AUDIT COMMITTEE

Tuesday 7 March 2000
(*Afternoon*)

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AUDIT COMMITTEE
4th Meeting 2000, Session 1

CONVENER

*Mr Andrew Welsh (Angus) (SNP)

DEPUTY CONVENER

*Nick Johnston (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*Brian Adam (North-East Scotland) (SNP)
*Scott Barrie (Dunfermline West) (Lab)
*Cathie Craigie (Cumbernauld and Kilsyth) (Lab)
*Miss Annabel Goldie (West of Scotland) (Con)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
Lewis Macdonald (Aberdeen Central) (Lab)
*Paul Martin (Glasgow Springburn) (Lab)
*Euan Robson (Roxburgh and Berwickshire) (LD)
*Andrew Wilson (Central Scotland) (SNP)

*attended

WITNESSES

Mr Mike Allen (Scottish Ambulance Service)
Sir David Carter (Chief Medical Officer for Scotland)
Mr Russell Frith (National Audit Office)
Mr Callum Kerr (Scottish Ambulance Service)
Mr Adrian Lucas (Scottish Ambulance Service)
Mr Geoff Scaife (NHS in Scotland)

CLERK TEAM LEADER

Sarah Davidson

ASSISTANT CLERK

Sean Wixted

LOCATION

Committee Room 1

Scottish Parliament

Audit Committee

Tuesday 7 March 2000

(*Afternoon*)

[THE CONVENER *opened the meeting in private at 14:00*]

14:28

Meeting continued in public.

Financial Reporting Advisory Board

The Convener (Mr Andrew Welsh): The first item on the agenda is the Financial Reporting Advisory Board to the Treasury—FRAB for short. The Audit Committee and the Finance Committee considered this item some weeks ago and gave comments to the Minister for Finance. He has responded with a detailed paper on the issues raised. Mr Russell Frith, the financial audit director at the National Audit Office, has also submitted a paper. Russell is in attendance and can deal with any further inquiries from the committee. I seek members' comments on the issues raised in these papers.

Miss Annabel Goldie (West of Scotland) (Con): I seek clarification on the papers appended, especially the submission by the Institute of Chartered Accountants and its public sector committee. Can Mr Frith clarify whether FRAB takes into account the discussion about "true and fair" rather than "presents fairly"?

Mr Russell Frith (National Audit Office): Yes, to an extent that is taken into account, in that the agreed opinion for resource accounts—as contained in the resource accounting manual—will be "a true and fair view".

Brian Adam (North-East Scotland) (SNP): Can you explain to a layman the subtle difference between "a true and fair view" and "presents fairly"?

Mr Frith: "True and fair" is the type of opinion that is legally required for corporate accounts; the phrase was incorporated into the Companies Acts. When it was incorporated, most, if not all, public sector accounts did not meet those standards—they were not prepared in accordance with the generally accepted accounting principles in use in the corporate sphere. As the sophistication of public sector accounting has developed, the standard of presentation and the method of calculating public sector accounts have become closer to those in the private sector and more of the opinions given on the various public sector accounts have moved towards being "true and fair".

It is generally regarded that "true and fair view" represents a higher standard overall than "presents fairly". The move, throughout the public sector, has been towards that standard.

Brian Adam: If that is a higher standard, does that imply that "presents fairly" may not be true?

Mr Frith: No. The implication is that the accounts were not necessarily prepared in accordance with the same body of accounting standards and principles as would definitely be the case if a "true and fair view" opinion was being given.

Brian Adam: I am sure that we will not want to go into all the intricate technical details, but I am not sure that I am any clearer now than I was when I first asked the question.

Nick Johnston (Mid Scotland and Fife) (Con): You say in your memorandum that local authorities are not covered by the FRAB remit, but that they are covered by the statement of recommended practice, or SORP. I know that the convener loves acronyms.

The Convener: I hate acronyms.

Nick Johnston: The SORP is endorsed by the ASB—the Accounting Standards Board. The Institute of Chartered Accountants seems to be making the case that the ASB, rather than FRAB, should set the standards for public accounts. Do I read that correctly?

Mr Frith: That is how I read it.

Nick Johnston: Although FRAB is independent of the Treasury, the Treasury has substantial influence in appointing its members. How independent is FRAB?

Mr Frith: In practice, FRAB seems to have operated so far with the degree of independence that you would expect, given the constitution of its membership, who are all well-respected people. The issue is not necessarily the independence of the members of FRAB, but the fact that the Treasury can overrule the board's recommendations.

Nick Johnston: The minister said in his letter that the Scottish Parliament and, indeed, the Welsh and Northern Irish Assemblies would have the independence from the Treasury to disregard FRAB's recommendations, if they so choose. Is it the case that the Treasury is not dictating to the Scottish Parliament which of FRAB's recommendations it should take up?

Mr Frith: That is correct.

Euan Robson (Roxburgh and Berwickshire) (LD): In one of the minister's letters, he said that the membership of FRAB might have to be reviewed to take into account the extended remit. Is that envisaged? Will there be a Scottish representative on FRAB in due course?

Mr Frith: I believe that that is one of the proposals that the Scottish Executive wishes to take to FRAB as part of the discussions.

Euan Robson: Will we hear the outcome of those discussions in due course?

Mr Frith: The Executive has said that it will come back to the Audit Committee with the results of its discussions.

The Convener: We have sought explanations and reassurances; they have been forthcoming, and for that we must thank our adviser and the minister. We now have to agree on our next step. If committee members are happy with the information that we have received, we can write to the minister to give him the go-ahead to negotiate the extension of FRAB's remit. Are we agreed?

Members *indicated agreement.*

14:35

Meeting adjourned.

14:36

On resuming—

Scottish Ambulance Service

The Convener: I welcome Mr Geoff Scaife, who is chief executive of the national health service in Scotland. Mr Scaife is accompanied by the chief medical officer for Scotland, Sir David Carter. Also with us is Mr Adrian Lucas, the chief executive of the Scottish Ambulance Service. I also welcome his colleagues, Mr Mike Allen and Mr Callum Kerr. The committee will first address Mr Scaife and Mr Lucas, although other witnesses may join in as appropriate. The committee would appreciate succinct answers, as we have a fair bit of ground to cover.

This is the second of two public evidence sessions on the performance of the emergency ambulance service in Scotland, based on the Comptroller and Auditor General's report on the Scottish Ambulance Service. We have already taken evidence from important users of the service in other parts of the NHS. As our witnesses may be aware, the committee has pioneered a new way of examining National Audit Office reports, which has included site visits.

Before I launch into detailed questions, I would like to say on the committee's behalf that we have learned a great deal from this exercise. We are grateful to Mr Lucas and his staff for the ready access that they granted us to their places of work, which we very much appreciated. I would be interested to know whether our witnesses have any comments to make on our methodology to date.

Mr Geoff Scaife (NHS in Scotland): We are aware not only that the committee is going out to visit ambulance stations and to look at control rooms, but that it is taking the trouble to examine board general managers from different parts of Scotland. The NHS is like an extended family; we all talk to one another. We have been getting reports back, and the overwhelming impression that I have been given is that the approach has been constructive and that you can now take evidence today from a position of knowledge and insight—you are not coming at this cold. The process of your inquiry is difficult to fault.

The Convener: Those comments are appreciated. I hope that we are setting a standard for future investigations.

In today's meeting, we shall be asking questions on three main areas: the performance against emergency response time targets; the scope for improving the planning and deployment of

operational ambulances; and how the service can improve the way in which it addresses the clinical and health issues that underlie its work.

I will address my first question to Mr Scaife. Shortfalls against response time targets occur not only in the more remote areas but in densely populated towns such as Glasgow and Edinburgh. The service has not met the national targets to respond to 50 per cent of emergency incidents within seven to eight minutes and to 95 per cent of incidents within 14 to 21 minutes. Moreover, it has not achieved the targets to answer all 999 calls within 10 seconds and 95 per cent of doctors' urgent calls within 30 seconds.

