OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 2 February 2021

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 2 February 2021

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HEALTH AND SPORT COMMITTEE
4th Meeting 2021, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Donald Cameron (Highlands and Islands) (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:

Pauline Howie OBE (Scottish Ambulance Service)
Lyndsay Lauder (Scottish Ambulance Service)
Tom Steele (Scottish Ambulance Service)
Gail Topping (Scottish Ambulance Service)
Dr Jim Ward (Scottish Ambulance Service)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Tuesday 2 February 2021

[The Convener opened the meeting at 10:00]

Scottish Ambulance Service

The Convener (Lewis Macdonald): Good morning and welcome to the fourth meeting in 2021 of the Health and Sport Committee. We have received apologies from Alex Cole-Hamilton.

I ask all members and witnesses to ensure that their mobile phones are in silent mode and that all other notifications are turned off during the meeting.

The first item on our agenda is an evidence session with the Scottish Ambulance Service. I welcome to the committee: Tom Steele, chair; Pauline Howie OBE, chief executive; Dr Jim Ward, medical director; Lyndsay Lauder, director of workforce; and Gail Topping, who is a paramedic at Livingston ambulance station. Thank you all for joining us today and for the information that you provided to the committee in advance of the meeting.

We move straight to questions. I will direct questions in the first instance to either the chair or the chief executive, but if other witnesses wish to contribute a response to any of the questions, please enter an R in the chat box. I will take questions from committee members in turn. I will ask the opening questions, the first of which is for Pauline Howie. How has the workload of the SAS been affected by the response to the Covid-19 pandemic?

Pauline Howie OBE (Scottish Ambulance Service): The Scottish Ambulance Service started dealing with Covid patients very early on in 2020. It quickly became apparent that we had to mount an organisation-wide response to ensure that we could continue to provide safe and effective ambulance services and protect our staff. I am pleased to advise the committee that we believe that we have done that. Indeed, we have introduced some new, innovative working practices, working closely not just with our staff in the service but with patients, communities and partners across the wider system.

Initially, at the time of the first lockdown, our workload dropped quite dramatically. From April 2020, there was a decrease of around 13 per cent in unscheduled 999 demand. As lockdown measures eased, demand started to increase, and it was back to normal levels around about August. As more restrictions have been introduced, demand has fallen again.

I am pleased to report that we have managed to maintain our cardiac arrest response outcomes during that time, despite some particular challenges with response times because of the enhanced infection prevention and control arrangements that we have had to put in place.

Interestingly, although unscheduled demand has decreased overall over that time period, demand for mental health calls has increased. There has been a 9 per cent increase in mental health presentations to our services, and mental health presentations now represent 6 per cent of all calls to the Ambulance Service.

Our scheduled care—our patient transport activity—has declined. As lockdown restrictions eased and more clinics started back up, we continued to service out-patients, renal and oncology patients and discharges. We are now operating at about 70 per cent of previous activity levels in our scheduled care services. That is largely because a lot of out-patient services that were previously provided face to face are now being provided through digital technologies such as Near Me.

We also introduced some new ways of working, not just in relation to staff who were office based and had to switch to working from home but in our ambulance control rooms. We put enhanced call-handling arrangements in place so that we could identify potential Covid patients early on and provide additional support for critically unwell patients.

We enhanced our triage and consultation arrangements, particularly through advanced paramedic and nurse practitioners. Recently, in the third wave, they have been handling about 12.5 per cent of all 999 demands. That has meant that about 45 per cent of those patients do not need to go to accident and emergency departments and can instead be referred into community pathways, which ensures that they get the right care at the right time in the right place. That was always part of the service's strategy.

Working closely with partners such as Loganair, we enhanced our air ambulance responses to ensure that we have suitable larger aircraft to deal with the enhanced infection prevention and control arrangements. Air ambulance activity levels have slightly declined and are around the 2018-19 levels of activity.

We increased our staffing, and I am pleased to say that many of our recent retirees were keen to come back and support us. We had support from students in wave 1, as well as from agencies such as the British Red Cross, the St Andrew's Ambulance Association and the Scottish Fire and

Rescue Service. We supported the establishment of the Covid assessment centres and, more recently, the flow navigation centres, as we have begun to redesign and enhance urgent care services.

In late June last year, we were asked to establish mobile testing units, and we set up 18 new units within eight weeks. Recently, we have been asked to extend that number to 42, and we are on track to do so by March.

Even with all that, we have continued to save lives; to ensure that we take care to people in their homes or as close to their homes as possible; to support our staff with enhanced training, equipment and supervision; and to support the wider system in its response to the pandemic.

The Convener: In that comprehensive answer, we heard about a significant increase in the number of cases in which mental illness or ill health is the issue. My next question is for Gail Topping. From a paramedic's point of view, given the nature or culture of the cases that you are traditionally trained to deal with, how has that increase impacted on your and your colleagues' working lives?

Gail Topping (Scottish Ambulance Service): It has certainly been challenging; we are no different from wider society with regard to the struggles that we face as human beings. However, in work, we respond to people who are acutely unwell, whether that is physically or mentally. With the enhanced personal protective equipment that we use, the human interaction is sometimes lost. Part of my care of a patient would be to hold their hand, reassure them and perhaps even give them a hug, but a lot of that has been lost. We are limited by not being able to see people's facial changes when everyone is wearing a face mask. Normally, we pick up a lot of cues about how someone is feeling from their face, and that has been lost. Trying to reassure someone with a smile is also not possible behind a mask.

I echo the statistics that show that we are responding to a lot more calls from people who are struggling mentally with the restrictions that are in place. A number of my colleagues have responded to death-by-suicide calls, the number of which has increased. I am not sure whether that is reflected in the statistics, but it seems to be picked up on more because of what we are going through as a nation. As an organisation, we empathise with the struggles that people are facing, so it has been a difficult time for all who have been involved and for everyone who works in the Ambulance Service.

We have had to adapt. As an organisation, we are very good at adapting; one of our core duties is to conduct a dynamic risk assessment and we do that daily. During Covid, that has been no different, but the threat to our personal health is perhaps a bit more at the forefront of our minds, because, due to the cases that we encounter, we are just as much at risk as the general public, if not more so.

The Convener: Thanks very much—it is helpful to have that insight.

