Scottish Ambulance Service
University National NHS Board

NHS SCOTLAND

NOT PROTECTIVELY MARKED

Public Board Meeting	**25 January 2023** **Item No 05**

THIS PAPER IS FOR DISCUSSION

BOARD QUALITY INDICATORS PERFORMANCE REPORT

Lead Director **Author**	Pauline Howie, Chief Executive Executive Directors
Action required	The Board is asked to discuss progress within the Service detailed through this Performance Report: - 1. Discuss and provide feedback on the format and content of this report. 2. Note performance against key performance metrics for the period to end December 2022. 3. Discuss actions being taken to make improvements.
Key points	This paper brings together measurement for improvement as highlighted by the Scottish Government's Quality Improvement and Measurement for Non Executives guidance. This paper highlights performance to end December 2022 against our strategic plans for Clinical, Operational, Scheduled Care and Staff Experience Measures. Patient Experience, Staff Health and Wellbeing and Financial Performance are reported in separate Board papers. The Service continues to experience significant pressure, exacerbated by the ongoing presence of COVID-19, with increased unscheduled care demand, higher patient acuity, workforce abstractions and challenges in handing over patients timeously at Emergency Departments because of wider health and care system pressures. Detailed plans to improve workforce capacity, create increased operational capacity, manage demand and progress joint turnaround improvement plans with hospitals have been developed and implementation continues at pace. <u>Clinical Performance</u> Purple Category 30-day survival rates continue to perform well with

	the survival rates at end September 2022 at over 54.8% Despite extraordinary system pressures which has resulted in a further increase in median and 95% purple response times in December 2022, our ROSC rates have been maintained. Updates on Trauma, Stroke and Urgent Care are also included. <u>Workforce</u> Our workforce plan for 2023 continues to be reviewed and monitored on a monthly basis and recruitment and training plans are being adjusted where necessary for the rest of 2022/23. We continue to recruit to fill vacancies and additional frontline staff this year as part of the Service's demand and capacity programme. We continue to work in partnership with staff side representatives including a weekly meeting to strengthen communications, enhance formal partnership structures and work through the agreed key workforce priorities. We are currently involved in detailed discussions in regard to rest breaks with positive progress having been made to date. In November and December 2022 we faced a difficult industrial relations environment with our staff side colleagues in light of the proposed industrial action that was subsequently postponed.
Timing	This paper is presented to the Board for discussion and feedback on the format and content of information it would like to see included in future reports.
Associated Corporate Risk Identification	4636 – Health and Wellbeing of staff 4638 – Wider system changes and pressures 4640 – Risk of further slippage in ESMCP 5062 – Failure to achieve financial target 4639 – Service's response to a cyber incident
Link to Corporate Ambitions	We will • Work collaboratively with citizens and our partners to create healthier and safer communities • Innovate to continuously improve our care and enhance the resilience and sustainability of our services • Improve population health and tackle the impact of inequalities • Deliver our net zero climate targets • Provide the people of Scotland with compassionate, safe and effective care when and where they need it • Be a great place to work, focusing on staff experience, health and wellbeing
Link to NHS Scotland's Quality Ambitions	This report highlights the Service's national priority areas and strategy progress to date. These programmes support the delivery of the Service's quality improvement objectives within the Service's Annual Operational Delivery Plan.
Benefit to Patients	This 'whole systems' programme of work is designed to support the Service to deliver safe, person-centred and effective care for patients, first time, every time. A comprehensive measurement

	framework underpins the evidence regarding the benefit to patients, staff and partners.
Equality and Diversity	This paper highlights progress to date across a number of work streams and programmes. Each individual programme is required to undertake Equality Impact Assessments at appropriate stages throughout the life of that programme. In terms of the overall approach to equality and diversity, key findings and recommendations from the various Equality Impact Assessment work undertaken throughout the implementation of Towards 2020: Taking Care to the Patient, are regularly reviewed and utilised to inform the equality and diversity needs.

SCOTTISH AMBULANCE SERVICE – BOARD PERFORMANCE REPORT

Introduction

The Board Performance Report collates and presents the Service's Key Performance Indicators. These measures are based on the Service's 2022/23 Measurement Framework. Following feedback from Board members the format and content of this report is under review.

What's New

Revised Board measures were presented to the Board Development Session on 31 August 2022. The revised measures were agreed and, where available, have been further implemented in this report. These include:

- 30 day survival of worked arrests (all rhythms)
- 30 day survival of worked arrests (patient in VF/VT)
- Return of spontaneous circulation (ROSC) of worked arrests (all rhythms)
- Bystander CPR for worked arrests (all rhythms)
- Public Access Defibrillator Usage for worked arrests (all rhythms)

What's Coming Next

In order to reduce duplication and to enhance our assurance reporting, over the next few months we are revising and aligning the various board papers.

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

Response Time Definition Change - In line with all other UK Ambulance Services, from 1st April 2022 the definition of the Service's response times has changed. The response to patients is now measured from the point at which the acuity of the patient is determined.

Under the previous definition, the response was measured from the same point in every 999 call regardless of patient acuity and when the chief complaint is established (T4). Often at this point, the dispatcher has insufficient information to determine the condition of the patient, whether an ambulance needs to be dispatched or some time may have passed since the patient was identified as not breathing or not awake.

