Chair David Garbutt QPM
Chief Executive Pauline Howie OBE

Neil Findlay, MSP
Convener, Health & Sport Committee
The Scottish Parliament
Edinburgh
EH99 1SP
healthandsport@parliament.scot

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Re: Response to Health and Sport Committee

Dear Neil

Thank you for your letter, dated 6 June 2017, subsequent to our attendance at the Health and Sport Committee meeting on 23 May 2017. As requested, I have sent the following information to your clerks:

- Performance information based on the new response model
- Board paper on future of the Patient Transport Service
- Data on the new NHS Lothian Flow Centre, and resulting improved turnaround times.

Please find more detailed information as requested in your letter below:

Staff Satisfaction and Absence

Our results from the NHS Scotland 2015 staff survey were disappointing. We actively encouraged staff to complete the survey and increased our staff participation rate from 33% in the previous survey to 37%, against an NHS Scotland national average of 38%. We reviewed the results with our National Partnership Forum and agreed actions to improve communications and engagement, to support staff welfare and wellbeing and increase our focus on leadership and management development.

Engaging with our operational staff is challenging: our A&E and Patient Transport Service staff spend most of their day in their vehicles, providing care to patients. Similarly, our Ambulance Control Centre staff are focused on responding to 999 calls or calls requesting support from the Patient Transport Service. Shift start times are staggered in most locations to allow resourcing levels to best match service demand; therefore there is little opportunity for whole team meetings. In 2016 we updated our Communications and Engagement Strategy and have also been testing digital communications channels to help improve staff access to information, to advice and support and to feedback or aid discussions. For example, we introduced a mobile version of our staff intranet, so staff can keep up to date with the latest information on their mobile phones, without having to log onto a station-based PC. In addition, I do a quarterly webcast with another senior member of staff to share information on key topics of interest to staff and to answer staff questions put to me live by staff across the country. Our staff newsletter, Response, provides staff with

information on key developments within the Service; shares staff stories about the work they do and celebrates successes. Response magazine was the winner in the Best Staff Newsletter category at the NHS Scotland Communications Awards in March this year.

We reviewed our approach to our programme of patient safety walk-rounds, and have now implemented a new format where staff can meet with senior managers and non executive directors at a dedicated place and time. This provides our staff with the opportunity for face to face dialogue with senior colleagues from frontline and support roles and with members of our board. Staff are able to provide feedback and raise concerns directly with them. We theme up the feedback from these visits and follow up with `You Said We Did' communications. A practical example of change directly driven from staff feedback on patient safety is that we have revised the content of the annual training for our operations staff in partnership with staff representatives.

Our Health and Wellbeing Strategy was approved in January 2016. Since then we have enhanced our employee support programme, undertaken stress audits, and tested Mindfulness programmes. We now provide mental health training for managers, and our divisions are making progress towards their next stage of their healthy Working Lives award. Our management development programme: `Delivering our Future Leaders and Managers' is improving the level of support managers give to frontline staff.

We are also maintaining our focus on leadership development, which helps existing and emerging leaders build and maintain highly engaged, high performing teams. Our performance management strategy will support staff in developing their skills, and help them put their own ideas for change into practice, helping them improve their experience at work, as well as the patient experience.

Over the last 12 months, we have rolled out the NHS Scotland staff engagement tool, iMatter, which enables staff to improve their experience at work at a local level through their team action plans. It is worth noting that while 38% of our staff participated in the 2015 staff survey, 70% of our staff have participated in iMatter to date, so more staff are having a say in how to make their work experience better, and are directly involved in taking steps to make this happen. Our Employee Engagement Index score is 67%, indicating high levels of staff engagement. We are not complacent and improving staff experience remains one of the Service's highest priorities.

Our new clinical response model will improve morale in a number of ways. Most importantly, the change we are implementing has been driven by feedback from front line staffs, that have felt for some time that we needed to refine our response model to use our resources more effectively to get the right response to patients. As we prepare to implement the pilot for the model, our staff have been engaged in the process, and had the opportunity to contribute their thoughts on how the model should work in practice. Throughout the pilot of the new model, we have continued to refine its operation based on staff feedback. Feedback from staff so far is positive and we expect to build on this, as we share more examples of the benefits of the new model for both our patients and our staff. An independent evaluation of the new clinical response model will be undertaken by the University of Stirling at the end of the one year pilot which finishes in November 2017.

