Scottish Ambulance Service

Remobilisation Plan
April 2021- March 2022

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Executive Summary

This Remobilisation Plan for 2021-2022 aligns to "Re-mobilise, Recover, Re-design: The Framework for NHS Scotland," published by the Scottish Government on 31 May 2020. Its overarching purpose is to maintain and to keep building on our contribution to the redesign of the wider health service in response to and recovery from the COVID-19 pandemic. As we do this, we will continue to embed new ways of working, while supporting the physical and psychological wellbeing of our workforce.

Our 2020-21 plan largely focused on our efforts to explore and nurture positive clinically driven changes that were established as part of our response to the pandemic, while continuing to deliver the best care whenever and wherever possible. This document is an iteration of last year's plan, applying what we learned during this period to keep improving our patient and staff experience, as well as learning from the wider health and care system: e.g. the rapid review of NHS Ayrshire and Arran's test of change for the Redesign of Urgent Care. It is also worth noting that as we restart the co-production process for our 2030 strategy, which we paused during our response to the pandemic, the 2021-22 plan will effectively become the first phase of our 2030 Strategy implementation plan.

As we did in last year's remobilisation plans, we will keep building on the gains of the recent COVID-19 pandemic. At the same time, we will continue to capture learning in order to transform services with new techniques, technology and clinically safe care and pathways for patients. We will do this whilst ensuring we have the capacity to deal with the continuing presence of COVID-19, winter and other potential pressures.

We will continue to support the national recovery from the pandemic in pursuit of Scotland's goals of a greener, fairer, more sustainable country.

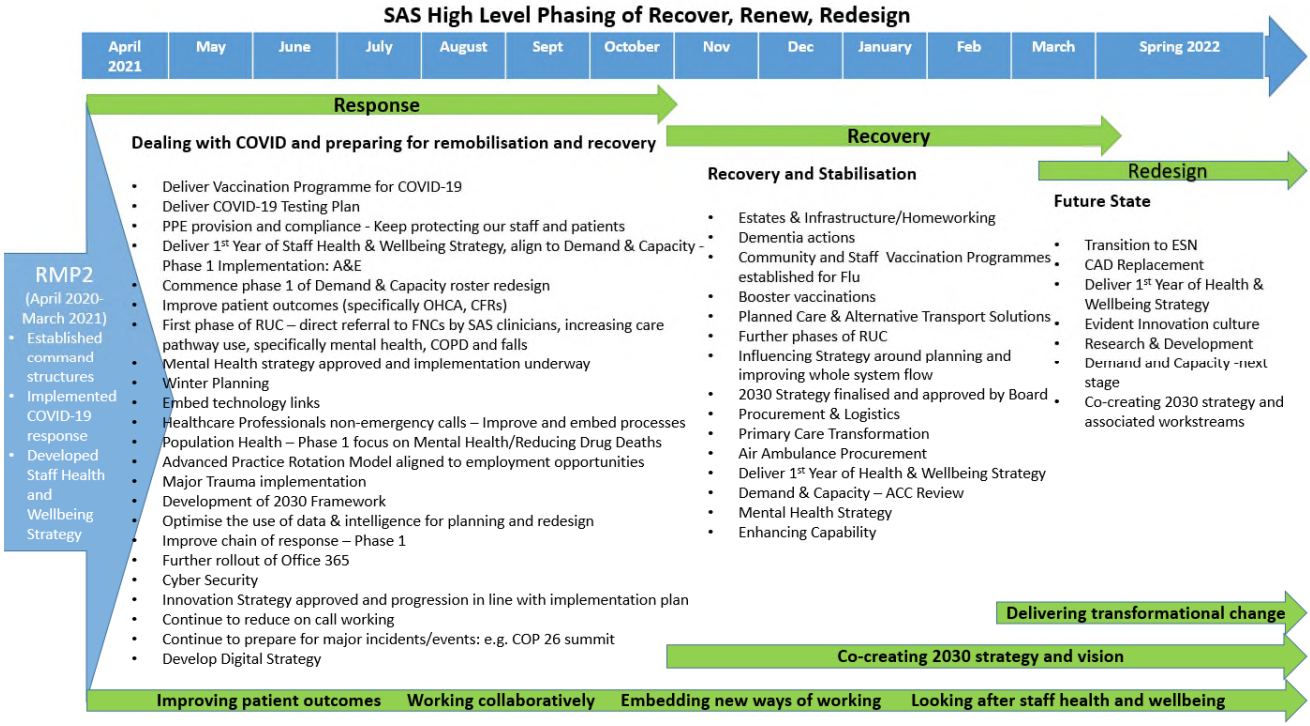
The broad **aims of the remobilisation plan** to March 2022 are to deliver essential services, while living with COVID-19. To do this we will:

- Ensure the **health, wellbeing and safety** of staff and patients.
- Reduce harm by ensuring effective **demand management** procedures are in place.
- Ensure that we have sufficient **workforce capacity** to manage further waves of COVID-19 incidents effectively, on top of existing demand and seasonal pressures.
- Recover and renew to a better, more **innovative and digitally enabled** sustainable model than the pre-pandemic one.

The document describes in some detail the work plan and deliverables across our Service between now and March 2022. As we embed new ways of working, some of the work streams will continue beyond 2022 as we build more whole system approaches and continue to prepare to drive forward innovations, as the demands of our pandemic

response, from winter pressures and any challenges from the UK's exit from the EU begin to reduce.

We have structured the plan into the 3 phases below with the key priorities aligned against each of the phases.



This document describes not only what we will do but also how we will do this. Our new ways of working depend on **collaboration**. We will continue our integrated and collaborative approach with our primary care colleagues, IJB's, Health Boards, Emergency Services, our staff, patients and the public.

Examples of this approach to working include:

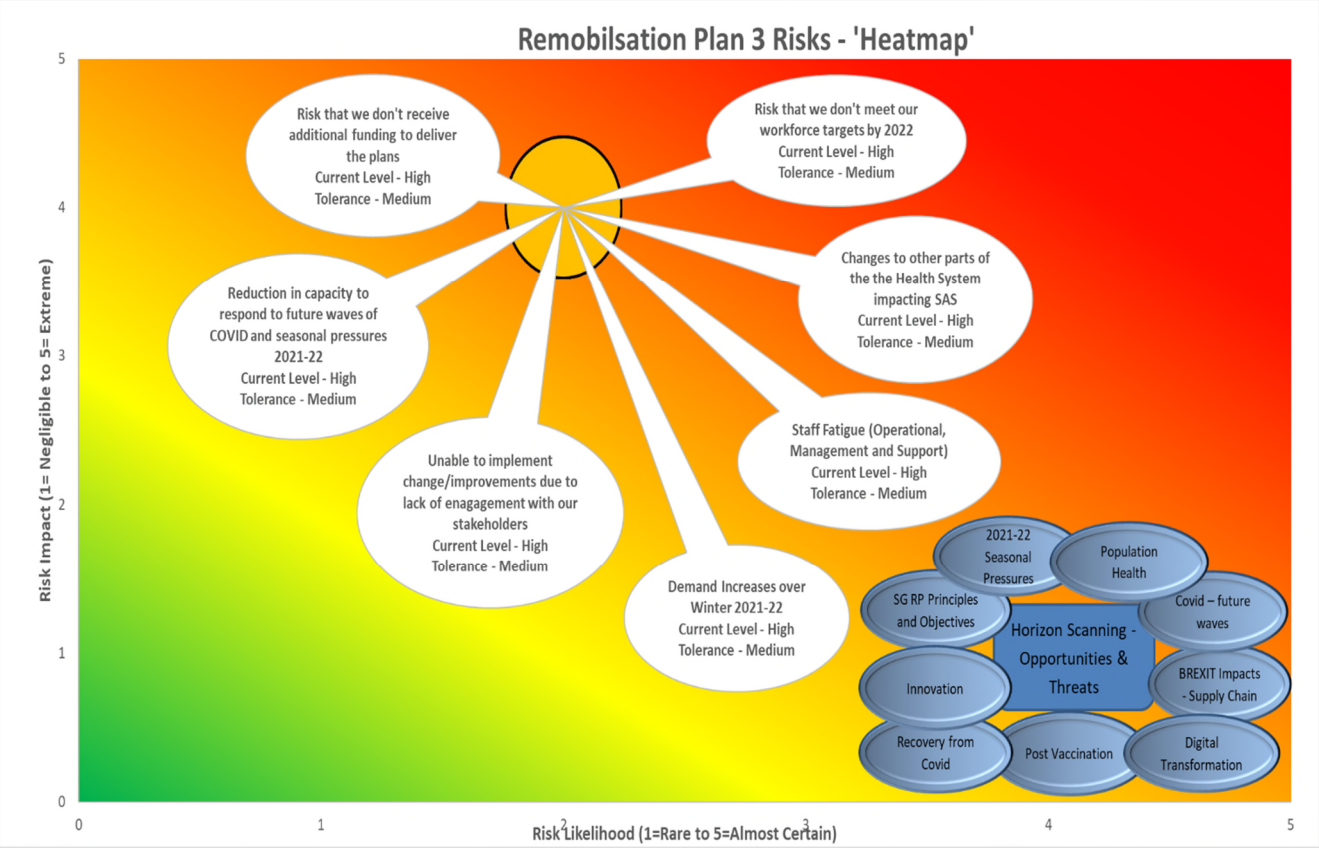
- Engaging with the public through a range of initiatives designed to improve Population Health.
- Working with IJB's to agree priority areas to improve patient experience and
- Redesign Urgent Care.
- Co-designing direct support models to primary care through delivery of patient interventions.
- Continuing to work closely with Board COVID-19 Community Hubs utilising the ability for both Advanced Practitioners and paramedics to make direct referrals.

We also recognise that as a National Board there is an opportunity to collaborate with the other National Boards and play a lead role in two important areas of recovery and renewal: the primary care reform agenda, including the Redesign of Urgent Care; and improved public health through shared data and improved intelligence. The Service participates in a range of national initiatives and is a member of the Planning Directors group, which includes representation from Scottish Government and all NHS Boards. The Group works to ensure there is alignment in planning across all NHS Boards, particularly for national initiatives such as the Redesign of Urgent Care, scheduled care, flu vaccination and finance.

We continue to manage and mitigate our Board **risks** in line with our risk management governance processes. These Board risks are clearly aligned to our remobilisation plan with our delivery plans providing additional mitigations against a number of them, including crucially against one of our highest risks; our demand and capacity.

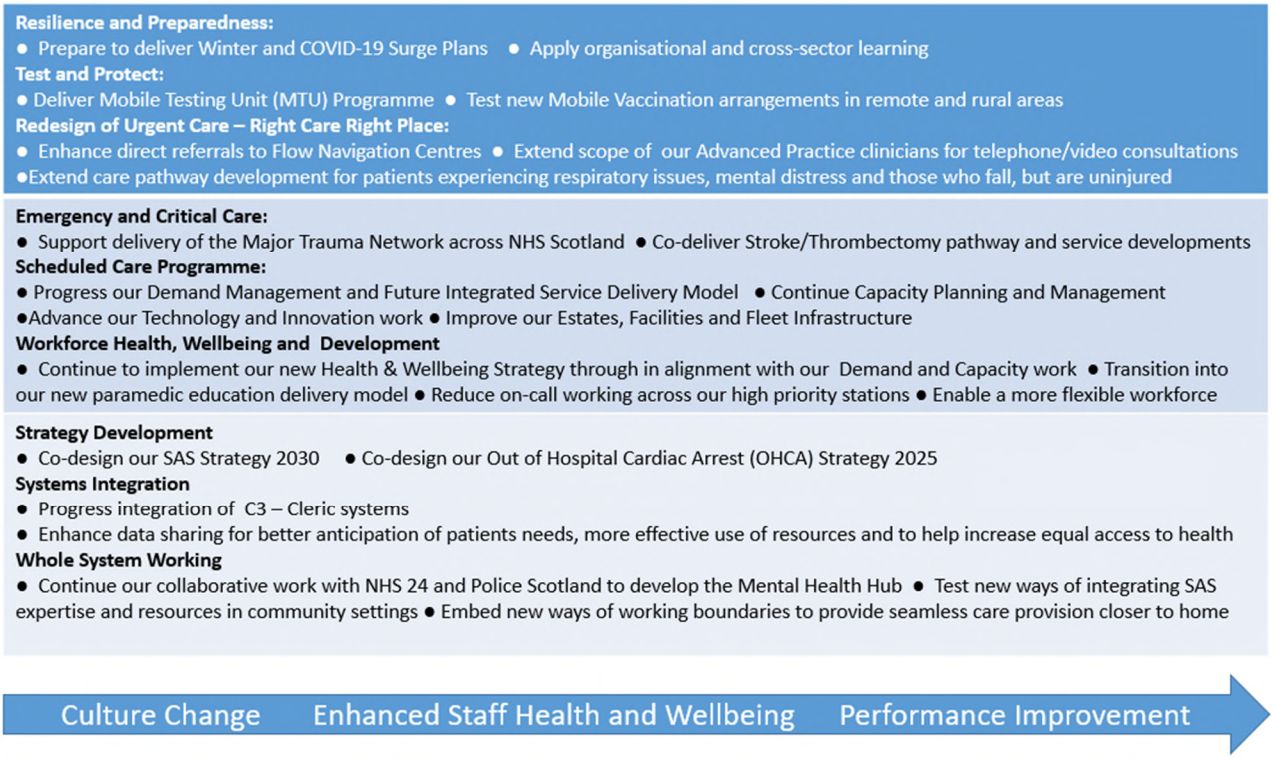
The heat map below describes the operational risks relating to this plan, assessed against the tolerance levels. There are also very detailed controls and mitigations in place to manage theses risk and bring them to within tolerance. We have also included horizon scanning information, identifying external factors and scenarios that we are aware of as we manage our key risks. No remobilisation risks cause us undue concern at this stage.

Remobilisation Risk Heat Map



The Board has also identified our appetite for risk across an agreed range of generic and specific clusters that describe the spread of our service and strategic priorities, the output of this is described in Appendix 1. The Board's appetite for risk along with our supporting risk appetite statement has informed the development of our plans within each work stream. This will continue into the future as the plans are refined and the Board's appetite for risk is reviewed on an annual basis. We have compiled and we are routinely monitoring a detailed risk register to support the delivery of this plan.

Our plan describes our role within a **whole system approach** of continuous improvement, digital innovation and sustainable delivery to ensure that safe, equitable, person centred, efficient, effective and timely care is provided, and will describe in detail the following key priorities.



Against each of the points above, the sections below will describe what will be delivered by 31st March 2022, and the intended outcomes because of this. These outcomes will link to our Remobilisation Measurement Framework that we will use to monitor progress on this plan.

1. Introduction

The Service continues to occupy a unique position and role within health care provision in Scotland. During our response to and remobilisation from the COVID-19 pandemic, we were able to build on the strengths of our traditional and emerging service provision, evidenced by our ability to establish a Mobile Testing Unit (MTU) model. This was developed and successfully delivered in under six weeks, with almost 500 new staff employed across the country, and achieving around 95% utilisation of MTU teams.

We operate across Public Safety, Health Care, Public Health, and as a mobile service meeting the scheduled, unscheduled and emergency care needs of the population of Scotland in every community 24 hours, 7 days a week. Our responsibility therefore, during this next phase of remobilising health and care services to March 2022, is to continue to deliver the best care when and where we can. We will build upon the gains of the recent COVID-19 period with new techniques, technologies and clinically safe and faster pathways to care for patients, whilst caring for staff, and we need to ensure we have the capacity to deal with the continuing presence of COVID-19 and to be prepared for the winter pressures.

We will continue to support the national recovery from the pandemic in pursuit of Scotland's goals of a greener, fairer, more sustainable country. This COVID-19 Remobilisation Plan details the work scheduled by the Service from April 2021 to March 2022 and our contribution to these three goals.

We have scrutinised the recently published Audit Scotland review of how the NHS in Scotland responded to the COVID-19 pandemic, NHS in Scotland 2020, and we have woven the key messages from this report into our remobilisation plan. Their suggested focus on the key areas of tackling health inequalities, improving staff wellbeing, increasing effective collaboration, and ensuring thought has been given to prioritise improvements have already been an influence on how we shape our Service, and we will continue to be aware of these as we move towards implementation of this plan.

This plan sets out our targeted initiatives showing what we aim to achieve during this timeframe and describes the benefits to our staff, improvements in care to all patients, and benefits to our partner organisations.

Governance Process

The first draft of this plan was presented to the Board at the January 2021 meeting for early feedback, this was further refined at a Board development session in February and the Board was fully supportive of this plan. The final version following Scottish Government feedback is due to be submitted to the March 2021 Board meeting.

Our Recovery Planning Group, chaired by the Chief Executive, will continue to meet on a 4-weekly basis, and is responsible overall for the implementation of the 2021-22 plan. In addition, a fortnightly Recovery Delivery Group, which reports to the Planning Group, will meet to ensure delivery risks and actions are being progressed. Each work stream in the plan has been allocated an Executive lead supported by a Delivery lead and highlight

reports are produced for review on a fortnightly basis. This group includes representation from our staff side colleagues, and engagement required with other stakeholders will continue as work streams get underway.