Work is still underway to develop the new measure and Response times will continue to be reported under the previous definition until verified. The aim is that this new way of reporting will report as soon as possible where it will be marked as provisional until it has been thoroughly tested.

On completion of this process, where possible figures from April 2022 will be retrospectively amended to reflect the new definition. Figures from April 2022 are to be treated as provisional until this amendment is made.

Remaining measures will be introduced in subsequent reports with the further measures planned for inclusion in the March 2023 report.

Additionally a review of the people measures is in progress and additional measures will be added when agreed, defined and built.

Performance Charts

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

Control Charts

Rule 1: A run of eight or more points in a row above or below the mean (light blue)

Rule 2: Six or more consecutive points increasing or decreasing (green)

Rule 3: A single point outside the control limits (orange)

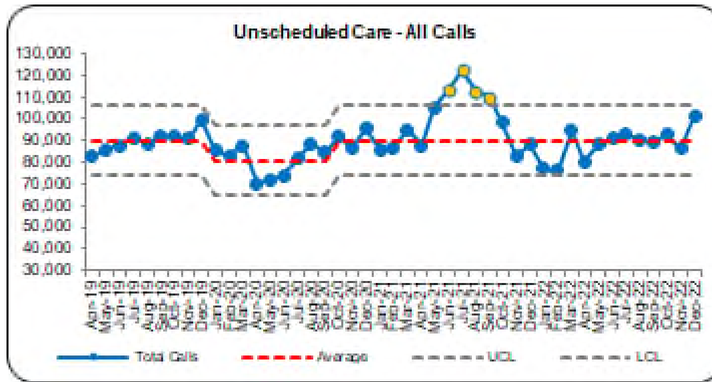
Run Charts

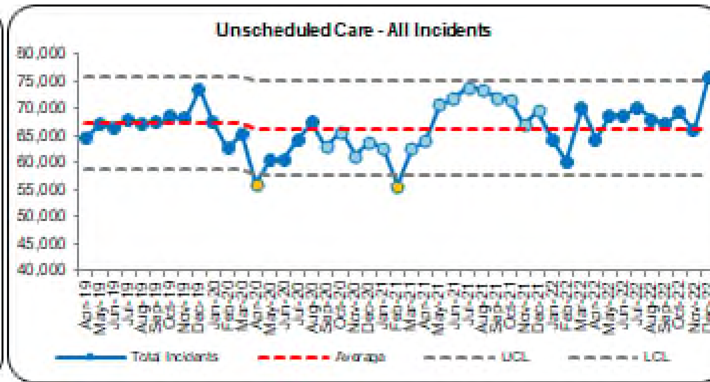
Rule 1: A run of six or more points in a row above or below the median (light blue)

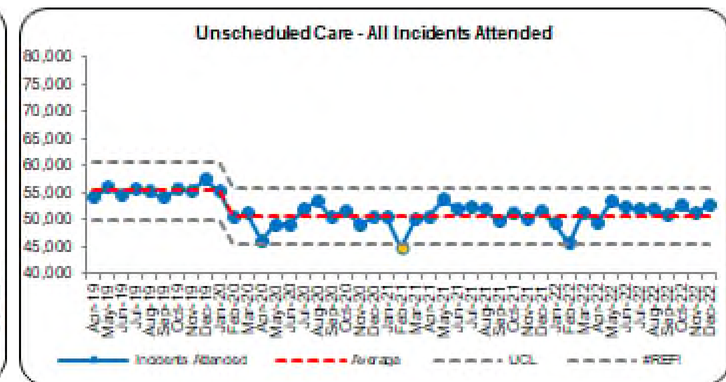
Rule 2: Five or more consecutive points increasing or decreasing (green)

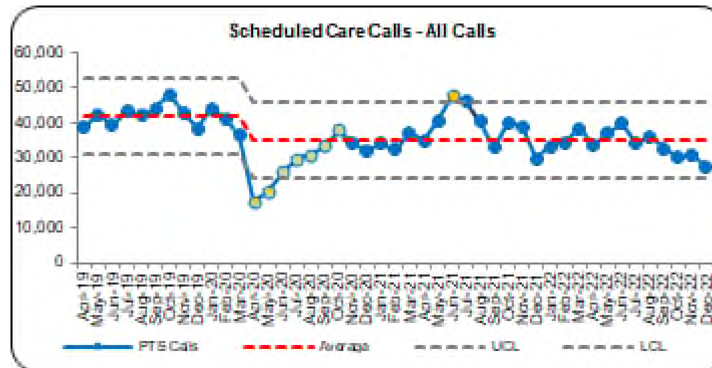
Rule 3: Undeniably large or small data point (orange)

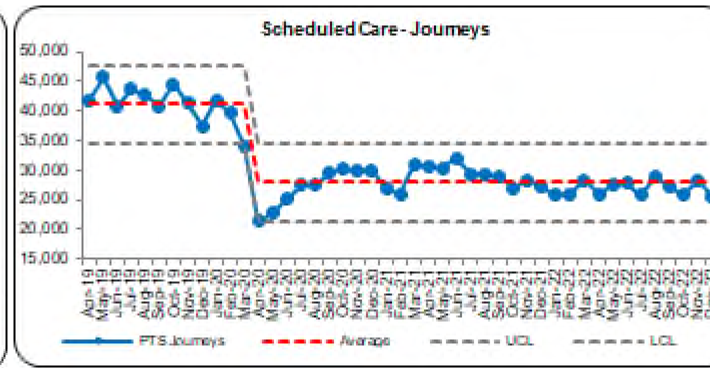
D: Demand Measures











What is the data telling us?

