OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 26 February 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 26 February 2019

CONTENTS

HEALTH AND SPORT COMMITTEE
6th Meeting 2019, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Donna Hendry (Scottish Ambulance Service)
Pauline Howie (Scottish Ambulance Service)
Tom Steele (Scottish Ambulance Service)
Dr James Ward (Scottish Ambulance Service)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 26 February 2019

[The Convener opened the meeting at 10:00]

Subordinate Legislation

Personal Injuries (NHS Charges) (Amounts) (Scotland) Amendment Regulations 2019

The Convener (Lewis Macdonald): Good morning and welcome to the sixth meeting in 2019 of the Health and Sport Committee. I ask everyone in the room to ensure that their mobile phones are switched off or to silent. Please do not film or record proceedings.

The first agenda item is the consideration of an instrument that is subject to negative procedure. No motion to annul the regulations has been lodged and the Delegated Powers and Law Reform Committee has not made any comments on the regulations.

As there are no comments from members, does the committee agree to make no recommendations on the regulations?

Members *indicated agreement.*

Scottish Ambulance Service

10:00

The Convener: The next agenda item is an evidence session with the Scottish Ambulance Service. It is one of a series of evidence sessions that the committee is holding with special and territorial health boards. We last took evidence from the Scottish Ambulance Service on 23 May 2017.

I welcome from the Scottish Ambulance Service Tom Steele, who is its chair; Pauline Howie, who is its chief executive; Dr James Ward, who is its medical director; and Donna Hendry, who is a specialist paramedic.

We should start with the item that is of greatest interest to the public, which is the changes to the triage system under which the service prioritises calls and responses to calls. I want to explore that.

Critical in the design of the system is the response to calls that relate to immediately life-threatening situations. We have seen the research on that by the University of Stirling. Do you intend to do research on the next category of calls, which are those that are serious and require clinical attention but are not immediately life threatening? Is any work planned to explore the impact of the change in the system on those types of call?

Tom Steele (Scottish Ambulance Service): Thank you for inviting us to give evidence to the committee this morning. I apologise for my croaky voice; some pesky virus has got me, but I will do my best.

I will defer to Dr Ward to answer your question and build on the information that you read last week.

Dr James Ward (Scottish Ambulance Service): The answer to your question is yes, convener. The response model that we have developed is about all our patients, whether they are affected by something that is very serious, such as a cardiac arrest or heart attack, or by any other of a range of conditions that we are required to respond to, from mental health crises to relatively minor peripheral limb injuries.

The model that we have developed aims to put the patient right at the centre of all the response decisions. It is based on a huge amount of data and evidence around patients' requirements, right across all elements of our 999 service. We consider a range of factors affecting all those patients. Historically, our thinking has been dominated by response times. Response times are important, but they are only one of a number of factors that affect the outcomes of patients.

To answer the question directly, in terms of patients who are outwith our purple and red categories—the immediately life-threatening calls that you referred to—a huge amount of work is being done for patients in our amber category who are affected by chest pain and stroke symptoms, and for patients in our yellow category who are affected by a wide range of conditions.

The Convener: Clearly, some of the conditions in the yellow and amber categories are potentially very serious. One concern that has been raised with me is that a decision that such a call may not be regarded as a priority could have consequences if, for example, the individual is on their own and an hour after having called experiences a level of deterioration that would not have been foreseen at the outset. Has that issue been acknowledged and, if it has, what can be done to address it?

Dr Ward: All the calls that we are talking about in this phase of our response model's development are 999 calls, so they are all priority calls. One of the challenges for a clinician in providing clinical care is to make rational decisions about the acuity of a response. For example, if we have two patients who are the same age and one has an ankle injury and the other has severe crushing chest pain, we would all agree who we would send the first ambulance to, but we would also want to keep the other patient in mind and be looking for a timely response for them, too.

We continually review our responses, both clinically and in terms of time. In particular, we look at our average response times and 90th centile response times for our patients across every category. We also look at the patients beyond that 90th centile—90 per cent is pretty good, but the patients beyond that matter, too.

We continually look at exceptional circumstances, refinements to triage, safety netting in ambulance control and a range of issues around making our service delivery as effective as possible.

The Convener: I recall being a member of the Audit Committee a long time ago, perhaps in 2001, when we considered prioritisation and categorisation of calls. Significant changes were made at that time. How are the current changes qualitatively different from the changes that were made then?

Dr Ward: The system that we had until October 2016 was based on three categories of response: A, B and C. Category A represented about 33 per cent of our call volume and our target was to respond to those patients within about eight minutes. That was the be-all and end-all. When we listened to staff and patients, we heard that there was a lot of frustration about the fact that such a large proportion of our call volume was determined as our highest priority.

We set in place a process to look at all the patients, right across the 999 family, which is divided into more than 1,200 codes. We sought to understand some very important parameters in the codes, and we have done that. For every single code, we can tell you the cardiac arrest rate, the conveyance rates, whether there are airway or breathing interventions and whether the patients are pre-alerted, and we can tell you how sick they are based on their early warning scores. Having got all that information, we set up a hierarchy, which is the purple, red, amber and yellow categories in our report.

We not only recategorised calls, but changed the method of response. For example, in the highest category, which is purple, a patient will get not just the nearest ambulance but the nearest two resources, because when someone requires active resuscitation, that needs at least three pairs of hands. We have significantly increased the extent to which we get two resources to such patients, in as timely a fashion as we ever did. In that category, the cardiac arrest rate in the first year was 52 per cent. That was more than we expected, but it reflected the fact that we had considered other codes that had previously had a lower response and put them into the purple category.

The codes that go into our highest acuity category, which is the purple category, tell us that the people are very sick and in immediately life-threatening circumstances. If we align our response to accurately identify those patients, that gives us the best opportunity to save lives. When we set off on this journey, we had no idea what would happen in relation to 24-hour or 30-day survival. What we have seen from the first year of the new system is a 43 per cent increase in 30-day survival. We have also seen very stable 30-day survival outcomes for all the other codes.

In going from the old system to the new one, we have taken an evidence base and implemented it on a national scale. From the evidence that we gathered, we have been able to sense check the data as we go along. Every week, every month, every quarter, every six months and every year, we have refined the data to check that patients are allocated to the right element of the response model. We have made some, but not many, refinements over the year: between six and 10 changes have been made by moving codes based on what we found. It is good to see that the model has worked, as we would expect it to, given that we looked at so many calls in the preparation and planning.

The Convener: Before I bring in colleagues, I ask Donna Hendry to provide a staff perspective of

the practical difference that the new model has made, in terms of attending the scene and getting to the right people at the right time.

Donna Hendry (Scottish Ambulance Service): There has been a difference in two ways. I often attend the immediately life-threatening calls as a second responder—a third pair of hands. In that respect, the new model has been really useful, because I am able to travel with the crews and attend purple or red calls. We know the immediate help and care that those people need, and I can be utilised to help them in a way that does not take too many resources away. That happens every time, or, if I am on my own, someone comes to back me up rapidly, so the system works from my point of view.