2. Principles & Objectives

On 31st May 2020, the Scottish Government published its *'Re-mobilise, Recover, Re-design: The Framework for NHS Scotland'* document which sets out the aims and approach for Scotland's health and care system as it emerges from the COVID-19 pandemic. This framework is the foundation for our 2021-2022 Remobilisation Plan. The framework describes the seven principles and eight objectives that should guide and focus our intentions through this next phase of remobilisation.

These principles and objectives are:

Principles	Objectives
i. Services that can resume most safely ii. Achieving greater integration iii. Quality, values and experience iv. Services close to people's home v. Improved population health vi. Services that promote equality vii. Sustainability	i. We will retain & build resilience ii. We will minimise excess mortality & morbidity from non-COVID-19 disease iii. We will re-establish services, prioritised to clinical need & reflecting population demand iv. We will focus on approaches that create better population health and wellbeing v. We will support people to recover, including their health & wellbeing vi. We will embed innovations & digital approaches vii. We will ensure the health & social care support system is focused on reducing health inequalities viii. We will engage with the people of Scotland to agree the basis of our future health & social care system

While recognising the many interdependencies between these principles and objectives, the following plan describes how our key themes and programmes will support delivery of these principles and objectives during 2021-2022, and, indeed, beyond this period.

3. Our Response, Remobilise & Renewal

This phase of our remobilisation plan will align closely to our longer-term response, recovery and renewal plan, and to the Scottish Government's four phase Route Map.

In summary, this comprises:

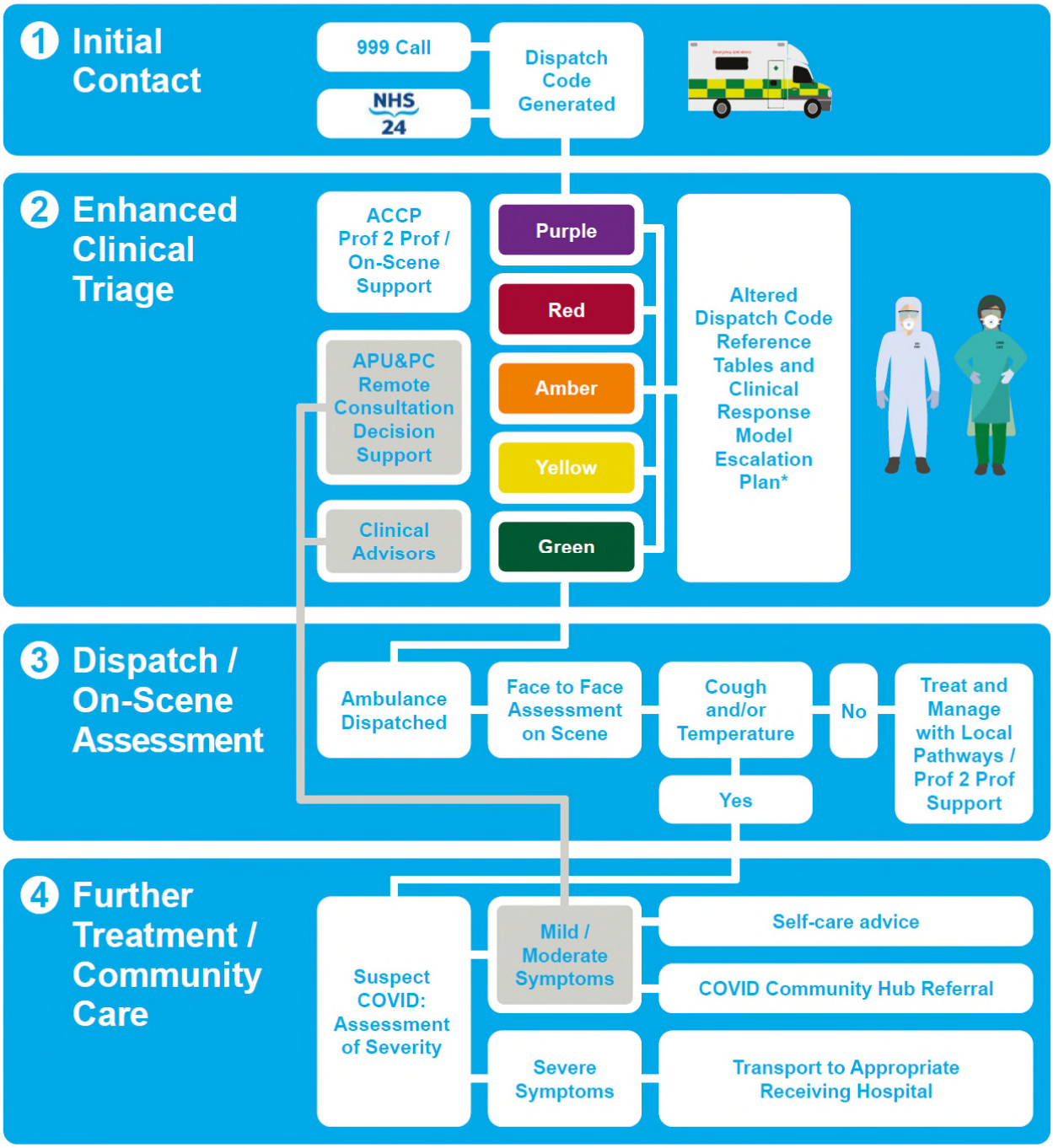
Response Phase: We have further reviewed our pre-COVID-19 service model in the context of changes and initiatives that were introduced in response to the crisis.

Remobilise Phase: We have created the conditions where our "new" service model can be developed, adopted and supported within a structured programme of work whilst at the same time recognising the remobilisation being put in place across NHS Scotland, to both restore the economy and population health. This plan to March 2022 sets out how we will keep building on this work.

Renewal Phase: We are still at the early stages of our renewal phase, and are beginning to adjust to a new way of service provision. To do this we will align our strategic ambitions to the improvements adopted through the Response and Remobilise phases, pushing the role and contribution of the Service into areas of provision that optimise the benefits we can bring to the public, staff and our partners. This phase will involve new and visionary thinking. As with our previous Remobilisation Plan, we will use the '*Bridges to the Future*' model and frameworks from the Royal Society for the encouragement of Arts, Manufactures and Commerce which aim to help organisations understand and develop the measures implemented as part of the crisis response.

The following illustration summarises our chain of response for emergency patients, which was developed so we are able to provide safe care for patients with suspected COVID-19, while also improving outcomes for non-COVID-19 patients. This response model will form the basis of our ongoing approach to the management of emergency, urgent, unscheduled and scheduled presentations throughout the lifetime of this remobilisation plan and into our renewal phase.

SAS adapted our chain of response



This remobilisation plan focuses on the opportunities, ambitions and actions we will pursue to the end of March 2022, and will describe:

- Our role in surveillance, whole system planning and integration of service delivery to support the emerging needs of the most vulnerable, as identified by Public Health Scotland: people with dementia, mental health deterioration, stroke, musculoskeletal (MSK) injuries, and Chronic Obstructive Pulmonary Disease (COPD).

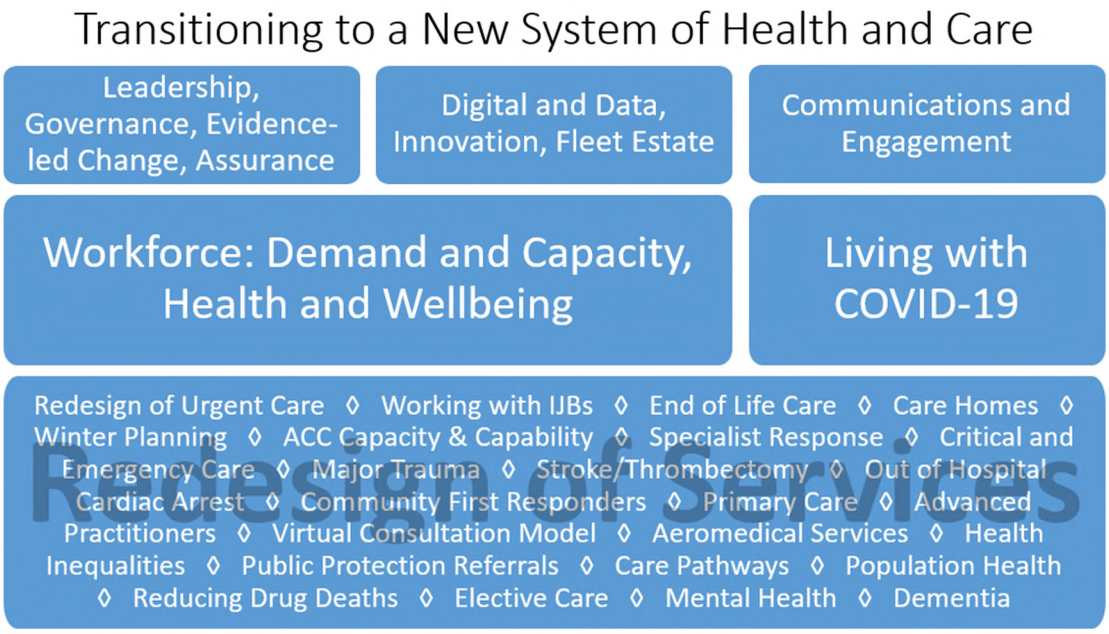
- Our role tackling inequalities in communities.
- How we are embedding and developing digital services.
- How we are supporting the development, and health and wellbeing of our people.
- Our approach to sustaining services post COVID-19 and managing the concurrent risks of increased demand.
- Opportunities for prevention, widening access to our services and working across boundaries to improve clinical care and quality.
- The financial planning assumptions we made in formulating this plan.

4. Our Remobilisation to March 2022

Our 2021-2022 plan builds on what we have achieved in our previous mobilisation plans and recognising both the relevance of, and the interdependencies between the principles and objectives described in the Scottish Government's framework document.

Audit Scotland have recommended that all NHS Boards including the Service take action to respond to the changing needs of patients in Scotland dealing with the effects of the COVID-19 pandemic. These include monitoring and reporting on the effectiveness of measures introduced to support the health and wellbeing of staff, to assess whether sufficient progress is being made, taking action to meet the needs of those whose access to healthcare has been reduced as a result of the pandemic and monitor the long-term impact of this on health outcomes, and also publish data on performance against the clinical prioritisation categories. We are committed to having these principles underpin the improvements detailed in this plan.

The Service recognises the contribution it can make to the resumption of health and care services, spanning from emergency to elective care, as we emerge from COVID-19. We also recognise the many successful initiatives, introduced by the Service and our partners in response to COVID-19, which will shape a radically different health service throughout the remobilisation period and beyond.



5. Managing and Maintaining our Response to Patients

Our key priority is to continue to provide a safe and effective response to our patients and maintain prioritisation of our response to immediately life threatening and seriously unwell patients whilst ensuring the health and wellbeing of our staff.

During this second wave of the pandemic, we have stood back up our robust command and control structures to lead, guide and support management of our response.

5.1 Leadership, Governance & Assurance

Using Integrated Emergency Management principles, an Incident Management Team (IMT) was established in order to exert 24/7 consequence management across all functional areas of our Service, whilst enabling business as usual to continue. Using JESIP (Joint Emergency Services Interoperability Principles) terminology of Strategic, Tactical and Operational, a structure was defined and is in place that differentiates levels of decision-making.

The IMT, based at the strategic level has been implemented to enable efficient decision-making, communication and coordination of Service delivery. The IMT has been flexible in its operation, adjusting to circumstances and perceived risk, but has largely been operating from 0800hrs to 2000hrs on weekdays with similar timings on-call over the weekends. The National Tactical Command function during the hours of operation is our duty Strategic Operations Manager, with Operational Command located in Regional Command Cells.

We have invested in roles to progress Clinical Leadership within our national and regional operational units to support the further strengthening and development of patient safety, governance and assurance mechanisms. These posts will be responsible to the Regional or National Director, and will work to improve outcomes and embed pathways of care for patients in relation Falls, Infection Control practices, Public Protection practices, Mental Health care, Dementia care, Quality and Safety of Care and person centred care, among many others.

This group of staff will provide focus, leadership and direction within the regional and national operations to improved care, develop an outcome measurement framework to track care development, lead regional improvement work supported by improvement specialists, learn from events and feedback to deliver improvement plans at a regional level, all aligned to our internal and external national strategic direction.

5.2 Maintaining our Response to Patients

Our response to the COVID-19 pandemic has further highlighted that we are an integral part of the health and social care system and that our performance and achieving the best outcome for our patients is directly linked to the design, structure and performance of other parts of the health and social care system and vice versa. Whilst maintaining our response to patients and surges in demand, the Service has taken a whole system approach to work collaboratively with our partners to redesign and implement services that take pressure out of the wider system. Through the redesign of services we have been able to manage a higher proportion of our patients safely over the telephone with self-care advice or onward referral **(Chart 1).** We have also increased the proportion of our patients treated at scene

or onward referred to an alternative care pathway **(Chart 2).** Improvements in both areas have contributed in a reduction in patients taken to hospital. **(Chart 3).**

