NOT PROTECTIVELY MARKED

Public Board Meeting **September 2020**
Item No 05

THIS PAPER IS FOR DISCUSSION

BOARD QUALITY INDICATORS PERFORMANCE REPORT

Lead Director **Author**	Pauline Howie, Chief Executive Executive Directors
Action required	The Board is asked to **discuss progress** within the Service detailed through this Performance Report: - 1. **Discuss** and provide feedback on the format and content of this report. 2. **Note** performance against Annual Operational Plan (AOP) standards for the period to end August 2020. 3. **Discuss** actions being taken to make improvements.
Key points	This paper brings together measurement for improvement as highlighted by the Scottish Government's Quality improvement and Measurement for Non Executives guidance. This paper highlights performance against our strategic plans for Clinical, Operational, Scheduled Care and Staff Experience Measures. Patient Experience and Financial Performance are reported in separate Board papers. <u>Clinical and Operational Performance</u> VF/VT Return of Spontaneous Circulation (ROSC) and 30 day survival in our highest acuity response category has recovered following a reduction during the early stages of the pandemic and now remain within control limits. The use of the Hyper Acute Stroke Bundle has remained stable at 95%. Overall demand has increased close to pre COVID-19 levels and associated with this there are slight increases in response times across all categories. The numbers of patients receiving care out with an Emergency Department remains stable.

	Workforce In July 2020, the sickness absence rate was 6.2%, this excludes those staff who may be shielding, suspected or confirmed as tested positive with the COVID-19 virus. The Staff Wellbeing & Support group has continued to progress a range of activities in consultation with staff. Our workforce plans for 2020/21 have been reviewed and recruitment and training targets updated for the remainder of this year. Enabling Technology The Emergency Service Network (ESN) Programme revised Full Business Case (FBC) pack was provided to the Service on 13 August 2020 and feedback has been provided. The project to provide an ESN compatible Integrated Communications Control System (ICCS) has been further delayed due to the software failing to pass final national testing (led through Ambulance Radio Programme (ARP)). Defibrillator Replacement – The rollout was completed by the end of March 2020 as originally scheduled and the project was formally closed at the Enabling Technology Board in August 2020. The Patient Transport System Mobile Data Procurement Project remains paused while the Scheduled Care Strategy is developed. Funding has been secured to purchase the additional tablets required to keep the existing system running. The Digital Workplace Project pilot for email migration has started. Both the Call Recording Project and the Telephony Replacement Project have commenced, with upgrades to Call Recording systems completed in Paisley and Cardonald.
Timing	This paper is presented to the Board for discussion and feedback on the format and content of information it would like to see included in future reports.
Link to Corporate Objectives	The Corporate Objectives this paper relates to are: 1.1 Engage with partners, patients and the public to design and co-produce future service. 1.2 Engaging with patients, carers and other providers of health and care services to deliver outcomes that matter to people. 1.3 Enhance our telephone triage and ability to See and Treat more patients at home through the provision of senior clinical

	decision support. 2.1 Develop a bespoke ambulance patient safety programme aligned to national priorities. Early priorities are Sepsis and Chest Pain. 2.4 Develop our mobile Telehealth and diagnostic capability. 3.1 Lead a national programme of improvement for out of hospital cardiac arrest. 3.2 Improve outcomes for stroke patients. 3.4 Develop our education model to provide more comprehensive care at the point of contact. 3.5 Offer new role opportunities for our staff within a career framework. 4.1 Develop appropriate alternative care pathways to provide more care safely, closer to home building on the work with frail elderly fallers - early priorities being mental health and COPD. 5.1 Improve our response to patients who are vulnerable in our communities. 6.2 Use continuous improvement methodologies to ensure we work smarter to improve quality, efficiency and effectiveness. 6.3 Invest in technology and advanced clinical skills to deliver the change.
Contribution to the 2020 vision for Health and Social Care	This programme of work underpins the Scottish Government's 2020 Vision. This report highlights the Service's national priority areas and strategy progress to date. These programmes support the delivery of the Service's quality improvement objectives within the Service's Annual Operational Delivery Plan.
Benefit to Patients	This 'whole systems' programme of work is designed to support the Scottish Ambulance Service to deliver on the key quality ambitions within Scottish Government's 2020 Vision and our internal Strategic Framework "Towards 2020: Taking Care to the Patient", which are to deliver safe, person-centred and effective care for patients, first time, every time. A comprehensive measurement framework underpins the evidence regarding the benefit to patients, staff and partners
Equality and Diversity	This paper highlights progress to date across a number of work streams and programmes. Each individual programme is required to undertake Equality Impact Assessments at appropriate stages throughout the life of that programme. In terms of the overall approach to equality and diversity, key findings and recommendations from the various Equality Impact Assessment work undertaken throughout the implementation of Towards 2020: Taking Care to the Patient are regularly reviewed and utilised to inform the equality and diversity needs.

SCOTTISH AMBULANCE SERVICE – BOARD PERFORMANCE REPORT

Introduction

The Board Performance Report collates and presents the Scottish Ambulance Service's Key Performance Indicators. These measures are based on the Service's 2020/21 Measurement Framework. Following feedback from Board members the format and content of this report is under review.

What's New

Changes in this report include:

- **Demand:** a simplified presentation of demand charts focused on unscheduled and scheduled care.
- Additional information about **shift coverage** in unscheduled care.

What's Coming Next

Development of additional KPI measures in future reports will bring together the time based measures alongside clinically focused measures. The key areas of future development of measures will aim to enhance the detail for each group of patients including patients at high risk of acute deterioration (red coded conditions), patients requiring further specialist intervention (amber coded conditions) and non-emergency patients. Indicators to measure the Service's contribution to wider population health are also under development.

Performance Charts

The Board Performance Report consists of data pertaining to a number of Scottish Ambulance Service measures plotted in control charts (with control limits) and run charts (without control limits). Both types of charts provide a statistical tool for understanding variance within a data set. Correctly interpreted these charts help the user to differentiate between random and non-random patterns, or 'signals'.

Control Charts

Rule 1: A single point outside the control limits

Rule 2: A run of eight or more points in a row above or below the mean

Rule 3: Six or more consecutive points increasing or decreasing

Rule 4: Two out of three consecutive points near (outer one-third) a control limit

Rule 5: Fifteen consecutive points close (inner one-third) to the mean

Run Charts

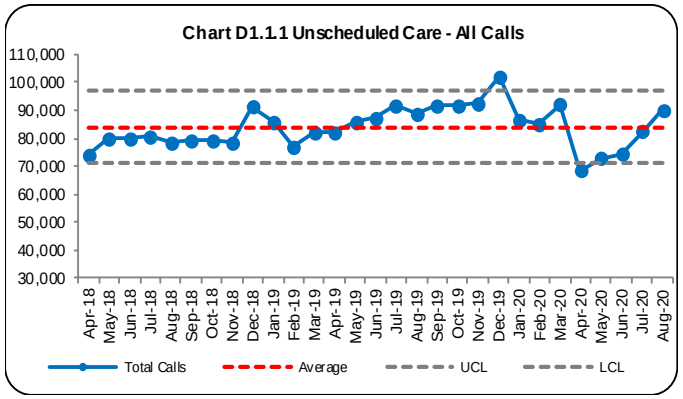
Rule 1: A run of six or more points in a row above or below the median

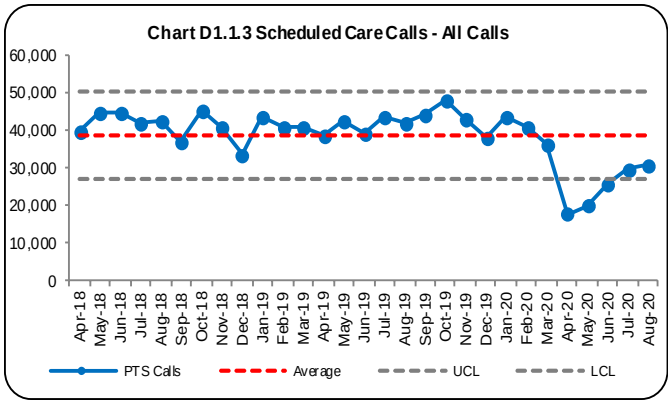
Rule 2: Five or more consecutive points increasing or decreasing