As a specialist paramedic, I am more often sent to the less life-threatening categories of calls—the yellow or amber calls—because, hopefully, we can treat the people at home or refer them to a more appropriate place than an accident and emergency department. How we deal with those categories of call is still developing; it is not always right, because the people who take the calls can work only on the information that they get. As Jim Ward said, every call that comes to the Ambulance Service is a 999 call, so they need to be categorised. We are trying to refine the codes so that the calls that we, as specialist paramedics, are sent to are more appropriate. Such calls will probably involve treating the patient at home or referring them to treatment in a more appropriate place, which will be in the best interests of the patient and their family.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, panel. I put on record my thanks for everything that you do for us, and I congratulate you on the demonstrable increase in the number of saved lives under the new system.

However, as constituency MSPs, we hear more about the cases in which people are left waiting as a result of the triaging system. I am not suggesting that the system is wrong, but I have some questions about the waits that people in non-life-threatening situations sometimes have to suffer. About this time last year, one of my constituents, who was in his late 70s, fell in a street in Corstorphine and had to wait nearly three hours for an ambulance. James Ward said that such patients are kept in mind, but what do you do to monitor the situation in relation to individuals who do not have life-threatening injuries but might need to wait more than an hour for uplift?

Dr Ward: Obviously, we prioritise resources, but that is by no means the single cause of delays in response. I can say more about that if you wish.

On specific patients to whom we do not respond in a timely manner, the first thing that is done is that our dispatchers continually monitor our resources, so that every possible resource that could go to the patient is allocated. The second thing relates to the clinical hub in our ambulance control centre, in which we have invested significantly in the past few years. The hub's job is to keep in contact with patients whom we are not able to get to. Our aim is to have called back every patient after 45 minutes, in order to check in with them and let them know that they are in our system and that we are responding, and, more important, to check that there has been no deterioration in their condition and that the call does not need to be escalated to a higher priority.

Alex Cole-Hamilton: If, for example, my constituent had had a serious fracture, gone into a state of shock and, possibly, had an underlying heart condition that was not known about, and if it had become a life-threatening situation, you would have picked that up through the monitoring process. Is that right?

10:15

Dr Ward: That would absolutely be the intention, and the priority allocated to that call would be based on the most recent information that we had. Obviously, I cannot refer directly to your constituent's case, but if a patient deteriorated and we picked that up as part of our interventions, that call would be reprioritised within the system.

Pauline Howie (Scottish Ambulance Service): Jim Ward spoke about some of the adaptations that we have made. Just before winter 2018, we took the learning from previous cases, such as the one that Alex Cole-Hamilton referred to, and we looked to see how we could recategorise those patients who are particularly vulnerable in outside places and who might also have fractures. Those types of patients have not waited as long as they did in previous winters, so a lot of learning has gone into in the implementation of the model, as Jim Ward said.

Alex Cole-Hamilton: That is very good to hear.

Tom Steele: I, too, have experienced what Alex Cole-Hamilton experienced. I like to go out with crews fairly regularly, and on one occasion I found that a patient had fallen in a bookie's shop and had been there for three hours. That struck home with me and, as a result of that, the chief executive and the board were very keen to look at vulnerable patients who, because they are in a public place and are outside, are subject to more clinical risk than they would be otherwise. We have reacted to that in the way that the chief executive has said.

Alex Cole-Hamilton: I have a final question. We are going to come on to a discussion about staff morale later. In cases where people have had

to wait hours for an ambulance and are understandably fed up and possibly distressed, have your front-line staff noticed an increase in aggression or abusive behaviour? Is that a factor that plays into the morale discussion? Perhaps Donna Hendry is best placed to answer that question.

Donna Hendry: Yes, it does. As I alluded to earlier, the codes and so on are still developing and at times we still ask, "Why did we not get sent to that?" However, we must bear it in mind that we do not know what the big picture is or what other calls are going on; we know only what we are sent to.

When it works, it works well. For example, I got sent to a 75-year-old patient last week who was at home alone and suffering from difficulty in breathing. She managed to phone 999 for the ambulance and, after the call was triaged, I was sent to attend to her. The symptoms that she had were an exacerbation of her chronic obstructive pulmonary disease and she had a bit of a chest infection. With that information, I was able to do an advance assessment and make a clinical decision based on her past medical history. I was able to help that lady to stay at home and avoid the increased risk that she would have faced if I had had to take her to hospital. I was able to contact an out-of-hours general practitioner for some professional support and I also contacted her family, who were absolutely delighted that their mother was not going to be dragged out of her bed at that time in the morning and taken to hospital. When the system works like that, it makes me feel really glad to do the job.

Alex Cole-Hamilton: What about the flipside of that? If somebody has been waiting for three hours with an elderly relative outside in the cold, do you sometimes get pushed back in anger when you respond?

Donna Hendry: Such situations are extremely frustrating, but they are not a regular occurrence. That is quite a rare thing to happen. When there is the pressure of other emergency calls, it would be just a case of trying to explain. A situation like that makes me feel sad for the patient, but I would like to think that I would be able to explain it to the patient in a way that they would accept.

Sandra White (Glasgow Kelvin) (SNP): Good morning. I put it on record that I am extremely grateful for the service that we receive. Today, I downloaded information that shows that the clinical response model saves an extra 1,182 lives, which is good, positive news.

I want to go back to the original question. [*Interruption*.] Excuse me—I think that I have picked up Mr Steele's cold.

It is not just a case of meeting the eight-minute response time; as Dr Ward has pointed out, there are many other people, such as paramedics, who can respond now. Will you talk us through what happens? I know that the operators have a great deal to do when calls come through—for example, if the response time is going to be longer than eight minutes, they will make a decision and talk people through what will happen.

I also note that, under the new clinical response model, the service will make a determination in relation to someone who has had a stroke, who might be taken to the most appropriate setting rather than just the local hospital. Unfortunately, I have had experience of such a situation in the past year, so I am quite familiar with the procedure, but the public might not be so familiar with it. Do the public understand what now happens under the new model when they phone 999? How can you give them a better understanding of the fact that an ambulance might not necessarily come in eight minutes? Will you put on record the procedure involved, bearing it in mind that it is a case not just of responding in eight minutes but of everyone working together?

Dr Ward: Absolutely. I will talk you through exactly what happens when someone phones 999, because I think that that is part of what you are asking about.

First, we have to establish where the patient is. We have invested in some technology to ensure that, with people who phone using a land-line, things are auto-populated; however, we are not quite there yet with those who phone on a mobile. After all, it is really important that we establish the location, especially if we lose contact with the patient.

Secondly, perhaps 20 seconds into the call, the caller will be asked whether the patient is breathing. If the answer is no, that will automatically generate a purple response, and we will send the two nearest resources, the first of which will usually be dispatched within 45 seconds of receiving the call. If the answer is yes, we will ask whether the patient is awake, and if the answer to that is no, we will generate a red response. We have come to that procedure by evaluating thousands of calls and understanding the journey. It means that even before people enter triage—which I will talk about next—we have identified many of our most critically ill patients simply through what we call pre-entry questions.