The next question is for Dr Jim Ward and is on the issue of hospitals receiving patients during the Covid crisis. In my area, I have heard about ambulances waiting to discharge patients into emergency departments for up to three and a half hours at a time, which has an impact on the ability of the service to respond and on the ability to provide the best possible care for patients.

Dr Jim Ward (Scottish Ambulance Service): One crucial area for us is collaboration with the wider health and care sector. Clearly, given that we are an emergency service and many of our patients need to go to the front end of hospital care, that interface with the front door of the hospitals is very important.

Often, things go exceptionally well, particularly for our most critically ill patients—the cases where we have to pre-alert and the patient goes straight to resuscitation. Generally, our experience of that has been very positive. However, the reality of working within the Covid-19 restrictions has put huge pressures on the front door of hospitals, because of the changes that have had to be made to how patients are processed—or I could say queued—with the aim of social distancing and making sure that patients who are either known to have or who are at high risk of having Covid are taken through separate pathways from other patients.

As you correctly say, on occasion, that has resulted in hospitals experiencing delays in processing our patients, particularly in the more recent wave. We are working closely at national and local levels with our ambulance service managers in the hospitals to look at solutions for managing flow, anticipating and processing demand, and ensuring that the acute sector escalates its internal processes to remove blockages at the back end of the emergency department. The aim is to avoid and manage the situations that we have seen recently in which patients have to wait in ambulances for a period that we all consider to be unhelpful and unsatisfactory. It is not just a Scottish issue; it is being faced by ambulances across not just the United Kingdom but Europe. However, the answer has to be whole-system collaboration, and those are the processes that we are following.

The Convener: That is helpful. When you talk about following a process of whole-system

collaboration, I take it that you mean that you are talking daily with those operating the emergency departments in acute hospitals about the things that you have described that would speed up admissions and discharges?

Dr Ward: Yes. It is about enhancing how we operationalise the levers that we can pull to manage demand and ensure that we have as much resource as possible available to respond to the patients who are waiting for us. However, it is also about working with other emerging strategies that allow us to safely manage people in communities to avoid their having to go to hospital where that is not in their best interests. Examples of that are our engagement with the redesign of urgent care work and our engagement with integration joint boards on pathways for patients whose needs would be best met at home.

It is very much about day-to-day operational optimisation, but it is also about the wider strategic engagement on how we deliver a lot of the objectives that we were looking to deliver pre-Covid in relation to shifting the balance of care and delivering more care at home and in homely settings and working with community care providers where that is in the best interests of our patients and their carers.

The Convener: My next question is for Tom Steele, as chair of the SAS. Jim Ward spoke about trends or objectives that were in place before Covid and how some of them have been facilitated by, or certainly affected by, the Covid situation. Have any changes happened in the past 12 months that you would hope to make permanent and are there other changes that you would want to reverse as quickly as you can?

10:15

Tom Steele (Scottish Ambulance Service): One of the upsides of the pandemic—there are not many—is that innovation has been increased not just in the Scottish Ambulance Service but across the health and social care system. Innovation has been increased in the way that we do things and, importantly, in the way that we all work together and see the problem as a whole problem rather than perhaps a siloed one. That has been an issue in the past.

Jim Ward has spoken about our work to shift the balance of care to provide more care in communities and to convey fewer people to emergency departments where doing so is not appropriate. That has been part of our strategy for a long time, and that work has undoubtedly accelerated. Jim Ward has given an overview of that.

In particular, we are looking at falls pathways, which we have now established across the country. We are looking in particular at falls without serious injury. Such a fall does not mean that the patient will not be vulnerable to falls subsequently. We can now refer them to local provision so that they can get the help that they need. Perhaps that will not just be clinical help; adaptations might be needed in their house to ensure that they have less risk of falling in the future.

Similarly, we are looking at respiratory disease, particularly chronic obstructive pulmonary disease, and developing local pathways for that. Local clinicians know their patients and what is normal for them. What is normal for them might not be normal for the rest of us. Simply conveying a person to an emergency department because the vital signs suggest that they should go to an ED is not necessarily always appropriate. We are using our data and the resources of the health and social care partnerships in particular, and we are working in close co-operation with the national health service EDs to develop much more suitable pathways.

The other area of focus is on mental health. Members have already heard Gail Topping talk about mental health patients. Frequently, attendance at the ED is not the most appropriate response for mental health patients, but if there is nowhere else to go and the patient is vulnerable, there is little option. That situation has improved significantly during the pandemic. More local pathways have been developed, and we can now directly refer to the NHS 24 hub for advice, which we can give to the patient. That means that we are able to make local provision many more times now.

In that regard, we are working closely with the police, who also have access to the NHS 24 hub. Collectively, those of us who respond to patients in mental health emergencies are increasingly not taking them to the emergency department. That is much better for the patient, and it takes pressure off the ED.

Overall, the strategy that we set out some time ago has been accelerated by the pandemic in a good way. There is closer working with EDs, and peer-to-peer support is really important. Our crews can get in direct contact with the emergency department physicians, discuss a patient, and make the most appropriate decision. Sometimes, that might mean going straight to medical receiving rather than going through the ED.

There have been a lot of improvements. Pauline Howie mentioned triaging. The remote triaging from our advanced paramedics is innovative. If it is appropriate, we can use video connections through mobile phones to talk to and see the patient. As members have heard, that is resulting in fewer attendances by A and E crews, which

means that they are available for the real emergencies.

In a strange way—this is true not just in the Scottish Ambulance Service—innovation has been accelerated. Although we would prefer there not to be the pressure on staff that there currently is and the extreme and difficult situations that they are in with the Covid response, I think that we will hold on to most of the innovations that we have made.

Donald Cameron (Highlands and Islands) (Con): In December, the trade union Unison alleged that the Scottish Ambulance Service had not reported transmission of coronavirus in the workplace, as is required by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. What is your response to those allegations?

The Convener: I put that question to Lyndsay Lauder, as the director.

Lyndsay Lauder (Scottish Ambulance Service): At that point, we had not reported any of our infections under RIDDOR, and we were confident that we had followed the regulations. Since then, we have met Unison and gone over the process that we followed, and we are working together to ensure that, in the future, if there are any reportable RIDDOR events, we report them.

