate point of care. Although Adrian enjoyed the role he had become more and more interested in becoming a Paramedic. He had done some observer shifts with local ambulance crews and had spoken to some of his Paramedic Clinical Advisor colleagues about their experiences out on the road. When the opportunity to apply for Paramedic training came up he jumped at the chance. Because he was already a qualified Health Care Professional he was able to sit down with the Programme Lead at GCU and map his previous education and experiences against the 3 years of the Paramedic programme looking for areas he might be able to apply for Recognition of Prior Learning with the university. There were a number of areas across the whole programme that he could RPL and the appropriate processes were followed at the university to allow these credits to be awarded. He then attended a condensed programme which covered the other areas of study, passed the assessments (which were practical and academic) and was awarded the BSc (Hons) in Paramedic Practice. This allowed him to register with the HCPC as a Paramedic alongside his registration with the NMC as a Nurse. Because Adrian could RPL some of the content he was able to qualify a little bit quicker than if he had been starting the programme from the beginning and he had been able to undertake bank shifts as a Clinical Advisor in the ACC alongside his study.

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Equality Impact: Screening and Assessment Form - Appendix 2



Section 1: Policy details - policy is shorthand for any activity of the organisation and could include strategies, criteria, provisions, functions, practices and activities including the delivery of our service.	
a. Name of policy or practice (list also any linked policies or decisions)	SAS Strategic Workforce Plan 2014-2020 linked to Equality Monitoring Report 2013-14, Refreshed Strategy: Taking Care to the Patient, Corporate Plan, Recruitment Policy
b. Name of department	Human Resources
c. Name of Lead	Rebecca Chalmers, Director of HR and OD/Coralie Colburn, HR Manager
d. Equality Impact Assessment Team [names, job roles]	Delivering our Future Workforce Group which consists of the following: - full Executive Team Coralie Colburn, HR Manager Steph Phillips, Head of Strategy John Burnham, Head of Education & Professional Development Matt Cooper, Education Team
e. Date of assessment	Initial date 5 th January 2015
f. Who are the main target groups / who will be affected by the policy?	All current and future workforce as we move towards 2020
g. What are the intended outcomes / purpose of the policy?	The landscape in which the Scottish Ambulance Service operates is changing and the need for SAS to become a modern, flexible and responsive organisation has never been more acute. The Service must be able to support the wider integration of health and social care and the delivery of the Scottish Government's 2020 Vision where care is increasingly delivered locally, often at home, with pathways for patients being person-centred and appropriate. Our current workforce will be the basis of our future workforce. Our future

	workforce will have to be affordable, available and, above all, adaptable. Our aim is to develop the right clinical skills and roles to enhance the treatment we offer and make better decisions for patients every day.
h. Is the policy relevant to the General Duty to eliminate discrimination? advance equality of opportunity? foster good relations?	Yes, all three elements of the duty
If yes to any of the three needs complete all sections of the form (2- 7) If no to all of the three needs provide brief detail as to why this is the case and complete only section 7 If don't know: complete sections 2 and 3 to help assess relevance	

Section 2: Evidence, consultation and involvement

Please list the available evidence used to assess the impact of this policy, including the sources listed below. Please also identify any gaps in evidence and what will be done to address this.

a. Previous consultation / involvement with community, including individuals or groups or staff as relevant. Please outline details of any involvement / consultation, including dates carried out and protected characteristics			
Details of consultations - where, who was involved	Date	Key findings	Protected characteristics
Developing Future Workforce Group	Monthly throughout 2014	The SAS Workforce data has been updated throughout the production of this plan. We have worked with NES to review the SAS data against the rest of the NHS as well as review the trends of the existing SAS reports.	Age
Staff Governance Group	4 th December 2014		Disability
National Partnership Forum	3 rd December 2014	As we have reviewed this data in line with the Equality Monitoring data the following areas have been highlighted and will require more in depth analysis and consultation: -The potential impact of the changes on our older workforce who may not feel that they have the same	Gender reassignment
Senior Management Team			Gender / sex