The next question is, "Can you tell me exactly what has happened?" That is when our call takers have to listen, often to someone who is very stressed and who might not know the patient at all. They might have come across them in the street or whatever. The call takers have really good listening skills, and that allows them to establish

what is called a chief complaint and which of the 32 different card sets, which cover everything from trauma to chest pain to breathing difficulties and so on, should be used. At the end of that process, which usually takes about two minutes, we will have established a final code, on the basis of which our dispatchers will allocate the nearest ambulance.

It is probably worth stressing that all the delays that we are talking about fall within our yellow category, which is our biggest basket of calls, and it is probably worth noting that, according to data from over the whole year, we probably reach 50 per cent of those calls in about 15 minutes and 90 per cent of them in less than 50 minutes. It is also worth saying that, due to improvements that we made, our response times this December were significantly better than last year's, despite a 5 per cent increase in purple and red demand. We are learning as we go.

For a relatively small proportion of our calls, there is a final bit, because we might need more information to determine the right response. That information can be gathered by our clinical advisers or, for a certain proportion of our patients, by NHS 24. There is a continual crossover between us and NHS 24, because people phone 111 when they actually need an ambulance, or they phone 999 when their acuity is such that they would get a better service through NHS 24. In all the time that we have been delivering those changes—we have been working with NHS 24 for three or four years now—I cannot remember our getting a single complaint about a patient being pushed in one direction or the other.

The issue is all about how things are done—it is about the quality of the communication. We make a robust attempt to understand exactly how sick the person is. If we ask permission to get additional triage information from them—by passing on their call or having someone call them back within 15 minutes—people generally accept that.

Sandra White: Thank you for that. How do we get that across to the public? As Alex Cole-Hamilton and others have said, we have constituents who come to us and do not quite understand what happens. How do we get it across to the public that even though the ambulance might not come straight away, they are on the phone to someone who can give them very good information and can carry out an assessment while the ambulance is on its way?

The Convener: Perhaps that question should be for the chair of the Scottish Ambulance Service.

Tom Steele: I am happy to pick that up. The old eight-minute model has been around since 1974 and is in the public psyche, but when it comes to holding the organisation to account, which is my role and that of the board, it is pretty useless. You have heard Dr Ward explain the new structure and the four categories. We have very clear expectations in relation to those categories, which we report to the Government on every week, as well as on the eight-minute response.

In the future, it will be in our collective interest for the public to understand how we are operating the new model. It is very effective and we are keen to publicise that. Equally, we do not want to do something that would frustrate the continued scrutiny by the Government of the eight-minute response.

Emma Harper (South Scotland) (SNP): Before I ask my question, I would like to echo Sandra White's comments about the new model saving lives. It is good to get some good news for a change.

Sandra White made a good point about the public's knowledge of the process. It is important that we engage with the public, particularly when we are using new models of care that can keep people out of hospital—for example, when paramedics go to the home of someone who has had a COPD exacerbation.

I want to move on to talk about Police Scotland's statement that officers are spending more time in emergency rooms accompanying people with mental health and other issues. What are your opinions about Police Scotland's comments about the extra time that the police are spending in hospitals? I would like to see further evidence on that. Is it possible that the new model has increased the amount of time that the police are spending in A and E departments?

Pauline Howie: We are working jointly with Police Scotland to do much better for patients who present with mental health distress issues. A number of initiatives are under way. The Scottish Ambulance Service is involved in the four distress brief intervention pilots that are happening in various localities across the country. As recently as three weeks ago, we made our 2,019th referral to a distress brief intervention pathway up in the Highlands. The patient experience feedback from those pilots is very positive indeed.

There are a limited number of pathways for our paramedics and other staff to refer to for patients who present in mental health distress, but who do not have any physical injuries or illnesses that would require attendance at an accident and emergency department. Along with Police Scotland, we are considering how we can better identify those patients and refer them to alternative pathways, where they exist. When those pathways do not exist at the times when patients need them, we are working with the integration joint boards to

gather data so that we can come up with better pathways for patients who meet their conditions at that point in time. That would mean that we would not take people unnecessarily to A and E departments, and that police officers would not have to do that or, worse still, take them into police custody.

We are involved in a pilot in Lanarkshire with Police Scotland and NHS 24 that is just about to go live. We would be delighted to explain the evaluation of that to the committee in due course.

The Convener: There was a street triage pilot in Glasgow recently, which was partly intended to divert away from A and E people who did not need to attend. Has an evaluation of that been carried out that we could see?

Pauline Howie: The evaluation of that pilot is under way. It took place in a small number of postcodes in Glasgow. There is an appetite on the part of both organisations that are involved to see how we could extend that pilot at appropriate times. We have a similar model in Inverness. We target that type of response at certain times of the year and on certain occasions, and it seems to be very effective.

10:30

The Convener: For a long time, the committee has been concerned that the NHS pilots some very good things that are evaluated to be successful, but they are not rolled out. What is your intention with regard to the two pilots that you have mentioned today?

Pauline Howie: The issue is about ensuring that we have a sustainable workforce and that we can appropriately deploy our assets so that they are well utilised. Those are the issues that we ask to be evaluated, so that we can scale up where appropriate.

We think that the pilot in Lanarkshire could be scaled up. We have looked at research from around the United Kingdom, and it seems that triage from police and ambulance into more appropriate and robust referral pathways is sustainable and evaluates well, which is why we are testing it in the Scottish setting.

Tom Steele: We have a close working relationship with the other two category 1 responders, which are the police and the Scottish Fire and Rescue Service. The three heads of service and the three chairs regularly meet to discuss issues such as our approach to mental health. At the most recent meeting in December, that was one of the items on the agenda.

I believe that there is no evidence—perhaps Dr Ward will speak to this—that the new model is having any impact on the amount of time that police officers spend in emergency departments.

Dr Ward: Just to be absolutely clear, we do not change the acuity of our response to a patient based on the police being in attendance.

The convener mentioned the wider NHS, and that is at the heart of the issue. Someone's journey starts before they dial 999, so we need to look at things such as anticipatory care, planning and primary care. Once we have triaged patients, there are appropriate pathways. What causes frustration for patients is when they feel that they are being delayed on any part of that journey, whether that is waiting for an ambulance, waiting for the ambulance to get into an ED or waiting to see a mental health specialist when they get into the ED. It is for all of us to work together to understand the flow across the system and make sure that our response to people is optimised in such circumstances.

Emma Harper: I have a quick supplementary question. NHS Dumfries and Galloway has police on site in its emergency department. I assume that that allows a handover to take place, so that other police officers who deliver people to the A and E department do not have to remain there. Has that model been looked at by other health boards in Scotland?

Pauline Howie: There are different models in place. As part of the mental health strategy, there is an ambition to get more mental health professionals into accident and emergency departments, so that they can look after patients who present with mental health conditions.