We had one recent outbreak that we are reporting under RIDDOR. I am very confident that we have followed the regulations, and we have been able to provide Unison with reassurance to that effect. As I said, there is one outbreak that we are confident falls within the definition set out by RIDDOR, and we are currently in the process of reporting it.

Donald Cameron: Thank you for that explanation.

I move on to the wider impact of Covid on staff. How large an impact has staff illness as a result of Covid-19 had on the service over recent months?

Lyndsay Lauder: As Gail Topping said, and as others have highlighted, this has been an extremely testing and difficult time for our staff. Since the beginning of the pandemic, we have been monitoring closely Covid-19-related absence as well as non-Covid-related absence. We saw Covid-related absence peak towards the end of March, at approximately 13 per cent. Since then, it has declined—it has gone up a little sometimes, but it has then gone down again, and at the end of the year it was at 2.99 per cent.

Our priority has always been to put staff who have been impacted at the centre of our thinking. We support staff through weekly welfare calls. If people are absent, either because they are Covid positive or because they are having to self-isolate for a range of reasons, we keep in close touch with them to ensure that they are okay. Interestingly, our non-Covid-related absence rate has declined; it is currently about 2 per cent lower than it was at the beginning of the year.

At the start of last year, we had already prioritised the development of a health and wellbeing strategy. Of course, the pandemic has completely focused our thinking in that regard, and we have been working hard to increase the health and wellbeing and welfare support that we give to staff in a number of different areas. I can talk a bit about that later.

Donald Cameron: My final question is on vaccination. I imagine that the vast majority of SAS staff, as front-line healthcare workers, are entitled to a vaccine, as they fall within the top two Joint Committee on Vaccination and Immunisation priority groups. What proportion of staff members have now been vaccinated?

Lyndsay Lauder: We have vaccinated nearly 5,000 of our staff. I will hand over to Dr Ward, who can confirm that. As I understand it, we will complete vaccination of all our patient-facing staff this week.

The Convener: Dr Ward, perhaps you could also indicate what proportion of staff have been affected directly by Covid, if you have that information.

Dr Ward: Lyndsay Lauder's description of our vaccine roll-out is correct. We have vaccinated in excess of 90 per cent of our patient-facing staff, and there are plans to vaccinate the rest, who have not been vaccinated for a variety of reasons, over the coming fortnight.

Sorry, convener—can you repeat the extra question, please?

The Convener: I was casting back to Donald Cameron's first question to Lyndsay Lauder, which was on the reported transmission of coronavirus cases. Could you provide the number of staff who have been affected by coronavirus?

Dr Ward: I do not have that number in front of me.

The Convener: That is all right. I see that Lyndsay Lauder is looking to come back in.

Lyndsay Lauder: I can confirm that, cumulatively, 670 staff have tested Covid positive since the beginning of the pandemic.

The Convener: That is helpful. We now move to questions on the triage system.

David Torrance (Kirkcaldy) (SNP): My question was partially answered at the start of the meeting. How is the new triage system coping with the demands that are imposed on it by Covid-19?

Pauline Howie: We have continued to develop the triage system that we described when we attended the Health and Sport Committee in 2019. We have enhanced arrangements so that we can more effectively triage calls from general practitioners and other healthcare professionals. We have done that in stages to understand the impact that changes have had before moving on to the next stage.

The triage system continues to focus our responses on the sickest, most time-critically unwell patients. We focus on getting them the most appropriate and timeliest response and, as I set out earlier, we look to identify more appropriate pathways for those who do not need to go to hospital. I am sure that Dr Ward will want to explain a bit more about how we have enhanced our triage capabilities over the past few months and years.

In the summer of 2019, we undertook a comprehensive public engagement exercise on the triage system. We reached more than 1 million people—holding 1,000 face-to-face consultations with members of the public and engaging with community councils, local media, our staff, voluntary groups and many other organisations—to understand from them what they would look for in a clinically robust triage system. The overwhelming majority—more than 90 per cent of people—said that they strongly supported us prioritising our resources on those with the most time-critical needs, even if that meant that some people might have to wait a little longer.

On that basis, we have refined our systems and performance framework to reflect what is important to people, which is a timely response for the most critically unwell patients and appropriate destinations and pathways for those who have a need for care and treatment but for whom it is not a time-critical emergency.

Dr Ward: I support Pauline Howie's overview. The principles of our response model are about improving outcomes for patients and optimising a response to those who are most in need due to a time-critical emergency. We aim to identify the right response through our retrospective use of a number of years of data, matching what the patient needs with what we can provide.

In the Covid context—I will not get overly technical—we use an internationally validated triage system called the medical priority dispatch system, which we optimised for Scottish data, in terms of our response to various codes. Through our partnership with UK ambulance services in particular, we have introduced updates to the international system with what is called a pandemic protocol. If you cast your mind back to last March, the updates were done in anticipation of having a huge number of patients affected by, principally, breathing problems as a result of Covid-19.

We implemented some elements of the pandemic protocol; in the event, our standard triage systems have stood the test of time. We have used normal triage systems, with various levels of escalation, depending on demand. Those levels can be switched off and on within a few hours, depending on what is happening.

10:30

I will highlight one area of our response that has already been mentioned. In relation to our chain of response across the health community, there is a sense that the sooner an appropriately senior clinical review of a patient's needs can be done, the better the response can be directed. We have identified that up to 14 per cent of our 999 calls will benefit from a remote consultation from an urgent care advanced practitioner, and we have added that to our triage and response model. Most of the consultations are done over the phone, but 10 to 15 per cent of them are done by video. We have found that about half the number of patients can be directed to other sources of support, such as self-care, general practice out-of-hours services and NHS 24. The rest of the patients receive an optimised ambulance response based on a senior consultation, rather than just our initial triage response.

A lot of what we have done has been in response to what we expected could happen from our modelling, and in response to what we have observed. We have used the resources at our disposal intelligently, thoughtfully and innovatively.

David Torrance: It takes time for a new system to bed in. Have you made any additional improvements to the new triage system, other than those that you have already mentioned?