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Shop Stewards Meetings	Confirm dates with Steph/John etc	<p>access and ability to respond to the changes in Education practice.</p> <ul style="list-style-type: none"> - the percentage of females within the Service is increasing but there is still a disproportionate number of males in Bands 6-8a. We are doing some further work on career moves (e.g. Tech to Para, Team Leader recruitment etc). - Further Education statistics, provided by NES, require further consultation. These show some interesting figures on age, gender, ethnicity, education levels and social background of our students. - During the review of our liV status, our guidance has been updated to reflect refreshed strategy and requirements of volunteers. - The overall SAS Strategy will ultimately impact on all protected groups as we increasingly take care to the patients. - The introduction of the VQ model aims to support a broader spectrum of people from across all educational, age and social groups who possibly do not have the necessary qualifications to access our current Certificate and Diploma courses. This model would also support internal movement and those from rural areas (expand). 	Marriage / civil partnership *
NES – National Education Scotland	2014/2015 various		Pregnancy / maternity
			Race
			Religion / belief
			Sexual orientation
		<p>Cross cutting - e.g. health inequalities - people with poor mental health, low incomes, involved in the criminal justice system, those with poor literacy, are homeless or those who live in rural areas.</p> <p>Other?</p>	

	Available evidence
b. Research and relevant information	SAS Strategy: Taking Care to the Patient, Everyone Matters: 2020 Workforce Vision. NHSS strategic direction linking the Health and Social Care agenda and the drive to deliver more care locally and often at home, has necessitated the need to review how our workforce delivers our service.
c. Knowledge of policy lead	Workforce Lead for SAS and member of NHSS National Workforce Forum (NWPF) who are working under the HRD's

	to review and improve workforce planning across NHSS.
d. Equality monitoring information -- including service and employee information	Equalities Manager and Equality Monitoring data HR Systems Administrator reporting NES – detailed workforce data
e. Feedback from service users, partner or other organisations as relevant	NWPF, SAS Stakeholder days, Shop Steward meetings, Work with voluntary sector
f. Other	
g. Are there any gaps in evidence? Please indicate how these will be addressed	Further analysis needs to be done at a local level on the following: <ul style="list-style-type: none"> - Age profiles - Gender balance on Certificate and Diploma courses - Career development opportunities across gender
Gaps identified	More work needs to be done on developing modern apprenticeships, socially inclusive recruitment access of certain ethnic and disability groups to our operational roles
Measure to address these; give brief details. Further research? Consultation? Other	As above in g. Further detailed analysis required and consultation on impact on both current and future workforce.
Note: specific actions relating to these measures can be listed at section 5	

Section 3: Analysis of positive and negative impacts
Please detail impacts in relation to the three needs specifying where the impact is in relation to a particular need - eliminating discrimination, advancing equality of opportunity and fostering good relations

Protected characteristics	i. Eliminating discrimination	ii. Advancing equality of opportunity	iii. Fostering good relations
Age			
Positive impacts	The introduction of a VQ model will greater equality of access across age groups for those who possibly lack the required educational qualifications but would cope better with a more vocational route. Training will also be more locally based therefore supporting routes into our service across communities and potentially making our workforce more diverse in mix and reflective of the patients we see. Increased opportunities for those young people to enter the SAS under the Modern Apprentice Scheme.		
Negative impacts	Older staff who may struggle to cope with the rate and pace of change to Education system and news ways of working		
Opportunities to enhance equality	The potential new education model will cross a number of boundaries with the hope of improving access to training and development across all groups within our current and future workforce.		
Disability			
Positive impacts	The introduction of one year work placements for individuals from disability groups will support the independent living agenda		
Negative impacts	Inability for some disable staff to join the service e.g. how does the model fit with disabled staff who cannot drive		
Opportunities to enhance equality	Further work needs to be done around how this model where operational staff may work very differently e.g. in GP surgeries or with local health and social care teams, fits with adjustments which could be made for disabled staff.		
Gender reassignment	Not enough statistical information available at this time to assist with this analysis		
Positive impacts			
Negative impacts			
Opportunities to enhance equality			
Gender / sex			