Unscheduled call demand has remained within the control limits although was close to the upper control limit in December 2022 with 101,699 calls. The volume of unscheduled incidents in December 2022 reached the upper control limit with an increase in flu and respiratory presentations.

Scheduled care calls and journeys remains lower than pre-pandemic.

Why?

The rescheduling of services in the wider healthcare sector due to the pandemic, alongside the widespread adoption of NHS Near Me virtual consultations has been the main driver behind the drop in scheduled care activity. The requirement for physical distancing reduced the Service's capacity until April 2022 when this requirement was removed, although some specific infection control arrangements remain for certain patient types.

What are we doing to further improve and by when?

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

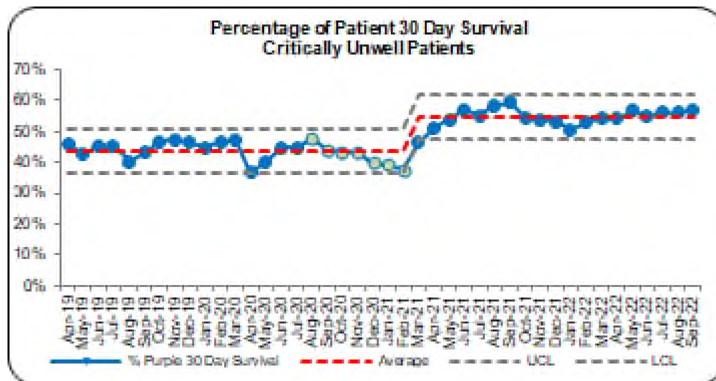
Our annual delivery plan this year is focused on those priority areas highlighted by Government that we can influence, which will reduce pressures on the wider Health & Social Care system, support the stabilisation of services, accelerate recovery and provide the most benefit to patients and staff.

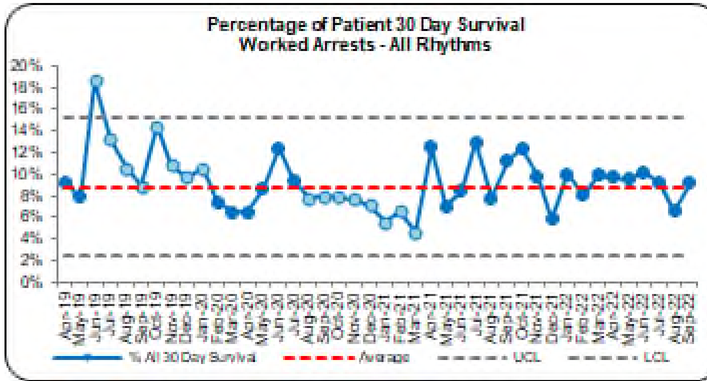
We have established a number of work streams to increase our workforce, improve demand management and increase capacity which include working collaboratively with our partners across the wider system to reduce unnecessary Emergency Department attendance by ensuring patients receive care that meets their needs. A full update of progress against delivery of our plans is included in the 2030 Strategy Portfolio update.

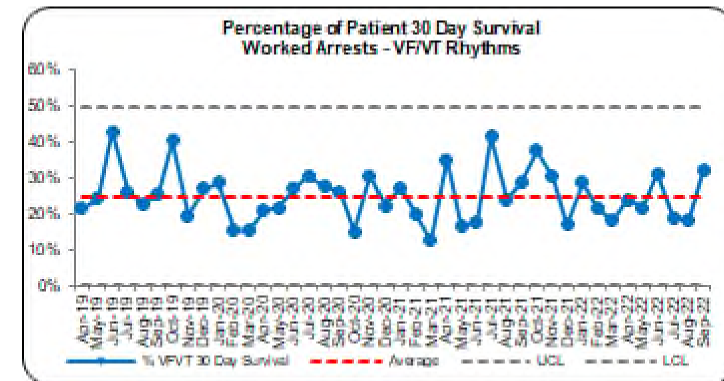
Significant work is being undertaken with hospitals to improve flow and reduce ambulance handover times. Details are included in the section of the paper specifically to Hospital Turnaround.

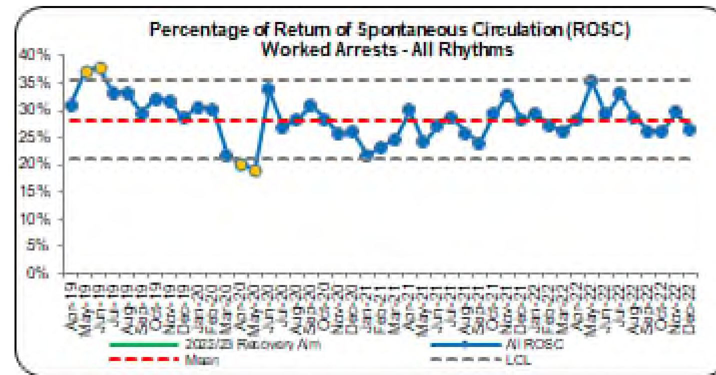
Our work to support staff health and wellbeing is detailed in a separate Health & Wellbeing paper on the board meeting agenda.