Dr Ward: Our biggest source of demand comes from GP and hospital colleagues. We have implemented two changes in that regard. In October 2019, in collaboration with our GP colleagues, we refreshed our process for managing GP and interfacility emergency calls. In November 2020, we delivered an enhanced approach to managing and understanding the clinical needs of patients who require the Scottish Ambulance Service to move them from A to B, in cases that are not classed as emergencies but which involve time-based transfers of between one and four hours. Both changes have been implemented, are bedding in well and set a platform for further improvements in our work with GP and hospital colleagues. As you can imagine, such work is crucial to the whole system working effectively.

The Convener: Does Gail Topping, as a paramedic who works on the front line, want to add anything about the implementation of the new triage system?

Gail Topping: The new triage system has worked very well. We are getting better support from our advanced and critical care paramedic colleagues. The support might be through telephone consultation. Those colleagues have access to patient information and data that we cannot access, so we can discuss our concerns with our peers. At the scene, we find that critical care paramedics, rather than hospital-based teams, are responding.

Overall, emergency calls that do not involve life-threatening emergencies but which relate to social care or on-going chronic illnesses are being referred through our control rooms and are not being passed to the front line as much. That eases the pressure on us.

David Torrance: My final question about public engagement was comprehensively answered earlier, so I am happy to stop there.

Sandra White (Glasgow Kelvin) (SNP): Good morning. I thank the ambulance service, the paramedics and everyone who has been involved in providing support not only during the Covid pandemic but previously.

I want to ask about response times, although you might have answered some of my questions already. The target for responding remains eight minutes, and 75 per cent of calls must be answered within that time. That was the situation before Covid. In your annual report for 2019-20, 64.7 per cent of calls for life-threatening emergencies were responded to within eight minutes, which compares with 70 per cent in 2018-19. There was an increase in the median response times across all categories of calls. Can you clarify, elaborate on or explain why there was a fall in the number of calls that were answered within the target time and an increase in median response times in 2019-20, before Covid?

Pauline Howie: Response times have been increasing gradually. From the summer of 2019, we have seen response times to the most critically ill and to other patients rise above our median aims. However, as we explained earlier, we are still meeting our aims and, indeed, we have improved on outcomes for those in cardiac arrest. As Dr Ward explained, response times are one component of the overall chain of survival, but we continue to ensure that we have a real focus on reducing response times where we can. Demand continues to increase, as it has for many years. Because of that, we asked an independent internationally renowned company—Operational Research in Health Ltd—to model our capacity requirements to meet not just our demand as it was in 2018-19 but projected demand for the following years. Since we have been enhancing our response, we have updated those modelling assumptions.

Since the summer of 2019, we have also seen a gradual increase in hospital turnaround times. As we have refined our model, we have seen more purple category calls. We have seen more abstractions, particularly recently as part of the Covid response, as Lyndsay Lauder described, as well as increased time to doff and don PPE, to clean and for staff hydration. Unfortunately, we had to briefly suspend our use of the British Association for Immediate Care Scotland responders and community first responders, to ensure that we could properly protect those responders. However, I am pleased to say that more than 570 of those responders have been retrained and stand ready to assist us, as many of them are doing in remote and rural communities.

We continue to focus on reducing response times. We have enhanced escalation procedures in place with all hospitals where we are seeing an exacerbation of the situation with turnaround times. We have introduced some system changes in the past few weeks on auto-dispatch for high acuity patients, and we have enhanced infection prevention and control support arrangements in place for our teams. In the autumn last year, we were delighted that the Government announced an additional £10.7 million of investment, which will allow us to increase our staffing by 148 whole-time equivalents by March this year. As Jim Ward has described, we are working across the whole system to redesign urgent care and ensure that there are appropriate and accessible pathways in place for those who do not need to attend an accident and emergency department but whose needs can be better catered for in their homes or community settings.

Response times remain a key focus as part of our response, and we continue to ensure that we are learning from other parts of the UK and globally about what we can do to improve response times, working as part of the wider system to ensure that we target the right response to the right patients at the right time.

Sandra White: From that information, what has just been described is similar to the new triage system, which was explained in response to David Torrance's questions. I want to ask a question that was asked at a previous evidence session, when we were talking about the target response time of eight minutes: is it realistic to have a target time of eight minutes or to have a target time at all?

Pauline Howie: As we explained the last time we were at the committee, time is one element in the chain of survival, particularly for cardiac

arrests. For critically unwell patients—those we code as purple—time is an important indicator but it is not the only indicator. That is why we are putting so much focus on linking up our data, so that we can understand 24-hour survival rates and 30-day survival rates. We are really pleased that those survival rates have been maintained; indeed, since we were last at the committee, they have been improving. We continue to focus on the whole chain of survival to ensure that we maintain and improve survival rates.

As members will be aware, the out-of-hospital cardiac arrest strategy is due for renewal. We have just completed all the elements of the 2015 to 2020 out-of-hospital cardiac arrest strategy. It is a whole-system strategy that applies not just to the Scottish Ambulance Service but to communities throughout Scotland. One of the successes of the strategy has been bystander cardiopulmonary resuscitation. Prior to the strategy, there were very low rates of bystander CPR. More than 600,000 people in Scotland are now trained and confident in commencing bystander CPR while the ambulance is on its way, which is a fantastic achievement and one that we really want to build on.

We are also looking at outcome data for other conditions, such as stroke and diabetes. Again, Dr Ward can talk much more about what we are doing in that space.

Time is important for some conditions but, as our public engagement exercise told us, although people appreciate that we should be prioritising our resources for the most time-critical cases, they do not want to wait too long, if they are not time critical, either for an ambulance response or a pathway into a local community service. That is why we continue to refine our demand and capacity modelling. We have been reporting on a wider range of indicators as part of our board pack. We shared with committee members our board pack up to the end of October, and we report regularly across a range of indicators. Tom Steele might want to say more about how we are engaging with our board to ensure that the reporting is relevant to what the public and our wider partners have told us is important to them.

Dr Ward: Further to Pauline Howie's answer, the timeliness of our response is important but it is not the singular factor in the outcome. However, because it is important, we need to optimise it, not just for our most critical cases but across the response model.

One important factor to consider is that our national response is reported as an aggregated figure and reflects the situation throughout the country. Committee members represent hugely different communities and will appreciate that the characteristics of those communities are very different, and that the constraints on ambulance response across those communities vary. In terms of improvement at an operational level, we disaggregate the data down to regional and sub-regional levels to understand it and then look to see what we can do to optimise that. We know that it is only really by getting into that level of detail that we can deliver our desired improvements for patients.