Figure 7 on page 26 of the NAO report shows the service's varying performance throughout Scotland. Why have you accepted such a wide gap between the performance of the service in different parts of the country?

Mr Scaife: I will answer first your question about the response times of ambulances. You will know, at least as well as I do, the characteristics of Scotland—we have an enormous land mass, huge distances and sparsely populated areas. We consider performance in the round and we compare performance in Scotland with that in the rest of the United Kingdom. Our evidence shows that, for most of Scotland, the performance is as good as, if not better than, comparable performance in other ambulance services. We are addressing problems in Glasgow and Lanarkshire.

Since 1 April 1999, the Ambulance Service has been constituted as a special health board, which is directly accountable through the management executive to ministers. We have much greater say over what the service does and can resource the service directly. For example, in the current year we have invested extra money into the service in Glasgow, specifically to improve response times. We plan a similar investment next year, which will probably enable another 20 front-line ambulance staff to be employed in Glasgow. As a consequence of that investment, we expect an improvement in performance.

The Convener: You are making an investment, but how will you measure the success of that investment in meeting targets? The figures show that targets have been in place but have been missed for many years. Why has the service not made improvements? What are your specific plans and quantified targets to show whether the investment is meeting the need?

Mr Scaife: Our target in urban Scotland is to respond to 50 per cent of calls within seven minutes and 95 per cent of calls within 14 minutes. Performance is improving modestly but steadily against those targets. That improvement is taking place against a backcloth of a steep increase in the demand for services—in the past five years, overall demand has increased by 28 per cent. We need to invest money and encourage performance, but we must acknowledge that the Ambulance Service, like almost every other aspect of the national health service, is under increasing demand as our population rightly expects more and better services.

The Convener: Do you think that you will be able to tell us next year that you have met the targets?

Mr Scaife: We will not meet the target in Glasgow in one year. Because of increased investment in Glasgow, there ought to be a steady improvement in performance. The rate at which that improvement will be secured will depend on the rate at which additional resources are deployed. We put in an extra £500,000 in the current year and plan to invest a further £500,000 in the financial year beginning 1 April. That will take us some way towards the target but we will not achieve it in one bound.

The Convener: When will you reach the target?

Mr Scaife: The Ambulance Service estimates that that could take up to four years, given the current rate of investment.

The Convener: Mr Lucas, according to paragraph 2.9 on page 27 of the NAO report, there is a natural problem in getting ambulances to patients quickly in rural areas. Earlier, we heard about the need for close working with general practitioners and others in the community. What are you doing to ensure that people in rural areas get the health care that they need more quickly?

Mr Adrian Lucas (Scottish Ambulance Service): The report points out that our standards measure up rather well in comparison with those of services south of the border, given the terrain that we are dealing with. You mentioned GPs; we work closely with the British Association for Immediate Care and are launching a number of schemes that will improve our relationship with that organisation and ensure a speedy response to patients. Very often GPs are the first to arrive at an incident in the rural areas. We are also among the first to arrive, so our communication with GPs is very important. We have a number of schemes to improve certain patients' conditions—not least in cardiology—in the rural areas. Those involve improving response times to patients. As part of the NHS, we are only one element of the response to patients.

14:45

The Convener: Do rural areas get a second-class service? Can you ensure that rural areas get a service that is specifically tailored to their needs

and will not suffer because resources are diverted elsewhere? In improving the service, can there be a rural solution to a rural problem?

Mr Lucas: The people who work in the rural areas work those areas very well. They know the terrain well and know the weather conditions that they will encounter. Invariably, they will also know a large proportion of the population. You will notice that we measure our response times in Scotland in terms of population density; many of the areas that we are discussing are very sparsely populated. In recent years, the Ambulance Service in Scotland has improved cover in rural areas. Although many of our ambulance stations do not have to deal with much demand, they have to provide cover to extensive areas. Far from getting a second-rate service, rural areas get a very good service in comparison with the rest of the United Kingdom. We are also supported by our two helicopters, one of which is based in Inverness, and our fixed-wing aircraft.

Sir David Carter (Chief Medical Officer for Scotland): There is a big problem in rural areas. The acute services review, which appeared about 18 months ago, expressed deep concerns about the provision of an equitable service. The committee may be aware that the remote and rural areas initiative, which was flagged up in the acute services review, was designed to develop thinking and to strengthen services in remote and rural areas throughout Scotland. It has an annual budget of some £2 million and its director has just been appointed. The issue that we are discussing will not be its only concern, but there are general concerns about the provision of services in remote and rural areas.

Andrew Wilson (Central Scotland) (SNP): I refer Mr Lucas and his team to figure 17 on page 46 of the report, which shows a wide variation in costs and implies the same for resourcing. What would be the implications of transferring resources from better performing to worse performing areas, specifically within the Ambulance Service? Mr Scaife may want to comment on the implications for the NHS as a whole.

Mr Lucas: First, we must consider how the service was funded over many years—by a stream of 15 different incomes from the 15 health boards. The report states that, if we were to cull the additional resources that are invested elsewhere, that would not solve all the problems in urban areas—it would be robbing Peter to pay Paul and would not achieve a great deal. The next question would be where the resources should come from. The danger would be that the areas affected would be disadvantaged.

Mr Scaife: Clearly, our perspective is the overall financing of the service for Scotland as a whole. As Adrian Lucas said, it would not make sense to rob Peter to pay Paul. We have discussed the problem in Glasgow with the Ambulance Service and we are resourcing the improvement of service. The service is not static and we want developments across the board. More paramedics should be deployed for our front-line ambulances. Next year, we will invest an extra £485,000 across Scotland to train and employ paramedics. That will add around 75 extra paramedics to the 600 or so that we already have. We are putting resources into such improvements across Scotland and development will be evident even in those areas where the service exceeds the performance levels that are achieved elsewhere. It is not only performance against targets that is important, but the quality of care that we give and the skill level of the staff.

Andrew Wilson: Obviously, resources are not all. Will the paramedics that you mentioned replace paramedics who retire or are they in addition to natural wastage?

Mr Scaife: They will be additional staff. Most will be ambulance technicians who have volunteered to be trained as paramedics.

Andrew Wilson: Mr Lucas, paragraph 2.19 on page 33 of the document talks about the fact that the response and activation targets are being missed. That does not seem to have been analysed before the period covered by this report. In your management team, are the reasons behind poor performance being tracked? What is being done to keep a handle on the situation?

Mr Lucas: The period covered by the report starts four or five years ago, when the service had not yet become a special health board. It was accountable in many ways to the health boards, which closely tracked the performance of the service in their areas. That explains why some areas are better resourced than others.

The response times are reported on a national basis. The annual reports that the service was required to produce, even when it was a trust, will show that the times have been well recorded.

Andrew Wilson: I believe that the targets use figures from quite a while ago—I believe that 25 years is mentioned—and are based on resource constraints as opposed to clinical assessments. Is that helpful? Is it still the case?

Mr Lucas: A lot has changed in 25 years, not least the introduction of paramedics and a greater emphasis on clinical care. Like other ambulance services, we are more interested in clinical outcomes, although we are still interested in response times. Response time is important, especially to the person waiting for the ambulance.

The highly populated areas of Scotland are the only places in the UK that have a seven-minute

response time. Everywhere else, the target is eight minutes.

The world has moved on and, as the authors of the report say, we need to consider better clinical evidence for what we are doing, alongside response time and other management performances.

The Convener: We will move on to deal with priority dispatch.

Miss Goldie: Dr Morrison of Ninewells hospital told us two weeks ago that people had died because of the present first-come-first-served system. He also said that the case for a priority-based system was so evident as not to be worth commenting on and that prioritisation took place in the NHS all the time. Why have you kept the present deployment system for so long and not required the service to give higher priority to the more seriously ill patients?