The Convener: As colleagues have commented, an increase in the number of lives saved is clearly a significant criterion. Nevertheless, it is important to note that some of the targets for responses to immediately life-threatening situations are not being achieved, and that the targets are not for 100 per cent of calls to be responded to within eight minutes. Why were targets set only for those calls that relate to immediately life-threatening circumstances? Given that the proportion of calls that have to be responded to within eight minutes has reduced significantly, why are those targets being missed?

Dr Ward: The eight-minute response target applied to the old category A basket, which, as I said, comprised 33 per cent of our call volume. We no longer have a category A response. However, that eight-minute target is currently being applied to our purple and red categories. The committee might be interested to know that, in the purple basket, the cardiac arrest rate was 52 per cent in the first year, whereas the cardiac arrest rate in the red category was 1.5 per cent. That tells me two things: that we are absolutely identifying the

sickest people in our highest priority and that our assumption in the planning phase that the purple and red categories would equate to calls about immediately life-threatening situations is not necessarily being borne out.

I can understand why the eight-minute target was put there, but it has lost its relevance, particularly to clinicians in the system. We get to the sickest people as quickly as we can, and that is when the role of the paramedic begins.

The Convener: You said that the eight-minute target is not relevant now, but it remains the criterion to which the service works. While acknowledging that it might not be adequate for all circumstances, I am keen to understand whether the Scottish Ambulance Service remains committed to the eight-minute target for calls about immediately life-threatening situations.

Dr Ward: Absolutely. We are committed to trying our best to deliver every target that has been agreed as part of our delivery plan. In addition, over the past two years we have reported publicly on median and 90th centile response times for the purple and red categories and, more recently in our board, the amber and yellow categories. We feel that we need to put all that information out there, particularly because of the concern that has been highlighted about times when there are longer delays.

As a clinician, I believe that a more nuanced use of targets and indicators—particularly in looking at stratification across the response criteria—is a much better way to go. For example, we look at median and 90th centile response times for our purple, red, amber and yellow categories. We set some indicators at the start of that process, because we wanted to benchmark our performance against that of other services and to hold ourselves to account internally on our expectations. Across the piece, in general, we have been achieving or have been very close to achieving those internal measures, particularly for the highest acuity patients, even during times of exceedingly high demand.

The transition from an established performance framework to a new performance framework must take into account new evidence, new ways of working and the paramedic skill set on the issues that Donna Hendry mentioned, such as shifting the balance of care and looking after more people at home, and it must involve an understanding not just of response times, which are important, but of outcomes for patients. That is the suite of measures that we are looking to develop and—we hope—agree with our sponsors.

The Convener: I understand the clinicians' focus on outcomes, which is absolutely right. Nonetheless, I look to the whole panel to confirm that the Ambulance Service remains committed to measurement of performance. The service's cardiac arrest target is to respond to 80 per cent of cardiac arrest patients within eight minutes, but the actual achievement is 70.4 per cent, which falls short of the target. I am keen to know whether the panel shares my concern about those numbers or do you see that simply as part of the process of change that Dr Ward described.

Tom Steele: I see that as a concern, but there is a context. I became chair of the Scottish Ambulance Service nine months ago. My recent background was in healthcare, on the board of NHS Lanarkshire, and I was previously in business. It seems to me that, in measuring an organisation, we are trying to achieve the best quality that we can achieve within the resources that we have, and that we do so with motivated and satisfied staff. The response times need to be meaningful, in that sense.

Although we still look at the eight-minute response target, it is a bit of a sledgehammer to crack a nut. Dr Ward mentioned nuance and the standards that my board is using internally. On response times to purple calls, we have a standard of six minutes, which we are beating. For red calls, we have a standard of seven minutes, which we are also beating. Standards are in place for the amber and yellow categories, too. Those standards are scrutinised at every board meeting.

On ensuring that we use the finances that are available to us in the most effective way, and that we take a person-centred and safe approach, the system is now more meaningful, and I commend it to the committee. We have not done the work in isolation. England moved to using a similar—although not identical—system about a year ago, and Wales has changed its system on a similar timescale. Ambulance services all over the world—including in Australia, for example—have moved to using such systems. That gives some context in relation to the old targets and the new standards.

The Convener: It is certainly important that we understand how you understand the targets to which you adhere. One of my colleagues said that a number of communities lie further than eight minutes away from an ambulance station. Given that you still have the eight-minute target for immediately life-threatening cases, how is that target applied in large rural areas?

Tom Steele: Perhaps the chief executive could answer that by referring to community and clinical first responders.

Pauline Howie: We have a variety of responders across the country, including in remote and rural areas, where we have increased investment significantly. The new clinical response

model is part of a wider five-year programme of investment and reform. As part of that five-year strategy we are investing in more staff, in the skills and development of existing staff and in new assets, equipment, processes and technology.

In remote and rural areas, we have a network of first responders who work very closely with our ambulance crews, and are a vital part of our response. Our new wildcat responders for patients who have had cardiac arrests have been in place for more than a year. That programme has been evaluated as doing very well: the responders are able to get to patients who have had cardiac arrests, in support of our crews. We also have our air ambulance service. Members will be aware that, from April this year, we will have the north of Scotland specialist transport and retrieval base in Aberdeen, which will significantly enhance our capability and capacity to help rural communities in the north of Scotland.

We have been working very closely, in conjunction with our staff representatives, on how we can further reduce the level of on-call working in remote and rural areas. There has been a significant reduction over the past few years, although we want to do more. That is linked to new ways of working. We have agreed a prioritised list of locations where we want to reduce on-call working further with our staff partners. In the past year, three locations from that list have become full-time 24/7 shift-working stations, and a few weeks ago we announced that we would recruit to a fourth station in Portree, so that we can eliminate on-call working there.

As I said, the work is part of a five-year programme of investment and reform. We have more to do, but we are absolutely committed to ensuring that we improve outcomes for patients in remote and rural communities.

The Convener: That is very helpful. Does the attendance of a first responder remove the obligation on the target for a crewed vehicle to attend an incident within eight minutes?

Pauline Howie: A recognised responder who works to our clinical governance standards counts against the clock, but that responder will be backed up by a crew.

10:45

David Stewart (Highlands and Islands) (Lab): I echo my colleagues' comments and thank all the front-line staff who do such a great job throughout Scotland. As someone who represents the Highlands and Islands, I know how important the service that covers that area is.

I want to focus on staffing and human resources issues. I have looked carefully at the Scottish Ambulance Service's employee engagement index score, which is the lowest of all the boards' scores. Its scores in the 2017 dignity at work survey were the worst in terms of the proportion of staff who experienced unfair discrimination from their manager, the proportion who experienced unfair discrimination from colleagues and the proportion who experienced bullying and harassment from their manager. Is there a culture of bullying in the organisation?