Chart 1 – Hear & Treat

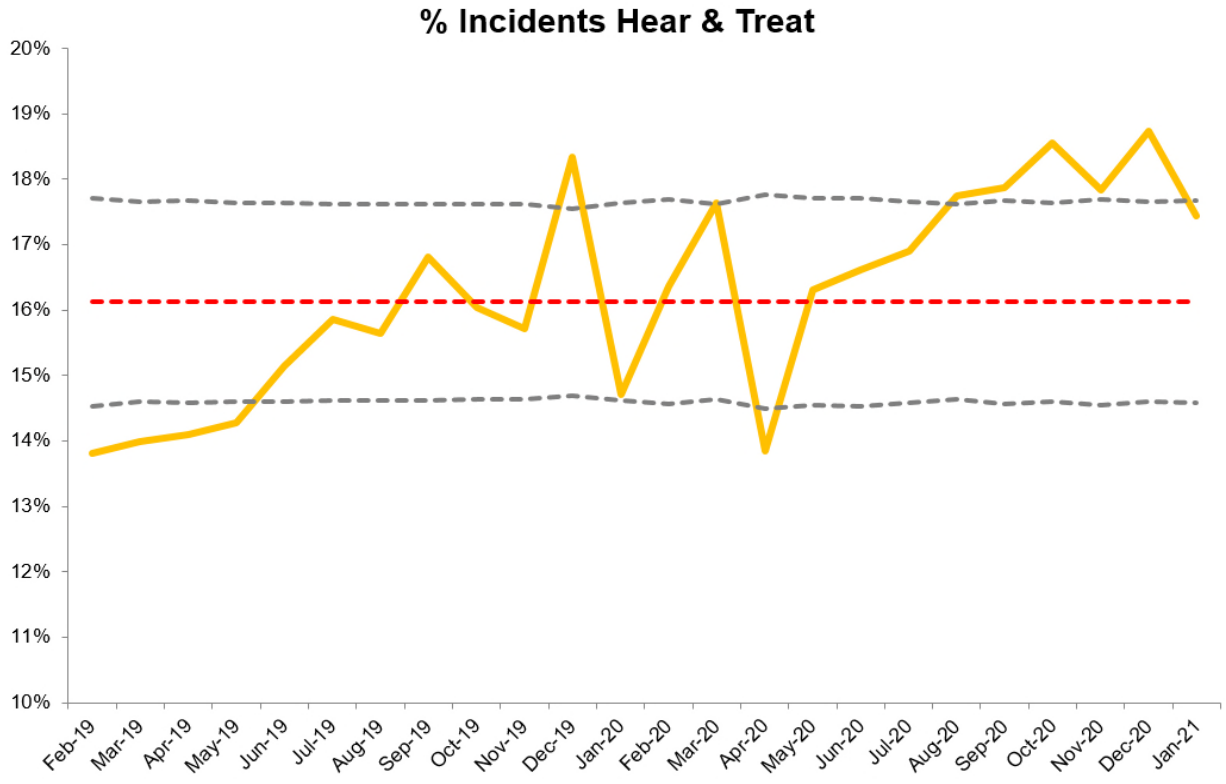


Chart 2 – See & Treat

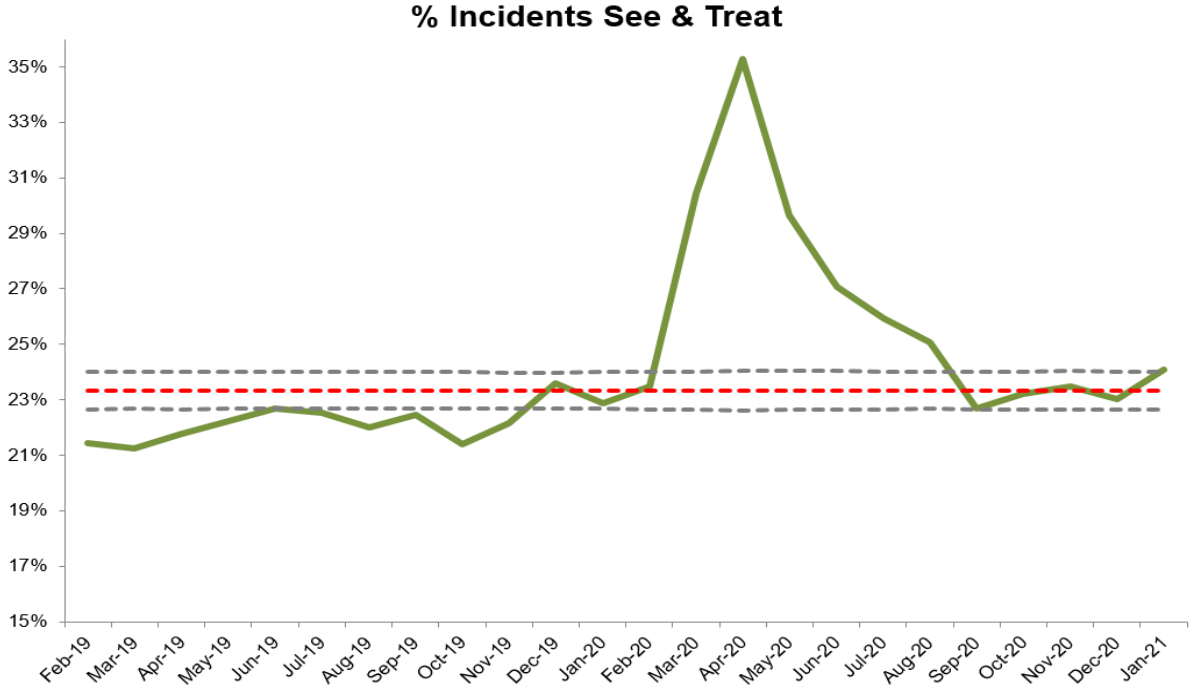
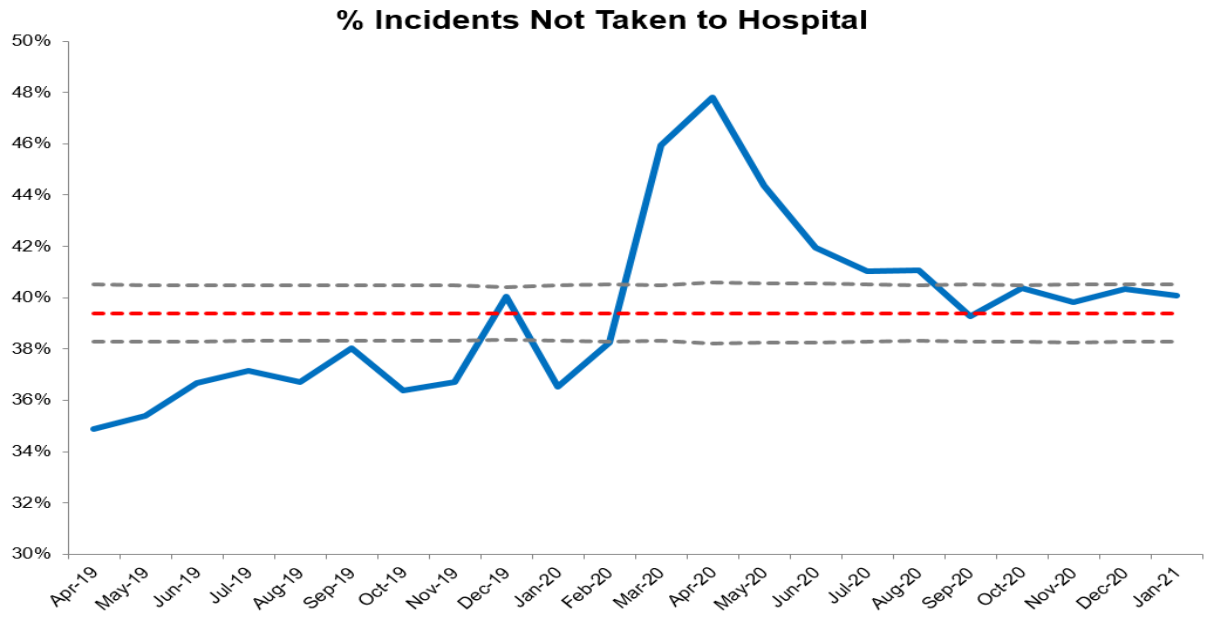


Chart 3 – % Incidents not taken to hospital



There have been a number of other additional pressures in the system that affect our ability to respond to our patients quickly.

There has been an increase in our incident service time due to an increase in the percentage of patients that are presenting with immediately life threating or serious symptoms. There has also been an increase in the time associated with ensuring appropriate compliance with vehicle cleanliness and PPE, as well as an increase in hospital turnaround times for boards under extreme pressure.

The increase in “see and treat” between March and June 2020 is directly linked to the first wave of the COVID-19 pandemic and the impact this had on the public’s appetite to be conveyed to hospital - with frontline clinicians looking to support patients to stay at home where possible. While there was a month on month reduction from June to September 2020, there is confidence that seeking alternatives to emergency departments is being promoted by our frontline clinicians, and remains a key priority for the Service.

Increased ambulance turnaround times at some hospital sites has been a challenge and we have been working to address this in collaboration with Health Boards. Reducing hospital turnaround times improves the patient and staff experience involved in each patient handover, and allows the ambulance crew to be ready to respond to another emergency. Given the importance of this, the Cabinet Secretary has established a short life working group chaired by our Medical Director.

Remobilisation offers a clear opportunity for ongoing improvement through collaborative working with other health and care partners, volunteers and voluntary groups, other ‘blue light services’ and research and innovation partners. We have an underpinning aim to evidence the benefits that we deliver together within a robust and relevant performance

framework. Working in this way allows us, as a national organisation providing clinical care 24 hours a day in every community in Scotland, to demonstrate our contribution to the realisation of Scotland's future national performance framework and ambitions. We continue to recognise and respond to the challenges of culture change, enabled by enhanced capacity and capability of our workforce, helping our own and our partner organisations to deliver fully against an ambitious programme of change in the coming months and years.

5.3 Data & Intelligence Led Planning

Data led demand and capacity intelligence is a critical enabler for identifying breaking points in the system and developing effective mitigation and mobilisation plans. COVID-19 has brought about new relationships and collaboration across health boards to gain greater insights into demand patterns and correlations between various systems with indications that COVID-19 demand in the Service and NHS 24 could be an early indicator for emerging demand for health boards.

Throughout 2020, we shared both COVID-19 and Non-COVID-19 demand patterns with Public Health Scotland and the Scottish Government to help inform the prediction and planning arrangements for future COVID-19 waves. The weekly modelling updates issued from the Scottish Government have been used to inform our local short and medium term planning both internally and with our partners.

By March 2022, we will:

- Maintain our ability to respond and scale up using the incident management framework.
- Continue to work with partners to understand demand on our system, and inform mitigating actions.

Outcome: To continue to provide a safe and effective response to our patients and support the health and wellbeing of our staff.

6. Living with COVID-19

6.1 Lateral Flow Testing

In response to the pandemic and commitment to controlling infection and supporting our staff, we introduced twice-weekly lateral flow testing for all patient facing staff in late December 2020. This is designed to be a quick way of testing for coronavirus symptoms and returns a result within 30 minutes.

By March 2022, we will:

- Continue to issue and monitor lateral flow testing devices for the period of the pandemic.

Outcome: To be aware of the impact of COVID-19 on our workforce, to allow us to make appropriate arrangements to ensure suitable coverage and response. The use of lateral

flow tests will mean that we will reduce the risk of exposing our staff and patients who are asymptomatically infected with COVID-19.

6.2 Vaccinations

In line with Scottish Government advice for prioritisation of receipt of the COVID-19 vaccination, we commenced a vaccination programme for patient facing staff in the week commencing 21st December 2020. The programme commenced later than expected due to legal and regulatory issues. Vaccination is being conducted under a Patient Group Directive (PGD) to all patient facing staff using a peer vaccination model. At the time of writing, we have vaccinated 3,448 of 4,600 patient facing staff.

In addition, we have been asked to develop a proposal to provide a mobile vaccination service to remote and rural communities. This proposal is for six vaccinator teams with mobile units, which aims to be in place once approved by March 2021.

By March 2022, we will:

- Complete the vaccination of staff during April 2021.
- Fully implement the COVID-19 mobile vaccination service for remote & rural communities.
- Review our vaccination programme and apply lessons learnt to any further vaccination campaigns that may be required.
- Appoint a vaccination lead to coordinate vaccination processes for COVID-19 and Seasonal Flu for staff, and where required to support mass vaccination of patients.
- Issue relevant clinical guidance and support to all staff to encourage all staff to be vaccinated.

Outcome: To have vaccinated all our eligible staff against COVID-19 which will ensure that we protect our crucial front line workers. To fully implement a mobile vaccination service for remote and rural communities which supports whole system emergency response resilience.

6.3 Test and Protect

The Service took over responsibility for the deployment and management of Mobile Testing Units (MTUs) from the military in August 2020. Initially, this was for a period of six months, to February 2021. Since implementation, we have conducted approaching 400,000 COVID-19 tests. We have received positive feedback from patients, the Scottish Government, Local Authorities and other key stakeholders, such as the laboratory services, who have commented on the improved quality of tests that they have received, and a reduced number of voided tests.

After a review of demand, we will increase the number of testing units from 18 to 42 and continue to deliver MTU provision until at least August 2021. Moreover, we secured investment to split into smaller units, thereby increasing our capacity to reach 84 communities, significantly increasing our reach into the population.

The MTUs will continue to be deployed to outbreaks as part of local incident management plans. To date this has included specific workplaces and a prison, and we have assisted with testing at universities. The MTU operational model continues to evolve to meet the testing needs of our communities and we have assisted with other requests such as community asymptomatic testing and assistance to the freight industry to support cross EU border activity. We will continue with these activities until there is high confidence that COVID-19 has been successfully suppressed.

Our MTU model means that through a mixture of people on secondment and new recruits on fixed term contracts, we will have deployed almost 1,300 staff into our national seven-day-a-week responsive delivery model. In the course of 2021/22, we will encourage staff in these fixed term roles to apply for appropriate permanent roles across the Service; a great deal of talent has been identified and a number of MTU staff have already applied to join other parts of our Service.

By March 2022, we will:

- Fully implement additional capacity to service up to 84 communities.
- Meet MTU requirements on symptomatic and asymptomatic testing needs in our communities.

Outcome: To provide a COVID-19 mobile testing service across Scotland which meets the needs of the population, supporting the nation's efforts to drive down the presence of COVID-19 infection in our communities.

6.4 Healthcare Acquired Infection and Infection Control

We comply with mandatory Healthcare Associated Infection (HAI) and antimicrobial resistance (AMR) policies through the monitoring and reporting requirements set out in DL (2019) 23. We continue to undertake a comprehensive programme of infection prevention and control and cleanliness audits across Scotland to provide assurance around the safety of patient care practices and the cleanliness of the patient care environment and equipment. The administration of antimicrobials is overseen by our Medicines Management Group (MMG), which reports directly to our Clinical Governance Committee. The Annual Infection Prevention and Control (IPC) Programme of Work for 2020/21 focused on the key delivery areas of the current antimicrobial resistant/healthcare-associated infection (HAI) delivery plan in the context of the pre-hospital ambulance setting. The programme was widely circulated for consultation and formally approved by the Infection Control Committee (ICC), the Chief Executive and Clinical Governance Group, with progress being monitored by the ICC.

In order to support the prevention of healthcare associated infection and compliance with antimicrobial prescribing policy requirements during 2021/22, we remain committed to

ensuring the National Infection Prevention and Control Policy Manual is fully embedded across the Service in the context of the pre-hospital setting. Staff compliance monitored and managed through a comprehensive infection prevention and control audit programme. We will continue to develop and implement annual infection prevention and control work plans for 2021/22 that will address key objectives to ensure compliance with current HAI Standards, the National Infection Prevention and Control Policy Manual, the National Cleaning Service Specifications (NCSS) and will align to the Scottish AMR and HAI delivery plan. Annual plans will also address specific areas where further improvement is required based on developing information.

6.4.1 Antimicrobial Prescribing

Our Medicines Management Group oversee the use of antimicrobials in the Service using the NICE (National Institute for Health and Care Excellence) Antimicrobial Prescribing Guidance in the development and review of Patient Group Directions, to ensure only appropriate antimicrobials are used, and in which specific patient groups, to reduce the risk of resistant organisms. The Medicines Management Group contributes to antimicrobial stewardship through the review of antimicrobial administration, which helps reduce the risk of antimicrobial resistance. The Scottish Antimicrobial Prescribing Group (SAPG) are regularly consulted as to which antimicrobials can be safely administered under patient group directions.

In line with our aim to enhance advanced practice capability, some Paramedics now prescribe medicines and the prescribing of antimicrobials complies with territorial board medicine formularies. A consultant microbiologist sits on our Medicines Management Group and provides specialist microbiology advice and feeds back information to the Infection Prevention Control Team and Infection Control Committee.

6.4.2 Education

The provision of HAI education on all induction training programmes for clinical staff will continue in 2021- 2022. Operational staff also complete 12 modules of the SIPCEP (Scottish Infection Prevention and Control Education Pathway) foundation programme in their first year. As the Paramedic education model changes to provision through Higher Education Institutes (HEIs), there will be an expectation that students complete appropriate Infection Prevention and Control education prior to undertaking clinical placements, as is the case with the wider nursing/AHP (Allied Health Professionals) syllabus currently delivered. The Education and Professional Development Department (EPDD) will continue to include HAI education as part of ongoing mandatory Learning in Practice courses for operational ambulance staff. The EPDD and Infection Prevention and Control Team work closely together and will collaborate to agree course content and the provision of learning resources.

6.4.3 Infection Control Audits

The infection prevention and control quality indicator for the recording of adherence with the peripheral vascular cannula (PVC) insertion care bundle continues to be monitored and

reported to the Board. Compliance remains above the current indicator aim and is anticipated to improve further. In order to support further improvement, we have this year collaborated with NHS Education Scotland to produce an ambulance specific pocket guide covering aseptic technique for insertion of PVC. We will also explore with our colleagues in NHS boards to identify and report outcome measures in relation to infection/phlebitis associated with PVC inserted prior to admission.

Results of Infection Prevention and Control and Cleanliness audits will continue to be reported to each Infection Prevention and Control and Clinical Governance Committee meetings. The Committees will be informed of any improvement action taken when results fall below expected targets. NCSS cleanliness monitoring results, hand hygiene compliance results and other pertinent issues will also be reported to bi-monthly board meetings as part of the HAI report.

6.4.4 Estates

In collaboration with our Estates department, a HAI assessment (Scribe) will continue to be completed for all station refurbishments and new build projects with plans based on an agreed infection prevention and control specification. Co-location projects are risk assessed based on the expected requirements with infection prevention and control advice provided on that basis, depending on the facilities being provided. Although ambulance stations have some clinical areas there are no patients in the stations and HAI Scribe risk assessment is therefore completed on that basis. There is no specialist mechanical ventilation within ambulance stations, water systems and temperature testing is regularly carried out on all sites with the results fed back to the Infection Control Committee.

6.4.5 Provision of Respiratory Protection

The requirement for all operational staff to be provided with respiratory protective equipment to ensure compliance with the National Infection Prevention and Control Policy Manual comes at a significant financial cost. This equates to costs in relation to providing face fit testing which includes the backfill of operational staff to allow sufficient time to complete this. There is also a requirement to provide alternative respiratory protective equipment for staff who cannot be successfully face fit tested due to face shape or facial hair. Our Executive Team took a decision, based on a detailed costs benefits analysis of the options, to invest in air-powered hoods as respiratory protection going forward. This decision was made based on experience of both types of protection utilised during our response to the COVID-19 pandemic.

The new national ensemble of personal protective equipment (PPE) for high consequence infectious diseases to be implemented across NHS Scotland in the near future will potentially have a further cost implication in terms of the provision of the equipment and comprehensive training and competency testing required for the staff transporting these patients.

By March 2022, we will:

- Implement the use of air-powered hoods, which are based on improving staff experience of working in PPE for long periods in challenging circumstances as well as consideration of the cost benefits analysis of the options for respiratory protection.
- Continue to undertake a comprehensive programme of infection prevention and control and cleanliness audits across the country, identifying areas of concern and addressing these as they emerge.
- Provide a robust response to infection outbreaks within our Service.
- Ensure the National Infection Prevention and Control Policy Manual is fully embedded across the Service.
- Monitor the administration of antimicrobials.
- Produce an ambulance specific pocket guide covering aseptic technique for insertion of the PVC bundle.
- Continue to provide all operational staff with appropriate respiratory protective equipment.
- Continue to work with Ambulance services across the UK and Scottish Government to align guidance to support safe practices for our staff.

Outcome: To ensure our staff are operating in a safe environment using equipment that supports a positive staff experience.

6.5 Procurement & Distribution of PPE & General Supplies

The COVID-19 pandemic highlighted the fragility of our current supply chain, and whilst a temporary solution was implemented, it was agreed to review our current model and provide alternate sustainable solutions.

Our proposal is to introduce a dedicated materials management function, responsible for delivering a robust, sustainable, long term, cost effective logistics and inventory management service supplying and controlling the movement of consumable stocks throughout the Service aiming to minimise stock holding and ensure continuity of supply. This will release both financial and non-financial efficiencies, release clinical staff time whilst gaining a comprehensive understanding of product mix and usage.

In addition, it was agreed that we should continue to utilise and increase the benefits achieved to date by remaining a customer/partner with the National Distribution Centre.

By March 2022, we will:

- Introduce an effective inventory management system hosted within our Procurement department.