Mr Scaife: Although the NAO report extols the virtues of priority-based dispatch, it also points to the need for balance, caution and evaluation. Systems have been piloted in the south during the past couple of years, but evaluations of those schemes have not yet been forthcoming. None the less, there are powerful arguments for exploring whether priority-based dispatch systems can be introduced, not just in densely populated areas—which is where they are being introduced in the south—but throughout Scotland, including in remote regions.

We have been discussing priority-based dispatch with the Scottish Ambulance Service. Ministers have agreed to allocate £100,000 next month for the service to undertake a careful review, not only of the perceived advantages of priority-based dispatch, but of how it would work across Scotland as a whole. That review will investigate whether the sums involved would produce benefits for the population as a whole, compared with other options for investing a similar sum. Ministers want to know whether there is a sound case for proceeding. Once they have the facts, they will want to consult ambulance staff and other interested parties before taking a decision.

Miss Goldie: You mentioned that information from the experiment down south had not been forthcoming. Is that because no one has asked for it, or because there is no statistical information on which to make an assessment?

Mr Scaife: As far as I am aware, there has not been a formal evaluation. Different approaches are being deployed in the south, including systems imported from America. There has not yet been an evaluation, as the development is fairly recent—the new systems have been in place only for about two years. The English appear to be deploying different approaches. There are 32 ambulance services in England and only one in Scotland. We need to see the evidence and hear an argued case. We need to understand the benefits and how the system would work throughout the country. We are resourcing that investigation. Once we have got the analysis from the Scottish Ambulance Service, ministers will consult—

The Convener: What is the £100,000 for if it is not for such an evaluation? Why have the English schemes not been evaluated? Who should be in charge of an evaluation that would be satisfactory?

Mr Scaife: That is a matter for the English ambulance services.

The Convener: If Scotland is going to investigate the idea, what is the £100,000 for if it is not for an evaluation?

Mr Scaife: It is for the Ambulance Service to decide how it goes about establishing the case. I imagine that it would consider closely what has been happening in the south and look for evidence that the approach will work across the country. We need an approach that works for Scotland.

Miss Goldie: I am not clear about this, Mr Scaife. Does it concern you that that question does not seem to have been gripped?

Mr Scaife: If there is a good case for the introduction of priority-based dispatch, if the benefits of the system warrant the investment—and we do not know what it would cost—and if the return on that investment is better than it would be simply in investing in more ambulances and ambulance staff, ministers would want to consider the case.

The Convener: But why are you not evaluating it? What is stopping you? Is it not important?

Mr Scaife: It is important. That is why ministers are allocating £100,000 for the Scottish Ambulance Service to examine the case for doing so. Ministers will then take a decision. Until we get a case from the Ambulance Service, we do not have a case for investment.

15:00

Euan Robson: Is the £100,000 to be spent on resurrecting the idea that appears in the report but was not followed through: for some experiment or pilot scheme in the Scottish Borders? That experiment in that discrete area never got going for certain obscure reasons—I do not quite know what happened there. Is part of the money going towards resurrecting that proposal?

Mr Scaife: It is not about resurrecting a proposal about the Borders, but to enable the Scottish Ambulance Service—now a special health board—to establish the facts and present a case

to ministers for investing in priority-based dispatch. We would want to get on with it.

The Convener: So it will be an evaluation of the scheme to present to ministers. Will it be adequate for the purpose?

Mr Scaife: We would certainly expect so.

Miss Goldie: I would like to ask Mr Lucas about figures 24 and 26 in the report. They show that, in 1998-99, the service saved around 300 lives by helping patients with out-of-hospital cardiac arrests—a survival rate of 11 per cent. To what extent would priority-based dispatch help you to improve performance in that vital area? How many more lives could you save?

Mr Lucas: I cannot quantify the answer to the latter part of that question, as there has been no real research. We are enthusiastic about prioritisation, but we are equally cautious. Dr Morrison, a consultant, said that as many lives can be lost through prioritisation. This is mainly theoretical, but the service is able to interrogate callers to find out whether the incident or the condition of one patient is more severe than another. By implication, we should be able to get to the patients who really need us more quickly.

Miss Goldie: But it is still the case that, in the absence of any other, competing, call, an ambulance may be required to go on what would be regarded as a facile mission for clinical purposes? The ambulance having departed, the urgent call might then come in. You are working on a first come, first served basis.

Mr Lucas: Yes. Equally, the situation described concerning the 11 per cent of patients was not achieved by prioritisation. Prioritisation is not a panacea; it is a tool, or one method to deal with a number of things. There are issues concerning the first responder programme that may also assist in the situation that you described, Miss Goldie.

The ambulances would be sent, according to the call interrogation, so yes, some more lives should be saved. However, I could not say how many, and the measure will simply be whether more lives are saved than at present.

Miss Goldie: Mr Scaife referred to the £100,000. That does not seem a large amount of money in my estimation for the significance of the task to be undertaken. Do you consider that an adequate budget for the purpose?

Mr Lucas: We are very grateful for that amount. It forms an important beginning for this discussion. The important thing about prioritisation is that the Ambulance Service cannot do it in isolation. We have been saying this for some time: very important issues are at stake, not least how other elements of the NHS relate to the service and the changes it is making. The acute services review and other developments have to be taken into account.

More important—this also applies to other parts of the United Kingdom—and as the report points out, what happens to category C patients? What route should we go down with regard to them?

The money will be extremely welcome, as it will enable us to get on and evaluate the situation. We would want any measures to be implemented throughout Scotland, but initially we would need to pilot them somewhere—probably in areas such as the central belt where they will do most good. We are grateful for that money and need to think carefully about how we will target it.

The Convener: Gratitude is one thing, but is the budget adequate for the very important purpose to which it is being applied?

Mr Lucas: It certainly is. We will be in regular discussion with the Scottish Executive on how to continue the progress that has been made.

The Convener: So, at the end of this, the Executive can expect a proper evaluation that will enable it to make a decision?

Mr Lucas: It will require that; everybody requires that. It will be our duty to provide that.

Brian Adam: To some extent, you have touched on what I was going to ask about. [*Interruption.*] On page 10 of the report, we are given an extensive series of recommendations on ways in which the Executive and the service might progress with the idea of prioritisation of dispatch. However, I am not sure what you are going to do with this £100,000; you have said only that you are going to evaluate the methodology.

Mr Robson has already referred to the fact that a pilot scheme, which was to cost £500,000, was in place but never came to fruition. You have referred to a pilot scheme that might be set up in the central belt. Can you give us a little more detail on the methodology of this evaluation of priority dispatch and details of some ways in which you might want to progress with a pilot programme?

The recommendations in this report imply that action needs to be taken fairly quickly. Can you give us some idea of the time scales that are involved from the evaluation to the pilot to any potential implementation of a priority dispatch scheme, or a series of schemes, for Scotland? From the evidence that we have received, it is quite clear that such schemes will be in place throughout England by the end of next year.

The Convener: We note with admiration your provision of appropriate off-stage noises. Who wants to answer? Mr Lucas?

Mr Lucas: I can certainly make a start. I begin by correcting a misunderstanding. The money is

being allocated to us not to start a pilot scheme, but to evaluate and consult to find out the measures that we would need to implement and to commence training. You mentioned urgency. We are dealing with this matter urgently, but a lot of work still has to be done to arrive at a prioritisation model along the lines of the English one. Our control room staff need to be trained and we will have to recruit training staff. Members of the committee have seen the enthusiasm in our control room and the work that goes on; the staff there would relish the opportunity. However, getting a response from a caller takes information technology, training and a high degree of understanding. We would want to ensure that this resource is put to best use.

I have not asked my colleague, Mr Scaife, what the Executive would want out of a priority dispatch scheme. We want to evaluate the need, to determine where we could do most good with such a scheme, and to get the training in place that would be necessary to start it.

The Convener: Brian, can we press on?

Brian Adam: I listened to some of the answers that you gave earlier, but I do not know why the response times of which you gave us details are poor. It seems that little progress has been made by the service on priority dispatch, in spite of the fact that a pilot scheme was in place a couple of years ago. Why has it taken so long to address what is clearly a problem?