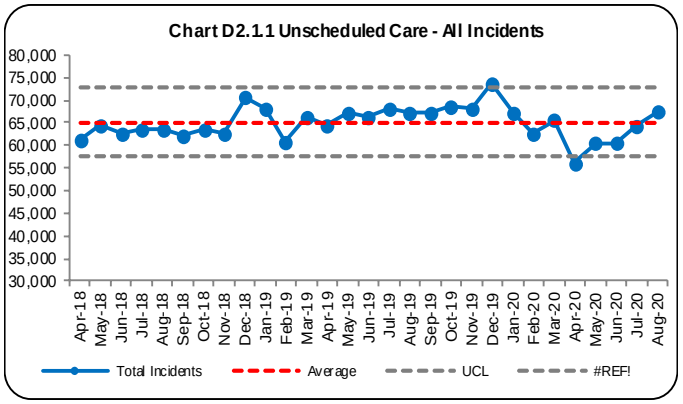
Rule 3: Too few or too many runs, or crossings, of the median

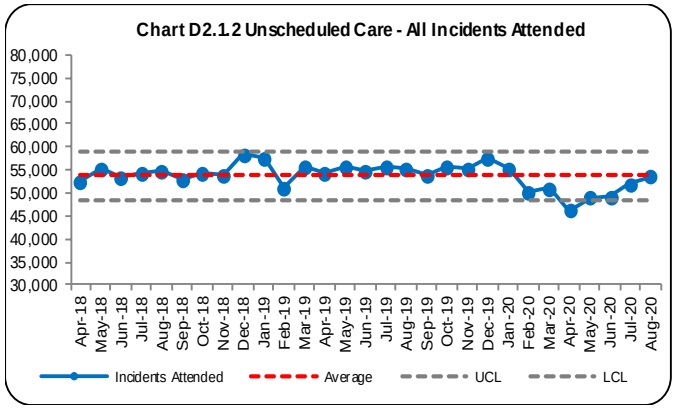
Rule 4: Undeniably large or small data point (astronomical data point)

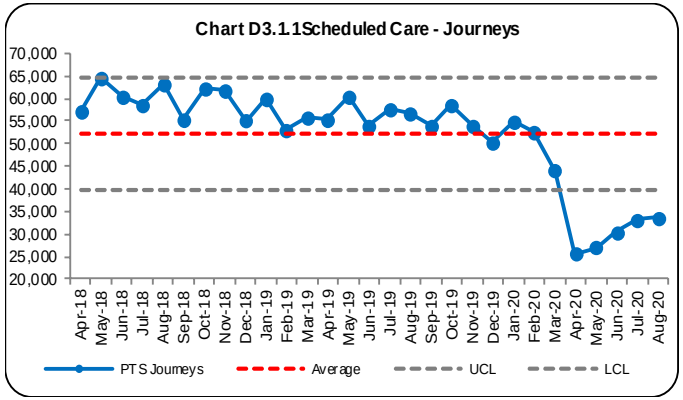
D: Demand Measures











What is the data telling us? – Since March 2020 the UK has been in the midst of the COVID-19 global pandemic. This has resulted in Scotland being placed in lockdown from the 23 March with restrictions easing gradually from the 27 May. Demand across all areas dropped in April and since April demand has increased month on month with unscheduled demand returning to pre-Covid levels. Scheduled care demand has seen a similar pattern of increase however the number of journeys remains below the lower control limit.

Why? The rescheduling of services in the wider healthcare sector due to the pandemic has been the main driver behind the drop in scheduled care activity.

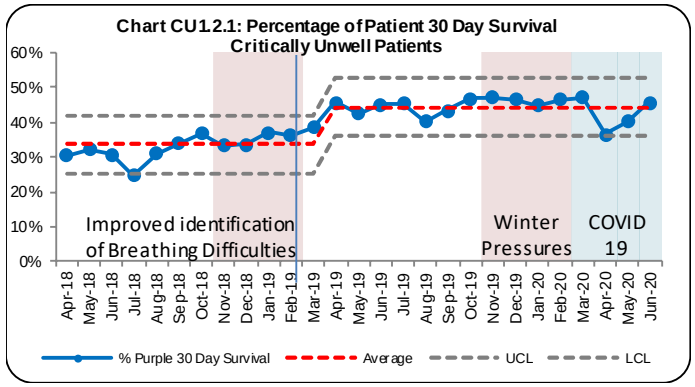
Unscheduled demand dropped across most key conditions (e.g. falls), however, notably demand related to mental health issues increased and continues to do so.

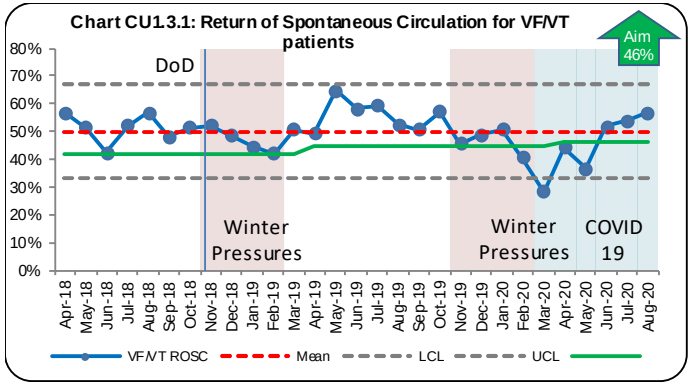
Demand across both scheduled and unscheduled activity has started to rise since April 2020 as lockdown was eased and we have observed busier traffic systems, more people going back to work, increased socialising and a communication drive by Scottish Government that the NHS is 'open for business'.

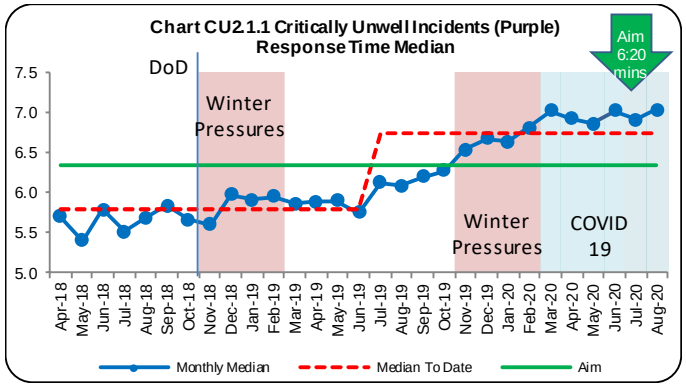
What are we doing to further improve and by when? – We are working closely with a collaboration of data analysts from across the health and social care system, led by Public Health Scotland, to forecast demand for the remainder of the year. Our forecasts are regularly updated based on intelligence of changes in the multitude of variables and Scottish Government planning assumptions.

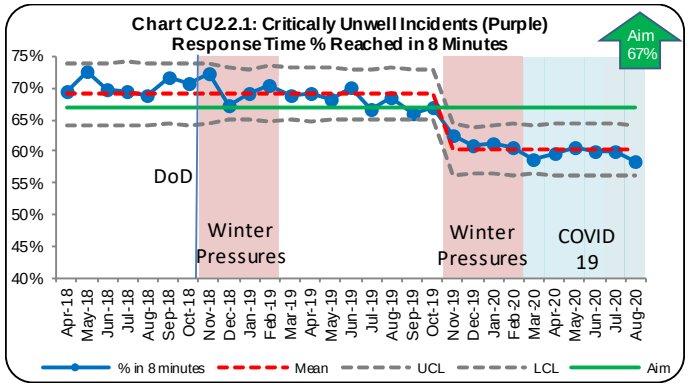
As part of our remobilisation plans we have established several workstreams to manage demand and resourcing which include working with the wider system to schedule urgent care where appropriate, increase advanced triage and consultation, and continue to recruit and train additional staff. These are explained later in the paper.