Outcome: To ensure we have a robust system in place to monitor and control procurement and distribution of required equipment and supplies.

7. Workforce Recovery/Transition

7.1 Building Workforce Capacity

Increasing workforce capacity in front line services is an immediate priority for the Service in response to an externally commissioned Demand & Capacity review we carried out in 2018. This review identified the requirement for additional workforce resources to enable the Service to continue meeting response time targets for patients, and improving the quality of care and support provided. Following submission of a business case in 2019, additional funding was provided by Scottish Government for the appointment of an additional 148 WTE (Whole Time Equivalents) frontline staff, and workforce plans were put in place to recruit and select the additional staff by the end of March 2021. Substantial progress has been made with this plan using new, virtual methods of recruitment appropriate to the current guidance due to the COVID-19 pandemic.

The pandemic has placed additional pressures on our workforce, with increased staff absences relating to COVID-19, increased incident response times as a result of infection control measures, our crews responding to sicker patients, and longer handover times at hospitals due to their increased pressure.

The requirement to respond quickly to staff abstractions during our response to the COVID-19 pandemic has led to innovative ideas and flexibility in the deployment of our workforce. New and expanded roles, skill mix changes and increased use of our community first responders have led the way for potential new models of care delivery. These in combination with the Demand and Capacity Programme workforce increase requirements will greatly transform the future workforce of the Service. This has been further supported by securing additional Organisational Development posts to create the conditions for change in taking forward these new models of care.

By March 2022, we will:

- Continue to increase and upskill our operational workforce to meet our Demand & Capacity Programme workforce Plan.
- Increase our Ambulance Control Centre workforce to improve call handling service levels.
- Develop organisational strategies and plans to reshape our workforce to meet current and future demands including legacies of COVID-19, generating a more agile, flexible, skilled workforce.
- Mobilise and signpost the talent identified with our Mobile Testing Units workforce to vocational and educational routes, to retain staff and build future capacity.
- Explore, develop and undertake an appropriate range of high quality apprenticeships that attract internal and external applicants into new career pathways.
- Develop incentives to attract external qualified front line candidates to join our Service.
- Refresh the Strategic Workforce Plan, ensuring it is aligned with our future strategy and reflects the roles, volume and skill mix required for current and future models of service delivery.

- Improve the use of digital technology to enhance the delivery of our training and simulation, and continuing professional development.
- Audit our wider support services workforce to ensure we have the right people, with the right skills, in the right place, at the right time.
- Expand and develop leadership & management development programmes, building on the start made pre-COVID-19, ensuring that by mid-2022 all managers and leaders have participated in a formal programme of leadership training and support.
- Develop an infrastructure to support development of pathways, designing appropriate training interventions, and working with partners to develop appropriate educational frameworks to meet the needs of new and emerging roles.
- Review our control centre processes and protocols, to ensure we have the right fit for our frontline operations and community needs.
- Utilise our community engagement teams to recruit staff from local communities.

Outcome: To improve our workforce capacity and capability to meet the changing needs of our population, and to maintain levels of care and response that they expect.

7.2 Demand & Capacity

A Business Case was submitted to the Scottish Government in 2019 following an externally commissioned Demand & Capacity review where modelling was carried out to assess the level of resource required to meet agreed performance standards at a Scotland-wide level.

The Service established a Demand & Capacity Programme to drive forward and enable delivery of the increase in workforce as well as a number of other key work streams such as training, roster design, fleet, estate and finance.

The programme aims to

- Increase staffing and front line vehicles to increase resourcing on the ground to meet demand requirements
- Increase station locations to ensure ambulance cover is available in prime demand locations.
- Design and align rosters to patient demand to improve response time for all patients;
- Improve staff experience by reducing the number of rest breaks interrupted, reduce the number of shift overruns and with the adoption of the new Core Principles, ensure rosters are safer for our staff;

The ‘Building Better Rosters’ work stream which started in 2020 will enable productivity improvements through better alignment of our workforce to meet demand both now and into the future.

Ahead of implementation of new rosters, additional resources will be deployed in our busiest and often, most deprived communities. Recruitment against the updated workforce plan continues and prioritises Edinburgh City, Lothian and Greater Glasgow, although there is

also a requirement to target a smaller proportion of the funding at other locations to improve response times for patients, reduce shift over runs and improve rest break compliance.

Our 2021/22 recruitment and training plan for emergency front line resources has been designed to assume that funding will be in place for another 148 WTE on top of the 148 from last year. Recruitment plans include staffing to cope with backfill attrition, internal movement to alternative posts and to meet growth under the Demand and Capacity Programme. The updated workforce plan is ambitious with an aim to have 3214 WTE A&E staff in post by the end of March 2022.

By March 2022, we will:

- Have concluded our staff-led roster design phase through the delivery of the virtual Working Parties and agreed safer and more equitable ambulance rosters for every ambulance station in Scotland.
- Have brought online new ambulance locations identified by the modelling and where possible, in collaboration with health boards and emergency service partners.
- Increase our A&E staffing to 3214 whole time equivalents.
- Continue to move to a proactive position in service redesign with the software and skills in-house to maximise both the ambulance simulation software and the roster design software.
- Have improved response time for patients in line with our agreed 2021/22 performance standards.

Outcome: To increase our workforce capacity to meet the demands on the service and to put tools in place to work with partners in redesigning and planning for demand changes across the whole system.

7.3 Health & Wellbeing

Supporting the health and wellbeing of our staff is a critical priority for us now and going forward, as we increasingly recognise and understand the impact of the COVID-19 pandemic on our workforce. It is particularly important that we recognise the potential for COVID-19 related long-term harm such as post-traumatic stress disorder, and mitigate against this with proactive support for mental health and wellbeing. Our new Health and Wellbeing Strategy & implementation plan has been co-designed with our staff to support the health and wellbeing of our workforce during our response to COVID-19 and beyond.

During the pandemic our aim has been to promote evidence based practice and guidance, and encourage our staff to utilise the excellent national and local resources available to health care organisations. Revising our current wellbeing resources and guidance provision for our staff has enabled us to streamline our resources and make it easier for staff to quickly access support when it is needed. The National Wellbeing Hub and associated resources align closely with and complement local provisions and we have contributed to the National Wellbeing Champions Network sharing and are benefitting from information and

developments. We have promoted the National Wellbeing Hub and encouraged uptake of these resources through a range of communications channels.

Following an initial decrease in staff sickness levels at the start of the pandemic, levels are increasing for both COVID-19 and non COVID-19 related illness as the pandemic progresses. Staff in all roles have been working to full capacity as they strive to deal with the challenges the pandemic has presented and support their colleagues in addition to maintaining business as usual activity. This is increasingly taking its toll on staff wellbeing over such a prolonged period, with no definitive end in sight to allow recuperation and restoration. Morale is low, our workforce is fatigued and this is compounded further by winter pressures and staff not taking their full entitlement of annual leave.

Our workforce however pulls together in such difficult times, showing great strength and resilience on a daily basis and working collaboratively to overcome the challenges across departments and with our partner organisations. We will continue to take a proactive approach to strengthen the resilience of our workforce and further develop peer support to combat staff stress, anxiety and burnout. We have had success with our IPRS referral pathway for staff with musculo-skeletal issues in being able to see a high proportion of staff return to work earlier as a result.

Our activity and achievements since August 2020 have included:

- Approval of our Health & Wellbeing Strategy 2021 – 2024 and development of our Wellbeing Roadmap 2021 – 2022 that outlines the milestones we will achieve in the first year of the strategy.
- Setting up staff groups to engage, consult and refine our Health & Wellbeing Strategy, and raising staff awareness raising of resources and services to help wellbeing.
- Weekly staff engagement sessions to keep staff informed of Service developments, consult with them on key issues, and provide them with an opportunity to ask our senior leaders any questions or come forward with their ideas and suggestions for improvement.
- Lifelines Ambulance website has been launched with a huge amount of resources and assistance available to staff, their families and friends and retired staff too.
- Sessions delivered to managers to raise awareness of the resources and help available to support their staff and generate discussion between colleagues to share good practice.
- Welfare calls to staff who are shielding or off work due to illness from local managers and HR colleagues.

By March 2022, we will:

- Implement our Wellbeing Roadmap 2021/22 with five overarching themes of healthy culture, healthy environment, health mind, healthy body and healthy lifestyle.
- Make our Health & Wellbeing Strategy and Wellbeing Roadmap interactive so that staff can be involved and engaged with it, and be informed of progress.

- Recommence our leadership programmes and developing a cohort of leadership mentors.
- Work with partners in Health, Fire & Police Services to identify opportunities for a wider systems approach to leadership development.
- Enable positive cultural change with a programme of interventions based on 'Civility saves lives'.
- Approve our Fatigue Management Framework and developing an e-learning Fatigue Management module.
- Review our estate and facilities to identify opportunities and spaces that promote wellbeing and enable staff to de-stress.
- Finalise a peer support framework and peer support training, delivered by Lifelines.
- Develop a wellbeing calendar with events, campaigns and promotional activity scheduled for the year.
- Develop a proposal for a Service wellbeing vehicle for health promotion activity.

Outcome: To support and improve the health and wellbeing of our staff by creating a culture where staff wellbeing is at the heart of what we do, and that this is evidenced by practical accessible options for staff support, leading to improved staff experience.

7.4 Supporting New Working Arrangements

Since the onset of the COVID-19 pandemic, we have reviewed many of our workforce policies to adapt to the extraordinary circumstances facing us an emergency service. One area we have particularly focused on is the requirement for non-front facing staff to be working from home instead of in a defined work location. We have had a home working policy in place for a long time, but we have recently reviewed this guidance and updated the policy to reflect the exceptional circumstances we are experiencing. We introduced our revised Agile Working guidance in advance of the national rollout across the NHS in Scotland and our guidance is very much in line with the national position. By means of a fully documented risk assessment, staff can work effectively from home with the appropriate support, both emotionally and practically, with the physical infrastructure provided by IT colleagues. This has allowed staff to work seamlessly from home whilst still being able to participate actively in Service business, using advancements in digital technology, particularly MS teams. This new way of working has taken time for staff to adjust to, but it is now widely acknowledged as the way forward post-pandemic. We have also been keen to implement temporary revisions to some of our standard terms and conditions for staff, which have in turn provided us with additional flexibility around staff utilisation. Whilst these are only interim revisions, we hope that some of these can remain on a permanent basis. To develop this further we have established an Agile Working short life working group.

Due to the engagement with shielded staff members, we have gained some good insight about each shielded staff member's personal circumstances and their thoughts, anxieties and expectations. We have used this intelligence to determine whether each member of staff is physically, mentally and emotionally able to return to their substantive role and within

appropriate associated timelines. In implementing this approach, we have continued to be supportive and flexible to the needs of individual staff members in order that they can re-adjust to their workplace in a safe and managed manner.

7.5 On Call Working

We are continuing to work through a phased implementation plan to eliminate on call working. This is a long-term implementation plan which is updated every 12 months by the National On Call Working Group. The Group is chaired by the National Employee Director with partnership representation.

£750,000 of recurring investment was made available by the Scottish Government to reduce on call working in the high priority on call locations across Scotland. £250,000 was ring-fenced to provide recurring funding to support the elimination of on call working at Portree ambulance station in Skye, which went live on 11th November 2020. A further £500,000 of recurring funding was made available to eliminate on call working in Rothesay, Oban, Aviemore and Golspie.

During the period of the 2020-2021 Remobilisation Plan, on call was reduced from 41 to 37 locations, which still provide on call cover. 24 of these are in the North and 13 in the West Region. It is important to note that this includes Fort William, Kirkwall, Lerwick, and Campeltown stations which have one ambulance already operating on a 24/7 basis and another ambulance operating different levels of shift and on call cover.

In addition to the £750,000 of recurring investment that has been made available to eliminate on call working in five high-priority on call locations across Scotland, a further £300,000 of recurring funding will be required during 2021/22 to fund these changes fully on a recurring basis. Further investment will also be sought during 2021/22 to continue to reduce the number of high priority on call locations in Scotland.

Positive progress continues to be made in reducing the number of stations with on call working across Scotland and the Service will continue to identify high priority ambulance locations and direct funding into reducing on call hours and reducing the number of on call locations each year.

We will also continue to explore new opportunities and tests of change to look at different ways of reducing the impact of on call working on our frontline staff.

By March 2022, we will:

- Eliminate on call working from 4 high priority locations.
- Recruit to locations where funding has been received for reduction of on call working.
- Reduce lost operational hours in remote and rural areas through fatigue, compensatory rest and lie ins.
- Work closely with local communities and partners to deliver innovative technological solutions to help to deliver health and care in remote and rural areas.

Outcome: To reduce the number of locations utilising 'on call' working practices, improving staff experience and extending our availability for patients in these communities.

8. Whole System Redesign

8.1 Redesign of Urgent Care

The Service has been working closely with Scottish Government and other key stakeholders including territorial Health Boards and NHS 24, in the large-scale programme of work associated with the Redesign of Urgent Care. We have developed an internal Redesign of Urgent Care Programme aligned with the overall aims and objectives of the national programme and aligned with the strategic intent and objectives of the Service.

This work has moved at significant pace and during November 2020, NHS Ayrshire and Arran acted as a pathfinder Board to test this new approach to urgent care for Scotland with the aim of reducing the number of self-presenters at Emergency Departments. The learning from this pathfinder site, supported by an evaluation group chaired by Sir Lewis Ritchie, considered the output of the pathfinder work alongside the Service, NHS 24, and the state of readiness of Boards across Scotland. Approval to proceed resulted in the Redesign of Urgent Care Flow Navigation Centres (FNC) going live on 1 December 2020 across Scotland.

The Service is a key partner in this work and we aim to strengthen our role in these over the short to medium term. We are working both nationally and regionally to enhance already positive partnerships by ensuring the Service is able to maximise the functionality offered by these FNCs. This includes advice and feedback to crews, decision-making support and the potential ability to direct patients who do not need emergency care to the alternatives these offer. We aim to ensure that the Service has an opportunity to inform the further design and development of urgent care across Scotland.

In November 2020, an upgrade to our triage process for urgent GP and inter facility transfers was implemented to further enhance our clinical response model. The new model identifies the type of resource required for the patient and we are already starting to see reduced pressure on our A&E resources with a number of patients being managed appropriately by a Patient Transport resource. The impact of these changes are being closely monitored to identify areas for improvement to ensure that we continue to refine and develop the model in the months ahead.

Technology enabled developments will support improved information sharing between the Service and other health care providers and work is underway at pace to scope out the requirements and opportunities available through the recently launched FNCs. Territorial health boards are keen to access the Service's rich data set and use this pre-hospital information to optimise patient care. Progressing these developments will be a priority for 2021-22.

We continue to work closely with our health board partners to explore opportunities to improve patient flow across sites. We recognise that our access to dedicated discharge vehicles can support the movement of patients and we also have dedicated Hospital Ambulance Liaison Officers whose focus is to optimise patient flow. The Hospital Turnaround Time Group with representation from a number of Boards and chaired by the Medical Director of Scottish Ambulance Service recognises that prolonged turnaround times are often a consequence of wider system blockages affecting flow. This work will be a focus of the national Unscheduled Care work from April 2021 onwards.

By March 2022, we will:

- Continue to develop our relationship with the FNCs to enable access to professional-to-professional advice for crews and advanced practitioners and alternatives to ED.
- Work with our Health Board partners to increase access to clinical portals and share patient information to inform and develop improvements in patient care.
- Review our demands for urgent health care professional calls to develop shift pattern that match demand profiles.

Outcome: To support NHS Scotland's Redesign of Urgent Care Programme, which will mean better patient experience in terms of accessing community support and Emergency Departments, where this is needed in urgent care scenarios.

8.2 Working with Integrated Joint Boards (IJBs)

As part of its contribution to improving the health and wellbeing of Scotland's population, a key interface for us is with Scotland's IJBs, which are responsible for commissioning and improving the provision of health and care in Scotland's communities. This is where the vast majority of healthcare interventions and support already take place and we, similarly, have a presence in every community in Scotland 24 hours per day.

What has become clear in recent times, illustrated by our IJB level data sets (see below), is that we have a significant role beyond responding to those in need, in terms of:

- direct clinical care
- signposting and referral to community providers
- secondary prevention of long term conditions
- highlighting risk to individuals and families

In order to realise the benefits of this, it is essential that effective connections continue to be developed between the Service and IJBs at strategic, operational and front line clinical levels. We are working closely with a number of IJBs and Health and Social Care Partnerships on specific initiatives within communities across Scotland and this will remain a key focus in 2021-22.

Some of this work includes the development of referral pathways for patients as an alternative to the Emergency Department with the aim of delivering care closer to home for many of the patients who present to us.

For our areas of specific focus (Falls, Mental Health, Respiratory) we are confident that as a consequence of improved working with IJBs we can influence outcomes for patients.

Currently people who fall represent around 10% of 999 calls to the Service. The primary response by the Service is aimed at managing any associated injury and identification of potential causes. Many of these patients have not sustained an injury which requires hospital assessment and have no underlying cause for concern. Nevertheless, people in this group are vulnerable. Community services are ideally placed to offer both immediate support to mitigate risks. Following specialist community assessment, the latter will consider the provision of direct support such as occupational therapy and physiotherapy, or environmental support, including the provision of aids and adaptations to make living circumstances safer for people in this group. We need to support these arrangements with clear and functioning referral pathways between Service clinicians and community IJB services taking into account the factors listed above.