Staff Absence

The most recent validated absence figure is for April 2017. Our absence rate for April 2017 was 7.12%. Our short term sickness absence is comparable to other NHS boards, however our long term absence is higher and our action is focused in three areas: staff health and wellbeing, policy and process and working practices.

Most long term absence is caused by musculoskeletal illness – we have invested significantly in equipment and lifting aids for staff as well as bariatric equipment in recent years. Staff have speedy access to physiotherapy services, where injuries can be treated and support and advice provided which enables an individual's return to good health. More generally, we provide occupational health services which give both staff and managers' advice and information on how to manage health conditions and promote better, or more sustained attendance. We have been reviewing interventions to help with anxiety, stress and depression. Following a successful test, Mindfulness training will be rolled out across the Service this year; other action includes the promotion of the `See Me' campaign, providing mental health awareness and training to managers and a refresh of the national campaign on Healthy Working Lives.

In terms of policy and support, we regularly provide awareness raising sessions for managers on the use of the Attendance Management policy and measure that staff are being managed in line with this. This policy also includes the provision of support channels for those absent from work including, fast track physiotherapy, employee counselling and occupational health advice and assessment.

It is difficult to place an accurate cost on the impact of hours lost due to sickness absence: some hours would simply be replaced through normal relief working arrangements; some would be covered by overtime working and some hours would be absorbed within the system.

We have a Fatigue Policy, which makes provisions in the event that a crew or individual crew member believe they are fatigued and cannot continue on duty. In these circumstances the person requests to `book-off fatigued' and is stood down until they are available to return to duty. The book-off process is predominantly used by staff working from on call locations; but is available to all staff. On call activity is managed on an incident by incident basis and is regularly monitored. On call working has been reducing and we are working with staff and their representatives to make further reductions.

Staff Vacancy Rate and Recruitment

The Service continues to implement its plan to train 1,000 new paramedics by 2020. We prepare detailed plans at divisional levels for recruitment, education and training of staff on an annual basis to meet this commitment and are ahead of schedule at this point. A number of actions, some of which I've already highlighted are helping mitigate the pressures on the Service until these staff are fully operational. The new clinical response model pilot is helping the Service use its existing resources more effectively. Ongoing actions to reduce sickness absence will help ensure more staff are at work. Enhanced partnership working with Police Scotland, the Scottish Fire and Rescue Service, BASICS GPs and nurses along with our Community First Responder volunteers is helping us work together to reach more patients in cardiac arrest more quickly and save more lives.

Performance

We currently use a number of clinical outcome measures. For example:

Cardiac Arrest – we measure Return of Spontaneous Circulation (ROSC) rates. This indicates whether or not a patient who was in cardiac arrest, has evidence that their heart has started beating again spontaneously, for example after defibrillation. We are measuring ROSC rates

nationally and monitoring the trends to ensure we meet the agreed standard and drive continuous improvement.

Stroke – we have developed a 'bundle of care' that should be applied and documented for all patients presenting with possible stroke symptoms. We monitor compliance of stroke patients who receive the stroke bundle to ensure consistent quality of response for stroke patients.

PVC bundle – this is a quality measure relating to the management of those patients in whom we have inserted a venous cannula. This ensures that as patients pass through the health system this important potential cause of Healthcare Acquired Infection (HAI) is managed right from the start of the patient journey.

Would individual improved clinical outcomes also result if a paramedic arrived on scene quickly even if they could not convey?

This depends on the need of the patient. If the patient has a condition that could be treated in the community: e.g. hypoglycaemias, then they are suitable for a solo paramedic response and our Ambulance Control Centre staff direct such resources accordingly. Where patients have minimal benefit from treatment at scene but absolutely require secondary care assessment and diagnostic intervention: e.g. stroke, then a conveying resource first time to such a patient is the optimal response.

New Clinical Response Model

Do you have a measurement to record the effectiveness of the call screening process?