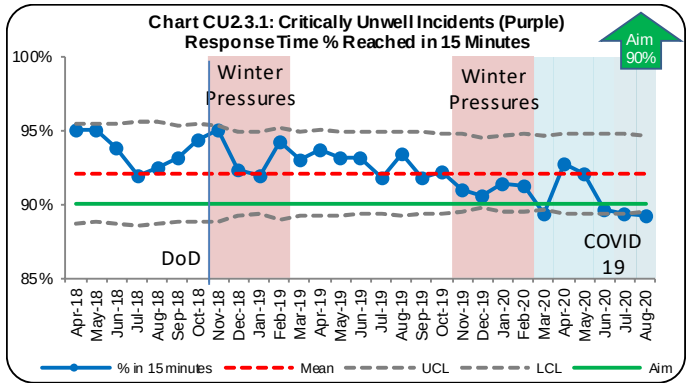
Purple Response Category: Critically Unwell Patients











What is the data telling us?

Purple Category 30 day survival data is collated three months in arrears in order to validate the figures. Chart CU1.2.1 illustrates that survival figures have risen slightly to the end of June, while remaining within control measures.

Chart CU1.3.1 looking at the Return of Spontaneous Circulation for VF/VT patients shows a consecutive increase for the third month in a row with the rate moving back into the range similar to that prior to the winter pressures of 2019.

An increase in response times has been observed and more detailed explanation of this follows below, however this has to be seen in the context of strong outcomes in terms of VF/VT ROSC and 30 day survival, and reflects the point that timeliness of Ambulance response is one of a range of elements that influences outcomes.

Purple Median Response

The median response to purple calls (Chart CU 2.1.1) has increased by about a minute from 2019 to 2020.

Demand within the Purple category has increased by an average of five incidents per day from 36 incidents per day in 2019 to 41 per day in 2020. This translates to around two incidents in West Region and one in each of the North and East Regions per day. Four of these calls relate to serious breathing difficulties and on average one additional call per day relates to OHCA.

While response times were increasing through the winter of 2019/2020, we have seen more sustained and stable increased response times since March 2020.

Why? - To understand why response times have increased, the first question is to consider whether or not there has been a change in the response process.

Clearly responding to time critical emergencies has been impacted by COVID-19 considerations as illustrated below:

- Community First Responder volunteers have not been active since the COVID-19 changes were implemented due to risk of infection and changes in PPE guidance.
- Many Tactical Deployment Points (TDPs) were de-activated with, as a result, crews being dispatched from station or diverted away from an existing call.
- Wider considerations determined by COVID-19 such as minimising face to face contact, availability of PPE in the initial phases, and general uncertainty about dynamic risk assessment also need to be factored in.

In terms of understanding the elements that have contributed to the response time increase, the following points have been identified:

- The time to dispatch the first resource to a purple incident has increased by an average of 10 seconds to 27 seconds in 2020, possibly reflecting changes in the complexity of dispatch practice.
- The time for crews to mobilise once dispatched has also increased by an average of 12 seconds to 44 seconds in 2020.
- Once crews are mobile we have seen a 36 second increase in response time in 2020 compared with 2019.

- The potential reasons for why these increases have occurred include some staff partially donning PPE prior to mobilisation, the lack of TDPs and other as yet not fully understood 'human factors'. For example, the overall increase in cardiac arrest response time is 51 seconds, while for breathing difficulty codes this is 70 seconds.

- A further consideration is the time at which the 'clock starts'. In 2019 17% of Purple calls were upgraded within the call. This means that the initial presentation was not for example a cardiac arrest, but during the call, the position became clearer or the patient deteriorated and the code was upgraded to Purple response. At the point the Purple response is identified, the clock does not re-start and the time continues to run, the overall Purple response time reported therefore includes a period of time when the call was not within the Purple Category. The proportion of calls identified in this way has increased to 25% in 2020. This reflects good call handler practice of staying on the line and allocating both the correct response and working to the correct 'sudden arrest' algorithm. An important element is that using the sudden arrest tool enables both bystander CPR and AED instruction to optimise interventions pre-ambulance arrival. However, the out turn of this is that our reported purple response times may be artificially inflated.

  Taking all of these factors together, we are able to understand the process changes and component elements of why we have seen an increase in Purple median response times.

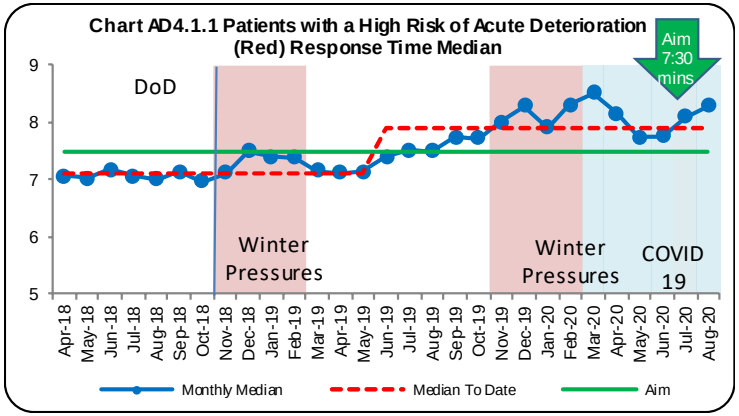
This summarises as 10 seconds more to dispatch, 12 seconds more to mobilise and 36 seconds more in drive time. These are average figures across the country and collectively amount to an average of a 58 second increase in response. This data has been disaggregated and shared with ACC and regional colleagues in order that we consider the marginal gains that can be applied across the system to improve our response times to our most critically unwell patients.

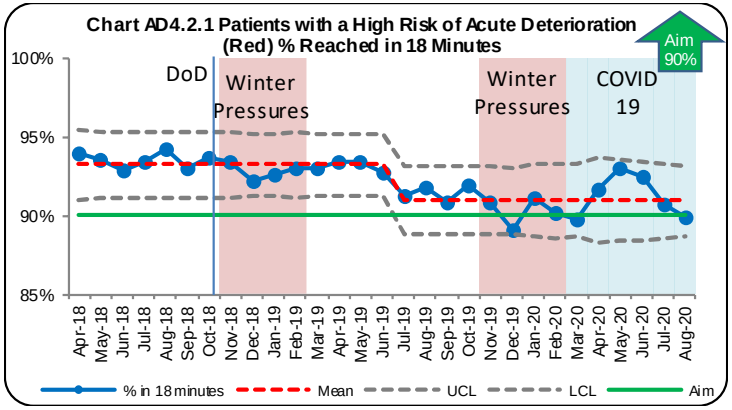
Mitigating actions include;

- Re-establish Community First Responders as part of the Service's Recovery planning. This will be re-introduced in a phased way from 14 September 2020 with additional training and guidance on the use of PPE.
- Re-establish Tactical Deployment Points as part of the Service's Recovery Planning – work is underway to reinstate these in the weeks ahead.
- Progress the Demand and Capacity modelling work as part of the Service's Recovery Planning.
- Review individual purple category codes in line with Clinical Response Model principles to ensure full understanding of process.

While response times are important and the focus of this update is to provide assurance around the Service's understanding of the reasons for the reported increases and the mitigating actions, in terms of patient outcomes, our VF/VT ROSC performance and overall 30 day survival rates have recovered well through the Covid period and remain strong.

Red Response Category: Patients at risk of Acute Deterioration





What is the data telling us? – The Service aims to respond to 50% of these patients within 7 minutes 30 seconds and 90% within 18 minutes. The volume of these calls reduced by 18.8% throughout April to August 2020 when compared to the same period the previous year.

The percentage of patients reached in 18 minutes is slightly below target at 89.9% however remains within control limits. The Median response time in August 2020 was 8 minutes 18 seconds which is higher than the same period in 2019 and above the aim.

Why? – Many of the elements described in the Purple Median response time analysis above also apply to Red response. Although the cardiac arrest rate in this group is much lower the response required needs to be both timely and robust in terms of skill set. Work is ongoing to understand Red response elements similar to that described for the purple category.

This will result in internal improvement measures identified and we will report further to the Board regarding the details of this.