Patients presenting with breathing difficulties represent 9% of 999 demand. While many of these patients require assessment, stabilisation and conveyance to definitive acute care, others are potentially suitable for management in communities. Such patients, particularly those with identified underlying conditions such as COPD, could be considered suitable for community management.

Appropriate care and treatment of patients who present in mental health distress is a focus for the Service and further information is available at section 8.17. What we understand from our call demand is that many patients present in distress and crisis but thankfully with no physical or toxicology concerns. For these patient's timely referral to community based support services, whether statutory or voluntary depending on the nature of the circumstances, can provide a much better experience than the Emergency Department.

We have an abundance of data recorded within our Service, and pulling out information that is meaningful and useable remains our key focus when working alongside partner organisations.

Our information can be stratified by incident:

Scottish Ambulance Service - Sample Integration Joint Board Report 01/01/2020 to 30/06/2020

Breathing Problems

		Incident Count	Conveyed	% Conveyed	Conveyed - NEWS <4
2020	January	217	161	74.2%	51
2020	February	139	104	74.8%	43
2020	March	206	145	70.4%	37
2020	April	146	90	61.6%	14
2020	May	92	64	69.6%	18
2020	June	110	62	56.4%	21
Sum:		**910**	**626**	**68.8%**	**184**

Mental Health

		Incident Count	Conveyed	% Conveyed
2020	January	63	26	41.3%
2020	February	51	22	43.1%
2020	March	62	26	41.9%
2020	April	62	19	30.6%
2020	May	68	21	30.9%
2020	June	117	43	36.8%
Sum:		**423**	**157**	**37.1%**

Falls - Over 65s

		Incident Count	Referred	% Referred	Conveyed	% Conveyed
2020	January	124	5	4.0%	73	58.9%
2020	February	127	6	4.7%	73	57.5%
2020	March	124	9	7.3%	74	59.7%
2020	April	123	Under 5		67	54.5%
2020	May	119	8	6.7%	62	52.1%
2020	June	110	5	4.5%	66	60.0%
Sum:		**727**	**36**	**5.0%**	**415**	**57.1%**

Out of Hosptial Cardiac Arrests (OHCA) and Return Of Spontaneous Circulation (ROSC)

	OHCA	Incident Count	Conveyed	% Conveyed
2019 - 2020	Q4	109	18	16.5%
2020 - 2021	Q1	105	21	20.0%
Sum:		**214**	**39**	**18.2%**

	ROSC	Incident Count	Number ROSC	% ROSC
2019 - 2020	Q4	22	Under 5	
2020 - 2021	Q1	23	Under 5	
Sum:		**45**	**8**	**17.8%**

Our information can also be drilled down into time of day and week, which is particularly helpful when planning service changes and support:

Scottish Ambulance Service - Sample Integration Joint Board Report 01/01/2020 to 30/06/2020

SAS Total Demand by Hour of Day / Day of Week

	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday		Total	
	Incidents	Proportion	Incidents	Proportion	Incidents	Proportion	Incidents	Proportion	Incidents	Proportion	Incidents	Proportion	Incidents	Proportion	Incidents	Proportion
0	52	0.5%	40	0.4%	42	0.4%	49	0.5%	46	0.5%	44	0.4%	55	0.6%	**328**	**3.3%**
1	43	0.4%	40	0.4%	47	0.5%	26	0.3%	38	0.4%	54	0.6%	55	0.6%	**303**	**3.1%**
2	29	0.3%	34	0.3%	27	0.3%	27	0.3%	39	0.4%	43	0.4%	49	0.5%	**248**	**2.5%**
3	35	0.4%	32	0.3%	30	0.3%	27	0.3%	34	0.3%	36	0.4%	43	0.4%	**237**	**2.4%**
4	26	0.3%	17	0.2%	34	0.3%	24	0.2%	29	0.3%	35	0.4%	37	0.4%	**202**	**2.1%**
5	27	0.3%	16	0.2%	35	0.4%	20	0.2%	33	0.3%	29	0.3%	22	0.2%	**182**	**1.9%**
6	30	0.3%	26	0.3%	28	0.3%	28	0.3%	22	0.2%	26	0.3%	25	0.3%	**185**	**1.9%**
7	36	0.4%	44	0.4%	35	0.4%	29	0.3%	36	0.4%	37	0.4%	37	0.4%	**254**	**2.6%**
8	57	0.6%	48	0.5%	60	0.6%	52	0.5%	45	0.5%	56	0.6%	47	0.5%	**365**	**3.7%**
9	61	0.6%	50	0.5%	57	0.6%	55	0.6%	69	0.7%	59	0.6%	62	0.6%	**413**	**4.2%**
10	84	0.9%	55	0.6%	55	0.6%	75	0.8%	78	0.8%	84	0.9%	72	0.7%	**503**	**5.1%**
11	73	0.7%	76	0.8%	78	0.8%	78	0.8%	70	0.7%	79	0.8%	87	0.9%	**541**	**5.5%**
12	79	0.8%	90	0.9%	77	0.8%	93	0.9%	103	1.1%	86	0.9%	68	0.7%	**596**	**6.1%**
13	96	1.0%	86	0.9%	79	0.8%	90	0.9%	77	0.8%	83	0.8%	67	0.7%	**578**	**5.9%**
14	84	0.9%	89	0.9%	82	0.8%	76	0.8%	76	0.8%	77	0.8%	69	0.7%	**553**	**5.6%**
15	89	0.9%	69	0.7%	82	0.8%	73	0.7%	85	0.9%	85	0.9%	80	0.8%	**563**	**5.7%**
16	70	0.7%	83	0.8%	77	0.8%	62	0.6%	87	0.9%	88	0.9%	96	1.0%	**563**	**5.7%**
17	85	0.9%	73	0.7%	74	0.8%	76	0.8%	75	0.8%	67	0.7%	82	0.8%	**532**	**5.4%**
18	69	0.7%	75	0.8%	51	0.5%	73	0.7%	83	0.8%	68	0.7%	72	0.7%	**491**	**5.0%**
19	61	0.6%	66	0.7%	76	0.8%	59	0.6%	60	0.6%	62	0.6%	68	0.7%	**452**	**4.6%**
20	72	0.7%	72	0.7%	71	0.7%	53	0.5%	66	0.7%	76	0.8%	77	0.8%	**487**	**5.0%**

By March 2022, we will:

- Work with IJB partners to develop and implement more alternative pathways as alternatives to ED to appropriate deliver care closer to home.
- Utilise our IJB dataset (samples as above) to inform and understand the impact of alternative pathway development on patient care to refine models of care where required.

Outcome: To ensure data and intelligence is used as the basis for introducing new and improved pathways for patient care, and that where appropriate, care is delivered close to home.

8.3 End of Life Care and Care Homes

The development in our ability to provide better End of Life Care continues to be a key focus for the Service both within and out with the context of COVID-19. We strive to ensure that when responding to a patient in end of life care, the patient's wishes regarding their preferred place of care, and death, are known, respected and facilitated as appropriately as possible. To achieve this, we will continue to work closely with our frontline clinicians and other healthcare providers including the third sector.

We have improved access to pertinent patient information available to frontline clinicians via the Emergency Care Summary and Key Information Summary, which ensures immediate access to patients Special Notes and Priority diagnosis to inform best clinical decision making.

We have completed the evaluation of medication administrations associated with End of Life Care to improve understanding of how current guidelines support clinicians and patients to manage symptoms in crisis. We have also developed and evaluated a joint education package with Strathcarron Hospice. Education and training, including the administration of Just in Case Medications and Anticipatory Care Planning, remains a key education and training focus to support End of Life Care patients.

Our aim is to improve access to the National Digital Platform (NDP), which will initially host an electronic version of the ReSPECT process – Recommended Summary Plan for Emergency Care and Treatment to develop solutions to access the NDP both via our in-cab terminals and via a web service so clinicians have access to this information both on scene and remotely.

Our Service will fully support the digitalising of care homes action plan, which will open up new channels of communication for residents to communicate with their loved ones as well as new opportunities to access virtual care. This will provide a real opportunity to undertake a clinical assessment of residents/patients virtually, where appropriate. We have asked that the potential to open up further opportunities to explore professional-to-professional discussions between clinicians in both environments be considered. This promotes

improved care at home and aims to reduce unnecessary admissions to Emergency Departments.

Integrating and sharing data between care homes and key health & social care providers is a critical enabler for ensuring that care home residents and our potential patients receive the right care and clinical interventions. There is real opportunity for our Service and wider healthcare providers to actively analyse data and co-design scheduled/unscheduled care services and pathways that meet the needs of the public and improve public health.

By March 2022, we will:

- Continue to work closely with other healthcare providers in the delivery of improved End of Life Care.
- Improve access to the National Digital Platform.
- Support and deliver relevant education packages to achieve our aims.
- Support the delivery of the digitalising of care homes action plan.

Outcome: To support and improve our clinical care where it relates to end of life scenarios, to ensure dignity in death in line with the wishes of patients and their families. To provide high quality support to emergency care in care homes in line with established best practice, and to work with care home providers and residents to work in ways that meet their needs and expectations.

8.4 Winter Planning

In preparation for winter and in accordance with national guidance, we develop and enact our annual Winter Plan, which aims to provide safe and effective care for people using services and to ensure effective levels of capacity and funding are in place to meet expected activity levels. The heart of our plan is in supporting the Scottish Government's plan of integration, improving delayed discharge, and focussing on the Redesign of Urgent Care. COVID-19 was a prominent feature in our 2020/21 Winter Plan, with a national cell put in place to oversee winter, COVID-19 and EU Exit response. Closely associated with this winter plan is our Resource Escalatory Action Plan (REAP) which details how we escalate and focus resource during prolonged periods of reduced capacity or increased demand. In addition, our National Escalation Plan, which has replaced our Demand Management Plan, allows for optimal management of short-term spikes in demand and actions for immediate mitigation of the impact.

8.5 Ambulance Control Centre Capacity and Capability

Our three Ambulance Control Centres deal with Emergency, Urgent and Routine calls from the public and a wide range of stakeholders. The COVID-19 outbreak continues to create additional pressures in relation to workforce, and supporting infrastructure due to the requirement to maintain safe social distancing.

A capacity plan has been developed to predict future call demand, and the workforce required to ensure calls are answered within the agreed performance standards. The plan

has identified a requirement for additional investment in call handling to achieve those standards, and build in a necessary degree of future proofing to mitigate against increasing incident demand and changing processes. There is also a need to expand our estate to cope with the additional increase in workforce, and to protect the health and wellbeing of staff. We have been able to secure additional estate at Meridian Court in Glasgow. This programme of work to increase our workforce and move into Meridian Court is progressing well and should be concluded by the end of September 2021.

We continue to explore opportunities to improve patient response times and outcomes, and have been ambitious in exploring digital opportunities. The use of Auto Dispatch was implemented in December 2020. This means that the system now automatically allocates resources to Immediately Life Threating calls, rather than resources being manually allocated by a dispatcher. Whilst this work is still evolving, early results have shown significant improvements in how quickly resources are allocated and dispatched to our sickest patients. We will continue to explore how to develop the use of Auto Dispatch to keep improving our response times in pursuit of saving more lives.

We also continue to work collaboratively with our partners to ensure patients are signposted to appropriate alternative care pathways. We are actively working with NHS 24 and Police Scotland in relation to the Mental Health Hub, and we continue to refine processes to ensure this group of patients are receiving the most effective and appropriate response to their episode of mental ill health.

By March 2022, we will:

- Ensure that our new estate is operational.
- Continue to embed and develop Auto Dispatch to ensure 90% of purple incidents and 80% of red incidents are serviced by Auto Dispatch and ensure a reduction in resource allocation time.
- Increase our call handling establishment to improve on our call handling 'time to answer' 90th percentile target of 10 seconds.

Outcome: To support our ACC staff to deliver optimal call handling and dispatch, to improve our performance, to increase appreciation of the vital role played by these staff members, and to utilise technology to continually improve the accuracy of our triage and dispatch decisions.

8.6 Event Management, Incident Management, and Specialist Response

This year sees Scotland hosting the 26th United Nations Conference of Parties on Climate Change (COP 26) in November. Expected attendance at the COP 26 summit is 180 Heads of State with 30,000 visitors on a daily basis. It is further predicted that 500,000 activists will be attracted to the event. We will provide cover for COP 26 through a combination of generalist support, specialist support from our National Risk and Resilience Department (NRRD), with medical support provided through ScotSTAR and primary care support from NHS Greater Glasgow and Clyde. There will be a significant training requirement placed on the Service in order to ensure that all support to the event is properly trained and exercised

in time, against some demanding timelines. As with these large events, there may also be a requirement to approach English Ambulance Trusts for mutual aid.

We have recently produced a Command Competency Policy that describes the Incident Management competency and currency required of managers at all Command levels. We will begin implementing the policy this year, firstly identifying resource to establish and run the courses required, and then in training the managers in order to qualify them and thereafter, to maintain their currency. This process, once adopted as part of routine yearly business, will further enable us to meet some of our obligations under the Civil Contingencies Act.

We continue to meet our obligations to the Civil Contingencies Act 2004, largely through the activities of NRRD, which contains National Assets and delivers primarily against our statutory obligations under the Act. The National Assets within the department are specified as the Specialist Operations Response Teams (SORT) and we are limited by agreement with Scottish Government as to how these teams can be used. Specialist response capability is not delivered by SORT alone, however. Our compliance with our statutory obligations requires the support of the entire department working in conjunction with wider Service assets.

In order to understand threat and risk, a good intelligence relationship with the security organisations is key. An assessment of threat and risk and how likely they are to impact adversely on operational delivery must also be made. This is achieved through an Intelligence and Security Team. It is then necessary to generate appropriate, robust, organisation-wide arrangements for the management of such threats and risks, ensuring that suitable policies and plans are created to consider prevention, mitigation, emergency response and recovery. This activity brings into play NRRD's Risk and Resilience teams.

Our SORT capability has a key role to play in that response alongside our Service-wide resources. The department, through its team of Strategic Operations Managers (SOMs) and its on-call teams, provides the strategic oversight, coordination, and advice required by the Service during a response. The Resilience Team supports the Service's role in such a response and it liaises and works with multi-agency and resilience partners to ensure that our response is coherent and coordinated. SORT must also be trained in specialist capabilities, and, in order to maintain their skills, exercises will be planned and run both in the single service and multi-agency environment to test them, with activities run and coordinated by a combination of NRRD's Training and Resilience Teams. All this additional functional capability is integral to NRRD. Furthermore, the department is also the home for the our management of clinical risk and review of Significant Adverse Events and for the management of Community First Responders, volunteers who support the Service in providing a rapid response to our sickest patients. This latter activity sits at the core of the department's involvement in many national strategies including Out of Hospital Cardiac Arrest (OHCA), Save a Life for Scotland management and promotion of Public Access Defibrillators, and in strengthening community resilience.

Specialists within the NRRD have been heavily involved with the Scottish Health Protection Network (SHPN) Health Protection Preparedness Group, to address and review the challenges around retrieval and transfer of High Consequence Infectious Diseases (HCID) patients from remote and rural sites, including the island health boards around Scotland.

The response to COVID-19 saw significant progress made by NRRD and ScotSTAR, Scotland's Specialist Transport and Retrieval Service, in addressing the challenges of retrieving and transporting critically ill patients from those locations.

We continue to build on our ability to respond to Chemical Biological Radiological and Nuclear (CBRN), Marauding Terrorist Attack (MTA), and/ or Mass Casualty incidents, in line with the revised National Risk Assessment. We submitted the Enhancing Specialist Response Capability Programme (ESRCP) Phase 2 Business Case to Scottish Government before the Pandemic to bridge the CBRN gap identified through learning from previous terrorist attacks. The Phase 2 Business Case, if endorsed, will enable us to provide a full CBRN clinical decontamination team, 24/7, to support SORT and wider non-specialist Service elements at CBRN incidents. This team will be formed of appropriate volunteers from the wider Service and geographically sited to support the four main Scottish centres of population and each team member will need to undertake an initial training course, periodic updates and exercises through the year to remain current. This will require significant oversight to ensure it is implemented with minimal impact to, but fully embedded as daily business, whilst assuring that cover is maintained.

We will continue with our ESRCP beyond Phase 2, where we will be collaborating with our partners, the wider ambulance service, staff, public representatives and the Scottish Government to provide a proportionate and effective initial and specialist operational response to Major Incidents with Mass Casualties (MIMC) and MTAs. We will ensure the right response at the right time and in the right place as identified in the National Risk Assessment. Our programme will also be flexible enough to evolve to support changes to strategy, priorities, risks and requirements as they are identified. This will be support through a Phase 3 to ESRCP.

In line with our previous objectives, we completed the redesign of NRRD's training structure and review of our training arrangements, with the transition of staff from old posts to new completed. A new specialist training plan for 2021-2022 has been developed and started in February 2021, following COVID-19 guidance. In addition, COVID-19 mitigation has also allowed our NRRD teams to develop new training, including Safe Working at Heights (SWAH), which will be launched later in 2021.