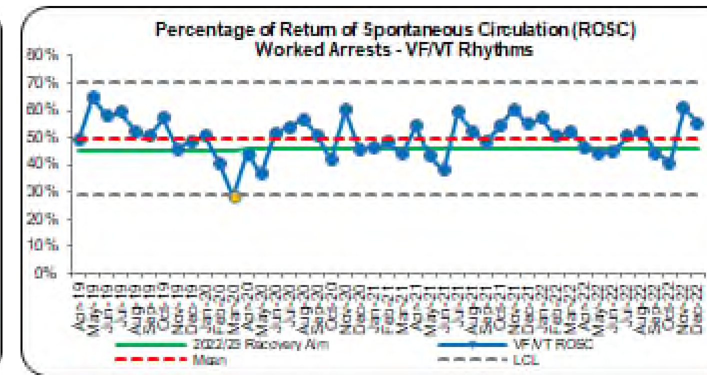
Purple Response Category: Critically Unwell Patients

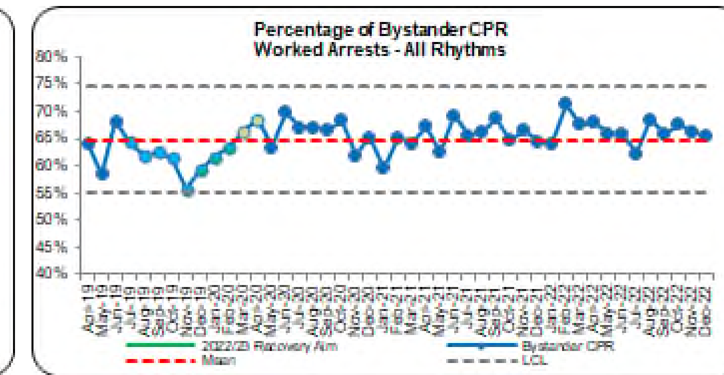


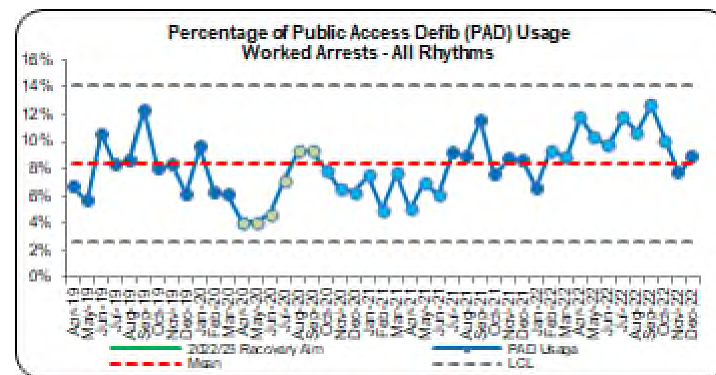


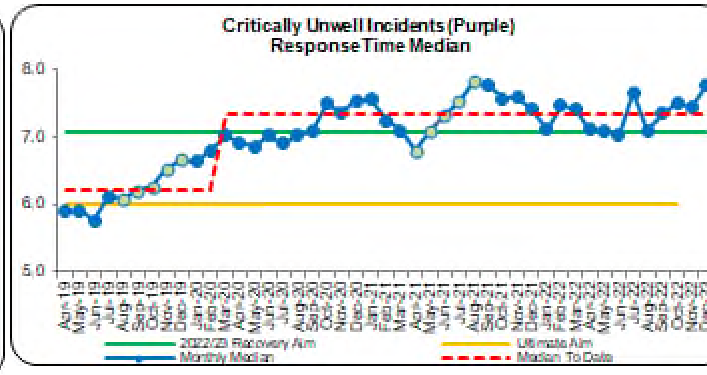


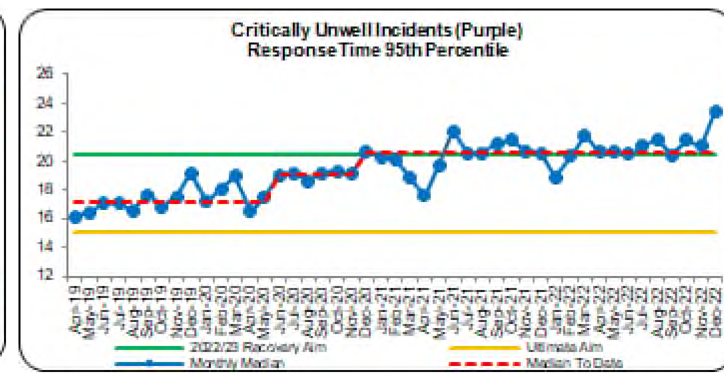












What is the data telling us?