As Purple calls now receive a dual rather than a single ambulance response this may affect response times to lower acuity calls. Due to its geography, the North Region has a higher number of single vehicle and on call ambulance locations than other parts of Scotland. There has been an increase in the number of calls being upgraded to purple calls in the North Region.

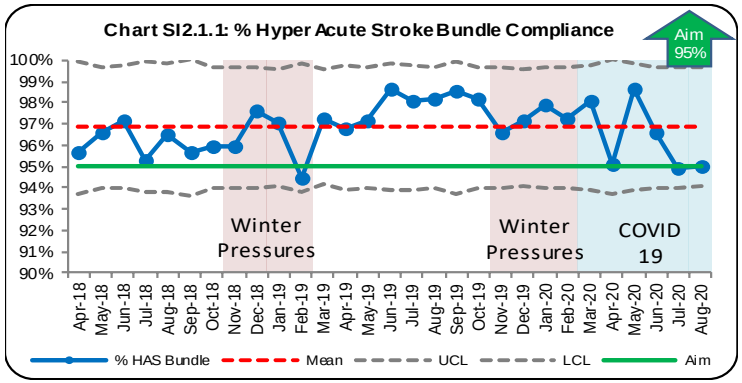
What are we doing and by when? – Work is ongoing by the Clinical and Business Intelligence Teams to understand Red response elements similar to that described for the purple category.

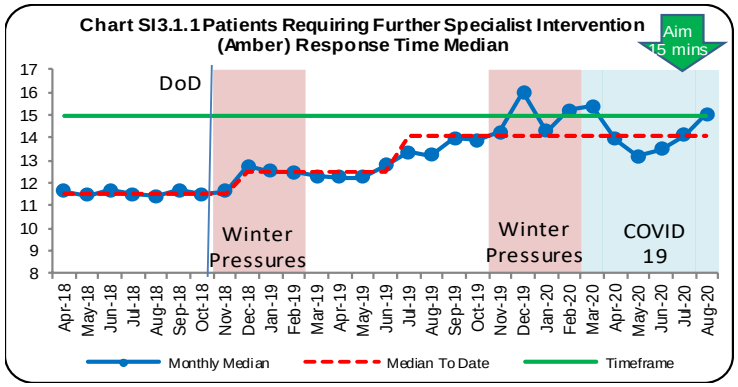
The Remobilisation of Community First Responders will improve our first on scene time to emergency calls. Whilst demand has not exceeded pre-Covid levels the utilised hours units (UHUs) have increased due to the increased use of PPE and Infection Prevention and Control precautions for COVID-19.

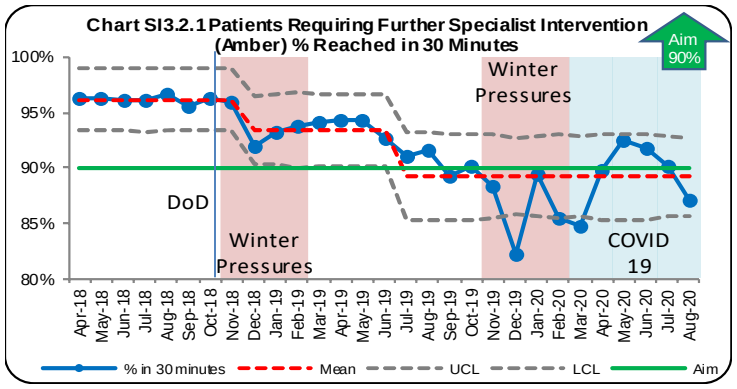
Work is underway to develop Low Acuity Hubs within Grampian (Elgin and Aberdeen) and Highland (Inverness) to support existing ambulance resources to respond to emergency calls.

Collaborative work is being progressed with Health Boards and Integrated Joint Boards (IJBs) around the redesign of urgent care, remobilisation plans and pathways of care.

Amber Response Category: Patients Requiring Specialist Intervention







What is the data telling us? – The use of the Hyper Acute Stroke bundle is at the aim of 95% for August 2020. While this is in line with our target and within control limits we are looking at this closely to understand any clinical, geographical or record keeping elements that may need to be addressed.

Our Median and 90th centile performance is being challenged by a number of factors that impact on resource availability and work across clinical and operational teams is progressing to address a range of factors such as Hospital Turn Around Time increases and shift coverage.

Why? – Overall 999 demand levels have been lower, enabling improved capacity to timeously & effectively work with these patients.

What are we doing and by when? - Further clinical detail around process and outcomes for patients affected by stroke and heart attacks is being developed and will be reported in this new format in the coming months.

We are working in collaboration with the wider Stroke Improvement Team at the Scottish Government and overseen by the National Advisory Committee for Stroke and the Thrombectomy Action Group (TAG); the aim of this work is to ensure that anyone suffering from suspected stroke is recognised as such and through collaboration with our health board partners, receives definitive interventions and treatments within recommended timeframes.

This allows for the greatest chance of 'good' patient outcomes resulting in minimising those requiring long term care following stroke and the continuation of independent living with as little physical disability as possible.

Recent developments include:

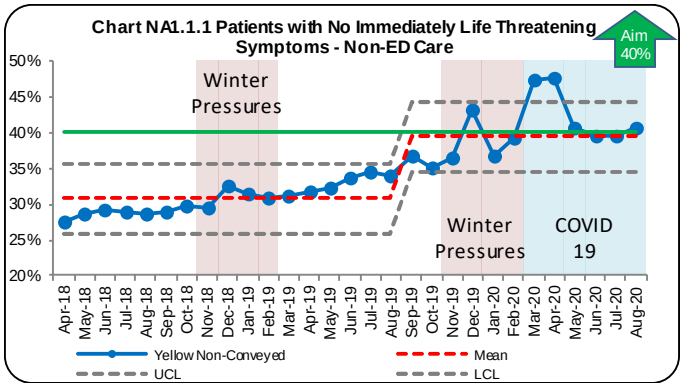
- The West Region working with Greater Glasgow and Clyde have implemented hospital bypass to ensure most appropriate and timely care for suspected stroke patients.

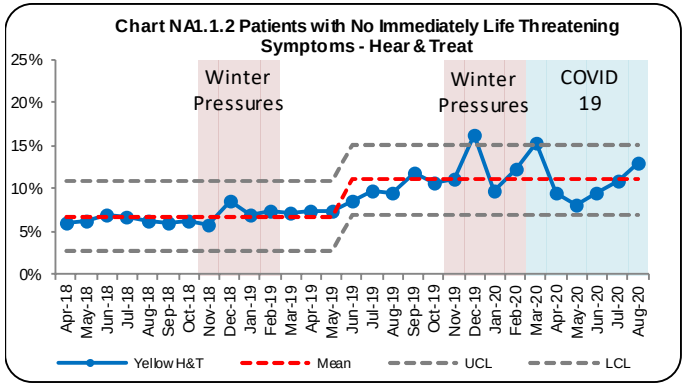
- Working with NHS Tayside on the staged implementation of a new stroke pathway which as a first step will involve patients being taken direct to a CT scanner, avoiding delays and ultimately allowing thrombectomy to be undertaken where clinically indicated.

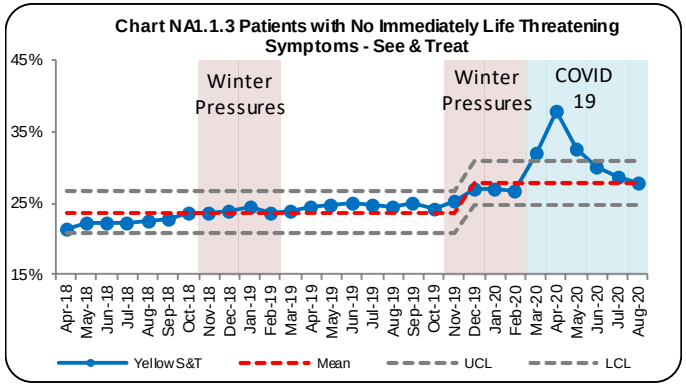
- The North Region is working in collaboration with health boards in relation to the development of a thrombectomy centre.