Both the Specialist Operations Response Team and wider NRRD will continue to engage internally and externally to ensure lessons learned during 2020/21 are captured, and embedded in the development of future plans and response models.

By March 2022, we will:

- Plan, prepare for, and manage the Ambulance Service elements of COP 26
- Complete recruitment to new vacant posts to ensure team resilience.
- Complete the roll out of the 2021/22 training plan.
- Identify resource and begin the roll out of an Incident Command training delivery programme and Command Competency assurance framework.
- Deliver the plan agreed by the Short Life Working Group, which has been established to review the current High Consequence Infectious Diseases.

- Begin to implement the elements of the Enhancing Specialist Response Capability Programme (ESRCP) Phase 2 Business Case (following approval by Scottish Government).
- Complete the business case for ESRCP Phase 3.

Outcome:
To ensure that COP26 runs as a safe event and has minimal impact on service delivery to the nation. To continue to build on our specialist response capability

8.7 Critical and Emergency Care

8.7.1 Major Trauma

The Scottish Trauma Network (STN) comprises four regional trauma networks working alongside the Service. STN holds a unique position as a national network in its own right, and is alo embedded within and across all the other STN regions. Regional networks work with key stakeholders, such as NHS Boards and Health and Social Care Partnerships within and adjoining their region, as well as the Service to co-ordinate the delivery of this comprehensive care pathway for patients.

Our vision for a pre-hospital care model to support delivery of the STN and to improve outcomes for patients is: “Improving injured patients’ outcomes by responding effectively to time-critical clinical needs irrespective of geography” and that this would be achieved through:

- Early recognition of critically injured and deteriorating patients through central co-ordination.
- Effective tasking of resources with the skills and equipment to maximise patients’ chances of survival with least burden of functional impairment.
- Reduction of the time to meaningful intervention through rapid transport to most appropriate hospital.
- Ensuring resources are in place to assure national pre-hospital resilience in event of major incidents with mass casualties.

A key feature of our STN strategy has been to develop a fully integrated system of trauma care, in which regional variations are minimised to allow maximum interoperability. This has a number of components:

1. Standardised Trauma Equipment on each of our frontline vehicles.
2. Identical guidelines and PGDs for enhanced care assets.
3. Centralised national tasking from the Trauma Desk in West Ambulance Control Centre (ACC).

With the Major Trauma Networks in the West and South East of Scotland due to "go live" in 2021, we are ready to extend our role in delivering our vision for patients' experiencing major trauma. Originally planned for March 2021, the impact and additional pressures faced by the Trauma regions due to the increased demands of the COVID-19 pandemic have meant that it is in the best interests of the services to delay the opening of the Major Trauma Centres. We expect both the West, and South East to be open by the end of summer 2021.

When the services "go live", this will include the full implementation of the Major Trauma Triage Tool (MTTT) for assessing patients in these regions. The MTTT was developed by the STN as a whole to identify which patients are most likely to benefit from being taken directly to a Major Trauma Centre (MTC), even if it means bypassing closer hospitals. We have already started to see the benefits to patient outcomes from using the tool in the North and East of Scotland, but it is important capacity and pathways are in place to support its introduction in the remaining MTCs.

By March 2022, we will:

- Continue to deliver our role within the STN and support continuing learning to consistently improve patient outcomes for trauma patients, through a fully joined-up Scottish Trauma Network of four Major Trauma Centres and supporting facilities.

Outcome: To provide the highest quality pre-hospital assessment care and treatment for patients affected by major trauma, as the first link in the chain of a co-ordinated whole system re-design that is Scotland's Major Trauma Network.

8.7.2 Stroke and Thrombectomy

Through the Programme for Government, the development and delivery of the national Thrombectomy service remains a key priority. The planning and delivery of all Service objectives is inextricably aligned to the planning and delivery of objectives as set out by all host health boards (hub and spoke), the Scottish Government and key stakeholders.

We continue to assess the practicalities and sustainability in delivering a consistent and effective professional-to-professional support for Stroke Physicians to operational ambulance crews.

The success of the pilot trialled by the Service and NHS Lothian during the first wave of the COVID-19 pandemic is still under review with the Stroke Horizons scanning group. To ensure progress is not halted in this area in the interim, where possible, the Service is working with specific health boards to assess potential avenues for localised stroke prof-prof.

We anticipate that professional-to-professional arrangements will spread to other areas of the Scottish Government's Stroke and Thrombectomy strategy as the availability and national roll out of Thrombectomy gathers pace and momentum. This includes rural areas where remote clinical decision-making support will be vital in the assessment for thrombolysis/Thrombectomy suitability.

Thrombectomy

The Service is responsible for the safe inter-hospital transfer for patients considered suitable for Thrombectomy following Hyper acute (HAS) ischaemic stroke. Patients will be transferred to one of three Thrombectomy Centres (Hubs) from all appropriate receiving hospitals which can undertake a CT/CTA and begin thrombolysis therapy where indicated.

We work with Chest Heart and Stroke Scotland to deliver training around Thrombectomy transfers to all stroke nurses across Scotland. It is anticipated that this work will be completed by March 2022.

Planning around the operational aspect and availability of the three Thrombectomy centres proves challenging to align to a specific timeframe due to the consistently changing timeframes proposed by each health board. Working with the Thrombectomy Action Group, we are currently developing our outline business case for submission to Scottish Government, which will describe the impact and resources required to deliver the changes to these clinical pathways.

The impact of COVID-19 is having a profound impact on each Board in their ability to progress or commit with their own objectives around Thrombectomy and has a de-stabilising effect on this service.

By March 2022, we will:

- Review our clinical pathway for stroke and implement a clinical triage assessment tool.
- Deliver an improved, clinically focussed measurement framework for stroke.
- Develop a clinically focussed stroke and Thrombectomy education programme to develop our stroke recognition.
- Re-design Control Centre protocols to enhance telephone triage for stroke.

Outcome: To improve outcomes for patients who have experienced stroke, by accurate triage, accurate on scene assessment, and conveyance to definitive care in line with Scotland's stroke improvement ambitions.

8.7.3 Out of Hospital Cardiac Arrest

We continue to lead a national programme contributing to improved patient outcomes from OHCA, in collaboration with key stakeholders, including Scottish Government. The vital pre-hospital work by the Service is recognised nationally and internationally and held up as an exemplar national strategy by the Global Resuscitation Academy. The development of Scotland's 2020-25 OHCA Strategy, will build on the foundations established within the previous strategy resulting in the doubling of survival from 1 in 20 people to 1 in 10, increasing bystander Cardio-Pulmonary Resuscitation (CPR) by over 20% and, through the Save a Life Scotland partnership, training over 600,000 people with lifesaving CPR skills.

Our Ambulance Control Centre Call Handlers represent the first step in our chain of survival and, as a result of increased awareness and targeted training, these staff are able to more

effectively recognise cardiac arrest over the telephone. Prior to the arrival of our paramedics/ambulance crews these Call Handlers are positively impacting patient survival by both encouraging the person who called, or others at the scene to perform bystander CPR and providing CPR instructions and reassurance over the phone, while help is on its way.

The 2020-25 OHCA Strategy has been delayed due to the pandemic, but approval by the Scottish Government OHCA Reference group is anticipated by the end of January 2021. The delay has not prevented us continuing to embed new ways of working into business as usual practices including the introduction of high performance CPR practices: use of checklist and 3RU and a defibrillator mapping system so that our Call Handlers can signpost bystanders to publicly available defibrillators.

By March 2022, we will:

- Reduce futile resuscitation attempts by promoting understanding of resuscitation decision making.
- Identify further areas of improvement to ensure continued assurance of a patient centred response to OHCA.
- Optimise the deployment of Cardiac Responders.
- Develop the use of the GoodSAM responder alerting app to maximise an early response to bystander CPR.

Outcome: To further improve outcomes for patients who have experienced out of hospital cardiac arrests.

8.7.4 Community First Responders

Our volunteer Community First Responders (CFRs) continue to be highly valued, complementing our emergency response to Out of Hospital Cardiac Arrests and a range of other immediate life threatening calls. Due to safety considerations, the utilisation of CFRs was suspended during the initial stages of the COVID-19 pandemic. We have begun the safe remobilisation of CFRs, ensuring they have appropriate PPE and additional training to enable them to operate confidently and safely, with over 100 of our CFR groups across Scotland already reactivated. A very small number of groups have opted not to resume volunteering in the current environment and we will review this position on a regular basis.

Recognising the passion and commitment of our volunteers, some were used innovatively during our pandemic response to support other areas of the service, such as within our Ambulance Control Centres. We will continue to evaluate opportunities to maximise the contribution they make to our service and communities, during both periods of exceptional demand and more generally to our existing and new ways of service provision.

We met our 2020/21 objective to conduct a strategic review of CFRs. The preferred option will be implemented during 2021/22. We also progressed the integration of Cardiac Responders, appointing a Cardiac Responder Development Lead to take this work forward.

By March 2022, we will:

- Implement the preferred option from the Strategic Review.
- Integrate an initial cohort of Cardiac Responders into our volunteer community.
- Engage with partner organisations such as Public Health Scotland to scope out potential collaborative opportunities for a broader roll out of Cardiac Responders.
- Explore opportunities to use new technology to support enhanced deployment of volunteers and support improved clinical decision making.

Outcome: To ensure our volunteering capabilities are working to maximum efficiency and effectiveness.

8.8 Our Role in Primary Care

The Service already works with a number of GP Practices across Scotland, providing predominantly Advanced Paramedics and Nurse Practitioners in Urgent and Primary Care settings. They work as part of multidisciplinary teams, offering services such as In-Hours home visiting and Out of Hours urgent appointments. This releases GP time and offers additional resilience to services. In return, our trainee Advanced Practitioners receive senior clinical supervision, and exposure to new services and pathways that can be brought back into provision by the Service, which has proved extremely beneficial. This was a key enabler of the new GMS (General Medical Services) contract.

While Integration within Primary care has been extremely challenging during 2020/21 due to COVID-19 and the subsequent altered working practices within the Service and Primary care, we are still fully committed to rotating our Advanced Practitioners through Primary Care (In and Out of Hours) and have continued our communication and forward planning with individual trainee Advanced Paramedics still maintaining contact where possible to support prescribing practice.

By March 2022, we will:

- Develop clear and appropriate referral pathways through the Redesigning Urgent Care programme to ensure patients get access to the right care first time, every time.
- Develop a sustainable rotational model which will include rotation through NHS primary care and out of hours, as well as internally through virtual triage and responding to patients.
- Work with NHS National Education for Scotland to develop a standard educational supervision programme for a multidisciplinary workforce in primary care.

Outcome: To work with Primary Care colleagues and help deliver high quality sustainable models for primary care provision, particularly where this affects people who become unexpectedly unwell. To signpost patients to relevant primary care interventions when they have experience exacerbations of long-term conditions or present with vulnerabilities.

8.9 Advanced Practitioners in Urgent Care - Virtual Consultation Model

On considering our Chain of Response at the outset of the COVID-19 pandemic we recognised the potential of utilising the skills and experience of our Advanced Practitioners in Urgent and Primary Care to undertake clinical assessment and consultation remotely by telephone or video link for selected clinical presentations.

This new and innovative way of meeting our patient's needs creates greater capacity within the 999 system and enables the Service to target the most appropriate clinician to patient requirements. This may be through direct contact with the patient via virtual consultation, through Advanced Practitioners in cars delivering care face to face, and through decision support for crews attending a patient.

This development has delivered optimised care management and provided patients with an experience and outcome which is aligned to their needs. From a service provision perspective, this additional clinical consultation offers an improved ability to avoid an A&E attendance where it is clinically identified a home or community service outcome would be better for the patient. As well as an improved patient experience the development has reduced demand on the acute hospital setting.

This clinical intervention is an innovative and evolving step change from our normal delivery model with the Advanced Practitioners currently triaging on average 12.5% of our overall 999 demand and in the region of 45% of these patients managed without the need for a traditional ambulance response. Since April 2020, this represented in the region of 20,000 patients who have been given self-care advice or referred to an appropriate pathway within their community. Where we have dispatched an ambulance, a further 12,000 patients have been discharged after face to face assessment. This has resulted in approximately 32,000 patients not taken to an emergency department and is a model that we intend to retain as part of the Advanced Practice rotational working model.

An evaluation framework has been developed, and feedback from patients indicates a high level of satisfaction with being treated in this way with patients also receptive to being cared for in this way in the future. We are also looking at the impact of the patient pathway by engaging with Public Health Scotland to understand whether these patients present at hospital within seven days of contacting our Service.

Staff feedback on this new virtual model of working for our Advanced Practitioners has been positive. During 2021/22, we will develop a sustainable rotational model that will see the Advanced Practitioners in Urgent Community and Primary Care working both within their traditional roles as well as in the provision of this newly developed model. Following our

most recent Advanced Practitioner recruitment in December 2020, we identified 20 internal Paramedic staff for recruitment to Advanced Practitioner training roles, with education commencing in January 2021, and 12 external trainee and qualified Nurses and Paramedics joining our Service in the coming months to expand and enhance our Advanced Practitioner cohort.

By March 2022, we will:

- Include regular evaluation points to support ongoing assessment and improvement of this model of care.
- Work with NHS National Education for Scotland and other key stakeholders in the ongoing development of clinical practice and education within academia.
- Continue to increase our Advanced Practitioner workforce through direct entry recruitment of a multi-disciplinary workforce as well as the upskilling of existing paramedics and alternative practitioners in line with workforce plans.
- Implement internal professional-to-professional services to provide decision support for on scene crews.

Outcome: To maximise the effective utilisation of this cohort of advanced practitioners at various points in our chain of response, whether that be by remote consultation, supporting our ACC, working as part of our community based 999 response resource, or supporting other parts of the health and care system such as GP Out of Hours.

8.10 Aeromedical Services

As current contracts with providers come to an end, our Air Ambulance service has begun a tender re-procurement process that will run from 2021 to 2024. Contracts for air services will span the next decade and we will undertake a major consultation exercise throughout this period with all stakeholders, as we consider the future of air services in the context of the future strategies of both our Service, and health and care in Scotland in general. It will also be essential to consider the lessons learnt from our response to the pandemic as we re-procure this service.

This consultation will be multi-factorial, taking a collaborative co-design approach to bring together expertise from the aviation industry, air ambulance clinicians, partners such as Scotland's Charity Air Ambulance, patients and members of the public. The outcome of this will shape the future of Air Ambulance provision in Scotland. We will also consider the implications of the Best Start plan for the improvement of maternity and neonatal services in Scotland.

This plan will eventually see the concentration of specialist neonatal intensive care units in three centres, in contrast to the existing eight. For this reason, work is underway to review our existing service, to ensure that a model is in place that is able to support the neonatal units effectively. A Project Board has been established, along with work streams focusing

on Workforce, Education & Training and Remote and Rural care. The project aims to conclude its work and provide recommendations on the future model for the Neonatal Transport Service by June 2021. Work was also being progressed to support the development of an in-uteral transfer model, to include the use of regional resources and our specialist services desk located within our ambulance control centres. This work unfortunately has been paused due to the impact of the COVID-19 pandemic and will be restarted over the next six months.

As with other parts of our health and care system, the pandemic placed significant pressure and challenging expectations on the Air Ambulance Service. Our continued focus has been on ensuring a safe working environment for air crew and clinical staff. We addressed this through the introduction of a COVID-19 fixed wing patient carrying capability, as an emergency measure through a temporary agreement with Loganair. Further partnership working to mitigate the impact of COVID-19 on our aeromedical services was also progressed with the Maritime and Coastguard Agency, to agree support with COVID-19 transfer requests, and Scotland's Charity Air Ambulance, and Babcock Mission Critical Services, to achieve consistency of approach across all our tasked air assets.

Various options have been explored and an option paper is being finalised detailing costs, risks for consideration by our Board. The introduction of the vaccination programme has resulted in some further consideration being given to potential options on a medium term basis.

By March 2022, we will:

- Implement a new model of care for Neonatal incidents.
- Ongoing stakeholder and community engagement to inform requirements for the provision of new air ambulance resources.

Outcome: To ensure our aeromedical capabilities are working effectively to support patients in remote communities, support the centralisation of specialist paediatric and neonatal services, and continue to provide pre-hospital critical care.

8.11 Health Inequalities

Health inequalities are the unjust and avoidable differences in people's health across the population and between specific population groups. Given that the Service provides services to all population groups, it is therefore important that we plan our service delivery models to ensure that staff are able to better support patients while at the same time reducing health inequalities.

Providing access to universal services for those groups deemed to be vulnerable ensures that there are fewer or no barriers in terms of stigma, accessibility, discrimination. We are committed to providing equity of access for all routes of care, using a human rights based approach.

In order to support this approach, we are currently strengthening our commitment to supporting vulnerable groups by increasing the specialist knowledge, skills and capability of the Service through permanent recruitment of a dedicated Public Protection Team. The proposed team would comprise of Practitioner leads aligned to Adult/Mental Health, Children, and High Intensity Users.

The current strategy in Public Protection seeks to promote co-ordinated thinking and delivery of services to safeguard children, young people, adults and their families/carers; especially as children, young people and adults do not exist, or operate, in isolation from each other or from other services.

By March 2022, we will:

- Build strong links with the Integrated Joint Boards, Health & Social Care Partnerships, and National Adult and Child Protection Committees, to promote better access to local services for patients and for our staff.