Pauline Howie: We were very concerned about the results of the dignity at work survey, which we have been working hard to understand. You will be aware that, as part of the NHS Scotland staff experience measures, we use the iMatter staff experience index, to which you alluded. The results from that show that there was much greater participation in it: almost double the number of people in our service participated in iMatter than in the dignity at work survey.

We are, nonetheless, concerned about the findings and have been working to engage with staff across the country to understand their experience and what more we can do, because it is completely unacceptable for our staff and volunteers, who do a fantastic job day in and day out, to face violence, bullying or harassment.

As a result of the dignity at work survey that was done a couple of years ago, we set up a network of confidential harassment advisers, whom staff can contact confidentially if they are experiencing issues. We have very regular reporting through our governance committees—our health, safety and wellbeing committee and our staff governance committee—which report to our board on specific cases that we are concerned about.

We have invested significantly in our leadership and management development so that we can continue to create supportive and encouraging networks for our people. Given the amount that we are investing in their development, we want them to feel supported to work well in what is often an emotionally and physically very demanding job up and down the country.

We are absolutely not complacent. We are pleased that the participation rate in the staff experience survey continues to increase, and that teams are taking action as a result of the feedback at local level and throughout the organisation. Our performance in that regard is very strong: at 89 per cent, it is 30 per cent higher than all the rest of NHS health and social care as a whole's participants in the survey. We are pleased that people report that they get a tremendous sense of satisfaction from their job, but we have much more to do, and we want to continue on that journey.

Tom Steele: I mentioned that I have been the chair of the SAS board for nine months. In that

time, I have been out and about a lot. I am concerned about some of the results that David Stewart mentioned, but there is conflicting information. When I talk to staff, I hear a lot of enthusiasm for the job that they do. In addition, our staff turnover of just over 4 per cent is very low, as is our vacancy level—

David Stewart: Can I stop you there? I am willing to be corrected, but I understand that staff turnover among ambulance personnel is the second-highest of all staff groups.

Tom Steele: I was referring to the whole organisation.

Pauline Howie: We monitor staff turnover monthly. According to the latest figures that we have, at the end of January, staff turnover was 4.1 per cent and we had 25 vacancies, which is the lowest number for a long time.

David Stewart: How does your performance on that compare with that of other boards?

Pauline Howie: I think that our turnover rate is lower than that of other boards. As Tom Steele mentioned, we work closely with the other UK ambulance services: I know that our vacancy rate is a lot lower than those of other UK ambulance services.

David Stewart: I am sorry for interrupting you, Mr Steele.

Tom Steele: No—your point was well made.

There is evidence on both sides. I have experience of working in many different industries and businesses. I accept that the evidence that I cited is anecdotal, but such a high level of enthusiasm is unusual. The number of paramedics and technicians who have said to me that they have the best job in the world is in double figures.

I would be keen for Donna Hendry to say a few words, if that would be okay.

Donna Hendry: I have been in the Scottish Ambulance Service for almost 25 years. When I joined, I did not think that it would be my job for life, but thankfully it is—or hopefully, in case I say something wrong today. [*Laughter*.]

When I joined the service, I was one of the only females in the job, and the culture was very different then. It was pretty anti-female. If I was filling in a form then about how I felt about my job—whether I felt bullied and so on—I might have said very different things. I have seen a massive culture change in the past 10 to 15 years, and I certainly do not see any bullying or harassment. I could compare that with the situations of some of my friends in other jobs. We have policies to protect us in almost everything that we do.

We also now have opportunities to engage in all kinds of activities within our work. I am part of the health and wellbeing committee, so I do a lot of healthy working lives stuff. We arrange lots of activities including things to try to improve staff wellbeing. I certainly do not feel or see bullying or harassment, and I have been around for some time.

David Stewart: Thank you for that.

Like Mr Steele, I have been involved in a number of organisations. I know that another indicator of the health of an organisation is its sickness rate, which is certainly something that I would look at carefully. You will know that, in 2017-18, the target was 5 per cent but the actual rate was 7.6 per cent. I understand that, in day-to-day life, you meet dedicated staff such as Donna Hendry who speak positively of the organisation, but I would look at what the statistics say. I would look at the dignity at work survey, the employee engagement index score and the accounts of bullying. The sickness rate is a factual thing and the current rate is higher than your target. What are you going to do to try to reduce the sickness rate in the organisation?

Tom Steele: I will ask the chief executive to respond to that in a moment, but I absolutely agree that 7.6 per cent, which is the rate that we are still at, is a high rate of sickness absence.

All ambulance services in the UK and abroad have significantly higher levels of sickness absence than the rest of the healthcare systems, which reflects the physically demanding and mentally extremely stressful roles that paramedics and wider staff play. We are increasingly aware of that and we are responding to it in a way that will initially raise awareness and then, we hope, reduce sickness absence. The sickness absence level is of concern to me: equally, the health and wellbeing of our staff are of concern.

David Stewart: Perhaps you could send us the comparative sickness rates for the other organisations that you mentioned. However, if I was running an organisation and the going rate was 7.5 per cent, I would make the target 7.5 per cent. Why did you make the target 5 per cent if you are not achieving that?

Tom Steele: I ask the chief executive to respond to that.

Pauline Howie: There are financial targets for sickness absence in NHS Scotland, and the Scottish Ambulance Service tries to reduce sickness absence, as you would expect. The top two reasons for sickness absence in our service are musculoskeletal illnesses and mental health illnesses including anxiety, stress and depression.

As I said earlier, our staff do an outstanding job in trying and emotionally distressing circumstances. On any shift they might see the best and the worst—life and death. It is also often a physically demanding job. We have been investing significantly in new equipment and new policies and procedures. For example, we are one of the only UK ambulance services to have an ergonomics adviser who helps with advice on equipment and manual handling, lifting and so on.

We have also been paying a lot of attention to our approach to supporting the mental health and wellbeing of our staff. Other industries have seen an increase in that area, as well.

We have a number of employee assistance programmes that are well utilised by staff. Those who use the programmes report an improvement in their mental health and wellbeing, and people who have accessed our fast-track physiotherapy have reported improved outcomes.

We want to do more, particularly in relation to how we support people's mental health and wellbeing. We are working across the UK ambulance services to understand what works in our environment, because ours is a unique environment. We are also working with the other emergency services in Scotland to understand what they are doing and how we can learn from each other and share practice where it makes sense to do so. We are absolutely—

David Stewart: I am sorry to interrupt. That sounds very positive, but will you meet your 2018-19 sickness absence target of 5 per cent?

Pauline Howie: As Tom Steele said, we are sitting at a similar sickness absence rate to last year's. We are not complacent, and we want to do more to support people to be well and to attend in the best of health.

David Stewart: I will push you on that, because you did not really answer the question. What is the 2018-19 rate currently sitting at? Obviously, we have not completed the year, but you will know what the trend is from your human resources department.

Pauline Howie: Yes, the target remains at 5 per cent, and—

David Stewart: What is the rate now?

Pauline Howie: As Tom Steele said, we are sitting at a sickness absence rate of 7.6 per cent at the moment.

David Stewart: It that the same as the rate was in the previous year.