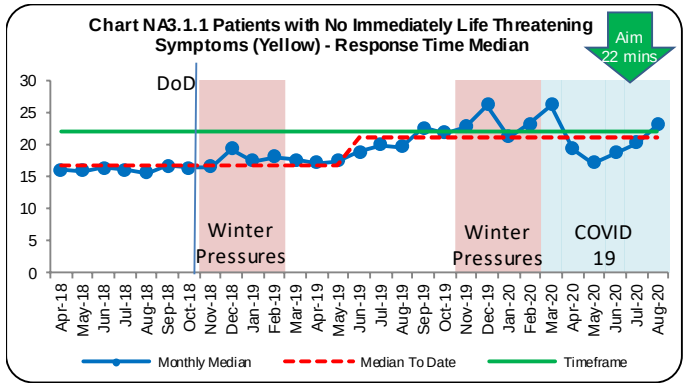
- Also in the North, work is being progressed to develop Low Acuity Hubs within Grampian (Elgin and Aberdeen) and Highland (Inverness) to support existing ambulance resources to respond to emergency calls.

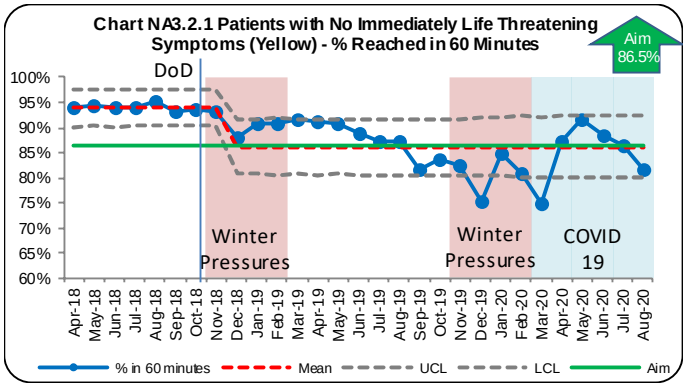
Yellow Response Category: Emergency Patients with no Life Threatening Symptoms

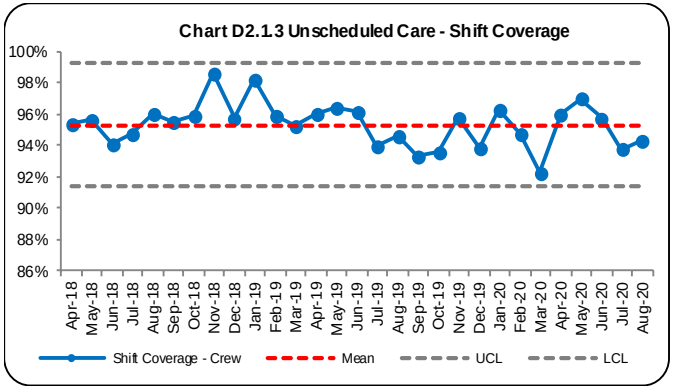












What is the data telling us – The data in Chart NA1.1.1 indicates that delivering the most appropriate care for patients in the Yellow category remains a key focus for the Service. While there was a significant increase in the proportion of these patients being cared for out with an emergency department (ED) setting during March and April 2020 this had reduced during the subsequent months with a slight increase in August 2020 to 40%, in line with our strategic aim.

The data in Chart NA1.1.2 and NA1.1.3 reflect the percentage of patients who are provided with the relevant care and advice by the Service over the phone, augmented by video link or through face-to-face assessment on scene.

There is a third consecutive month increase in the percentage of patients being cared for without the need for a crew to be dispatched. Looking at the percentage of patients being discharged following face to face assessment we can see a slight reduction on the previous month. However, this is consistent with the perceived increased confidence of patients to travel to hospital that was absent at the height of the pandemic.

The overall picture of patients being cared for out with the ED remains on target and this will be strengthened by the work described above to ensure that patients are provided with more appropriate alternative pathways.

Between April and August 2020 this additional triage and assessment has resulted in 9,286 patients (3.8% of emergency demand) being assessed and referred to appropriate services and not requiring a Service crew to attend on scene.

In total, over the six months from March to August 2020 this equates to 54,116 patients in this category not requiring attendance at an ED setting.

The volume of these calls reduced by 19.0% throughout April to August 2020 when compared to the same period the previous year. In August 2020 the Service responded to 50% of patients within 22 minutes 59 seconds and 81.6% in 60 minutes.

Both median and 90th percentile response times have increased for the Yellow response category, reflecting increasing demand levels as the country re-mobilises following the Covid lock down. A range of interventions to mitigate long delays are being reviewed and from a clinical safety perspective our safety netting interventions to detect any clinical deterioration remain in place.

Why –

During the COVID-19 pandemic positive collaborative work has been undertaken with the wider health and care system to reduce the number of patients being taken to hospital and to safely manage patients through different pathways of care including care provision through our Advanced Practice cohort.

The Advanced Practice cohort have been contributing a high percentage of their working hours to telephone triage.

Regarding response times, chart D2.1.1 shows an increase in 999 demand while chart D2.1.3 shows that shift coverage has not increased in line with demand. The fundamental reason for delays in response to patients in the Yellow category is this gap between 999 call demand and resource availability. Multiple factors contribute to this such as hospital turnaround times and ongoing work streams are addressing these abstractions, however fundamentally matching resource availability to predicted demand is a key priority. As such the full implementation of the

findings from the Service's Demand and Capacity review is essential to improve the timeliness of response across all of our response categories.

What are we doing and by when –

Demand and Capacity implementation is a key part of the Service's remobilisation planning. Full implementation is anticipated in 2022.

Recognising the opportunities that exist through close collaboration with IJBs work is underway across the regions and nationally to utilise the rich data set that captures the demand received by the Service and our conveyance rate across a number of clinical conditions including Falls, Mental Health and Breathing difficulties. We are assembling robust pathway information for crews and taking cognisance of the developing national Redesign of Urgent Care programme that will provide further alternatives to Emergency Department (ED) attendance through the introduction of Mental Health hubs and Flow Centres.

The use of the Board COVID-19 community hubs is another aspect that we will look to build on as we move towards winter with our Paramedics and Advanced Practitioners able to make direct referrals to these hubs.

Each of these workstreams requires a whole system approach ensuring that there is wide communication and engagement and empowering of all those involved to progress with the identified priorities.

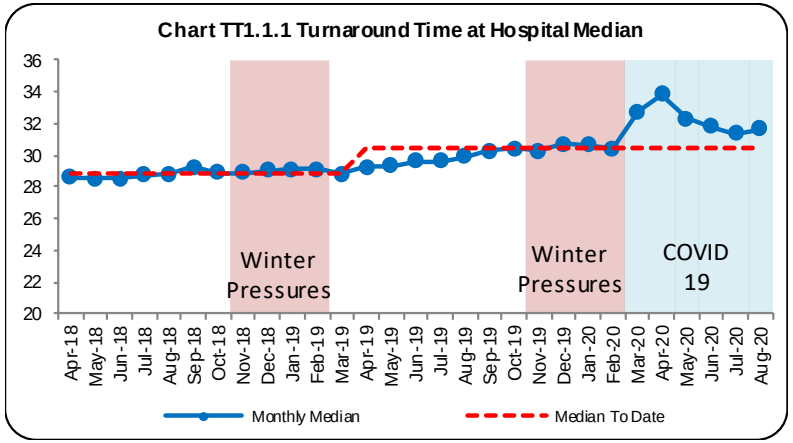
Accessing alternative pathways which allow patients to be safely treated in their community or referred directly to the appropriate setting are key elements of avoiding unnecessary attendance at Emergency Departments.