We audit a representative sample of calls on a rolling basis to check that we have carried out the triage process according to our policies and procedures. Triage is based on the information we gather from the person calling 999. This may be the patient in person, or someone who has witnessed the patient become ill or sustain injury. On patient assessment by our Accident and Emergency crews, the code given to the patient during triage may be changed by the crews, who will have then assessed the patient face to face. We currently do not capture call screening information in a format that directly corresponds to the initial response code which is generated from the information we gather about the patient from the person calling 999. We are currently reviewing how we can do this better and this will be introduced as a key measure in the release of the next phase of the electronic patient record that will be rolled out across Scotland by December 2017.

We would be pleased to show Committee members round our Ambulance Control Centres so that they can learn more about our call handling, triage and dispatch arrangements.

NCRM and Training: Has any consideration been given to increasing the frequency of training? What is the training trailer and its role?

The Service regularly reviews the frequency, delivery and effectiveness of training and updates. This has identified the need to use a blended approach to training delivery over and above the annual face to face sessions. This year, face to face training sessions for our staff have increased from one day to two, with the addition of a third day for Paramedics. We have also enhanced access to learning through digital channels. We introduced opportunities for learning through a range of webcast on specific topics, including Paediatric Trauma, Cardiac Arrest and changes to

the New Clinical Response Model. Staff can view the webcasts on various electronic devices. In addition, to this we have local CPD programmes which are supported by subject matter experts from NHS Boards.

The most recent innovative approach to learning was generated by staff through the iMatter process. This resulted in the use of the NHS Education for Scotland Mobile Clinical Skills Unit. T his unit allows for simulation training using state of the art equipment (manikins) as well as video recording facilities for feedback and learning. This initiative was again supported by subject matter experts and local clinicians and teams the crews regularly encounter. The evaluation from the staff has identified this as much needed and very worthwhile. We are looking at a similar approach in other areas and will seek further staff feedback to see if this could be rolled out further.

Feedback from Patients, patients, Service Users about NCRM

The Service has undertaken a comprehensive and proactive programme of internal and external communications and engagement with key stakeholders.

Feedback from public engagement has been largely positive. To date, the Service has presented to our Patient Focus Public Involvement Group and has attended or provided information to Public Partnership Forums in Shetland, North Lanarkshire, South Lanarkshire, Grampian, Tayside, Forth Valley, Moray and the Western Isles. Participants were keen to know how the model would work in their local area, particularly in rural areas. Feedback themes have been broken down below:

- How does the new model take into account the challenges of remote and rural communities
- How big a driver is pressure on NHS budgets in implementing the new model
- How will the independent evaluation of the model be carried out and will the report be shared publicly
- Clarification on whether or not the new model is a local or national pilot
- Responding to cardiac arrests – what evidence is there for sending three A&E staff to respond to these patients.

Engagement with out of hours services and integrated joint boards (IJBs)

The Service and NHS 24 have established a national group to co-ordinate planning with integrated joint boards. Our regional structure also has identified staff representatives who participate in IJB / locality meetings to support pathway development and improve patient experience through ongoing development of a whole system approach to patient care. The Service is represented in Scotland's National Out of Hours (OOH) Providers Group and local managers' work closely with GP OOH services across Scotland to support the provision of urgent care.

We are also testing the role of specialist paramedics working in multi-disciplinary teams within GP surgeries.

Diagnostic Capability and Use of Technology to Support Patient Care

One of the key objectives of the Scottish Ambulance Service strategic framework *Towards 2020: Taking Care to the Patient* is to improve patient safety and care by using technology and enhancing our diagnostic capability. Three examples of how we are doing this are summarised below:

Ambulance Telehealth

Phase 1 of the Ambulance Telehealth Programme has already delivered new mobile technology hardware in our unscheduled care fleet. This includes the provision of tablet devices for recording patient data and a communications hub providing a range of wireless communications options including commercial mobile network access, Wi-Fi and Bluetooth. In addition, Service clinicians can now access information such as ECS/KIS at the point of care in order to inform and improve their clinical decision making and the resulting patient care. This new technology also provides a potential capability to deliver a mobile tele-health service. This service could support the transmission of clinical data in real time to other healthcare professionals where there is sufficient mobile network coverage to do so. A typical application would be professional to professional patient telemedicine assessments for critically unwell patients.