Could you elaborate on your answer about why response times are not being met? You said that monitoring took place that provided evidence that targets had not been met. Have you found out why targets were not met? If so, would the answer help you to evaluate whether using priority-based dispatch would be helpful?

Mr Lucas: There are many issues related to that question. We should, first, undo the part of your question about response times. Response times throughout Scotland, except in Glasgow, measure favourably against those of English ambulance services. The problem in Glasgow results from the target of responding to 50 per cent of calls within seven minutes allied to a 28 per cent increase in the volume of 999 calls that we have been asked to deal with. That has been a major problem for the service.

We are, however, improving. A comparison of February 2000 with February 1999 shows a 7 per cent improvement in response times in the Glasgow area—we are now responding to 38 per cent of calls within seven minutes. That is still a long way from the target, but it is a vast improvement given the increase in demand during that period. If Glasgow is taken out of the equation, response times elsewhere in Scotland stand up extremely favourably—

Brian Adam: You have given one reason—the greatly increased work load—why response time targets were not being met. Is that the only reason? You have readily admitted that you are still not meeting response time targets, although there have been improvements.

Mr Lucas: Prioritisation—as the report points out—is not the only answer to improving response times. I will—if I may—continue with my previous answer.

The combination of distance and demand is an important factor and the service has continued to meet the increase in demand. Priority-based dispatch was tested a few of years ago and there was not a great deal of enthusiasm for it, other than in one area of Scotland. The result of that test is, to some extent, a moot point. It happened at the start of priority-based dispatch in England and the system was evaluated at three sites only.

The Convener: All 32 English ambulance services will have moved to priority dispatch by 2001. Why are we in Scotland so far behind, if it is such a good system? English services have moved very quickly on this.

Mr Lucas: Prioritisation is a means to an end. The English ambulance services were given revised response times, which have not yet been achieved throughout England. Their target is that by 2001 they should be responding to 75 per cent of calls relating to life-threatening emergencies within eight minutes. Many services in England are still on their way to achieving that target and prioritisation is not the only means by which that target will be achieved, although it will contribute.

Brian Adam: Priority-based dispatch is only one means of improving the service and I have detected—certainly from witnesses who have answered questions so far—a lack of conviction about its significance. That is, presumably, why an evaluation exercise is being undertaken. Are there other ways in which the service can be improved? When is it likely they will be introduced?

Mr Lucas: There is an issue about resources in parts of Scotland, not least in the central belt. We intend to roll out other systems that are being developed, such as automatic vehicle location systems, which are operating successfully in Glasgow. We are continuously learning about how to predict demand. For example, we are positioning our vehicles where we believe demand will come from. We are introducing methods of improving response times that are being used in England.

The service has been through a high degree of restructure and, as you have heard, it has been divisionalised. Those changes took time to bed in,

but now the improvements that they have caused are apparent.

The Convener: I think that Nick Johnston wants to ask a question on priority despatch, which is clearly an important topic.

Nick Johnston: Mr Scaife, you have been chief executive of the national health service in Scotland since 1993. A witness at our meeting two weeks ago said that the Ambulance Service had intended to introduce a priority-despatch service in 1995. Five years on, we still do not have such a service. Mr Lucas said that an important criterion would be to establish robust guidelines on priority 999 calls. How long will it take to establish the criteria, bearing in mind that criteria-based despatch was agreed in the UK in 1991?

15:15

Mr Scaife: In 1995 and 1996, the NHS in Scotland was organised around the internal market. The NHS trusts and territorial health boards, which were responsible for deciding on priorities and areas for investment, were both strategic planners and funders of emergency ambulance services. At that time there was discussion between the 15 health boards and the Scottish Ambulance Service NHS Trust about the idea of introducing priority-based systems of dispatch. The individual health boards, which were responsible for deciding their priorities and areas for investment, did not want to pursue that idea.

Later, an idea—not a pilot—emanated from Borders Health Board when the Borders was suffering economic decline because of the closure of mills and so on. The proposal was for job creation. It was not accepted by the health boards, which were commissioners of services.

As I explained, our system changed fundamentally from 1 April 1999. Instead of there being 15 territorial health boards funding and deciding on priorities for the Ambulance Service, the Ambulance Service was made a special health board with a direct relationship with the Scottish Executive. We have a responsibility to advise ministers, to decide on priorities and to determine the investment path.

I have explained the extra investment in Glasgow and in the training and employment of additional paramedic staff. In light of the evidence, and prompted by the information that the National Audit Office produced and by the investigation that is under way, ministers have decided to allocate £100,000 so that the Ambulance Service can undertake the study, produce the case and put ministers in a position to consult and take a decision.

There has been a fundamental change from an internal market in which there was a relationship between 15 health boards and the Scottish Ambulance Service NHS Trust to a system in which there is a direct relationship between the Executive and the special health board.

Andrew Wilson: When will you complete the evaluation to which you referred?

Mr Scaife: We have not set a deadline by which the Ambulance Service should complete the work. I am not clear exactly how long the work will take. It will take a few months to do the detailed work and to produce the argument for the investment.

Andrew Wilson: Do you expect ministers to decide at that stage—perhaps within six months—on priority despatch?

Mr Scaife: I cannot give a specific deadline. Money is being made available to allow the work to begin straightaway. It is for the Ambulance Service to do the work and produce the case as quickly as it can. We will stay in close touch with the service and it will get any support from us that it needs. There will be no hanging around on this.

Nick Johnston: I would like an answer to my first question, about how long it will take to establish the criteria for CBD.

Mr Lucas: Ambulance dispatch software is now available, although the protocols for it need to be verified. It is not difficult to do that—such work is usually done by medical consultants in Scotland—but it will take a little time. There will be opportunities to shave some time off the lead time. However, it will take time for our call-takers to get used to the new system and to become confident and competent in using the protocols.

Nick Johnston: I will move on. Two weeks ago, health board managers told us that an estimated £3 million might be required to implement priority despatch in Scotland. How accurate is that estimate? From where would the additional resources come? Specifically, would Mr Scaife have to reallocate funds from health boards to the Ambulance Service?

Mr Scaife: I was aware of the guesstimate produced by health board general managers. We do not know what the cost would be. We would have to consider whether to introduce the system for Scotland as a whole or to concentrate it in the more densely populated areas. The Ambulance Service will have to do some work on that question.

I have spoken about the extra resources that are being invested in the Scottish Ambulance Service this year and next. An additional amount approaching £3 million is being spent on the service as a whole—the patient transfer service as well as the emergency service—this year and

next. Ministers will consider the case alongside all the other competing demands.

Nick Johnston: When you make the case, you will be able to estimate the annual cost.

Mr Scaife: Yes. I think that the figure of £3 million refers to the cost of introducing the system and would include one-off costs. We would expect the annual running cost to be significantly lower.

The Convener: We will now look westwards to my native city, Glasgow, and to response-time targets.

Paul Martin (Glasgow Springburn) (Lab): Can we bring Glasgow back into the equation, convener?

Mr Lucas, paragraph 2.11 on page 27 shows that only one in three 999 ambulance calls are dealt with within seven minutes, against a target of one in two. What are the consequences of that poor performance? How does it relate to health statistics in Glasgow, which we know are pretty appalling compared with those in the rest of Europe?

Mr Lucas: Mr Kerr may have more detailed knowledge on this. Since this report was written, our performance has improved. In February, there was an important, modest improvement in our response times, despite an increased number of calls.

Your question takes us into the area of prioritisation. Like any other area in the United Kingdom most of our patients come from urban areas. That group of patients ranges from the very ill to the not-so-very ill and, at present, we are not responding to those patients in a helpful way, which is an issue that particularly affects urban environments. I do not know, and therefore cannot comment on, whether that is a big problem for Glasgow, although we know that there are many health issues in Glasgow—which obviously impact on our organisation.

Paul Martin: I repeat my question, which was about the consequences of that poor performance for the health of patients in Glasgow.