That takes us back to the question about whether we should have targets, which is difficult to answer. It is more about understanding what is happening and continually improving the outcomes and experience for patients. I am looking to give the committee the assurance that behind those national and aggregated targets is a series of workstreams where we are looking at the response not just to our highest acuity patients but, probably in equal part, to patients who do not have immediate life-threatening symptoms but who need to be assured that the ambulance service is there for them to meet their needs in a timely fashion. A lot of that means not just responding but engaging and keeping in touch with people while the ambulance is being dispatched.

10:45

Our review of targets and indicators has been somewhat paused during Covid. We had started on a whole series of work to help to illustrate the Scottish Ambulance Service's contribution to population health more widely, such as indicators around our management of patients' mental health problems, our efforts in support of reducing drug deaths and our work in relation to shifting the balance of care and working with partners.

In terms of what is probably more traditional ambulance business, it is also about understanding and articulating the ambulance service's contribution to optimising outcomes for patients who have suffered stroke or who are taken to percutaneous coronary intervention centres for treatment of their heart attacks, for example. The ambulance service's contribution to the start of that journey contributes to, but is not the sole factor in, a good outcome for patients. That is pre-Covid work that we are looking to pick up in advance of our next discussions around what will be in our annual operational plan for 2021-22.

Tom Steele: The work to redesign the measures commenced with the new triage system, which we spoke about when we were here two years ago and on which the committee has had an update today. As Jim Ward described, it goes much wider than just a response time. Although I do not mean to be flippant, even within the response times, targets can be gamed. For example, we know that most of our cardiac arrest

patients have been in our highly populous areas. If it was all about time, we could get some more motorbikes and get a paramedic to be there on time. Clearly, however, that is not the answer.

That is why we as a board have put the focus on outcomes and on joining up the ambulance service all the way through the system in order to understand where we impact the outcomes, what our part is, and what the meaningful measures around that are. The public told us that that is what they are keen for us to do. Although things have paused for Covid, we made good progress as we were working over the past year; for example, I mentioned the much greater co-operation. The Cabinet Secretary for Health and Sport has been helpful in that regard in encouraging us and others to look at what measures the public wish to see that are meaningful to the operation of the Ambulance Service and of the whole system more widely.

Sandra White: Thank you for that update. It would be good if the committee could see any update on the report and what you are actually looking at. Obviously, it is not as black and white as just the response time of eight minutes; there are other areas. It would therefore be good to see a report on that once you have finalised it.

I think that my last question has been answered, as it is about the implications of Covid for target and response times. I think that Pauline Howie mentioned that the time it takes to put on preventative PPE and so on affects the response times. Does anything else affect response times during Covid? We can all imagine how busy people are, but I would welcome anything that you would like to add around that question.

The Convener: Could you also add your prediction for the trends in response times for 2020-21, which is the year that we are in currently? How do the trends for the year look?

Pauline Howie: Our response times this year have increased across all the different categories. That is because of the additional time for the doffing and donning of equipment and for the cleaning of ambulance vehicles between patients, which is more intensive than it was previously.

As we have described, there are also more stringent cleaning requirements in the hospital bays where patients are assessed. That adds a bit of time.

As Gail Topping has described, the PPE can be quite uncomfortable, so we need to ensure that we provide our staff with time to rehydrate and cool down after wearing the equipment. We have continued to take on board staff feedback on what is appropriate in relation to PPE. Gail Topping might want to say a wee bit more about how challenging it has been. We had to pause our utilisation of first responders and basic schemes, but they are coming back on board and are contributing, particularly in remote and rural areas. Those are the main reasons why there has been an increase in response times. We are working very hard to reduce those times as much as we can.

In relation to predictions for this year, we do not yet have the refined figures for January. December was a really busy month, as it always is. At that time, we were at the start of wave 3 of the pandemic, so there were real challenges, such as increases in hospital turnaround times, which led to an increase in our response times.

David Stewart (Highlands and Islands) (Lab): Good morning. I have a number of questions on staffing. As the witnesses know, the Scottish Government published “Everyone Matters Pulse Survey: National Report 2020”. The SAS scored poorly in comparison with other health boards. Why was that?

Lyndsay Lauder: I have a couple of reflections on that. There was a 40 per cent response rate to our pulse survey, whereas the national average was 43 per cent. As you said, our figures on staff experience were the lowest across the NHS. However, I sound a note of caution in comparing us with some other special health boards and with territorial boards, because we are obviously an emergency response service with unique challenges and pressures on staff. That is reflected in the responses for similar response services in the UK. We are, of course, working very hard to improve the figures, and there is no room for complacency. However, if we drill down into the figures, we see that the responses on wellbeing generally mirror those for other health boards.

Some interesting themes came out of the survey. In order to support staff, we are taking active measures on the issues that worry them most, such as excessive workload, feeling Covid-safe in the workplace, PPE and the pressures of working from home. We have weaved those measures into our health and wellbeing strategy to ensure that we respond to the themes that came out of the survey. We have also done that for the areas that staff said gave them most support and comfort in the current environment, which included supportive peers and colleagues, family, team work and exercise.

Although our pulse survey results were a little disappointing, there are some green shoots. We improved our iMatter scores on issues such as collaborative working. We are building on that and responding to feedback.

David Stewart: Thank you for that answer but, in with regard to my question, what specific work

has been carried out to improve the experience of staff? Clearly, the pulse survey results will affect future recruitment and the retention of staff.

Lyndsay Lauder: We have put a lot of time and work into our staff health and wellbeing response. We have put staff feedback and consultation at the heart of that response. We have asked staff what would improve their experience and make their working life better, and they have given feedback on a number of themes. For example, they have given us feedback about what would help them as they respond during the Covid pandemic. They would like to have hot drinks and refreshments at hospitals. At the height of summer, they would like water bottles and a cooler uniform. We are responding to some immediate staff needs.

In addition to that, we have a medium-term to long-term strategy looking at our organisational culture and finding out what is important to staff. They want support from their leaders. They want to feel that their managers communicate and engage well with them. They want openness. We are doing a lot of work on improving our culture.