The data presented in the charts is referenced to different measurement points depending on the complexities of data linkage. This means that mortality data is historical compared with response time and Return of Spontaneous Circulation (ROSC) data.

Overall, the position is stable on outcome measures (Mortality) with 30 day survival measures within control limits. These figures relate to September 2022 time stamps due to requirements for data linkage.

All Purple Category 30 day survival in September 2022 was 57.1%.

For those patients in cardiac arrest who received critical support from SAS crews, overall, 30 day survival in September was 8.8% and for patients with a 'shockable' cardiac rhythm, survival was 32.1%. Patients with a shockable rhythm represent those with the best chance of surviving a cardiac arrest and our efforts to further improve this figure, include increasing rates of bystander CPR and use of PADs, as well as continually optimising our own Advanced Life Support interventions.

The response time measures for December (process measures), have risen, reflecting significant system pressures affecting ambulance availability. However, our median purple response time remains under 8 minutes.

Despite these increases in response times, our ROSC rates for December, VF/VT (Utstein) at 55.6% and 'All Rhythms' at 28.3%, remain within control limits.

As the charts illustrate, Bystander CPR is reported at 64.8%, and PAD usage at 8.4%, are also within control measures.

The Board are aware that the aim of Scotland's Out of Hospital Cardiac Arrest (OHCA) Strategy is to improve OHCA survival to 15% by 2026. This will require a relative 50% improvement in OHCA survival from where we are now, where survival is around 10%.

Scotland's Out of Hospital Cardiac Arrest Annual Report was published in November 2022. This contains a range of data including linked outcome data and used by the Service and our key stakeholders to identify and drive improvements.

In terms of community preparedness, the Service continues to register more PADs on our system, with over 4500 currently flagged. We also re-launched our GoodSAM responder app in October 2022 and have recruited a further 1300 volunteer responders in addition to the 4000 already recorded on the system

<u>Purple Median Times</u>

Median response times to purple in December 2022 was 7 minutes 47 seconds. We reached 95% of these patients in 23 minutes 27 second in December (95th percentile). The key influencing factors on response times are service time (which includes hospital turnaround times), emergency demand, shift cover and staff availability during shift.

Work is ongoing around these four priority areas

1) Reducing service time (through auto-allocation, new static sites for ambulances, reducing hospital turnaround times and timely access to professional-to-professional support).
2) Reducing the number of Accident and Emergency unit dispatches (through Advanced Paramedic clinical assessment, alternative pathways of care, flow navigation centres, specialist response vehicles for mental health and accessing mental health assessment centres).

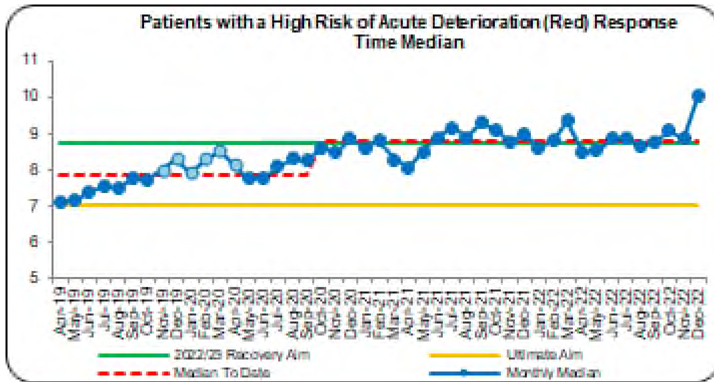
3) Increasing ambulance resources (demand and capacity programme).
4) Reducing unavailable time (through make ready, equipment, cleaning vehicles, welfare packs at hospital sites).

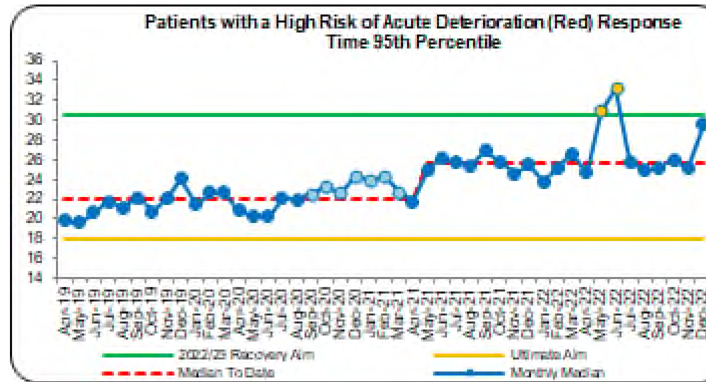
We have increased ambulance resources and are implementing new rosters through the demand and capacity programme. We are focused on working to maximise shift coverage, support abstractions for paramedic training and managing sickness absence levels.

Community first responders and cardiac responders continue to play a valuable role in responding to immediately life threatening calls across Scotland and work is underway to increase their availability and their deployment.