Mr Lucas: We are not talking about lives being lost, as the delay is still minimal in many cases. Waiting for an ambulance is an anxious time. We are not concerned because it is not about lives being lost; rather, as was said two weeks ago, prioritisation will result in lives being lost.

Perhaps Mr Kerr has greater knowledge of the situation in Glasgow than I have.

Cathie Craigie (Cumbernauld and Kilsyth) (Lab): I appreciate your comments, Mr Lucas, but how can you be sure, in answering that question, that lives are not being lost because of the length of response times in the Glasgow area? What evidence do you have to back up that statement?

Mr Lucas: We are newcomers to clinical audit and the honest answer is that we do not know precisely how many lives are lost. However, we are interested in quality of care—by getting to people who are alive more quickly, there is an improvement to the outcome of their treatment. We are not complacent; we recognise that we must improve our response times. That is why we have changed the rosters, put in additional resources and so on.

The problem is almost impossible to quantify. Equally, the National Audit Office's report says that much of that envelope of calls does not relate to life-threatening conditions. The proportion of such calls from Glasgow is higher than from anywhere else.

The Convener: Paul Martin holds the floor, but I will bring in Brian Adam for a quick point.

Brian Adam: Mr Lucas, you referred earlier to the fact that research had not been undertaken in a particular area, and in your last reply you said that you are a newcomer to clinical audit. Could you, in a written submission, give us details of the research and clinical audit work that you are involved in and which you believe is necessary, and say who you are working with to provide the evidence-based approach that is clearly needed?

Mr Lucas: In terms of clinical audit and clinical governance, which, as I said, are new to ambulance services throughout the UK, we are more than happy to supply that information. We are not, as we speak, involved in research and development.

Paul Martin: On page 29 of the report, figure 9 shows that 300 to 400 people in Glasgow waited more than 17 or 18 minutes for a 999 ambulance. A couple of weeks ago, your colleagues from Greater Glasgow Health Board told us that it was

"unacceptable by any standard for people to wait that long when one does not know what is wrong with them."—[*Official Report, Audit Committee,* 22 February 2000; c 189.]

How can you justify the fact that patients with serious conditions face additional risks by having to wait 17 or 18 minutes, which is a long time to wait for a 999 ambulance?

Mr Lucas: By the very nature of the situation, which we are working hard to improve, we are not here to justify it. Equally, taking those particular times as examples, nearly 6,000 patients received the service in seven minutes, because of our procedure.

Mr Scaife: We are putting in more staff on the ground. In the current year an additional 10 staff went in, and we are putting an additional £500,000 into Glasgow. We are funding the Ambulance

Service so that it can put in the equivalent of an extra 20 men and women on the ground to improve service. We are taking practical steps of that sort to improve response times. Mr Kerr is also exploring detailed improvements to the management and organisation of the service.

Paul Martin: Figure 11 on page 31 shows the poor performance of the Ambulance Service in Glasgow, compared with urban areas in England. Do you think that additional resources are needed to improve performance in Glasgow? If so, when are you going to find them?

15:30

Mr Lucas: To a large extent, that question has been answered. We have put in an additional 10 staff this year and we will be putting in another 20 staff next year. We are working very closely with the Scottish Executive to make the case for Glasgow. We know what is needed to put things right—to bring us up to the figure of 50 per cent—and that could be done over four to five years if the resources are forthcoming.

Andrew Wilson: I want to follow up on that comment from Mr Lucas and on what Mr Scaife said a moment ago. If you have allocated extra resources, there must be an outcome that you are seeking to achieve. What improvement in response time are you aiming for in Glasgow?

Mr Scaife: We would like Glasgow to reach the operational research consultancy, or ORCON, standards: that 50 per cent of all responses should be achieved within seven minutes and that 95 per cent should be achieved within 14 minutes. The latest figures that we have are for February and tell us that in Glasgow 37 per cent of responses are achieved within seven minutes, which is an improvement, and that 91 per cent of response are achieved within 14 minutes. Those figures have been achieved against the background of an increase in demand for emergency ambulances of close to 3 per cent. That means that we are chasing a moving target. There is more demand, more need and more that can be done.

We are working not only to deploy more ambulances and staff and to improve targeting of resources so that ambulances are around at peak times, but to ensure that ambulances are staffed by appropriately trained people and that there is investment in paramedics, so that when ambulances arrive at the scene of an incident they can do the right job. We are also trying to integrate the Ambulance Service better into the planning for acute hospital services and accident and emergency services generally, joining up the Ambulance Service with the acute hospital trusts across the country and with general practice.

Andrew Wilson: That is a clear answer. Mr Lucas, did you say that you were seeking to achieve the targets in four or five years?

Mr Lucas: With current funding levels, we would achieve the targets in four to five years.

Cathie Craigie: The targets were set some 25 years ago. Do they mean anything now, and is it worth trying to achieve them? We do not know what the clinical outcome of achieving the targets would be, but you are still putting resources, time and energy into trying to achieve them.

Mr Scaife: They mean something as far as equity and fairness across the country are concerned. If we are able to achieve a quality and time of response in some parts of Scotland, we should strive to achieve that in Glasgow and Lanarkshire as well. That is what we are doing.

However, Cathie Craigie's point is well made, in the sense that when the Ambulance Service investigates in detail the advantages of and possible approaches to the introduction of a priority-based system of dispatch, that will throw up questions about what the appropriate response time is for different categories of severity or urgency of condition. The debate that we are now having will be overtaken by priority-based dispatch, but until the case for that is made, I cannot begin to guess at what it will mean by way of actual targets.

The Convener: I would like to move on to the section about management of available resources.

Scott Barrie (Dunfermline West) (Lab): In answer to Andrew Wilson's question, Mr Scaife talked about targeting resources, and I would like to ask Mr Lucas about that. The service's policy is to provide sufficient ambulances to meet at least average demand. Figure 19 on page 49 shows how that can result in different levels of resources relative to demand. Have you considered what impact priority dispatch might have on available resources?

Mr Lucas: We have not done that yet, because we would be required to provide the information on that as part of the business case for prioritisation that we would make to the Scottish Executive. Prioritisation would have resource implications. We may have cause to ask about the type of response, whether in certain areas we ought to send a standard double-crewed vehicle or something else. As you say, the resources that are available to us now are geared towards meeting average demand. In some cases, the target response time is exceeded, whereas in some cases it is not. However, the requirement is to meet average demand.

Scott Barrie: I take that point. However, page 52 of the report indicates that having sufficient ambulances available

"does not guarantee the response time targets will be met."

Clearly, it is not just a matter of having sufficient ambulances available.

I am surprised that it takes as long as two minutes just to get an ambulance mobile generally, and even longer in response to a 999 call in Glasgow. How can we speed up that response?

Mr Lucas: The activation time that is laid down by the 25-year-old ORCON standards that we have been discussing is three minutes for 95 per cent of calls, so we are doing well in that area. The report highlights the fact that we need to improve our call-taking speed, and we acknowledge that. However, we are talking seconds there.

Everything comes back to availability of resources. Those members of the committee who went to Glasgow probably saw that there were calls waiting for ambulances to be allocated to them. Delays in response are not due to people being slow at getting to their vehicle. You will have seen the enthusiasm and dedication of our staff and how quickly they respond.

What can we do to improve matters? We are continuing to examine those aspects of our overall service time that affect us most. There are three elements: activation, the time that we spend at the scene of an incident and the time that we spend at hospitals. In various parts of Scotland, through our new divisional structures, we are closely examining those issues. In Glasgow, through Mr Kerr's innovation, his team spend a considerable amount of time at the hospital examining ways in which that can be improved, not only by having equipment ready to give to crews so that they are available again, but by reducing the amount of time that is taken up by our crews going to wards.

Scott Barrie: Figure 21 on page 53 of the report indicates that the average amount of time spent in hospitals varies considerably. There are examples of crews spending up to 90 minutes in a hospital before they leave a patient. I am sure that there are good clinical reasons for that. However, can you justify the large differences that exist between average times from different ambulance stations? What improvements could be made?