We are also improving the working environment. We are bringing in additional resources through our demand and capacity review, which Pauline Howie alluded to. We are bringing in an additional 148 staff, so there will be more boots on the ground.

We are looking at themes such as healthy working lives and healthy minds. We have talked a lot about our provision for building up the emotional and mental resilience of our staff at this difficult time.

I could go on, but I will stop and let you ask questions.

The Convener: I will let Gail Topping respond first.

Gail Topping: The organisational culture is definitely improving. I have been in the service for more than 20 years. When I started, it was a culture of, “Man up. Get on with it. Don’t raise concerns.” Anyone who raised concerns felt that they became a bit of a target. People tried to keep their heads below the parapet.

The culture has very much improved. We still have improvements to make, but now, as a front-line clinician, I am not afraid to speak up. I know that people are actively listening. We have values in the NHS. The first one would be kindness and compassion. Our leaders and managers are beginning to adopt the kindness and the compassionate leadership that we would hope to see throughout the service.

Nobody is better placed than Pauline Howie. She started holding dedicated staff engagement sessions each week during the pandemic. Any member of staff can come online to speak to her. I have never seen such engagement in the Scottish Ambulance Service. Anyone, at any level, can speak directly to the chief executive.

Lifelines Scotland is coming on board, and we have the dedicated Lifelines ambulance website. Staff have been innovative in trying to improve their colleagues’ welfare by using things like online yoga or wellbeing blogs.

The culture is turning round. It will take time, because we had a different culture for a long time. However, I see positive improvement in the work being done at all levels.

Pauline Howie: David Stewart asked about the recruitment and retention of staff. We are in the fortunate position of not having struggled to recruit and retain staff. In the past few years, we have had hundreds of application for posts at all grades. Recently, we were delighted to employ more than 1,200 additional staff for mobile testing units. We had thousands of applications for those jobs.

Our retention rates have improved since 2015. Our staff turnover was at about 6 per cent then, and it has since declined to less than 4 per cent. That is because it is very rewarding to work in the Scottish Ambulance Service. We really are in the business of saving lives and improving outcomes for patients. Every role is focused around that desire and that aim, whether someone is a member of the recruitment team or the fleet maintenance staff—every role is essential to our delivering effective and safe improvements in patient care. We very much adopt that team ethos that every role and everything that we do is important.

11:00

We have also significantly enhanced training and development opportunities for our staff across a range of roles. We described earlier the advanced practitioner-type roles, and I am sure that as the world of work develops and we take all the lessons from Covid-19 with regard to new ways of working, new roles will continue to develop. Our staff are highly valued healthcare professionals who make a huge contribution, not just in emergency care but across the whole spectrum of care from pre-cradle to the grave, in primary, acute and tertiary care.

David Stewart: I thank the witnesses for their previous answers. In particular, Gail Topping’s response about the way in which the organisation is changing was very positive.

On sickness absence rates, Donald Cameron spoke earlier about Covid issues, but I want to take us back to the time before that. I ask organisations about sickness rates because I have

always found them to be a good indicator of the health of an organisation, if you will pardon the pun. When I asked the question two years ago—I think that I asked you, chief executive—the average sickness rate was 7.6 per cent, when the average for the NHS was around 5 per cent. The rate that I have for the time pre-Covid, which is the period on which I want to focus, was 8.3 per cent. Therefore, there appears to be an underlying trend for increasing absence. I recall that Pauline Howie's answer to me then was that that absence was to do with anxiety, stress and depression, to name just three of the reasons. If you take Covid out of the equation, is the underlying trend that absence is still increasing?

Pauline Howie: As Lyndsay Lauder described earlier, this year, our non-Covid absence rates have declined to 2 per cent lower than the figure for last year. The top reasons for absence remain anxiety, stress and depression, followed by musculoskeletal injuries. As Lyndsay Lauder and Gail Topping have described, we have done a lot, focusing particularly on the top two reasons for absence. We are delighted that the Lifeline Scotland service, which is for all emergency services—for staff, retirees and their families, which is important—is now live, and enhanced wellbeing and health resources for all of the NHS and care workforce in Scotland have been introduced over recent months.

In one of our recent staff engagement sessions, we heard about work that is being done on peer-to-peer support, which is important. Gail Topping can talk more eloquently about it, but paramedics are more comfortable talking about how they feel to other paramedics. It does not necessarily have to be someone who works in the same location, but someone who understands the role, including its stressors and highlights, what it is like to sign off for the day and go home after that, how people can de-stress and what coping techniques they can use.

We have done a lot of work to understand what we can do to really support staff in their unique circumstances, given the range of scenarios that they face daily, tailoring our health and wellbeing work specifically to those findings. We have looked internationally at what is being done by other ambulance and emergency services and other health and social care systems. We are ensuring that we can take that learning and implement it in the Scottish Ambulance Service.

For musculoskeletal injuries, we introduced fast-track physiotherapy services, and there is good evidence that that is helping people to get healthy quicker and to get back to work quicker. We have invested significantly in lifting equipment, including in new tail lifts for ambulances. All of that goes some way towards protecting our staff from the challenges of the job, some of which are physical and some of which are very much emotional.

The Convener: Brian Whittle has a supplementary question.

Brian Whittle (South Scotland) (Con): Good morning, I have a question that follows on from what David Stewart said in relation to previous evidence from the Scottish Ambulance Service, when the issue of bullying and lack of support from line management raised its head. I heard about that in my surgeries at the time. How have you responded to that and dealt with it to improve communication with the work force, across all the health boards? Are you monitoring that consistently?

Lyndsay Lauder: I will pick out a couple of issues. Gail Topping talked about the staff engagement sessions and the significant efforts that we have put into communication. We are also investing in an organisation-wide development plan. At the heart of that is a foundation training programme for our leaders and managers. That focuses on some of the issues that staff have said are very important to them, such as communications, supportive rather than directive leadership, ensuring that they have the freedom to speak up and that they have good working conditions.

We are investing a lot in training for leaders and managers. We monitor dignity at work issues and grievances very closely. As Gail Topping said, we are working to change the culture of the organisation. That is a gradual process but we have seen some reduction in dignity at work grievances in the past six months. That might be a result of Covid, but we are working on several levels to improve the culture of the organisation.