Pauline Howie: Yes.

David Stewart: What you have suggested seems to be a sensible management approach, but the rate has not changed at all. What is the cost to your organisation of that level of staff absence?

Pauline Howie: We monitor abstractions and we try to cover as many of them as we possibly can. There are a number of ways in which we can provide cover: for example, we have relief staff built in for a predicted level of sickness absence, and we can ask staff to work additional shifts.

The additional investment in our service means that we have over 500 more staff in place than we did in 2015. Our shift coverage rates have significantly increased.

David Stewart: You might not have the figure in front of you, so it is not fair to ask you for the detail, but what difference does a 7.6 per cent sickness absence rate, rather than a 5 per cent rate, make to your budget? I presume that a higher rate adds costs to your budget because you have to cover staff who are on long-term sickness absence.

Pauline Howie: Yes.

David Stewart: Has your finance department calculated the cost to your budget of having an above-target sickness rate?

Pauline Howie: I cannot give that figure off the top of my head, but—

David Stewart: I did not think that you would be able to.

Pauline Howie: I can certainly get back to you, because we monitor that through our finance department.

David Stewart: Thank you very much for that.

The Convener: That would be helpful.

Emma Harper: I have a couple of questions about primary care. I am interested in the jobs that people do. We have ambulance care assistants, paramedics, specialty paramedics and technicians. I do not want people to think that technicians are just drivers, because both paramedics and techs drive and care for people. I want to get it out there that paramedics and technicians are highly skilled when they are crewing ambulances and resource cars. There are some differences between the two—only paramedics can give morphine, thrombolising agents or tension pneumothorax. What other differences are there between the two jobs? Will you make it clear that all those staff are competent and skilled professionals?

The Convener: When responding to that question, please also refer to the shift in the balance of the workforce.

Dr Ward: Emma Harper is absolutely right. All our patient-facing staff provide clinical care, including our ambulance care assistants on patient transport, who have a duty of care from the second they arrive.

The bulk of our clinical care is provided by a combination of paramedics and technicians working as a team. Emma Harper is right that both paramedics and technicians are clinicians and that there are some differences in their skill sets. We have recently been looking at advanced practice. Donna Hendry is a good example of that stratification in the workforce.

Our new clinical response model categorises time using a colour-based approach; it also defines the skill set. For example, if we have a patient with a condition that we think will require paramedic intervention—that will be based on the fact that patients in that code often require such intervention—we will aim to send that help to them.

11:00

We are also investing a lot in guidelines, additional training, additional equipment—major trauma is a good example; we have completely transformed the kit for that on our ambulances—and new medicines. As much as we can, we make those medicines available to everybody, and associated training and support is required to follow that through.

We are becoming an ever more relevant part of the primary care system. Often, that involves working in partnership with GPs and conveying patients to definitive care, but more and more we are seeing models being developed and tested in which paramedics, including the specialists, work within a practice and see patients, which is an interesting development.

We have to be careful to maintain our core business, which is always balanced against such areas of thinking, but the potential role of the Ambulance Service is becoming more apparent across emergency care as well as urgent and primary care. It is a testament to our staff that they are willing and able to step into that space.

Emma Harper: You picked up on the point that the Ambulance Service is doing more work in primary care. I am aware of programmes in my South Scotland region, in Stranraer, Newton Stewart and the Machars, that are testing models in which the Ambulance Service, instead of a GP, will assess or triage a patient, or go to someone's home to treat hypoglycaemia or some such thing. I am interested in that and in the models that we now have using specialist paramedics. Are we looking at training more of them so that wider primary care support can be given?

Donna Hendry: At the moment, we specialist paramedics in Fife work in out-of-hours primary care. We also helped for a wee while at one of the local GP surgeries that did not have enough GPs. We do not profess to be GPs, who are obviously specialists, but we can cover a lot of what callers to the GP require. We can make home visits and treat things such as chest infections and abdominal pains that are brought to the surgery.

Out of hours, we make all the home visits apart from in specialised areas such as palliative care or mental health; the GPs, with their high level of clinical skill, deal with those. That work gives us the opportunity to develop our skills with minor injuries and illness, as opposed to the emergency setting, and we are given some mentoring, too, in most situations. That helps us to develop as specialists and, potentially, to become more advanced specialists.

I want to emphasise the great skills of other crew members; we work as a fantastic team. As part of that team, I can use what we call D2 resources instead of an ambulance. If one of my patients needs to go to hospital and does not have transport, I can arrange it for them. There are various vehicles that we can use instead of emergency ambulances, which we need for immediately threatening calls. For example, we can use our ambulance care assistants, who provide transport vehicles, or a technician vehicle.

We sometimes have an urgent vehicle, which has a technician and an ambulance care assistant. They provide the same kind of emergency care as somebody would get anywhere else, because the vehicle is full of all the ambulance kit. The difference between the care provided by a technician and a paramedic concerns invasive techniques such as administering intravenous drugs or more complex care such as chest intubation, which was mentioned earlier.

Emma Harper: Is it too early to assess whether keeping patients out of hospital is being cost effective? Have the models been in place long enough for us to assess the value of keeping people out of hospital, which carries an additional cost? Our goal is to support people at home as much as possible.

Pauline Howie: We based our evaluation on wider work that had been done by the Nuffield Trust, which reported in March 2017 on the economic value of community paramedics, as Donna Hendry has described. It showed that, for every £1 that is invested in community paramedics and the wider reform programme that we have spoken about this morning, there is a £4 return to the wider health and social care economy. We built a case around that, and the evaluation of our model so far bears that out.

Tom Steele: Increasingly, we are able to track the journey of the patient. We have recently done a lot of work with the Information Services Division on the issue of matching records because, frequently, we do not have the exact level of detail that the hospital has. We are now using fuzzy matching techniques and are getting much better end-to-end information, including on patients who have stayed at home.

It is important that we start working closely with the integration joint boards and the health and social care partnerships because they are increasingly developing new pathways for patients, and we can play a significant role in that, as Donna Hendry has indicated. That will continue to become a much greater part of the work that is being done as the pressures on general medical services and GPs become greater. We are having early discussions with IJBs in that regard. That is a significant development for the future.

Miles Briggs (Lothian) (Con): I want to return to some of the issues that David Stewart touched on, specifically those relating to single-crew ambulances. I know that, in 2008, the then health secretary, Nicola Sturgeon, said that single-crew ambulances would be used only in exceptional circumstances. Over the past four years, there have been 10,000 single-crew ambulance journeys. What is the picture today, and what work is going on to end that practice?

Pauline Howie: We have detailed action plans in place to reduce single crewing so that it happens only in extremely exceptional circumstances. I can report that we are making improvements, although we are not where we want to be yet. We have a trajectory that will get us to below 1 per cent of journeys, which is the figure that we think would reflect those extremely exceptional circumstances, by next year. The action plans are very much linked to our recruitment and training and development strategies, which is why we are not there yet. However, I can give an assurance to the committee that we are making improvements on that trajectory, in line with those expectations.