Mr Lucas: I do not know whether we can justify those differences, but I will try to explain them.

We have examined this matter closely. We must remember that there are differences throughout Scotland. Some of the patients that we take to hospitals in Scotland have been on our vehicles for two hours, so it is not unreasonable for the crews to continue that patient episode and take them to the ward. In a coronary care situation, for example, we are delighted to do that, because it is part of the continuity of care.

In a busy area such as the central belt, service time impacts on our available resources so we continue to look for ways in which we can bring it down. That time includes getting back equipment which is attached to the patient, so that the vehicle is fully equipped. That is often the case in fracture management and the like. Sometimes there is a lack of support in the hospitals, as has been mentioned, when portering services are stretched and our crews fill that gap. Those issues concern us, hence the use of management at the hospitals.

Scott Barrie: I accept your point about patients being in an ambulance for a long time. However, it would seem strange if that were the main reason for the variation, because in Inverness the average time was 10 minutes. Given the geographical location of Inverness, I assume that patients are more likely to be in an ambulance for a long time there, compared with Glasgow, for example, yet the average time there is 17 minutes, despite the fact that journeys to the hospital should be shorter as it is an urban area.

Mr Lucas: I am worried about a one-size-fits-all approach on this issue, because there are occasions when it is beneficial for our crews to spend time with accident and emergency consultants. Our need is to be able to get hold of those crews when we want them, and we can do that. We can redeploy them very quickly from those areas, so we are not too concerned about that.

Equally, the report stated that on-scene time should be an average of 12 minutes, but some incidents take longer than that. As long as we are performing well and bringing benefit to the patient, so be it. Where we can make that time faster, we are keen to do so, but we are also keen to give each patient the time, courtesy and care that they require.

Mr Scaife: I think it is worth remembering that we are dealing with ambulancemen and ambulancewomen, human beings who have been exposed to traumatic experiences. It is not unreasonable that we be sensitive to that and to the fact that they might take some downtime when they have handed over their patient. We should all be sensitive to the fact that these people are not robots; they are caring professionals who are doing a very good job and need support and help, which they receive in and around the accident and emergency departments of Scotland.

The Convener: That point is well made. We have seen the dedication of the crews at first hand.

Mr Lucas, you talked about a lack of support in hospitals. Can you quantify that, and tell us what is being done to eliminate it?

Mr Lucas: Scottish hospitals have sometimes reduced their portering services through various processes, and we feel that gap when we take patients to or away from wards. Another problem that affects our accident and emergency crews in particular is that some hospitals do not have admission units. However, now that we have become a special health board with six divisional managers, we have a structure that allows us to address these issues locally. So far, although it is still early days, the system is working well. The managers are in regular contact with hospitals and health boards to deal with the problem, and the situation is improving.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): That very issue was raised when we met ambulance staff in Glasgow. They told us that any time spent finding their way around Glasgow Royal Infirmary, for example, is time that they are not out on the road responding to 999 calls. Furthermore, it is ironic that highly trained personnel are doing portering work to replace important staff that the health service seems to have got rid of. As that problem will badly affect areas such as staff morale, how is the Ambulance Service addressing it?

Mr Lucas: We are using our local management structures to work with hospitals to eliminate that practice. However, we should be careful. In certain cases, it is appropriate for paramedics to take patients—cardiac patients, in particular—to the wards as part of the continuing care process. As you quite rightly point out, sometimes that is not appropriate, and we are working with hospitals to eliminate such cases. Although the hospitals have been very receptive so far, it is an on-going process and we must keep battling with it.

Nick Johnston: I want to switch briefly to the issue of control centres. Figure 22 on page 57 of the report shows how productivity varies across the eight control centres, which has led to the decision to review provision and resourcing by March 2000. Has that review produced any outcomes? Furthermore, has the review considered evidence from health boards that it might be more efficient to base ambulances at hospitals?

Mr Lucas: There are two distinct elements to that question. First, I should say that the review to the NAO will not be completed by March.

Nick Johnston: Sorry—did you say that it will not be completed by March?

Mr Lucas: That is right. The review will come out later in the year, and we have identified it in our healthy improvement programme.

One of our clear aims is to review the number and function of control centres; for example, some centres offer twilight services, and others are dedicated to non-emergency or emergency services. That said, we must be very careful about how we undertake that review, as it touches again on the issue of prioritisation. We aim to complete the review by the autumn.

However, your second question about basing ambulances at hospitals raises a different matter. There are more than 150 ambulance stations throughout Scotland; by implication, there are not that many hospitals. As we have been, and are, the extension of the hospital into the community, it is usual for us not to be at the hospital; it can take ambulances a lot longer to get from a hospital to an incident, instead of being able to respond to incidents from stations based in centres of population.

As the role of the Ambulance Service shifts, its relationship with pre-hospital care should change slightly. Our involvement in primary care and with GPs means that some of our interventions might result in a patient not having to be taken to hospital, in which case we would want to save resources for other areas. For example, we want to keep ambulances in areas such as the islands where they can respond to 999 calls.

As I said, your question raises two very distinct issues. First, we must review the number of control centres to achieve consistency, best value and standards that work across Scotland. However, the location of ambulance services is an on-going feast, from busy city areas where there will be a high demand to areas that are far from hospitals.

Nick Johnston: I take your point.

The Convener: Although I want to allow the witnesses to answer as fully as possible, I want to cover the whole range of topics. We will now discuss the issue of clinical direction and development.

Cathie Craigie: As a provider of pre-hospital care, the service must have processes that ensure that appropriately trained staff can provide an effective health care service that is delivered in line with professionally recognised standards. When we visited the training centre at Peebles, we found that the paramedics and care assistants there had a clear view of how to deliver treatment that would best benefit the patient.

Pages 8 and 9 of the report contain recommendations on improving how to address the clinical and health issues that underlie the service's work, and you have taken on board some of those recommendations such as the clinical audit and quality monitoring. However, the report also suggests that there should be more external representation on the service's boards to foster necessary changes. What is your view on that?

Mr Lucas: Your question raises several issues. The Scottish Ambulance Service is the only UK medical service with its own full-time medical director, which is an important fact that should be acknowledged. As for external input into the service, Professor Stuart Cobbe chairs a policy advisory group of eminent clinicians who bring a wide range of specialisms to the service. That group is able to help us with the earlier issue of protocols for prioritisation.

However, the Ambulance Service is a newcomer to clinical audit and clinical governance. This year we have been required to establish the clinical audit groups, which are composed of board members and other medical practitioners. We have recently appointed our own clinical audit manager to start that process off. We are looking for lay membership for our clinical governance panel.

In Scotland, it is difficult to find people who can contribute, but the non-executive chairman of the group is actively engaged in trying to do that. Since the NAO report was written, there has been a lot of movement in that area, but we hold our hands up to acknowledge that we are new to this. We are working hard to get information to flow so that we know what we can do better.

Sir David Carter: I chair the clinical resource and audit group, which has a budget of £2.6 million. It is multidisciplinary; it is concerned not just with audit but with clinical effectiveness. As a consequence of the NAO report and the discussions that we have been having, we feel that it would be an excellent idea to get the audit manager from the Ambulance Service on board with CRAG so that we can use the service's expertise to help with further development.

However, I would hate people around this table to go away with the idea that audit was completely new to the Ambulance Service. The report talks about Heartstart Scotland and thrombolysis. The committee should be aware that, since 1991, we have had a Scottish trauma audit group; the Ambulance Service is plugged into that. In preparation for this meeting, I have taken the latest cut of data from the Scottish trauma audit group relating to the Ambulance Service. The data contain information about 10,000 people, half of whom were attended by paramedics. The difference between those treated by paramedics and those treated by technicians is considered.