Emma Harper (South Scotland) (SNP): Good morning. Thank you all—including the ambulance crews—for the work that you have done during the pandemic.

I have a couple of questions regarding the mental health of people who the Scottish Ambulance Service deals with. In February 2019, the committee heard that significant police resources were used to escort people experiencing mental health distress. At that meeting, Pauline Howie suggested that the Ambulance Service was working with Police Scotland to find better pathways to help to support people experiencing distress and that four distress intervention pilots were happening, including a street triage pilot in Glasgow and a pilot involving the police and NHS 24 in Lanarkshire. Can you tell us about the current position on pathways for patients experiencing mental health distress?

Dr Ward: Thank you for those questions. As others have said, there has been an increase in

patients presenting with mental health problems. There has been an acknowledgement that dealing with that is a hugely important part of our role.

There is a strong interface between the Scottish Ambulance Service and Police Scotland in relation to our joint responsibilities for people who present. Often, they present to SAS and a police response is required. The main concern was Police Scotland's perception that it was filling a space that healthcare provision should have been filling. We have worked very closely with Police Scotland on several different elements, including: working between our respective control rooms to ensure that we get the right and timely response to the police when they need an ambulance; joint initiatives around working together to understand the nature of the issues being presented; and, more recently, opening up new pathways to mental health support lines in NHS 24, which both the police and the ambulance service are now using daily.

Further work is required and will be undertaken as boards set up their mental health crisis centres. Many of those are established and there is a clear expectation that appropriate referrers can access those. SAS has set up a dedicated team with new leadership under Frances Dodd, our director of care quality, which is giving mental health a priority through our clinical governance committees, with a new approach to safeguarding in terms of signposting patients to appropriate services, and the board.

Emma Harper: Thank you. I am interested in issues around Covid, too. Earlier, Gail Topping spoke about the increased number of suicides and we heard that last week from the trauma network, too. It is really distressing to hear about those increases. Will you be measuring all the responses, interventions and pilot schemes and considering the outcomes to ensure that what is being changed and applied is making improvements in supporting people experiencing mental health distress?

Pauline Howie: Yes. The work that we mentioned between Police Scotland, NHS 24 and the Scottish Ambulance Service is being evaluated. We are looking at how we manage those patients, not just in their initial presentation, but in ensuring that they are supported in their on-going recovery. The distress brief intervention projects were initially set up with four pilots. Those have been evaluated well and have been rolled out into other areas, such as Moray and Dumfries and Galloway. We are involved in all those developments and the full implementation of those initiatives.

We spoke earlier about the mental health ambulance car that we set up in Glasgow. We enhanced that in 2019 with a community psychiatric nurse, police officer and paramedic. The learning from the first pilot was taken on board and we were delighted with how that evaluated. It is now being rolled out to Dundee and Inverness, which are two areas where we think particular improvements can be made. We will continue to evaluate and enhance our arrangements as necessary.

Emma Harper: It is good to hear that implementation is going forward. I was reading an education article in *The BMJ* about simulation training for ambulance personnel and the police as a way of teaching them how to engage with people who are experiencing mental health distress. Is that something that you engage in to help to support your ambulance crews and paramedics to learn about the best way to deal with people experiencing mental health distress?

Dr Ward: I am not aware that we are using simulation directly in partnership with Police Scotland currently but I will make inquiries about that.

It all comes down to communication. In her first answer, Gail Topping gave a powerful description of some of the constraints of working within the reality that is Covid and its impact on our ability to communicate with vulnerable people who are distressed and are often affected by issues of frailty, communication difficulties such as hearing problems and so on. I will look into the simulation element and I would be happy to report back to the committee on that.

We are doing a lot of work on how we enter mental health into our learning in practice programmes and how we broach the issue of shared decision making between Scottish Ambulance Service staff and the patients and carers we are working with. That includes those affected by mental health presentations.

Emma Harper: Thank you all. I commend you all for the work that you are doing.

11:15

Brian Whittle: I want to ask questions about trauma support. In 2016, the Scottish Government announced the creation of the Scottish Trauma Network with the four major trauma centres around the country. In an evidence session with the Scottish Ambulance Service in 2019, some of the witnesses highlighted the fact that assisting the set-up for the network was a large responsibility for the SAS but that it was too early to say at that time how it would improve outcomes for patients.

In an evidence session with the Scottish Trauma Network last week, we heard evidence from Peter Lindle that the investment in that service, which

included training of advanced practitioners who were then able to provide levels of care at the roadside that paramedics could not provide before, had led to improvements in pre-hospital care and outcomes for patients. What impact has the Scottish Trauma Network had on Scottish Ambulance Service planning and delivery?

Pauline Howie: Dr Ward might want to contribute as well. We enhanced our equipment and training for major trauma for all our staff and we have put in additional support in ambulance control. We now have a trauma desk so that advanced clinicians can ensure that we identify early all the trauma incidents that could benefit from the highly trained and skilled resources that you mentioned in your question.

Major trauma centres in the north and the east of the country are now live and, as you heard from Peter Lindle and colleagues last week, we are ready to go live in the next few months in the west and south-east as well. There have been solid improvements thus far and it is fair to say that our staff feel more confident and supported with the specialists to whom they have access for clinical decision support and advice. Jim Ward will say a bit more about certain enhancements that we are making.

Dr Ward: The establishment of Scotland's major trauma network is both a huge responsibility and a great opportunity for the Scottish Ambulance Service. I will list a number of the areas in which we have made progress. The first is the establishment of ScotSTAR north—both a pre-hospital and a retrieval service, which was designed from scratch to support the major trauma centre in Aberdeen.

Further support of the network has come from a bespoke model of support to Inverness, which is obviously not a major trauma centre but is an important healthcare site that supports a huge area in the Highlands and beyond. An AP model has been established, which has been designed with the ED specialist there. We recruited and trained our APs to support the south-east, as Pauline Howie mentioned, in anticipation of going live with Edinburgh soon, and established APs work in ScotSTAR at Glasgow airport to provide outreach work in the west of Scotland.