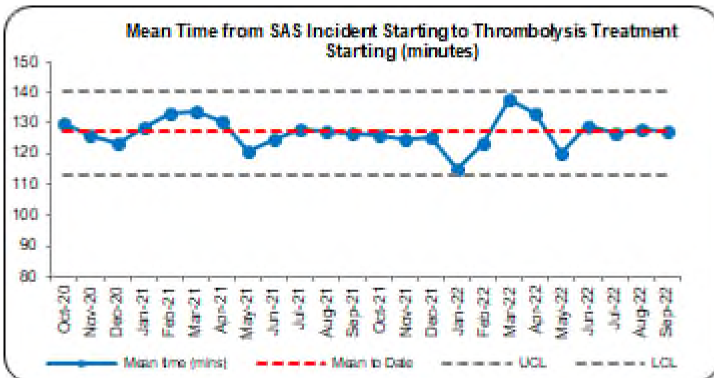
We are continuing to see extended hospital turnaround times in many hospital sites. This remains an area of significant concern. Extended hospital turnaround times are affecting staff rest periods, ambulance availability, ambulance response times and shift over runs. Health Boards have been working with regional management teams to produce site action plans to support flow and reduce ambulance handover delays. Work is also underway to embed the use of the Hospital Arrival Screens handover module at all major hospital sites in Scotland. The system has been reconfigured to allow us to report on the notify time (the time at which the crew informed the hospital they were in the department and ready to handover) and the handover time. Compliance with the use of these screens is now monitored and reported to regional teams, Health Board partners, and Scottish Government. Additional Hospital Ambulance Liaison Officer (HALO) posts have been funded by Scottish Government with all the additional people now in post. The Performance Manager appointed on a secondment, based at the QEUH, also now works with the Ayrshire Hospitals, to share improvement work with their site teams and help with ambulance handover and hospital flow.

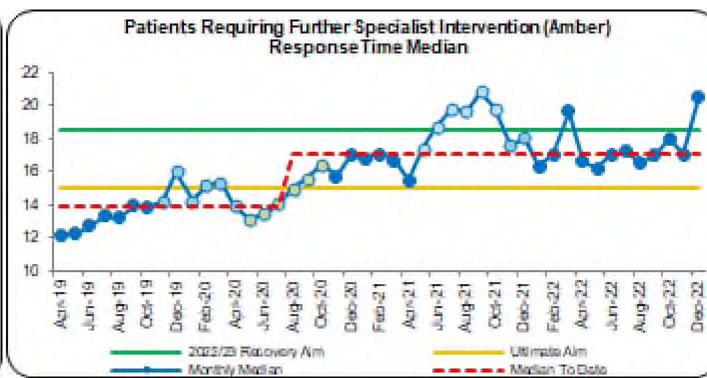
Red Response Categories: Patients at risk of Acute Deterioration

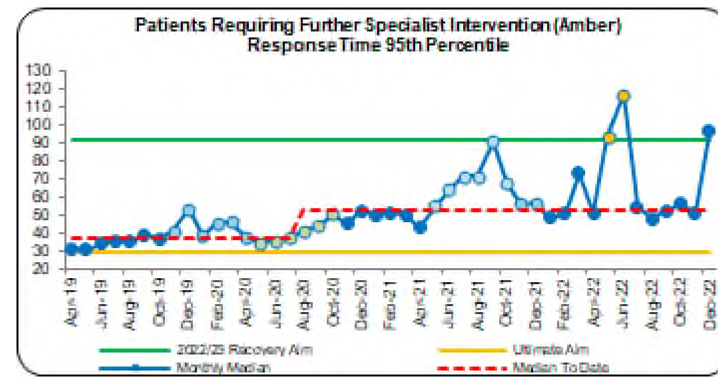




Amber Response Categories: Patients requiring Further Specialist Intervention







What is the data telling us?

The median and 95th percentile response times for both red and amber categories of call saw an increase in December 2022 due to the associated system pressures. In December 2022, we attended 50% of red category incidents within 10 minutes 1 second and amber within 20 minutes 33 seconds.

The clinical detail around the red category of call relating to Major Trauma response is under development and will be introduced in the March 2023 Board paper.

A significant development in our Major Trauma response was to complete the redesign of our Critical Care Desk in Ambulance Control Centre (ACC). This resource went live in November 2022 and the expected increase in activity from front line crews seeking specialist advice has been observed. In addition, the senior clinical decision support applied to resource allocation to major trauma cases is resulting in an optimised use of SAS clinical resources. Further information regarding the Critical Care Desk will be provided as we develop our Major Trauma reporting.

The Stroke incident start (call coding) to thrombolysis start data is collated three months in arrears in order to validate the figures. In September 2022, this was an average of 127 minutes across Scotland and had been stable at this point for the preceding two months.

Why?

Demand in the amber category has levelled out over the last 3 months, returning to median levels.

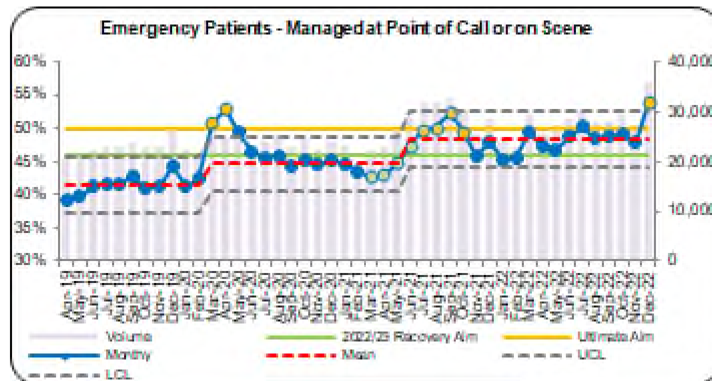
Similarly, the monthly median and 95th percentile response times stabilised over the spring, summer and autumn 2022 however saw a rise in December 2022 due to pressures on the wider health care service.