Phase 2 of the Ambulance Telehealth Programme is due to be implemented by the end of 2017. It will deliver a new electronic patient record (ePR) that will be used to record details of clinical episodes via a user-friendly, intuitive interface. It will also deliver a paramedic 'app' which will provide Service staff with access to key information about appropriate services, pathways and guidelines. The aim being to aid decision making and enable our staff to ensure patients receive the most appropriate care and to avoid hospital admission where it is safe to do so.

Electronic Patient Record Transfer

As part of our strategic aim to improving patient care through the wider sharing of information, ePR data is being sent electronically to a number of NHSS Health Boards. This involves sending Service electronic patient records to GPs to provide effective, continued care for those patients who have been involved in an unscheduled care incident but are not conveyed to hospital. The information provided includes the actions taken by Service clinicians as well as any treatments and advice given. This enables GPs to offer follow-up patient care as they feel appropriate. The Service currently sends ePR data to Greater Glasgow & Clyde, Grampian and Ayrshire & Arran Health Boards. The Service is also actively engaging with other NHSS partners regarding the benefits of receiving ePR data, however it is ultimately the decision of each partner whether to implement the solution or not.

Advance Life Support Monitor / Defibrillator

The Service is currently in the early stages of the Business Case process for the procurement of Advance Life Support (ALS) Monitor / Defibrillator units. These are the core medical devices used by Scottish Ambulance Service clinicians; they provide a patient monitoring capability similar to that in a hospital Emergency Department. The Initial Agreement has been submitted to the Scottish Government's Capital Investment Group for approval to proceed to the procurement process.

The ALS unit allows clinicians to monitor the patient's heart rhythm and manually intervene if it is determined that a shock is required. It also includes a 12 lead ECG that is used on over 1million patients per annum in both the emergency and urgent care settings. In addition every patient attended will require some form of baseline checks to be carried out e.g. temperature and SPO_2 levels. This is done using the ALS monitor / defibrillator unit.

The project includes the ability to interface the ALS units to the communication hub within the ambulance to enable communication with the tablets. This provides the opportunity to pre-populate the Service's patient record with observations and recordings from the ALS monitor / defibrillator. A number of patient care and service delivery benefits will be realised through this interface capability and therefore aid clinical decision making in a safe and effective way:

- It ensures that key event data, vital for service audit and post clinical event feedback, is not lost or entered incorrectly;
- Advances in defibrillator pad technology along with advanced data handling can also ensure that data measuring resuscitation quality can be automatically collected for audit and targeted feedback to staff;
- Analysis of ALS monitor / defibrillator data can facilitate audit of clinical decision making;
- Provides information on common themes to enable effective training strategies to be developed;
- The patient's clinical data can be transmitted in real time to other healthcare professionals. This could be as part of a professional to professional patient telemedicine assessment or for pre-alert conditions for critically unwell patients.

Through the Enabling Technology Programme, the Service aims to enhance patient safety and care by improving clinical decision support as well as developing and improving its capability to share data with relevant partners.

I hope this information is helpful to the Committee. It may also be helpful for Committee members to see how we are meeting the changing needs of our patients first hand. I would be delighted to arrange for members of the committee to observe our Accident and Emergency and Patient Transport Service crews responding to patients, and for committee members to visit one of our three Ambulance Control Centres to see how our staff respond to people calling for help.