As Pauline Howie mentioned, we have invested heavily in new equipment and the associated training to enhance our pre-hospital care delivery and its co-ordination through the trauma desk. We now rotate some of those critical care advanced practitioners through a supportive critical care desk and look to align that function with a view to providing not just identification but real-time support in decision making.

I watched some of last week's session and thought that Peter Lindle gave an excellent representation of the Scottish Ambulance Service's role, and there was good appreciation of that role from the other participants. The question that was raised about making the decision to bypass the local trauma unit—how specialists in the centre provide support for that decision when it might be equivocal—is important. All that work is aimed at optimisation of the wider effectiveness of the network, which has had so much investment.

Next steps include testing and refining our trauma triage tool, and we have a dedicated programme to do that. Our business case to support the most complex trauma network—in the west of Scotland—has been developed and signed off, and we stand ready to go live with it when the system comes out of the current Covid challenges.

Brian Whittle: Ultimately, we are looking for improved outcomes for patients as well as a working environment that helps the Scottish Ambulance Service. Where is the evidence that the set-up of the centres is delivering improved outcomes for patients and staff?

Dr Ward: The evidence is collated through the Scottish Trauma Network and the Scottish trauma audit group. The Scottish Ambulance Service will measure things such as the nature of the response, response times and our contribution. As the committee might be aware, major trauma cases are defined as such after the fact, and there can then be retrospective analysis of the SAS's contribution. However, the key provider of such information is the Scottish trauma audit group, which reports to the Scottish Trauma Network.

The Convener: We will perhaps get a paramedic perspective on the Scottish Trauma Network from Gail Topping.

Gail Topping: I hope that there will be vast improvements in patient outcomes. The evidence shows that, in areas where major trauma centres have been established, survival rates and recovery after major trauma are significantly improved by transporting patients through an appropriate receiving centre. I hope that the major trauma network will reflect that evidence.

Some front-line clinicians have concerns about the increased distances that are travelled to reach the centres, but the level of support that we receive from advanced critical care paramedics helps to alleviate those concerns. There will always be a little bit of uncertainty about any change. People would like everything to remain the same for ever more, but life does not work like that. I hope that, once the network is established, it will be business as usual, we will reflect that the

new system is much better for patients and we will become more comfortable with it.

George Adam (Paisley) (SNP): Good morning. I join my colleagues in thanking the witnesses—particularly Gail Topping and her colleagues on the front line—for the work that they have done in the past year, in very difficult circumstances.

I have a simple question—well, it might not be a simple question. Last year, we discussed the budgetary pressures on the Scottish Ambulance Service and the need for a financial recovery plan. Where are you with that plan, and what impact has the pandemic had on it?

Pauline Howie: In common with other health and care services, we had additional costs in coping with, and responding to, the pandemic. Our best estimate is that the additional Covid costs for 2020-21 will be in the region of £18.5 million. About £9 million of that is due to additional staffing requirements, whether that relates to returning staff, students whom we employed or additional hours that were worked by paramedics, technicians, care assistants and so on. We also incurred additional costs such as those from the air ambulance enhancements. Our best estimate is that non-pay costs amounted to an extra £6 million. In this year's plan, we also had about £2 million of efficiency savings that we were unable to make, because our focus was on responding to the Covid pandemic.

However, in working through our draft financial plan for next year and the coming years, we anticipate that our recurring deficit will continue to decline as a result of a number of efficiency schemes that are focused not just on saving money but on making improvements for staff and patients, and our wider commitments. For example, our fleet replacement business case has just been approved by the Scottish Government. As part of that investment of more than £100 million over the next five years, we will introduce electric vehicles for our paramedic response units, patient transport service vehicles and support vehicles. We are working with manufacturers on whether we can electrify our accident and emergency vehicles, too. The latter are more challenging because of their size and weight, and the charge time, but we are determined to work towards that as part of our sustainability target commitments.

We are also looking at whether there are other opportunities in estates rationalisation. As we have seen, remote working is very possible now, and that would be balanced with face-to-face communication where appropriate.

We are looking at digital enhancements to maximise the use of technology in all our services, for example roster management and drugs utilisation and productivity. We are determined to bring the organisation into recurring balance and are making progress towards that.

The Convener: I thank all our witnesses—it has been an informative session. As a number of my colleagues have said, we are all very grateful to the staff of the service for their work in these highly pressured circumstances. I think that we have covered most of the areas that we were looking for information on but, as has been said a couple of times during the meeting, you may be able to provide us with further information and, if so, the committee would welcome that. I am particularly encouraged by what Tom Steele said about capturing and retaining the benefits of innovation. We look forward to hearing about the continuing challenge of response times and the prospect of a sustainable service.

European Union (Withdrawal) Act 2018

Food and Drink (Miscellaneous Amendments Relating to Food and Wine Composition, Information and Labelling) Regulations 2021

11:27

The Convener: Item 2 is consideration of a consent notification proposing that the Scottish Government give consent to the UK Government legislating using the powers in the European Union (Withdrawal) Act 2018 in relation to a UK statutory instrument. The regulations cover subject areas that cross this committee's remit and the remit of the Rural Economy and Connectivity Committee. Both committees have responsibility for parts of the regulations. The Health and Sport Committee is dealing with food information and country of origin aspects of the regulations and the Rural Economy and Connectivity Committee is considering provisions relating to wine.

The notification that the committee has received states that the regulations are

"based on a presumed 'no deal' scenario at the end of the implementation period."

The implementation period ended on Hogmanay. The trade deal between the EU and the UK was agreed on 24 December—the day after the notification was sent—so, in that sense, the notification is not entirely accurate. However, Scottish Government officials have confirmed that the deal does not affect the need to make the changes that are provided for in the regulations and therefore does not affect the substance of the regulations.

I draw members' attention to the paper on the regulations. Given the largely technical nature of the regulations and the fact that they respect devolved competence, the advice that the committee has received suggests that we may wish to confirm that we are content for the Scottish ministers to consent to UK ministers making this SI in the devolved areas affected. Is that agreed?

Members *indicated agreement.*

The Convener: It is further suggested that we may wish to be content that the changes being made are made at UK level. The notification indicates that there is

"no transfer of functions in relation to food information and labelling matters."

Are we agreed on that point, too?

Members *indicated agreement.*

The Convener: That concludes the public part of the meeting.

11:30

Meeting continued in private until 12:12.

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