The committee should also be aware that, when Scotland as a whole is considered in terms of its performance with seriously injured people, we do significantly better than the predicted mortality suggests that we should, and we do significantly better than England. We can give you chapter and verse on what the Scottish trauma audit group is revealing.

We have good audit data for the transport of critically ill and injured children. The most recent cut of the data covered the 1997-98 period and dealt with 1,000 children in Scotland who required level 2 or 3 intensive care; in other words, who were critically ill. Again, the observed mortality of those children was significantly better than the predicted mortality for children so seriously ill.

We look after those children in 14 different places in Scotland, and there is a feeling that we should dispense care of that intensity in only three or possibly four sites. None of the children requiring transfer in the course of the audit to which I am referring died during transfer, but a working group is considering the issue of the transport of critically ill and injured children in case we reduce the number of sites at which we dispense level 2 and 3 care.

I could go on, but the committee should be aware that the Ambulance Service itself is looking at ways in which it can audit its performance. There is currently a pilot scheme in Dumfries and Galloway on thrombolysis, and there will shortly be another in Grampian and Highland; spine immobilisation is being assessed in Highland; and the use of analgesia by the Ambulance Service is being audited in Fife.

I am sorry to go on. I know that you are under time pressure.

The Convener: Feel free to go on. Our objective is to seek the truth and always to attempt to raise standards. Your contributions are welcome and are gratefully accepted.

Cathie Craigie: I would like to go back to what Adrian Lucas said. You have obviously already taken on board some of the points that were made in the NAO report. However, the report says that there is still scope for bringing in other professionals to give advice and to work in partnership with other health providers and other agencies of the NHS. Are you pursuing that?

Mr Lucas: Through our divisional structure, we want to localise things and bring other players on board. What I meant to say before was that we are relative newcomers but, yes, we accept that recommendation.

16:00

Brian Adam: Sir David rightly advised us that audit is on-going. Would it be fair to say that most of the examples that you gave us were not initiated by the Ambulance Service, nor were they primarily to do with the Ambulance Service? They were to do with the mortality and morbidity of patients who had been subsequently treated elsewhere, in intensive care, for example. Will the role of the Ambulance Service be looked at?

You referred to thrombolysis and a number of pilot projects. On a visit that I made, we were asked whether it might be considered appropriate for ambulancemen or paramedics to be given training in streptokinase. Would it be useful to have a pilot scheme for that?

Sir David Carter: You are right in as much as the Scottish trauma audit group audit was not initiated by the service, but was initiated largely by accident and emergency consultants. However, the Ambulance Service has been plugged into the audit from the audit's earliest days and it is possible to examine the data in detail for the Ambulance Service's contribution. The data to which I alluded give a detailed description of what paramedics did or did not achieve in terms of triage and how long it took from the arrival of an ambulance crew to get a person from the scene of an accident to hospital and so on. The Ambulance Service is relatively new to conducting an audit on its own initiative—that is why I gave examples of other audits that are being initiated by the Ambulance Service. We have an opportunity to maximise potential.

I take your point about thrombolysis. It has been a source of great frustration to people, including me, that there has not been a readily available drug. Streptokinase must be kept in a fridge. Urokinase, which can be and is used for thrombolysis, must be administered on a named-patient basis. There is, however, light at the end of the tunnel: later this year, we will get clearance to use the new generation of clot-busting drugs—alteplase and tenecteplase—that will be more readily usable by paramedics in concert with general practitioners. That will allow us to treat thrombolysis at the scene of the heart attack and to shorten the pain-to-needle time.

Brian Adam: We look forward to that.

The Convener: The ever-patient Euan Robson will finish this part of the meeting.

Euan Robson: I would like to ask Mr Lucas about maintaining the skills of rural crews. Some rural crews have work loads of about 25 per cent of those of some urban crews. Is that a cause of concern in the Ambulance Service? What measures are being taken to address the difference? Would you consider a formal exchange between health authorities or boards, or a system that ensures that crews see certain types of cases regularly, and that they occasionally see cases that they would not ordinarily see?

Mr Lucas: The report did not touch on maintaining skills and quality in care. We put a lot of emphasis on our training systems. We do that not only at the training headquarters at the Scottish Ambulance College at Barony Castle, which members of the committee have seen, but through our divisional structures. At the sharp end we are well blessed with instructors and trainers who work regularly with staff.

The Ambulance Service is also able to make use of training manikins and so on. Therefore, people who work in areas in which there is not a lot of regular practice still have the opportunity for regular training, which is, in many cases, supervised. We are not complacent about that, but we are not too concerned about it. Staff who work on islands and in sparsely populated areas go through a regular annual programme of rotation. The body that accredits paramedic training for ambulance services throughout the UK—the Institute of Health Care Development—requires us to arrange tri-annual requalification updates for our paramedics.

We recognise the needs and problems of our staff and we deal with those needs. We are trying to develop distance-learning packages, using information technology on soon-to-arrive intranet systems.

Euan Robson: Will such packages be available in ambulance stations?

Mr Lucas: All our ambulance stations have computers that are linked by modem, and we will use that system to deliver the training packages.

Euan Robson: When the committee went to Galashiels we saw how the Galashiels ambulance station and Borders general hospital are collaborating to give paramedics specific training. Is that an informal process? Does it happen elsewhere?

Mr Lucas: It is a recognised process. As I said about service time, there are certain areas in which we think that such a relationship is healthy. If ambulance crews have concerns, it can be difficult to get feedback on how successful they have been with a patient. That can be easier in a busy urban area than in a rural area.

Euan Robson: It is an invaluable relationship to develop, and credit must be given for that.

The report says that, in 1991-92, a target was set of having a paramedic in every ambulance. About 64 per cent of ambulances now have paramedics. We heard earlier that £485,000 will be invested in recruiting a further 75 paramedics. When do you think we will have a paramedic in every ambulance?

Mr Lucas: We recently put in a bid to the Scottish Executive to achieve that by 2005.

Euan Robson: How much, in addition to the £485,000, would that cost?

Mr Lucas: Apart from the money that is required, paramedics must have two years' operational experience as a technician. We must

be able to take those people off the road for the nine or 10 weeks it takes to train a paramedic, which would put immense pressure on our service. We must be realistic; it is not just a money problem. Training 75 paramedics a year, and allowing for retirement and promotion, makes 2005 a realistic target. We have taken account of those factors in our bid.

Euan Robson: If I multiplied £500,000 by five years or so, would I be close to the round total figure that would be needed to get a paramedic in every ambulance?

Mr Lucas: At current prices—yes.

The Convener: Cathie Craigie will ask the last—very brief—question.

Cathie Craigie: Page 64, paragraph 4.11 of the report says that the service has no specific targets for health gain, although such targets could be useful. Could you explain briefly why that is, when the Scottish Executive has set targets, such as halving by 2010 the number of people who die from coronary heart disease?

Mr Lucas: We have, for the first time, produced a health improvement programme for the Scottish Ambulance Service. The five-year plan is set out in an important document that includes consultation undertaken far and wide with many groups, including the 15 health boards, local health care co-operatives and the like. We consulted more than 200 bodies for information to tackle health gain. In the fullness of time, we will use audit to tell us what we could do better and, perhaps more important, what we should stop doing.

Cathie Craigie: Is that a public document?

Mr Lucas: Yes.

The Convener: I asked for brevity to concentrate members' minds. We could stay here until midnight if we wanted, but I would like to get to the nub of the issues.

Finally, we will look at clinical information and monitoring. Margaret Jamieson has some brief questions.

Margaret Jamieson: My questions follow on from what we have said about clinical audit and clinical governance. I appreciate that the Scottish Ambulance Service is new to that, but I am sure that its partners in accident and emergency services will have a great deal of knowledge to share with it.

Recommendation 1c) on page 9 states:

"The full impact of the Service's work can only be demonstrated by tracking the complete patient care pathway. For example access to hospital patient care and outcome information is required".

How can the Executive help the service and other health care providers to share that important information?