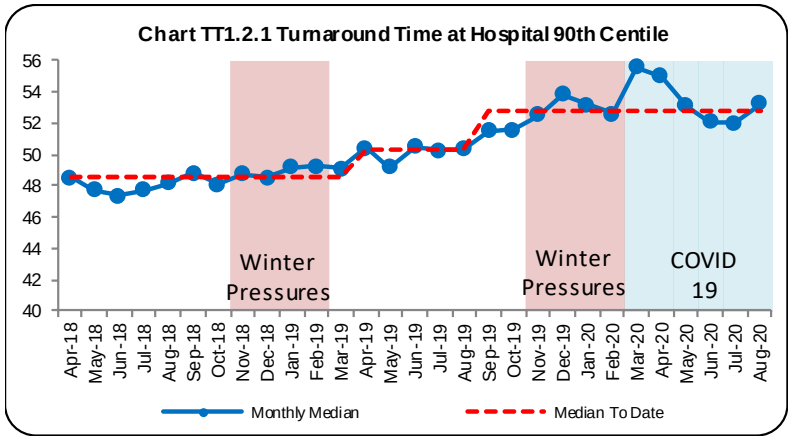
As part of the Service's response to the COVID-19 pandemic we have sought to optimise all elements of our 'chain of response. Examples of this include Advanced Practitioners working in support of Ambulance Control functions to offer remote consultation to patients presenting without time critical symptoms in order to better understand their needs and address these effectively. Around 50% of these consultations result in an ambulance response with the remainder being managed through alternative pathways or with self-care advice.

In East region we are working with partners to design the systems and processes which will allow this to happen more consistently and efficiently through the flow navigation centres which are being introduced. This has been assisted with the introduction of 24/7 Profession to Profession support through Community Hubs within the North Region and additionally in Inverness via the PICT Team and in Aberdeen through the Registrar led Profession to Profession Service in Aberdeen Royal Infirmary.

West Region continue to work closely with staff and partners to improve the safety and effectiveness of our processes for older people who fall but do not require to be conveyed to hospital. One particular example is the work within NHS Dumfries and Galloway and NHS Lanarkshire where there is an increase in falls referrals in recent months. The use of "improvement conversations" is being adopted to support this work with the aim of increasing the numbers in the months ahead

TT: Turnaround Time at Hospital





What is the data telling us?– On average we transport 29,283 (59.5%) unscheduled care patients to hospitals per month; these are patients who present through the accident and emergency service. For August 2020, we transported 30,168 (58.9%) patients with a median turnaround time at hospital of 31 minutes 39 seconds.

Why? – The acuity and numbers of self-presenting patients impact on our ability to turn around at hospital. The chart demonstrates that the system has remained under varying degrees of pressure since last winter. This is predominantly as a result of the complexity and acuity of the sickest patients and their required length of stay in hospital affecting flow and capacity. Additionally, in April 2020, COVID-19 has introduced additional complexity with multiple access points at hospitals, and crews being required to safely remove PPE then rehydrate.

What are we doing and by when? – There has been an increase in turnaround in the North and East of the country. The West is relatively stable however it still is the longest turnaround time in Scotland. Three main reasons for the increase are:

- Introduction of red and green zones within hospitals for COVID-19 and non COVID-19. This has seen different entrances and procedures for patients and ambulance crews attending hospital sites. Initially this changed frequently however now seems to have settled into set procedures for each hospital site. It should be acknowledged that each hospital has different processes so crews from different areas may not know what the specifics are for each site. We are at times also seeing hospitals holding patients in ambulances until they are assured the patient is going in through the correct pathway either COVID-19 or non COVID-19.

- Donning and Doffing of PPE has added time to staff procedures along with undertaking processes like completing the EPR as this cannot be undertaken whilst the highest level of PPE is worn and has to be undertaken once the patient is off loaded. There is also an acknowledgement that undertaking physical effort within the PPE does increase staff requirement for hydration and rest after each event.

- Cleaning - there has been increased time as staff must ensure that the vehicle has been thoroughly cleaned to ensure there is no cross infection. Although staff would have generally undertaken infection control procedures they are being more cautious with this and taking longer to undertake this.

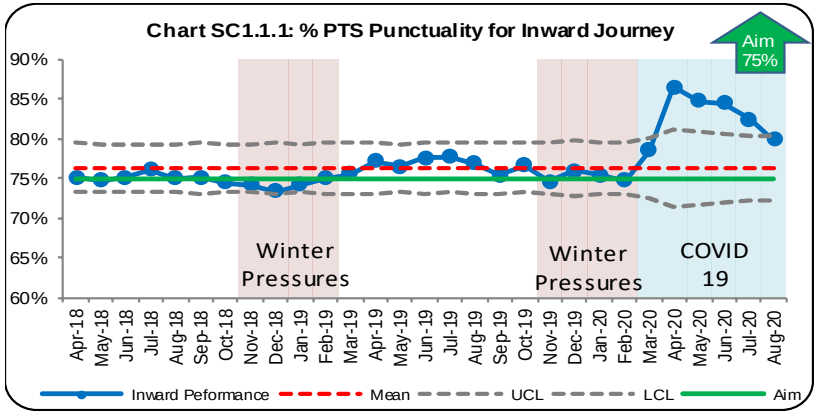
Hospital Ambulance Liaison Officers (HALOs) continue to be deployed at the busiest hospital sites to ensure we are fully integrated and that we collectively manage flow, through the facilitation of discharges earlier in the day when identified. We have escalation plans in place with acute sites and closely monitor hospital turnaround times to ensure delays at hospital are minimised with appropriate actions taken.

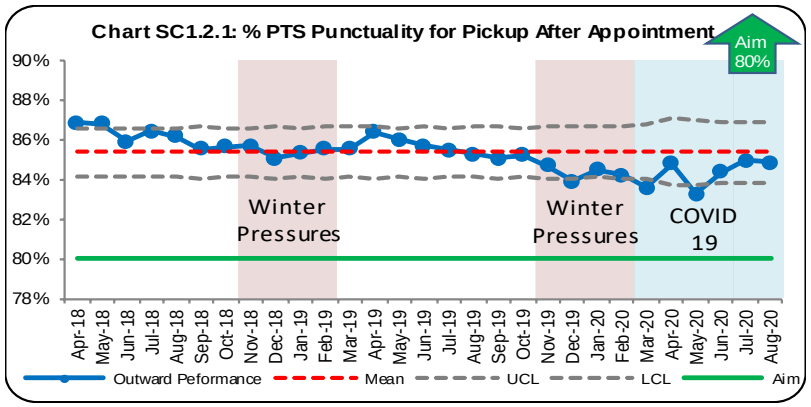
Within the West of Scotland there has been a dedicated Area Service Manager and HALO specifically aligned to both QEUH and Ayr to provide local leadership and engagement to reduce hospital turnaround issues. In addition to this through the pandemic there were up to three conference calls daily with senior hospital managers, SAS Heads of Service and Deputy Regional Directors attending the hospital sites, and Regional Director along with Medical Director meeting regularly with Queen Elizabeth University Hospital to discuss solutions to reduce turnaround times. Work with Scottish Government to reduce turnaround times have resumed.

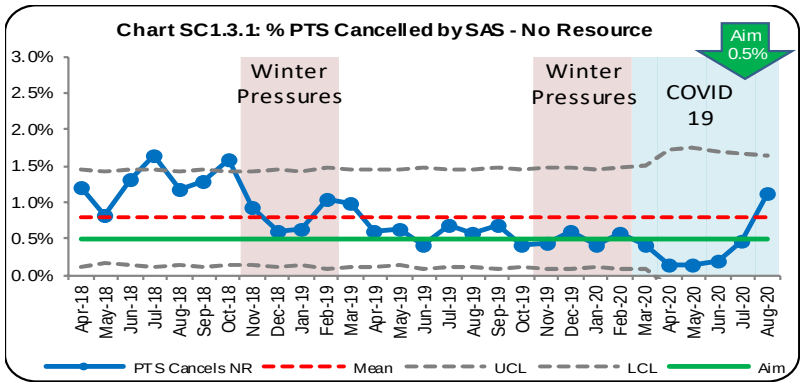
In the East of Scotland funding is in place through NHS Lothian which will allow increased HALO capacity over the winter months. This additional capacity will extend HALO cover across the key hospital sites supporting collaborative work to redesign the ED flow at St John's in particular.

Aberdeen Royal Infirmary (ARI) are forecasting that through redesign of urgent care and frailty pathways the flow through the ED will significantly improve. We are also working with ARI to develop a briefing template to forecast the incoming demand on the department by SAS resource to allow the receiving department to plan accordingly. An open communications pathway has been created with ARI so that local management can highlight live time issues/exceptions for early resolution.