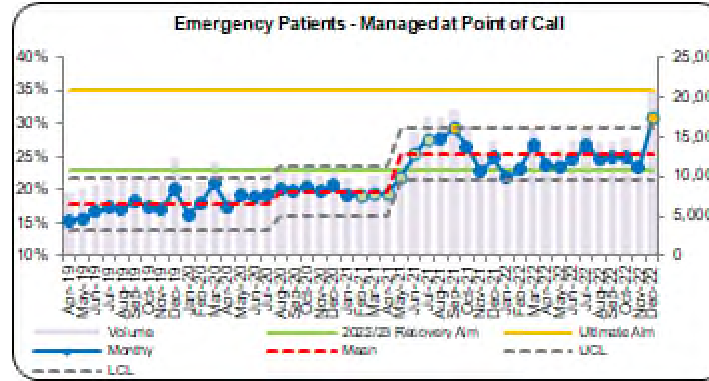
What are we doing and by when?

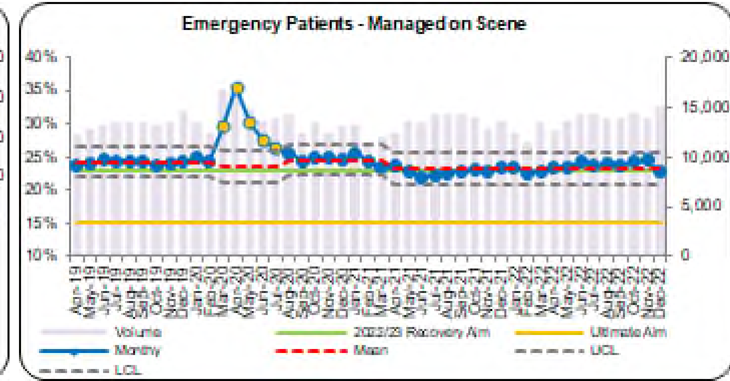
Ongoing work to reduce 999 to thrombolysis interval includes:

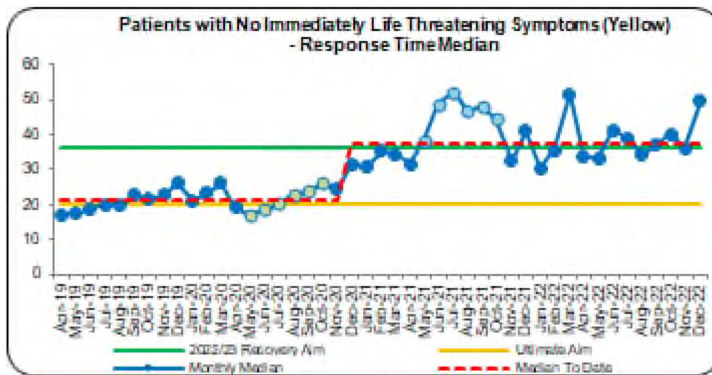
- Improved recognition of stroke at point of first contact within the ACC.
- Optimise dispatch arrangements and understand variation in practice through observation
- FAST – improve recognition of hyper-acute stroke through utilisation of FAST (face to face)
- On-Scene times – improve on-scene times by limiting unnecessary clinical interventions as a time critical condition
- Implement improved and refined ‘whole service’ stroke pathways to ensure seamless and definitive care (thrombolysis)
- Clinical feedback to clinicians.

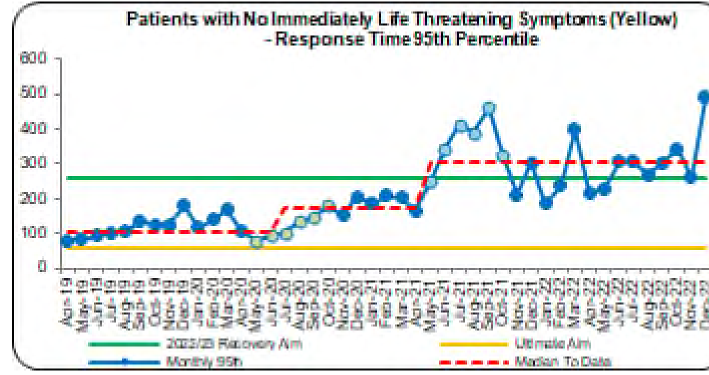
Yellow Response Category: Patients with Highest Potential for Non-Emergency Department Attendance











What is the data telling us?

The proportion of emergency patients managed either at point of call or on scene has remained around the mean of 48% since November 2021. However, in December 2022 it was above the upper control limit at 53.9%, made up of 31.1% of patients managed at point of call and 22.8% managed on scene. The overall picture of patients being cared for out with the Emergency Department remains substantial and will be supported by the work that is underway through the national Integrated Urgent and Unscheduled Care Collaborative of which the Service is playing a pivotal role.