Miles Briggs: Patient transport is an issue that MSPs raise regularly. I have visited your call centre in South Queensferry and have also seen NHS Lothian's patient flow centre, which I think is making a big difference—I know that other health boards are looking to replicate it. On my visit, I met the embedded ambulance crew there and learned about how it is playing a role in that.

As we look to the future, in my region, I know that more will be going on at St John's hospital, with the regional treatment centre. However, I would like to know what work is being done to redesign efficient transport systems. The committee touched on that in 2013.

Pauline Howie: When we were here in 2017, we were able to tell the committee that we had achieved the objectives that had been set out with regard to redesign at that time, which were to improve punctuality in getting patients to and from their appointments and to reduce cancellations. Since then, as you describe, we have been working with health boards to understand how services are changing in line with changes to out-patient services, renal services and cancer services, for example. We work closely with regional planning fora, with the health boards and, as Tom Steele has described, with IJBs with regard to service changes. We try to flex our model as best we can.

We have also tried to understand what alternative providers might be available in communities, for patients who do not require the clinical skills of our ambulance staff. A great example of that is the Lothian flow centre, which has a database of providers that are available for patients. We also have such databases in our ambulance control centres, to enable call handlers to signpost people to alternatives where they exist. We continue to engage with people, and we expect to continue to flex our service to meet future demand by patients who have a clinical need for it.

Miles Briggs: What changes need to be made to put powers in the hands of ambulance drivers and paramedics? My other question is perhaps for Donna Hendry. In which areas are you not being given the skills that might help you to prevent people from being taken into hospital? You have outlined cases in which you have been involved and in which you have not had those. A point that has been raised with me is the ability to discharge. I feel that the committee should undertake work to see whether that would make an improvement.

Donna Hendry: We already have a lot of see-and-treat services, in which we can discharge patients once we have treated them. However, we often refer patients to their own GPs for review if they do not get better. Bear it in mind that we only get a snapshot—we see patients for only a short time, and we do not know their history or how they get on afterwards. The safest option is to refer the patients whom we discharge. For example, if a patient with diabetes has a hypoglycaemic attack, we will be able to treat that without a problem. However, if that happens regularly and their diabetes is not controlled, they might need to be seen at a diabetic centre or by their own GP. That option is available to patients, but they need to take it up themselves. Therefore we do discharge patients after we have seen treated them for such conditions.

Tom Steele: I want to follow up Miles Briggs's question. The patient transport service is an

extremely important part of what we do. It provides access to healthcare that would not otherwise be available to a significant part of the population. Mr Briggs also touched on hospital discharge. A number of our large hospitals now have ambulance liaison officers who work closely with hospitals' acute teams to speed up discharge activities and make them more efficient. Pauline Howie might want to say a little bit more about that. The service makes a significant difference to overall patient flow through the acute hospitals.

Pauline Howie: Hospital ambulance liaison officers are very much part of hospital flow teams. Daily, and sometimes more frequently, they join meetings of the wider hospital teams to understand which patients might be ready to be discharged and how we can ensure that we can best match their needs. That also helps with the wider flow of unscheduled care across local systems, so they are a very valuable resource. They were introduced a couple of winters ago, but we are now keen to continue with them throughout the year, because they evaluate cases very well.

David Torrance (Kirkcaldy) (SNP): Good morning, panel. What impact has the creation of the new Scottish trauma network had on service delivery and planning?

Pauline Howie: The Scottish trauma network is a very welcome development for the Ambulance Service, which works across the regions as a member of its implementation team. Committee members will be aware that the north and Tayside trauma centres are now live. Earlier, I mentioned the SCOTSTAR north base that will be live from April this year. We have also invested significantly in equipment and skills for our people—and also in triage arrangements, on which Jim Ward might want to say a bit more. We now have a dedicated call-handling and dispatch desk in ambulance control so that we can identify trauma patients much more accurately and get the right resources to them first time, thereby improving outcomes.

11:15

Dr Ward: As the network matures—and especially as the four major trauma centres and the trauma units come into being—it will have a huge impact on us, and that will put the onus on our clinicians to make the right decisions around definitive care. At the moment, we are testing a trauma triage tool, which is used to match a decision on how unwell a patient is with a decision to, say, drive past a trauma unit and take the patient to a major trauma centre.

Pauline Howie has mentioned some of the elements that are being put in place but, in addition to that, I would just mention our first advanced critical care practitioner cohort, which is being set up in Edinburgh. There are therefore opportunities right across the service with regard to ambulance control improvements, our specialist retrieval requirements and our A and E ambulance fleet.

Perhaps at this point I should say something about the whole issue of definitive care, given that it is the essence of the establishment of major trauma centres. Not only is that having an impact on us in the area of trauma, it has had a long-standing impact on heart attack centres where percutaneous coronary intervention is carried out. We are seeing more and more centralisation of children's services—for, I would say, good reason as far as specialist provision is concerned—and, although we have stroke units at the moment, the Ambulance Service will, as our thrombectomy service comes into being, have ever more responsibility with regard to understanding patients' needs and getting the pathways right. Trauma is a live, active and interesting challenge at the moment but, given the Ambulance Service's responsibility to glue a lot of these pathways together, another huge responsibility for us is to carry out more regional and local planning.

David Torrance: Have the two centres that have been opened—Aberdeen and Dundee—improved outcomes for patients?

Dr Ward: The data on outcomes is pulled together by the Scottish trauma audit group, or STAG, but it would be fair to say that, at this stage, we do not have enough data to support any view in that respect. The outcome will be based on a number of processes and will require a clear understanding of bypass protocols, triage and the like, but STAG has a long track record of publishing really good evaluations and will be the source of the outcome data that will be generated.

The Convener: But it will, I think, confirm that the major trauma centres that are now in place are already affecting the operation of the service in the regions concerned.

Dr Ward: That is correct.

The Convener: That is excellent.

Sandra White: I will follow up on the really important issue of patient transport as well as on some of the financial aspects, although one of my colleagues is going to ask about those, too.

You mentioned a depot in East Lothian that has a patient transport database, and you talked about closer working with IJBs and the voluntary sector, with the aim of using ambulances less for certain things. I think that that is important, but, given what has happened with IJBs, will we ever reach a point at which every area will have a patient transport database to ensure that ambulances—or, indeed, taxis—are not used for certain tasks?

How far can we go in that respect? Such an exercise is costly not just in financial terms but, for those being transported in ambulances or whatever, in terms of time.

Pauline Howie: It would be fantastic if we had such a database. The last time that we tried to understand the position regarding the alternative provision that is out there, we found more than 1,000 different providers, and they were working to different criteria at different times of the day and on different days of the week. Ensuring that such a database was kept up to date would be quite a challenge, but we know of a range of different providers that our patients, their carers and others can access reliably. They are certainly on our databases, and we are really keen to add to that list as often as we can.