SC: Scheduled Care







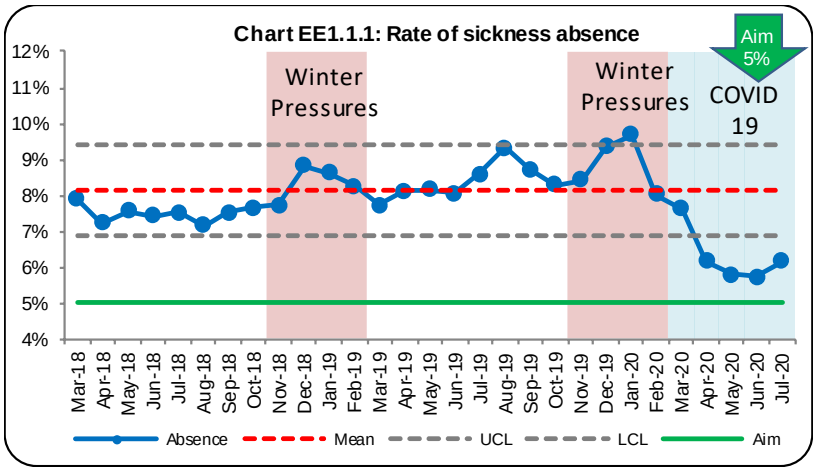
What is the data telling us? – Demand on scheduled care services has seen a marked decrease since the beginning of the COVID-19 pandemic in Scotland with a 39.7% reduction in scheduled care calls received by Ambulance Control and 47.3% reduction in journeys during April to August 2020 when compared to the same period in 2019. Punctuality for pickup after appointments (Chart SC1.2.1) has continued to be around or below the lower control limit since winter 2019, however remains above the target of 80%. PTS cancelled by SAS no resource (Chart 1.3.1) has increased and for August 2020 is above the aim of 0.5% at 1%.

Why? – The pandemic has brought new challenges for the scheduled care service in terms of the social distancing requirements which reduces the number of patients who can be conveyed on a vehicle. However due to the reduction in demand the Service has seen a positive effect on the punctuality of pickup for patient appointments and a reduction in journeys cancelled by the Service. However, in the month of August the Service cancellation rate was significantly higher than the target due demand increasing and compliance with social distancing standards.

What are we doing and by when? - As NHS services are remobilised we will align our resources to the demand where possible. Alternative providers have supported many of our life saving treatments in oncology, renal dialysis etc. and this continues. The Service are developing a detailed risk assessment and mitigation plan to reduce the impact of social distancing on patient numbers to reduce cancellations and resultant patient safety concerns around missed care.

SE: Staff Experience

Sickness Absence



What is the data telling us? – In July 2020, the non COVID-19 sickness absence rate was 6.2%, this is a 2.4% reduction on the same month in 2019.

Why? – Overall sickness absence has been significantly improved over the COVID-19 response period, particularly in terms of short-term absence, but as the COVID-19 related absence has decreased the sickness absence rate has started to rise.

What are we doing and by when? - Attendance management processes paused during the initial phase of pandemic response to focus on immediate staff support needs, particularly those in the shielded staff category have been re-started. This work is now based on the new Once for Scotland policy framework and adoption of lessons learned from our COVID-19 response arrangements.

Specific elements of our activity include:

- Management/Staff Representative development sessions across all areas for the Once for Scotland Policy arrangements (August/September 2020), with plans to build into ongoing management development activity thereafter.

- Sickness absence data deep dive refresh to inform and direct prioritisation of attendance management activity (commenced July 2020), with a core group established to identify priority reporting needs as we develop standard management needs in light of a revised policy framework. Workforce Metrics development activity will further inform our longer-term plans.

- Re-establishing monitoring arrangements through the group established by our Executive Team to focus on absence, incorporating health and wellbeing initiatives to support staff in looking after their mental health, stress and anxiety (noting work in E1.2 below).

- Development work with regard to consistent use of GRS, tracking and reporting of absence has focussed on system changes to align with Once for Scotland policy requirements. Actions required have been identified and priority developments are being reviewed. Initial quick wins have been implemented to align GRS field descriptors to Once for Scotland policy, with other development requirements being discussed with the system provider and will be subject to agreed delivery timescales.

E1.2 Employee Experience

Aim – To have a workforce that feels valued and supported and would recommend our organisation as a great place to work

Status – Our primary effort in the first quarter of 2020/21 was to ensure staff were aware of and could quickly access the wellbeing resources and support required and that we could identify and address any gaps in provision. The focus for the second quarter of 2020/21 was to identify what has been beneficial and implement any improvements needed.

Findings – The Staff Wellbeing & Support Group conducted a wellbeing pulse survey with a sample of 114 staff in the last 2 weeks of June 2020 to obtain feedback directly from staff on their experience of health and wellbeing support during the pandemic.

The data gathered indicated that staff turn to one another for support first or their line manager. It also highlighted that many staff do not access any support or resources in the workplace.

This data reinforces the need to provide a range of peer support interventions to ensure our leaders and managers have the necessary skills to support the wellbeing of our staff and to continue promoting and publicising available support. These two themes will inform our support plans over the next 18 months.

What are we doing and by when? – Since June 2020:

- A wellbeing wallet card has been developed and distributed to all staff that complements the wellbeing pack with internal resources and support on one side and external resources on the other
- A cohort of ScotSTAR staff have received peer support training based on the principles of psychological first aid as a pilot prior to further refinement and roll out by Lifelines Ambulance in the final quarter of 2020/21
- A Paramedic from Dumfries has been one of the speakers in a series of three international mental health webinars between the US and the UK with a focus on building resilience and sharing good practice
- Health & Wellbeing has continued to feature in staff communications and the Chief Executive's weekly bulletin with signposting to resources available through @SAS and other sources of help
- The wellbeing blogs written by staff for staff have been very popular with 2,585 visits over 9 blogs (up until 8 September)
- We have continued to proactively seek staff feedback with 42 forms received in response to an email from CEO & Employee Director regarding health & wellbeing provision in the Service. There were many suggestions and views that will be fed into the Wellbeing Strategy
- During the reporting period, three staff engagement sessions have been hosted by our Chief Executive on MS Teams with an open invite to all staff with the themes of staff health & wellbeing, mental health and advanced practice with further sessions planned.
- A draft Health & Wellbeing Strategy has been developed for discussion and consultation over the coming months with a final draft to be submitted to Staff Governance Committee for approval in December 2020.

National Developments

A National Wellbeing support line was launched across Health & Social care on 20 July, hosted by NHS 24. This service is provided 24/7 with the number 0800 111 4191. From launch until the 31st August there have been a total of 29 calls to this support line across Health & Social Care.

An Everyone Matters Pulse Survey consisting of a reduced number of questions from the iMatter survey with additional wellbeing questions is being conducted across Health & Social Care from 1st – 23rd September 2020. The intent of the survey is to understand how people are feeling and what their experiences have been during COVID-19 at work and at home. There is no requirement to reach a 60% response rate, as is the case with iMatter and findings will be presented in Directorate reports in October 2020. The survey commenced in the Scottish Ambulance Service on 2nd September with 26% of staff completing the survey by 8th September.

Workforce Development

1. Employee Resourcing

Aim – To recruit and retain staff ensuring that the Service has the skills to deliver its 2020 workforce profile and improve staff experience.

Status – Plans are in place to deliver 2020-21 workforce requirements although adjustments have been (and will continue to be) made to respond to the challenges as identified below.

Improvement – The extensive recruitment effort planned for 2020/21 to maintain progress on the Service workforce plan targets has been significantly impacted by COVID-19. As we consider the implications, a cross service group has been tasked with identifying contingency plans. This group will consider how we continue to support transition to our new Paramedic education model.

As a consequence of the current COVID-19 situation the current Dip HE in Paramedic Practice courses were temporarily suspended due to the closure of Glasgow Caledonian University, lack of access to the Academy teaching facilities and the return of Associate Lecturer Secondees to frontline duties.