Outcome: By understanding the needs of our communities, we will improve our responsiveness, aiming to reduce inequalities of outcome in line with our commitments to improve population health.

8.12 Public Protection Referrals and Care Pathways

In response to the COVID-19 pandemic we implemented a health hub and introduced a temporary Single Point of Contact (SPOC) to enable staff to raise concerns about vulnerable patients that would benefit from further support interventions/ongoing referral to appropriate services. The Health Hub subsequently make onward referrals to the most appropriate local authority, service or third sector organisation to enable access to appropriate care and support.

The aim of the SPOC is to increase the quality and number of referrals made by crews and encourage a larger proportion of staff to help patients to access the care and support they need.

By March 2022, we will:

- Further scope and develop our Health Hub.
- Establish a dedicated Public Protection Team.
- Work to further develop the knowledge and skill of our staff in relation to Public Protection.

Outcome: To support vulnerable patients to get the support they need to address their situations, primarily ensuring their safety by working with local systems in a responsive and timely manner, and providing an infrastructure for early identification of vulnerability.

8.13 Data Sharing with Police Scotland

We are currently working towards a data analysis proposal with Police Scotland. The purpose of the agreement is to explore the sharing of specific data sets between Police Scotland and the Service to analyse potential shared benefits in service delivery.

By understanding and bringing together the information held by both organisations we can utilise our services better. The high level objectives include improved crew safety and support, a reduction of inappropriate calls and enhanced opportunities to provide the right care and support for vulnerable communities and individuals.

By March 2022, we will:

- Explore joint data analysis options with Police Scotland in relation to vulnerable patient groups.

Outcome: To be able to understand more about our joint vulnerable patient groups and to work with partners to plan how to provide improved access and support from services.

8.14 Population Health

The Service is well-placed to support national aspiration to improve the health and wellbeing of Scotland's population.

In addition to providing clinical care in every community in Scotland 24 hours daily every day of the year, we are also taking forward work to support wellbeing of its staff and people in Scotland' communities.

We employ over 5,000 people who live and work across the length and breadth of the country. We provide employment and development opportunities to a range of clinicians, both degree and vocationally qualified and to a whole range of support roles, again distributed across the country.

We also support and co-ordinate the response of many Community First Responder volunteers, again widely distributed across the mainland of Scotland and its island communities.

Our contribution to improving population health through leading on the design and implementation of Public Health policy is evidenced by examples such as Scotland's Out of Hospital Cardiac Arrest strategy. We have also been supporting efforts to reduce death relating to substance misuse and reducing ill health related harm by signposting patients appropriately to other parts of the health and care system.

Beyond work in communities, we are actively engaged in work to maximise the impact of new technology in an innovative manner to both improve efficiency and effectiveness of current activities and to work to transform how care is delivered.

The work to progress our population health requires us to work with a range of partners. Once such example is the newly formed Public Health Scotland.

At a recent workshop led by both organisations respective Chief Executives, we worked on the alignment of our activities with the established priorities of Public Health Scotland, namely:

- COVID-19
- Mental Wellbeing
- Community and Place
- Poverty and children

By March 2022, we will:

- Work with Public Health Scotland in how we can accelerate and strengthen partnership working.
- Explore possible options to increase our capacity and capability to improve the health of the people of Scotland.

Outcome: By working in partnership, we will improve our responsiveness, aiming to improve population health.

8.15 Reducing Drug Deaths

Reducing drug related deaths in Scotland remains a Scottish Government public health priority, particularly in light of the 2019 statistics released in December 2020. There were 1,264 drug related deaths in Scotland during 2019, which is an increase of 6% from 2018, and more than double from 2009. This is the largest number ever recorded in Scotland and is the highest rate in Europe.

The Service is a key member of the national Drug Death Task Force and at the start of 2020 we sponsored a pilot which meant ambulance clinicians were able to supply Take Home Naloxone (THN) at incidents to people who are likely to witness an opiate overdose in the near future. Based on this successful trial the Task Force subsequently approved a proposal and funding for a project team to support us to further contribute to drug-harm reduction. This funding supports the appointment of three full time Clinical Effectiveness Leads in Drug Harm Reduction posts to work across Scotland in the roll out of the national supply of THN kits and explore establishment of referral pathways to local Alcohol and Drug Partnerships (ADPs).

We will improve data sharing with territorial health boards on incidents where we have attended overdoses and administered or supplied naloxone to patients. Local support services can then make contact with the person affected, and discuss the best route of future care for them. Longer term, we plan to explore with ADPs how ambulance clinicians could refer to support services at the point of overdose, thereby reducing the time involved in sharing data and making contact with the person.

Additionally, we are liaising with Public Health Scotland to understand how our higher level data on responses to overdose calls could help inform an early warning system to highlight changes in overdoses in Scotland, to further influence support service interventions.

By March 2022, we will:

- Fully roll out of the national Take Home Naloxone programme.
- Work with Public Health Scotland to join up data and improve sharing of data with all territorial health boards to help inform how we collaboratively design services to improve public health.
- Establish links with all 31 Alcohol and Drug Partnerships in Scotland.

Outcome: To reduce the number of deaths due to drugs in Scotland by optimising both response and prevention opportunities.

8.16 Elective Care

Our Board has indicated that it wants to see our Elective Care Service reimagined as an all-encompassing 'lower acuity' service that provides care and transport to those who do not require the skills of a paramedic and technician ambulance crew, whether or not they are classified as scheduled or unscheduled care. As our Health and Care Service adapts to changes required due to the COVID-19 pandemic, a number of services are likely to see changing demand patterns, as remote consultation initiatives are expanded. Different modelling scenarios are being run to look at how future social distancing measures and future service need will impact on our capacity and resource levels. Through analysis we have identified that around 100 journeys a day, are currently resourced by Accident and Emergency ambulances despite being identified as suitable for transport by Ambulance Care Assistants.

A comprehensive review of the Elective Care Service is underway, examining all aspects of its operation, particularly in the context of how we can contribute to Redesigning Urgent Care and we are building our understanding of the implications for the demands on our Elective Care Service. Staff and vehicle resource levels are being reviewed utilising specialist demand and capacity modelling expertise to better match available resources to patient and health and care demand in all locations.

Work is also being done to revise key performance indicators and performance measures to ensure appropriate insight to the operational performance of the service in terms of productivity, efficiency and utilisation. This requires the reporting metrics to be rebuilt and a new measurement framework put into place, and will have a particular focus on staff experience including welfare, training and education, career progression and scope of practice.

We have been able to improve the service we provide to patients who have been assessed in the community by Health Care Professional (HCP) colleagues as requiring further hospital intervention, with our support to enable the patient to access hospital care. Increased use of our ‘card 46’ process has allowed more suitable patients to be transported by low acuity scheduled care resources. This is safeguarded by our Elective Care hub located in our control centre, which gives staff the opportunity to discuss the suitability of transporting patients with another health care professional.

We are building on existing models to expand the options for alternative hospital transport across the country, and have been working with our partners and local communities to develop these integrated transport models to support sustainable transport solutions. In addition to the existing Lothian Flow Centre, we have helped establish transport hubs in Forth Valley, Fife, Tayside and Paisley. These hubs will assess whether the patient requires support from the Service or alternative transport providers, prior to making contact with our service. This will support movement of patients from acute care, delayed discharges and support other opportunities for our Service to contribute to improved flow across sites.

We have been analysing the functionality and supervision of our planning and call taking processes, which has included the use of automated journey planning across our control centres. This has the aim to reduce the time spent journey planning, and increase our capacity to support short notice requests to support the wider health service.

Our objective for Elective Care is to have a fit-for-purpose, sustainable service which works in tandem with the A&E services we provide. To do this we need to reduce demand from patients who do not have a defined clinical need for ambulance care and ambulance transport and refocus this ambulance capacity to support clinical demand such as on the day hospital discharges, low acuity work and social distancing measures. We are always seeking to improve response times to patients, and improve clinical outcomes by introducing more low acuity ambulance resources in support of a 'one ambulance service' delivery model freeing up frontline accident and emergency ambulances for high acuity care and treatment of patients.

Demand Management and Future Service Delivery Model

Undertaking detailed demand modelling work based on current planning assumptions and future planning scenarios as well as scoping out a future integrated service delivery model aligned to the demand modelling work will be key to delivering improvements to our elective care service. As part of this we will be reviewing and updating the Patient Needs Assessment (PNA) and performance measures, and develop alternative transport options with stakeholders.

Capacity Planning and Management and Technology and Innovation

Full integration of our services to provide one service model, which combines Accident & Emergency responses with our Scheduled Care responses remains a key focus. We need to review our current end-to-end capacity planning and management processes and improve these to align with the future service delivery model, as well as reviewing our current general telephone requests and look at alternative ways of managing these through signposting and automation. Current call taking, journey planning and day control processes, and the use of auto plan should also be reviewed and improved where required to align with a future model.

Workforce Capability

We need to identify the workforce skills and capability required to support a new service delivery model, and secure the workforce investment required to realise this. We will plan the training and education provision for new and existing staff to realise the future service delivery model, and carry out engagement and ensure effective communications and support for workforce as the future model takes shape.

Estates, Facilities, Fleet Infrastructure & Communications

We need to develop a plan to realise all the fleet, estates and facilities requirements that will be aligned to a future integrated service delivery model, and secure the relevant investment required. We need to ensure appropriate engagement takes place and communications are clear and managed appropriately.

By March 2022, we will:

- Improve utilisation of existing resources.
- Commission a Demand & Capacity review of scheduled care.
- Review, refine and implement an improved PNA.
- Work towards integrating our services to provide one service delivery model, which combines Accident & Emergency responses with our Scheduled Care responses.

Outcome: To improve the service we provide to patients requiring non-emergency transport to hospital.

8.17 Mental Health

We were experiencing an increasing demand for help from people experiencing mental ill-health before the global pandemic. In response, we began the development of a Mental Health Strategy in order to better support patients through enhanced collaborative working with public and third sector partner organisations that were seeing similar trends. We also recognise that mental ill health is becoming more prevalent as a result of the four harms of COVID-19.

During 2020/21, we made good progress on a number of objectives to serve people better in our communities who are experiencing mental ill health. Through our collaborative work to develop a Mental Health Hub with NHS 24, low acuity calls to our emergency 999 number are now being sent directly to NHS 24 for referral to an appropriate pathway. Ambulance crews can now refer directly to the Mental Health Hub when they are on scene with a patient, providing them with the right support at that point, and helping the patient engage with the Mental Health Hub should they require support again in the future. The Mental Health Hub now also offers referral to the Distress Brief Intervention (DBI).

We have commenced recruitment for a clinical effectiveness lead and paramedics to staff the Mental Health Car. After a successful trial in Glasgow, this will be expanded into other areas of the country. We are also continuing our collaborative efforts with Police Scotland

to look at how we both respond individually and collectively to incidents involving patients experiencing mental ill health.

Working closely with NHS Boards and Integrated Joint Boards we have been improving access to local mental health services on a 24/7 basis. We now have arrangements in place at Stobhill and Leverndale hospitals in the West, and are now developing more pathways in Dumfries and Galloway and Inverness.

By March 2022, we will:

- Have an approved Mental Health Strategy and commence implementation.
- Increase the number of appropriate 999 calls directly referred to the Mental Health Hub to avoid inappropriate dispatching Accident and Emergency ambulance crews
- Develop our data sharing arrangements with Public Health Scotland, other NHS Boards, partners and IJBs to inform, develop and implement direct access to mental health pathways on a 24/7 basis.
- Implement direct ambulance crew referrals to the Mental Health Hub for adults and for young people in the 16-17 age range and 14+ that require mental health services.
- Expand our Mental Health Car provision from Greater Glasgow and Clyde into Dundee and Inverness.
- Complete the roll out our Supervising First Aid for Mental Health programme.

Outcome: To ensure we help and support patients experiencing mental ill-health in considering their needs and wishes, and in line with the principles of Realistic Medicine.

8.18 Dementia

We signed the Dementia Pledge 2025 alongside Police Scotland, Scottish Fire and Rescue, Alzheimer's Scotland, Purple Alert and University of the West of Scotland. Our commitment to the Pledge means that we will continue to work collaboratively to support people with dementia who present to all emergency services. Alongside carers, we will position ourselves as equal partners in care for dementia patients.

Some of our planned work to support of people with dementia, their family, friends and carers was put on hold during the pandemic, and we will re-start this during 2021/22.

By March 2022, we will:

- Develop and introduce dementia friendly ambulances and educate our staff and the public about why these are important in managing the care of our dementia patients.
- Build upon our education for all staff, through our Learning in Practice Programme that will be delivered virtually.
- Achieve 80% of staff becoming dementia friends through sessions developed with Alzheimer's Scotland for all emergency services.
- Continue the development of the dementia work area on our intranet to keep our staff informed and engaged in the development of improved services for dementia patients.
- Work alongside the Alzheimer's Scotland Allied Health Professions expert group to implement Connecting People, Connecting Support.

Outcome: To ensure we support patients experiencing problems associated with or directly due to dementia in a compassionate and caring manner, while robustly considering and addressing their clinical presentations.

9. Enabling Improvements

9.1 Digital Transformation

As described in the Service's Remobilisation Plan 2020-21 (RMP2), there are a number of developments we intend to proceed with in the upcoming years, falling broadly into the three separate categories below:

1. Transformational projects aimed at expanding our capabilities;
2. Projects aimed at incremental improvement of current capabilities;
3. Exploratory projects requiring additional consideration and potential long-term investment.

In year 1 (2020/21), the Service has focussed on implementing projects in the second category, whilst laying the foundations for the more transformational projects which will extend beyond 2021/22 as part of the delivery of our Digital Strategy 2021-2030. Projects in the third category will require further work to explore feasibility before being progressed.

Our Digital and Information Communications Technology (ICT) Steering Group has been set up to coordinate our digital development portfolio. The intention of this forum is to ensure appropriate strategic, clinical and operational leadership in the creation of our Digital Strategy, as well as appropriate capacity and capability across the Service. The Steering Group will also take a role in identifying and developing opportunities for innovation, ensuring that investment in new technology ultimately adds value to our ability to provide care.

Work to develop our first Digital Strategy is ongoing with Environmental Scanning and Stakeholder Engagement work complete, allowing us to establish our future ambitions and priorities. The Digital Strategy is on track for the Service Board approval in July 2021.

The aims, progress to date and planned developments for 2021/22 are detailed below,

Projects Aimed at Expanding Capabilities

Enhanced data sharing

- To identify and implement solutions to further link and merge patient-level data between SAS and other Health Boards.

Digital Workplace project

- To build on the current MS Teams capability and to replace the current email and intranet solutions with M365 cloud-based email and SharePoint respectively. This project aims to improve the security, productivity, and connectivity of individuals and teams

Replacement of Computer aided dispatch (CAD)

- To establish a project to replace the two discrete CAD systems (covering Unscheduled and Scheduled Care resources) used within our Ambulance Control Centres (ACC).

Enhanced video consultation

- Development, testing and rollout of the mobile NearMe solution planned for implementation by December 2021

Projects to Expand or Replace Existing Capabilities

ACC and mobile data developments

- Continuous development to increase the efficiency and effectiveness of existing ACC and mobile data systems, designed to minimise call waiting times, improve patient triage, ensure the most appropriate resources are despatched to patients in a timely manner and improve patient treatment and reporting mechanisms.

Telephony Upgrade

- To replace ACC telephony and call recorder systems that are approaching end-of-life and to add enhanced functionality where appropriate

NIS and Cyber Resilience

- to take a cyclic incremental approach to continually improving our maturity against the NIS CAF and therefore, our cyber resilience

Enhanced digital integration with NHS24

- Development of a fully integrated solution whereby clinicians have the option of seamlessly passing patient data between the two organisations using digital technology.

Hospital Turnaround Management

- Rollout of new module with the C3 command and control system to improve visibility and reporting of turnaround times at hospital and allow for improvements to be made to reduce delays in patient handover.

Emergency Services Network (ESN)

- This UK Government led, GB-wide, programme aims to replace the current Airwave communications network, used by all GB emergency services, with a new Emergency Services Network.

By March 2022, we will:

- Transition our Ambulance Control Centres to the LifeX solution in preparation for the ESN programme.
- Complete a full telephony infrastructure replacement and implement a new contact centre solution.
- Enable our Digital Workplace solution by completing the migration of all ICT users to the Windows 10 and Microsoft 365 environment.

Outcome: To support Service improvements and system redesigns with the appropriate digital solutions to enable them to achieve their aims.

9.2 Data and Intelligence Sharing

Throughout 2020/21, we developed Integrated Joint Board level reporting detailing demand on our resources for specific health conditions. These reports are being used by our Regional Management Teams in conjunction with the IJBs to identify areas that may benefit from additional patient pathways or collaborative working across services.

Our understanding of the pressures likely to be experienced by the Health and Social Care sectors across Scotland enables us to adapt to meet the needs of patients at predicted times of particular pressure. Throughout 2021/22, we will build on the relationships fostered in 2020/21 to develop data and intelligence sharing across the NHS in Scotland to assist in the planning process for potential future scenarios.