Sir David Carter: That is a good question. I alluded to that when I said that we are keen to include the Ambulance Service in the clinical resource and audit group. The service's involvement with a patient stops once the patient is admitted to hospital, but it would be useful to involve the service right round the audit loop. We want to work in partnership. There is no turf war between the Ambulance Service and the accident and emergency departments; both parties want to get closer together.

Involvement reaches even further back into the hospital. For example, the latest guidelines from the Scottish Intercollegiate Guidelines Network on the management of asthma are a good index of how successful the Ambulance Service is, as they follow a patient's entire journey. We would like that to develop from the multi-disciplinary forum that the clinical research and audit group provides.

Margaret Jamieson: Paragraph 4.25 says that capturing patient information is important for many reasons. During the sample period, however, patient report forms were absent for 44 per cent of 999 responses and for 38 per cent of urgent responses. Why do crews not complete patient report forms regularly?

Mr Scaife: We have given some examples of the pressures that crews are under and the need for turnaround. None the less, performance has improved in recent times. Adrian Lucas has figures on that, as he monitors it internally. About 80 per cent of forms are now completed, which is a marked improvement on the performance of almost two years ago when the initial fieldwork was being done by the National Audit Office. I have no doubt that the National Audit Office's prompting has helped in that regard.

Margaret Jamieson: I am aware of the technology that is available to doctors' on-call services, such as fax machines and internet access. Why is a paper transfer system being used? Why is there one set of paperwork for the Ambulance Service, another for accident and emergency and another when someone is admitted to a hospital ward? Paper can get lost and adds no value to the episode of care that the patient receives. Will there be investment in that area to contribute to the pathway of care?

Mr Scaife: Many millions of pounds are being invested in information technology and avoidance of paperwork. We have just completed an investment throughout Scotland to put computers into every general practice, and we had an 85 per cent take-up from the 1,030 general practices in the country. On the back of that, we are now

wiring up general practices and all hospitals and clinics in Scotland, so that we can transmit data between different centres.

The focus is primarily on trying to make referral discharge information, laboratory test results and so on available in real time. As we have said this afternoon, it is for the Ambulance Service to join in with that and get connected to it. The service has sophisticated computer systems for communications. The system that is described in the NAO report cost around £20 million, but as Sir David said, we need now to join up the contribution of the ambulance staff to that patient journey, and we must use technology to help us.

16:15

The Convener: You are wiring up different parts of the system, but how soon will you see complete coverage? What stage are you at now?

Mr Scaife: We are close to complete coverage for all general practices, hospitals and clinics, but we have not extended the system to the Ambulance Service.

The Convener: When do you see that happening?

Mr Scaife: There is no live proposal on the table to do that.

The Convener: Should there be? That would complete the answer.

Margaret Jamieson: That goes back to what Sir David said—we need to join up the circle, and if one part of the service is being kept outside that circle, we will never be able to audit properly or have proper clinical governance.

Sir David Carter: I am fully persuaded that that is absolutely right.

The Convener: That is unfinished business. The last word goes to Brian Adam.

Brian Adam: Gee, thanks.

Paragraph 4.28 indicates that the service does "not achieve good practice" in clinical quality monitoring. How will the service improve performance to give a more positive assurance on its health care standards and ensure that patients receive sufficient, effective, and quality health care? What is your quality assurance process like?

Mr Lucas: We have started that process through clinical governance, in which we are required to make an explicit statement about clinical effectiveness. I repeat—this year we were required to set in place a process of clinical governance. I am required to do that as the accounting officer for the service, so that we can be satisfied that our clinical processes are effective.

Where are we? We started with a new board on 1 April last year. We have invited clinicians to join that group and we have started to drill into the clinical audit to see that the quality assurance process is in place. The issue is what we want to find out from the process. It will measure a given number of situations per annum and take them forward.

Brian Adam: Given that that involves more meetings and paperwork, how enthusiastic are your staff about delivering clinical governance, clinical effectiveness and improvements in quality assurance? Do they understand the significance of those matters, or do they see them as a further burden that is being imposed on them because of yet another managerial style change that has been thought up by a bunch of gurus?

Mr Lucas: If you were to ask all 3,000 of them, I am sure that you would get various responses.

Through our training processes we are trying to encourage the need to deliver clinical governance and so on. In the past, we have been guilty of not explaining why they are needed, and your point about crews not filling in patient report forms is related to that. In addition, we must ask what we want from the patient report form. At the moment, the form does everything from answering complaints to recording good practice, clinical information and counting episodes.

We must focus on what information we want to extract from people in the future—that is part of our strategy for communications with our staff. It is a difficult process—it is about explaining the importance of such things as clinical governance to staff, from the time they join the service as new recruits, and through the regular contact that we have with them. I am sure that that message is getting through—that is why we have seen an increase to 80 per cent in patient report form responses.

Brian Adam: Have you been allocated appropriate resources to do that? If staff are doing that, they are not doing something else.

Mr Lucas: No, we have not. Part of our requirement, as a special health board, is to allocate resources. We have done that by appointing a clinical audit manager and by creating the new group, which is chaired by a non-executive member and has, through me, the ability to access resources as they are needed. Resources are not the problem; the problems are what we monitor and our newness to the situation.

Miss Goldie: Sir David, Dr Morrison, in his evidence to the committee a fortnight ago, said:

"I have studied 999 calls and there are many that should never have been made . . . people have died through

abuse of the 999 system: there is no doubt about that whatever . . . I also know of someone who dialled 999 because they took the head off a plook while they were shaving in the morning."—[*Official Report*, *Audit Committee*, 22 February 1999; c 191-92]

In light of that evidence, do you consider that an appraisal of a priority dispatch system for ambulances in Scotland is overdue?

Sir David Carter: That would be given high priority. When talking about audit of the performance of various aspects of the service, one might quickly come up with a list of four or five key indices that would be monitored as part of the regular clinical audit, performance and clinical effectiveness loop. A priority dispatch system would be one such aspect.

The Convener: Will you say what the other indices would be?

Sir David Carter: We will never lose sight of the trauma function of the Ambulance Service. Coronary heart disease is, as it should be, a priority in Scotland and the Ambulance Service can save lives by the early administration of thrombolysis. That would be one index. We need to be certain over the next few years that changes to the transport of critically ill and injured children who require intensive care retain high priority.

I would put those up front—one should not go forward on too broad a front and attempt to capture every last bit of data all the time, because people will ask why that is being done. If four or five indices are being audited because we want to know what is happening, and because we want to ensure that practice is as good as it could be, that will give the necessary motivation to those who must compile the data. It is that sort of discussion that CRAG can help with when it comes to providing a bigger forum in which the ambulance service can assess its needs. It is all part and parcel of the same process.

Miss Goldie: So is it your opinion that an attempt should be made to expedite the investigation of the appraisal system, which was referred to earlier?

Sir David Carter: Yes. The committee has heard that money has been made available for that and, as Mr Scaife indicated, it is expected that it will happen within a few months. I am working on the assumption that the investigation will happen. We would still have to make sure that we had in place the appropriate system for monitoring the results, which takes us back to the clinical audit. I see that as one of the top priorities for regular monitoring.

The Convener: This market day is wearing late. Do any of our witnesses wish to make any final comments?

Mr Callum Kerr (Scottish Ambulance Service): I would like to mention briefly the degree of commitment and dedication of the vehicle crew staff in west central division. There have been some initiatives over the past year that have resulted in a sustained improvement of around 3 per cent in the 50 per cent and 95 per cent targets. Several factors account for that, but the most significant has been the level of commitment and dedication from our vehicle crew staff—ambulance technicians and paramedics—who are working towards our ultimate goals for the greater benefit of patients.

The Convener: We have covered a wide range of topics on a crucial subject. Please pass the best wishes of the committee to the ambulance crews who serve throughout Scotland—we have seen at first hand their dedication, skills and expertise and we would like them to know that their work is appreciated. I thank all the witnesses—you have helped the committee in its work.

16:24

Meeting continued in private until 16:49.

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