This has affected the 2019 Part 2 cohorts progress and the commencement of 2020 cohorts (academic teaching is delivered in two parts). Education has recommenced and we are in discussions with the University on the plans for the remainder of the year.

Following submission of a proposal to extend the delivery of the Dip HE in Paramedic Practice the HCPC has confirmed a 9-month extension for the programme and all part 1 cohorts are re-planned to commence by this revised date.

Recruitment to the 2020/21 Dip HE courses commenced in August 2019, and further OSCEs are being planned to enable remaining candidates to progress through the selection process and be allocated to the remaining 2020/21 cohorts which will commence early in 2021.

Recruitment to the 2020/21 VQ Ambulance Technician has recommenced.

Fourteen Advanced Practitioners have now commenced training, an additional appointment pending confirmation of start date. Recruitment has commenced for (Trainee) Advanced Practitioners in Pre-Hospital Critical Care in the West region.

Planned Activities Include – The recruitment team will liaise with regional workforce leads to deliver workforce intake targets. The allocation of places for VQ Ambulance Technician and Ambulance Care Assistant roles continues in line with Regional workforce plan requirements. 2020/21 advertising for qualified Paramedic recruitment launched in July 2020 with an impressive response. Assessment and interview dates have been arranged for the 12th and 13th September 2020 in Grangemouth.

Other Considerations - Resourcing model developments will support continuing target delivery over the next three years as we transition from our Academy training to the new Educational Model to align with the

introduction of degree level qualification requirements for HCPC registration in 2021. This will build on the external pipeline which was expanded in 2017 with commencement of the first full-time degree programme in Scotland (first graduates in 2020). The degree programmes will commence in August/September 2020 pending successful validation by the universities and HCPC approval.

We continue to be actively engaged as one of the 6 Boards in the East Region Recruitment Transformation Programme Board. Part of the strategic proposal was the implementation of the National Recruitment IT system, Jobtrain, which went live in December 2019. Core Scottish Government funding is in place for Jobtrain until the year 2022/2023.

2. Employee Development

Aim - To ensure a capable workforce with the skills and knowledge to deliver a high quality service now and in the future.

Status – Planning and implementation of revised timetable of activities due to COVID19.

Improvement – Transition of numerous learning administration/management systems to a single learning management system that assists the service in identifying, planning and delivering learning and development interventions that support individual personal development and service strategic learning needs analysis is the focus for improvement.

Planned Activities Include – Our primary focus for the period is the resumption of a number of activities that were suspended/postponed in accordance with Scottish Government guidance during the COVID19 pandemic and the reallocation of resources in partner organisations such as NES as a result of the pandemic.

1. Talent Management and Succession Planning

Guidance on the processes and governance for Talent Management, Development and Succession Planning at the Service was agreed and published on @SAS in December 2019 and communicated to all Senior Leadership Team members; with March 2020 as commencement of the cycle.

Talent Management and Succession Planning activity was suspended due to COVID19 pandemic March 2020. The proposed rescheduled timetable for resumption of this activity is being planned.

2. Appraisal and Personal Development Planning.

Resumption of appraisal and personal development planning that was suspended as a non-essential activity is being planned.

3. Learning Management

Scoping meetings were arranged with NES Digital in March 2020 to commence transition planning to Turas Learn and Turas Learning Records Store. Postponed due to COVID-19 at the request of NES Digital.

Resumption of transition planning commenced in August 2020 – next stage is the completion of the Terms of Reference and a Memorandum of Understanding between NES and SAS for the governance of this work – to be completed by October 2020.

4. Once for Scotland Statutory Mandatory Training

Plans were in development for the transition of all NHSScotland “Once for Scotland” statutory and mandatory training to be available through Turas Learn to all staff groups. These plans have been paused due to COVID-19 but are currently being reinstated.

5. Microsoft Teams / Office 365

The COVID-19 pandemic has resulted in the adoption of Microsoft Teams and Office 365 for a number of Boards, including the Service, at a much faster pace. Microsoft Teams in particular has enabled a digital

alternative to face-to-face meetings with virtual and remote meetings and collaborative working taking place on-line. Learning resources to support staff and teams in getting started with Microsoft Teams have been made available through our Intranet systems and also supported by NES. remote collaborative working. The Service will be participating in this work-stream and look to implement best practice going forward.

Enabling Technology

1. Electronic Patient Record

The NRRD/SORT team are working on the preparation of patient cards to allow them to test the major incident module following a delay over the COVID-19 period, with a view to a fleet-wide software upgrade by year end. NRRD/SORT are considering the implications for training and rollout.

2. Emergency Service Network (ESN) Programme

The revised Full Business Case (FBC) pack has been released to the Service on 13 August 20. The FBC and accompanying finances have been initially reviewed by the Service and also in conjunction with the other emergency services in Scotland and the Scottish Government. Initial feedback provided to Scottish Government by the Service and 3ESS partners is that the FBC does not have credible information to support the proposed transition timelines and does not have a supporting plan or accurate finances. Scottish Government has fed this back to the Home office stating that they '*will be unable to provide any agreement or endorsement of the revised FBC or the financial modelling and underlying assumptions in their current form*'. As it stands, there is not an expectation that there will be a requirement for the Service to assure this version of the FBC and formally feedback to Scottish Government, however, this will be monitored.

3. Integrated Communications Control System

The project to provide an ESN compatible Integrated Communications Control System (ICCS) has been further delayed due to the software failing the final round of national testing. It cannot therefore be released to the Service to enable us to complete our own testing. No finalised dates for re-testing have been agreed and this will now definitely impact on the planned Service go-live date of March 2021. Workshops are scheduled with ARP to better understand the timeline and any mitigation that can be put in place to limit delays. The Service continues to progress what it can and in August the first 10 ICCS PCs were built – these will initially be used for testing and training. A Change Control Notice (CCN) to extend the current ICCS contract until June 2021 has been developed. Once funding for the extension has been agreed, the CCN will be signed-off.

4. Defibrillator Replacement

The Project Team and Project Board have approved the End of Project report. The project was formally closed at the Enabling Technology Programme Board meeting on 20 August 2020.

5. Patient Transport System Mobile Data

The Patient Transport System Mobile Data Procurement Project is still paused while the Scheduled Care Strategy is further developed. There are increasing operational, cyber and financial risks involved in delaying the replacement of the current solution as it relies on out of date hardware and software. A business case has been developed and funding has been secured to purchase the additional tablets required to keep the existing system running as the current spares holding will be exhausted in circa 7 months. A prototype of the new solution is under test before it is approved for deployment to the live PTS fleet.

6. Fleet

The 2020/21 Fleet Replacement Programme is in progress and on track to deliver the objectives of the current business case, which is in its final year. Development of the next Full Business Case (2021-2026) is ongoing, it will be presented to the Board in September and then the Scottish Government in October 2020 for approval.

7. Digital Workplace Project

The Digital Workplace Project (Phase 1) has been established and is underway to meet the national Office 365 programme timescale to migrate all Service mailboxes from NHS Mail to O365 mail by the end of October 2020. The migration is scheduled to start on 7 October 2020 and a pilot has begun with a small cohort of users from across the Service. Other preparatory work is also underway and the Service remains on course to migrate in line with national programme timelines. Work is also in progress to develop and migrate the Intranet (@SAS) and Work Area data to a new SharePoint Online environment, as well as the provision of Microsoft Teams across all users in the Service. Work on Phase 1 of the project is scheduled to complete by March 2021.

8. Other Projects

ACC Telephony Projects

Call Recording

This project involves an upgrade to the NICE Inform 9 call recording solution at each of the ACC locations. The migration work at Paisley and Cardonald is now complete with work at Norseman, Inverness and Oxgangs scheduled for completion by end October 2020.

Telephony Upgrade

This is a significant project, it involves upgrading the entire ACC telephony and contact centre platforms. Initial meetings with BT have been held with Project Board and Project Team membership identified. The High Level Design has been reviewed and low level design work is in progress. Hardware for the new system has been delivered into Service storage. The rollout plan will be finalised by the end of September 2020.