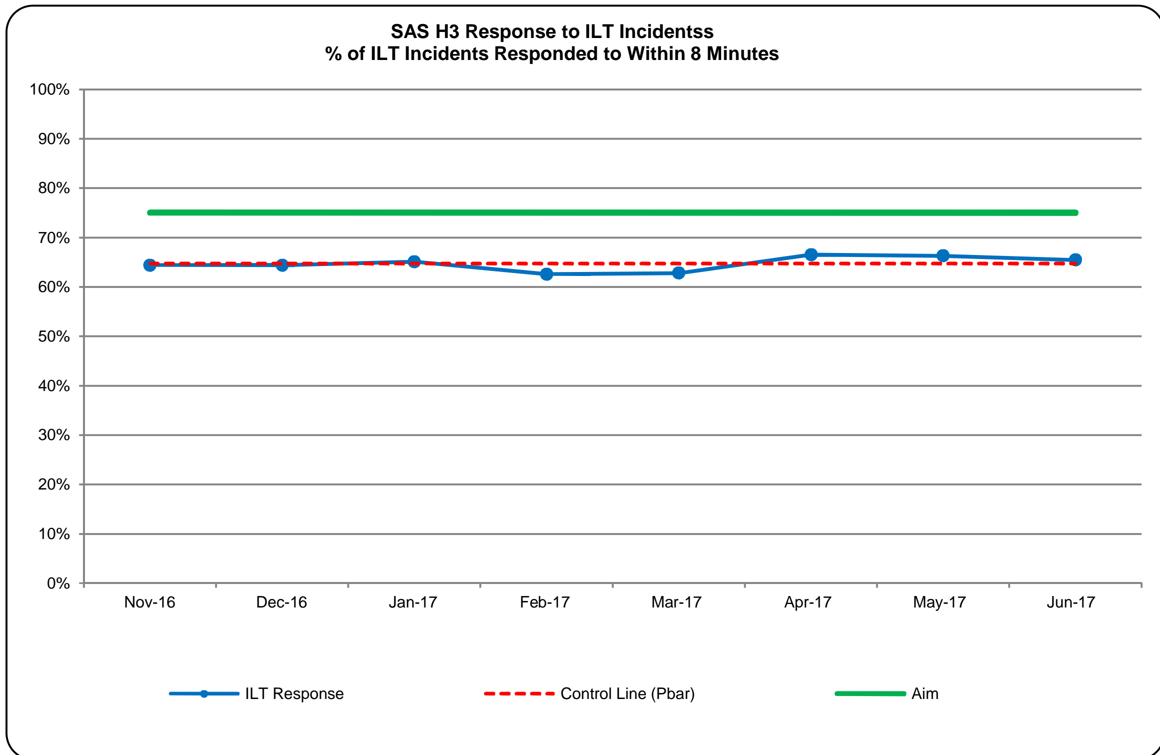
Yours sincerely

Pauline Howie, OBE
Chief Executive

Encl. As outlined on page 1

Performance data based on the new response model

The table below highlights performance to the standard of reaching patients with an immediately life-threatening illness or injury within eight minutes.



Extract Draft Local Delivery Plan

Board – 29 March 2017

2.6.2 Scheduled Care

We continue to play a key role in the redesign of scheduled care services across Scotland, in particular supporting the Modernising outpatient agenda, supporting patients access healthcare more closer to their home. We will work with NHS Boards to improve how Scheduled Care Services support the wider NHS Unscheduled Care agenda, through sharing of best practice and developing new ways of working to re-distribute inward acute hospital flow.

As we go through 2017/18 we will further progress key improvement areas to benefit patients and our partners through areas of focused work which include:

- We will work closely with Health Boards to develop a best practice guide in how to improve discharge and transfer processes to allow transport to be a key enabler to improving patient flow.
- We will model future requirements in anticipation of changes to how patients will interact with healthcare.
- We will test and implement changes to our assessment process used to determine the needs of patients who contact us for transport support, which has been done in consultation with patients and partners.
- We will engage with external partners regarding the future role of Scheduled Care in supporting Social and Health Care, at Local, Regional and National level..

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

Link to full Board paper

http://www.scottishambulance.com/TheService/PapersView.aspx?ID=1299

Lothian Flow Centre

As partnership working with the Lothian Flow Centre has evolved over the last three years, we've reduced each ambulance turnaround time by 10 seconds at Edinburgh Royal Infirmary and by 17 seconds across the Lothian Region.

Average Annual Emergency Turnaround Time for Lothians

Date	Avg. Turnaround
2013 - 2014	24.73
2016 - 2017	24.55

Average Annual Emergency Turnaround Time at RIE

Date	Avg. Turnaround
2013 - 2014	24.83
2016 - 2017	24.73