Positive impacts	Increased numbers of females will address the gender balance
Negative impacts	There is still a disproportionate number of males in Bands 6-8a
Opportunities to enhance equality	Further work required on careers development and gender balance on Academy courses.
Marriage / civil partnership	
Positive impacts	
Negative impacts	
Opportunities to enhance equality	
Pregnancy / maternity	
Positive impacts	
Negative impacts	
Opportunities to enhance equality	
Race	Limited information for analysis
Positive impacts	
Negative impacts	
Opportunities to enhance equality	There is limited information in this area although this is improving. Opportunities for employment need to be more widely publicised across a broader range of groups to get a broader range of applications from areas where we lack diversity in our current profile.
Religion / belief	As above
Positive impacts	
Negative impacts	
Opportunities to enhance equality	
Sexual orientation	The status of reporting needs to improve as this is not currently accurately reflected
Positive impacts	
Negative impacts	
Opportunities to enhance equality	
Cross cutting - e.g. health inequalities people with	Changes and improvements in access to training and education will be influential across all groups regardless of protected characteristics.

poor mental health, low incomes, involved in the criminal justice system, those with poor literacy, are homeless or those who live in rural areas. Other	Initial analysis of our absence data by geographical area is reflective of the Health Inequalities data which shows higher incidence of poor health within the West of Scotland. Further work required in this area.
Positive impacts	
Negative impacts	
Opportunities to enhance equality	Better understanding of how our workforce absence data fits within the broader health economy will help direct supported improvement in this area through our Occupational health Strategy.
Note: specific actions relating to these measures can be listed at section 5	

Section 4: Addressing impacts

Select which of the following apply to your policy and give a brief explanation - to be expanded in Section 5: Action plan

	Reasons
a. No major change - the EQIA shows that the policy is robust, there is no potential for discrimination or adverse impact and all opportunities to promote equality have been taken	There is general understanding of our current profile and areas for improvement. With the roll out of eESS and work with NES we will ensure better workforce data reporting and our ability to respond to this.
b. Adjust the policy – the EQIA identifies potential problems or missed opportunities and you are making adjustments or introducing new measures to the policy to remove barriers or promote equality or foster good relations	
c. Continue the development and implementation of the policy without adjustments – the EQIA identifies potential for adverse impact or missed opportunity to promote equality. Justifications for continuing without making changes must be clearly set out, these	

should be compelling and in line with the duty to have due regard. See option d. if you find unlawful discrimination. Before choosing this option you must contact the Equalities Manager to discuss the implications.	
d. Stop and remove the policy - there is actual or potential unlawful discrimination and these cannot be mitigated. The policy must be stopped and removed or changed. Before choosing this option you must contact the Equalities Manager to discuss the implications.	

Section 5: Action plan					
Please describe the action that will be taken following the assessment in order to reduce or remove any negative / adverse impacts, promote any positive impacts, or gather further information or evidence or further consultation					
Action	Output	Outcome	Lead responsible	Date	Protected characteristic / cross cutting issue*
* list which characteristic is relevant - age, disability, gender reassignment, gender / sex, marriage and civil partnership, pregnancy and maternity, race, religion / belief, sexual orientation or cross cutting issue e.g. poor mental health, illiteracy etc					

Section 6: Monitoring and review	
Please detail the arrangements for review and monitoring of the policy	
	Details
a. How will the policy be monitored? Provide dates as appropriate	
b. What equalities monitoring will be put in place?	
c. When will the policy be reviewed? Provide a	

review date.	
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Section 7: Sign off Please provide signatures as appropriate

Name of Lead	Title	Signature	Date

Completed form: copy of completed form to be retained by department and copy forwarded to Equalities Manager for publication on Service website

Provide date this was sent	
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