With our current focus on the development of community pathways to support our demand from Mental Health, Falls and Breathing Difficulties we recognise that there is much we can learn from linking our data with that of the Unscheduled Care Datamart. We have invested in developing linked data sets for these clinical conditions which will help us understand what happens to these cohorts of patients who are conveyed to hospital – e.g. length of stay, is there variation across the country, where do we take patients to hospital and they are discharged and what can we learn from a pathway development perspective. Enhancing and learning from this data is part of the next step of our internal "Redesign of Urgent Care" programme.

By March 2022, we will:

- Develop data and intelligence sharing in partnership across the NHS in Scotland.

Outcome: To use our data and information to improve the design and delivery of services across the NHS in Scotland.

9.3 Using Data to Develop Services

The Service has an established record of collaborating with other NHS Boards to provide a whole-system view of health care through the Unscheduled Care Datamart. The Datamart is used throughout the NHS in Scotland and has been used as the basis for the clinical outcomes work that is now embedded in the Service. Analysing further steps in the patient's journey provides unique and invaluable intelligence about our contribution to the wider patient pathway and identifies opportunities for collaboration and improvement. Throughout 2020/21 we have been working with Public Health Scotland and National Services Scotland to review the information we submit to the Unscheduled Care Datamart. The aim of this is to ensure the data and governance arrangements meet the needs of future data and intelligence requirements across the NHS in Scotland. It is anticipated that the implementation of these changes will take place throughout 2021/22.

During the COVID-19 pandemic, health services in Scotland worked collaboratively to understand emerging demand patterns through the sharing of data and intelligence. As the pandemic has continued, this collaboration has provided a vital platform for identifying

further waves of infections and associated increases in demand. It also assisted organisations with the future planning of services by understanding how demand will look.

Collaborative data and intelligence sharing between the Service, Public Health Scotland, NHS 24 and other NHS Health Boards through the Redesign of Urgent Care Programme has been key to understanding the impact of this change in delivering frontline services.

The COVID-19 pandemic has had a wide and measurable impact on health services and the wider society. The data that we collect during patient care is a significant source of intelligence for research. For example, during 2020 we supported Glasgow University on research into the impact on our Service alcohol related incidents had while licensed premises were closed due to lockdown.

The Service is a data driven organisation, the ability to use data and intelligence to its full potential is reliant on the Service's data warehouse. In 2019 we embarked on a process to renew the data warehouse based on current and future requirements. The requirements gathering phase has been completed with the build scheduled to begin in the last quarter of 2020/21. The build will incorporate information from across the Service and new data and intelligence functionality will be rolled out in a phased basis over 2021/22 and into 2022/23.

By March 2022, we will:

- Continue to build relationships with academic institutions to support and collaborate on research projects involving ambulance information.
- Improve our capabilities in producing workforce data.

Outcome: To use our data and information to improve the design and delivery of services across the NHS in Scotland.

10. Communication & Engagement

10.1 Staff & Partnership Engagement & Experience

We made staff engagement and communication a priority during the pandemic response phase and have positively engaged with our staff side colleagues during the last 12 months, introducing new ways to discuss and update on our plans and provide early issue resolution. This has been positively commented on by management and staff side colleagues in terms of enhancing our partnership working ethos and strengthening relationships as we move into recovery there is a mutual commitment to retain this way of working and build on progress made.

We have also increased the quality and frequency of our engagement with staff across the organisation using new and existing channels. This includes a new weekly 'all staff virtual engagement session' chaired by the CEO and supported by expert leads and gives staff an opportunity to hear about new developments within the Service and feedback directly. Staff are also given the opportunity to raise any issues of concern during these sessions and hear from senior leadership team members on the call in response. We have also rolled out a new intranet system in recent weeks and increased social media aimed at staff. Regional

managers continue to undertake regular face-to-face and virtual conversations with staff locally.

Our remobilisation communications plan is also being implemented internally and externally utilising a range of channels targeting our key audiences to promote new approaches, developments, services and current challenges being faced by our Service.

By March 2022, we will:

- Carry out internal and external engagement and communication on the delivery of our Remobilisation plan 2021/22.
- Undertake relevant engagement on our emerging future strategic framework.
- Ensure consideration of communication of our future strategic framework.

Outcome: To ensure our staff, partners and public are fully engaged in co-designing the future direction of our Service.

10.2 Patient Engagement & Experience

We are working in partnership with patients and patient groups to understand the implications of proposed changes and to co-produce service re-design together. This has required us to work with public partners to take opportunities to utilise digital platforms to continue the current engagement arrangements. We are working through the challenges in this space currently and ensuring public partners are supported to provide the level of engagement previously enjoyed, prior to the challenges that social distancing and shielding have introduced.

We are currently engaging on the developing Mental Health Strategy for the Board, as well as with staff partners in the development of the new staff Health and Wellbeing strategy. Both of these projects are supporting opportunities to understand the implications of service change on key groups. Following the introduction of a new approach for virtual assessment of certain categories of patients by Advanced Practitioners, we also undertook engagement with patients who had been treated to gain their direct feedback on their care and experience. The feedback was very positive and we are using the constructive suggestions from these patients to influence further improvements to the service moving forward.

We have developed a new best practice toolkit for patient and staff engagement on service change and are testing this approach through two pilots. The first involves our new Falls pathway in Glasgow but also takes into account national work currently ongoing around falls. Working with Third-Sector organisations (Age Scotland, Alzheimer's Scotland, Glasgow Disability Alliance), we are gathering patient opinion using an online survey, focus groups and our national PFPI group. Working in partnership with our Third-Sector partners, we are seeking their expert opinion and exploring possible co-design, with learnings and follow-on actions being taken on by our internal strategic oversight bodies following conclusion of the trial.

Our second pilot is focusing on our COPD pathway in Tayside and our engagement toolbox will be tailored to focus on staff engagement. We are surveying staff in the area, running

local focus-groups and a National engagement session with staff. This will help us to gain views directly from staff and also aid in the National rollout of the pathway.

In the wider work around Redesigning Urgent Care, we are also participating in a number of the work streams and patient partners are on these groups to understand the implications of proposed changes, to work to co-produce developments to the services across NHS Scotland.

11. Innovation

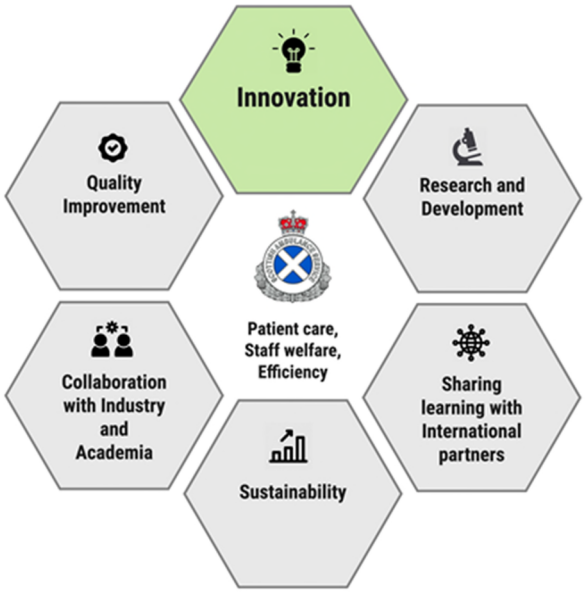
Innovation has been identified as an important enabler of the Renewal phase in "Re-mobilise, Recover, Re-design: The Framework for NHS Scotland". Significant innovation has already taken place in the Response phase of the pandemic, which was enabled by:

- Absolute clarity on required outcomes
- An organisation-wide appetite for implementing change
- Access to locally proven, but not widely implemented, tech-based processes and products
- Availability of rapid digital systems development.

Moving into Remobilise and Renewal, it will be important for us to decide what new ways have worked so well that they must be retained, what techniques need further development, and what approaches have failed to deliver as hoped.

The Service is committed to be a player in this space, building a systematic and reliable system that is not person dependant, that supports individuals to develop their ideas to their full potential.

Our Innovation aim is that by 2025, the Service will be recognised as a global healthcare innovator with a culture that encourages creativity and growth across all aspects the organisation. Income growth so we can do more research and development, and joint venture growth strategically linking and collaborating with partners to enable a healthier, happier and sustainable society.



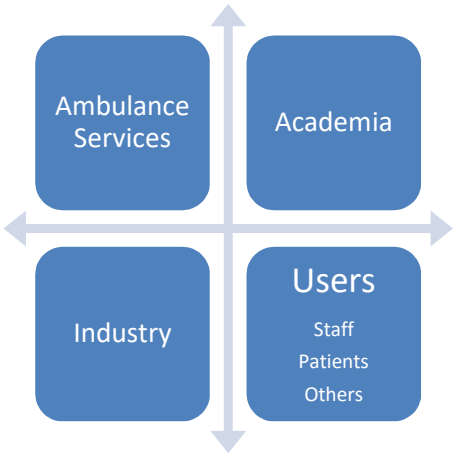
We aim to develop our innovation under the following set of principles:

- We will develop and use a proven step by step methodology.
- We will seek to understand the nature of the problem.
- We will build capacity for iterative prototyping.
- We will create compelling value propositions.
- We will start small, prove benefits, improve and then scale up.
- We will overcome any barriers through staff engagement.
- We will co-design solutions in partnership and work with experienced partners.
- We will focus resources on areas with the greatest need or opportunity
- We will create Board and widespread organisational buy-in.
- We will develop a self-funding and 'income growth' financial model to be reinvested in the Service, as laid out in the national performance framework.
- We will seek to deliver value for Scotland beyond our active engagement with SMEs (small and medium-sized enterprises) and other strategic partners in the innovation space, not just within Scotland but internationally.

As part of our 2030 strategy we want to be recognised as a global healthcare innovator with a culture that encourages creativity and growth across all aspects the organisation. As we commercialise innovation ideas to generate income, we will look at new sources of funding to support research and innovation to deliver world class evidence-based care. We also want to generate income growth through innovation to invest in further innovation, enhancing research and service improvement along with joint venture growth, strategically linking and collaborating with a wide range of partners to enable a healthier, happier and sustainable society and thereby economy.

These foundations play to our strengths with regard to innovation, our people and our data, identifying three key areas for immediate exploration with strategic partners using the quadruple innovation helix.

Quadruple Innovation Helix



Our immediate opportunities are:

- Data development and how can we maximise the value of this as a commodity
- Artificial Intelligence and machine learning, building upon the expertise we already have within our Service
- Use of robots and drones - focusing on our emergency and urgent response models.

Further investigations into areas for innovation will be looked at over the next year and as we identify priorities for innovation, we will work with the most appropriate partners who want to work with us using their specific skills to solve the prioritised problems.

Partners we would want to collaborate with:

- Those that have similar values to our own organisation
- Academia engaged in research
- Industries producing commercial goods that can be commercialised
- Those that we already engage with and have a proven track record
- Other leading ambulance services.

By March 2022, we will:

- Identify priorities for innovation creating an 'innovation funnel' collecting insights from frontline staff and patients, and we will work with the most appropriate partners using their specific skills to solve the prioritised problems.
- Identify and agree three priority areas to test through engagement with key stakeholders as identified in the Helix.
- Progress with proven methodologies to develop innovative solutions with partners in these three areas.
- Establish evaluation arrangements.
- Establish interim governance arrangements.
- Launch our Innovation, Research and Service Development Strategies, in alignment with the development of the wider Innovation Strategy for NHS Scotland.
- Identify and assess opportunities for funding solutions.

Outcome: To foster a culture of innovation, closely linked to delivering impactful service developments in pursuit of the delivery of safe, effective and efficient care.

12. Financial Impact

A separate financial plan has been completed to support this remobilisation plan.

13. Equality Impact Assessments

The Service recognises that the remobilisation and redesign of our services while beneficial for staff and patients, and indeed co-designed with our partners has the potential to have different impacts on different groups across our communities. We are committed to ensuring as we introduce new polices or practices in this new way of working that we will undertake Equality Impact Assessments to help us identify any potential barriers that these new ways of working may present. These will follow the COVID-19 guidance issued by the Equalities and Human Rights Commission. From there we will take appropriate steps to mitigate or minimise those impacts to ensure our services are as accessible as can be for our population.

14. Alignment with Annual & Strategic Planning Cycle within our 2030 strategic framework

As we continue to learn and adapt to new ways of working and embrace opportunities to remobilise and recover from the COVID-19 crisis, it is imperative that we take the time to learn from our experience, assess our 2030 strategic aims and reprioritise our deliverables in line with emerging national, regional and local priorities.

We propose we do this by building on our previous aims and the new emerging priorities and creating a strategic framework to work within, as we take time to redefine our 2030 strategy post COVID-19. We will introduce a new, continuous approach across the organisation to engaging with patients and communities, using their views and experiences to help shape improvements to services in partnership through co-design, and we will engage with Third-Sector partners around service redesign. We will build on the whole system planning and working, and develop this engagement working with Health Boards, IJBs and wider stakeholders through a focused engagement plan over the next year. As we move out of remobilisation into new models of working, we will reshape our governance and delivery model in the reporting and implementation of our strategic initiatives.

Appendix 1 – Risk Appetite 2020-2021
Our Risk Appetite Statement

SAS will never knowingly breach legislation or regulatory compliance.

SAS will never knowingly compromise patient safety, quality and reputation. Public confidence in our services are critical and we will not take risks that would impact adversely on patient safety and quality.

SAS has a cautious appetite for financial risk, taking cognisance of the requirement to make decisions that would involve a higher degree of financial risk to deliver enhanced quality patient care.

In terms of technology SAS has a cautious risk appetite for critical 'business as usual systems' with a more moderate risk appetite when exploring digital transformation options providing robust controls and mitigations are in place. Innovation and technology developments are about managing risks not avoiding them.

In terms of our workforce and the health and wellbeing of our staff SAS are willing to take moderate risks as we require to further upskill and educate our staff in order to continue to transform our services. All of this considered whilst continuing to work closely in partnership.

SAS must fully play its part in reforming NHS services and we accept a moderate level of risk with our Stakeholder Partners and in the development of improving population Health against an agreed evidence base without taking significant risks that would impact on our core objectives.

In order to achieve Primary and Community Care Transformation, improve Mental Health services and in the pursuit of our objectives in Elective Care Services as set out within our strategic direction and remobilisation plans we are willing to adopt a moderate appetite for risk providing patient care and services are not adversely affected.

SAS has a more cautious risk appetite when dealing with our Emergency and Critical Care services, including our Aeromedical Services. This is our highest acuity patients and covers many functional areas across the Service, including Emergency Care and Ambulance Control Centres.

In order to Redesign Urgent Care and in the pursuit of our objectives with our Special Operations Response Teams and Remote and Rural we have a cautious to moderate appetite for risk providing patient care and services are not adversely affected.

SAS has an open appetite for risk in innovation and research with assurance of strong risk controls and management.

	← Unacceptable to take risks		Higher Willingness to take risks →							
RISK LEVEL	**LOW**				**MEDIUM**				**HIGH**	
Risk Appetite	**Averse**		**Cautious**		**Moderate**		**Open**		**Willing**	
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Generic Clusters										
Regulation- *how much risk are we willing to take regarding complying/breaching legislation?*										
Financial – *how much risk are we willing to take in pursuit of our objective for financial sustainability?*										
Clinical Technology – *how much risk are we willing to accept in the pursuit of our objective to be a leading technology driven organisation?*										
Digital Transformation – *how much risk are we willing to accept in the pursuit of our objective to be a leading technology driven organisation?*										
Workforce – *how much risk are we willing to accept in the pursuit of our objective to increase and redesign our workforce*										
Health and Wellbeing - *how much risk are we willing to accept in the pursuit of our objective to improve the health and wellbeing of our staff?*										
Reputation – *how much risk are we willing to accept to maintain our good reputation?*										
Patient safety and Quality – *how much risk are we willing to accept to ensure we deliver high quality and safe services?*										
Population Health - *how much risk are we willing to accept in our objective to improve and maximise Population health?*										
Patient / User Experience – *how much risk are we willing to accept in our objective to maximise patient and user experience?*										
Partner Relations – *how much risk are we willing to accept our aim to improve and maximise partner relations?*										
Innovation and Research – *how much risk are we willing to accept in our objective to increase innovation and research?*										
RISK LEVEL	**LOW**				**MEDIUM**				**HIGH**	
Risk Appetite	**Averse**		**Cautious**		**Moderate**		**Open**		**Willing**	

Specific Clusters	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Emergency / Critical Care - *how much risk are we willing to accept in the pursuit of our objective and activities in emergency care?*										
Urgent Care - *how much risk are we willing to accept in the pursuit of our objectives and activities in urgent care?*										
Elective Care - *how much risk are we willing to accept in the pursuit of our objective and activities in elective care?*										
Mental Health – *how much risk are we willing to accept in the pursuit of our objective to ensure we deliver improved mental health services?*										
Primary and Community Care Transformation - *how much risk are we willing to accept in the pursuit of our objective to ensure we deliver our primary & community care transformation plans?*										
Education and Professional Development - *how much risk are we willing to accept in the pursuit of our objective and activities in education and professional development?*										
Remote and Rural – *how much risk are we willing to accept in pursuit of our objectives and activities in remote and rural care?*										
Specialist Response – *how much risk are we willing to accept in pursuit of our objectives and activities in specialist response care?*										
Aeromedical Services – *how much risk are we willing to accept in pursuit of our objectives and activities in Aeromedical Services?*										