You are right in saying that the integration joint boards, the community planning partners and the transport authorities are key partners in helping us to understand the alternative provision that might be out there to support patients. We work closely with those organisations. We also have ambulance liaison groups in the NHS boards, through which we try to share information so that, between us, we can help patients to navigate to the right support for their needs at the time.

Tom Steele: I spoke earlier about our working increasingly with the IJBs right down to the locality level. We are a national service, but, increasingly, we are having to deliver on three different levels: on a national level—for example, the trauma network, which David Torrance mentioned, is a national network and we have to plan on that basis; on a health board level, because each health board has a different number of hospitals, facilities and pathways; and on a health and social care partnership level. Increasingly, the value of those partnerships will be seen in their direct impact on the patient. It is helpful to think of it in that way. It is a new way for us to start working in, but, from discussions that I have had with IJB accountable officers, they seem to be increasingly keen to engage with us.

Sandra White: One concern that constituents and patients have is that, if they get into an ambulance or patient transport at 9 am, they might not get home or to the hospital until three hours later. Unfortunately, that is the norm, which is why I wanted to ask whether we could get a patient transport database.

For patients in Glasgow Kelvin, it is easy to get to hospital, but it is much more difficult and costly for patients who live up north or in the islands. Have you looked at that situation? When patients come from the islands or Oban—perhaps with a family member to accommodate—sometimes they come down in a taxi, never mind an ambulance, and that means an overnight stay. Will you look at that issue for those in far-flung areas?

Pauline Howie: We work closely with health boards, and you might be aware of the different ways of providing out-patient consultations, such as through video technology. Some island communities are big users of such consultations when they are appropriate to the patients' needs. In very remote areas, we also have arrangements whereby, if we have capacity on our patient transport vehicles, we try to help patients who might not strictly meet the clinical criteria but whom it makes sense for us to get to their healthcare appointments. We flex the service where it is possible to do so.

Brian Whittle (South Scotland) (Con): When we conduct these investigations, we tend always to look at the negatives, but I hope that you recognise the high regard in which the committee holds our front-line staff. Sometimes, politicians and the media could improve the language that we use when we discuss healthcare.

We recognise that you are being asked to deliver a crucial service under increasing financial constraints. The board expected to break even at the end of the financial year; however, as of October, there was an overspend of £1.3 million. I know that there were reasons for that overspend, but has it been addressed and will you be back on track to break even by the end of the financial year?

Pauline Howie: There has been significant investment in our service, but significant cost pressures and challenges remain, as you suggest. We have had an intensive efficiency identification programme and delivery plan in place, and we are on track to achieve our financial targets this year. The board is concerned that, at the moment, some of those savings are being achieved on a non-recurring basis, so we have been working closely with our staff, their representatives and managers across the service to understand where the opportunities for better value are. We benchmarked our performance on efficiency and effectiveness against the Lord Carter review of English ambulance services. We compare very well, but we are not complacent and are working to understand where we might make more savings.

Given that we are at the stage of developing our three-year national plan, we will shortly present to our board a best-value pipeline of ideas for over £8 million of savings that we want to achieve in the coming financial year to help us to meet our financial targets next year.

Brian Whittle: Audit Scotland reports that the SAS is relying on recurring savings to meet financial targets and that the board recognises that that is not sustainable. Audit Scotland refers to the management forecast that recurring savings in excess of £27 million are required for the service to continue to operate in a financially sustainable

way and that that represents a significant challenge. Do you consider that that level of savings is achievable while maintaining the level of service that you want to deliver?

Tom Steele: Can you confirm that you referred to £27 million?

Brian Whittle: Your management forecast is that, by 2022-23, recurring savings of over £27 million will be required for you to continue to operate in a financially sustainable way.

Tom Steele: I personally do not recognise that figure. Perhaps the chief executive does, so I will let her respond in a minute.

I assure the committee of the importance to the board of addressing financial matters. As you rightly say, we were in significant deficit halfway through the year, when the chief executive referred to a programme to find short-term savings, which we have found successfully. More important, that approach is not a one-off but will be embedded in the organisation going forward. It is for that reason that we, as a board, are committed to reducing any reliance on in-year savings and to returning to a sustainable basis.

On your question about what happens going forward and whether we can sustain everything that we want to do, we are funded for next year in an appropriate way. Beyond that, we are preparing our three-year plan and will await feedback from the Government on that.

The Convener: Does Pauline Howie want to comment on the three-year financial plan?

Pauline Howie: The figure that Brian Whittle referred to is probably what the cumulative figure will be by 2022-23, and there is no doubt that that is a challenging ask of the service. However, as the chairman said, we are working very closely with staff, staff representatives and managers to identify opportunities to improve value and make savings. As I said earlier, in relation to new ways of working, we are able to demonstrate that there is economic value to investment in the service that benefits the wider health and social care economy.

Brian Whittle: Inevitably, the opportunities to make those cost savings diminish as you identify them. Is there a concern that front-line services will suffer if you continue to squeeze?

Pauline Howie: When the board makes its assessment of whether to agree our savings programme, front-line service provision will be the top priority. We do all that we can to protect front-line service provision. Certainly, the savings programmes to date have not adversely impacted on front-line service provision, and it is our aim that that will continue to be the case.

The Convener: Are you confident that it is possible to continue to bear down on costs in the way that you describe without affecting the core services that you provide?

Pauline Howie: As I said, we are focused on achieving the financial targets that have been set for us. We have indicative allocations for next year, and we are taking proposals to our board next month around our budget for that year. We are in the process of developing the three-year financial plan, and we have to work on assumptions that we will agree with the Scottish Government in that time.

Sandra White: With regard to the figures for financial sustainability, I note that there was an overspend of £1.3 million for 2018 because of the cost of diesel, travel and subsistence. Does the ambulance service get discounted fuel?

Pauline Howie: We have a procurement process that gets us discounted fuel and we look to ensure that that is best value for the public purse. I mentioned the benchmarking with England, and we are constantly benchmarking to ensure that we get the best from any procurement opportunities. We collaborate on procurement across UK ambulance services, NHS Scotland and the Scottish public sector. We take advantage of all those opportunities, and over 90 per cent of our non-pay spend is through collaborative procurement opportunities.

The Convener: Miles Briggs has a final supplementary question.

Miles Briggs: My question is on financial management. The statistics that we have show that overtime payments reached over £6 million in 2017-18. Where do staff shortages and overtime stand today?

Pauline Howie: I am pleased to advise the committee that the overtime figure is coming down. I mentioned earlier that we have 500 more staff now than we had in 2015. Because those additional staff are now trained and focused on delivering services to patients, we have been able to reduce overtime. There are also one-off reasons why we have overtime, such as staff being in training and Scotland hosting events such as the European championships.

The Convener: I thank all our witnesses for their very full answers to a range of questions. In the course of those questions and answers, some points were raised on which witnesses have offered to provide further information. In addition, there will be points that we would like to follow up with you in correspondence—you will hear from us shortly on those. Thank you very much for your attendance today.

11:32

Meeting continued in private until 11:50.

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