Service pressures in December, including the significant impact of long delays handing patients over at EDs impacted the Service's response times, most evidently in our yellow category. In anticipation of these system pressures, the Service had increased its clinical resources in ACC with the primary aim of identifying seriously ill people and ensuring that delays in response were minimised.

Senior clinicians in ACC also play a crucial role in consulting with patients to ensure that we fully understand their needs. This often results in an alternative outcome from a standard Service ambulance response. This is evident from the figures where we see that for December 2022, 53.9% of people who called 999 were not conveyed to the Emergency Department, with 31.1% of people who called 999 being managed within ACC. Both these figures are above our upper control limit for their respective categories.

For those patients who we did attend, 23.2% were managed out with an Emergency Department pathway. The Service has strengthened our flow navigation function and we are seeing an increasing number of the Service's front line crews accessing this resource for support. In addition, across much of Scotland we have direct access to Board Flow Navigation Centres, and 'Call Before you Convey' arrangements in place for Service clinicians to access dedicated Health Board support for patients who do not have time critical presentations.

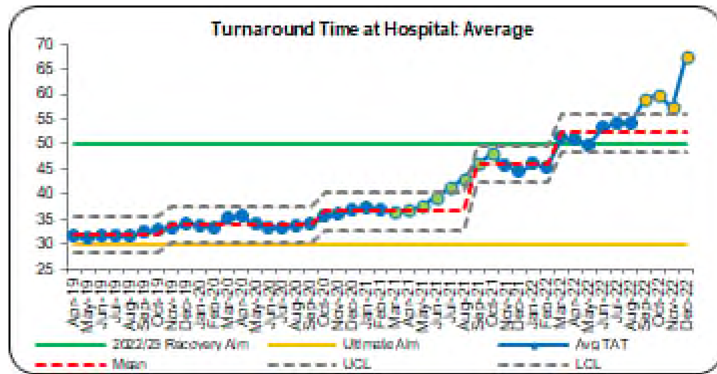
All of these elements sit within the Service's Urgent and Unscheduled Care work stream. Further work is progressing to enable improved access to the wider health and care system for those patients who present to the Service and whose needs can be better met by other parts of the system.

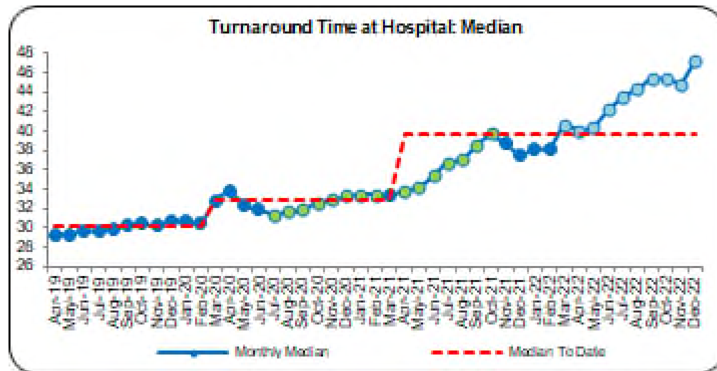
Clinical guidance for ambulance clinicians who continue to care for patients in ambulances outside hospitals for prolonged periods is currently being updated.

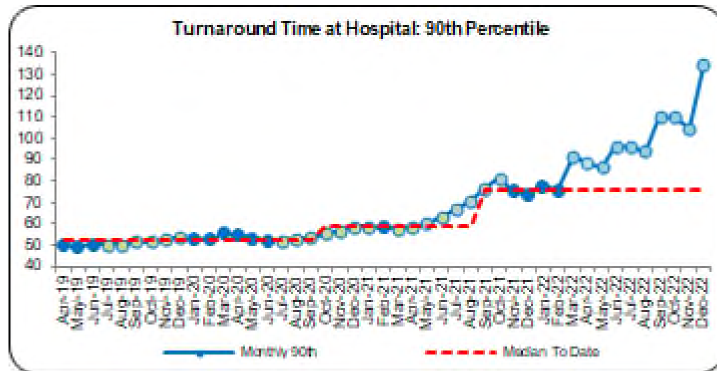
What are we doing and by when?

We continue to work closely with our partners to increase the range of alternatives available to the Service and work is progressing across a number of Flow Navigation Centres, Hospital at Home and expanding Mental Health pathway access as some examples of our breadth of work. A number of internal initiatives with a focus on supporting our frontline clinicians continues to progress including the application of the principles of Realistic Medicine to support shared decision making with our patients.

TT: Turnaround Time at Hospital







What is the data telling us? – Average, median and 90th centile turnaround times are reporting at levels significantly higher than have been seen historically. An increase in turnaround time translates to reduced availability of ambulances to respond to other patients who have made emergency calls. In addition to more time being spent at hospital, tasking crews from hospital rather than tactical deployment points can also negatively impact on the time taken to reach patients.

Between December 2019 and December 2022 the average turnaround time increased from 33 minutes 56 seconds to 1 hour 7 minutes 34 seconds. This means our crews are, on average, spending 33 minutes 38 seconds longer at hospital for every patient conveyed.

Why? – Hospital Turnaround Times for Ambulance Crews has been compounded by the strict infection prevention and control measures that hospitals have had to put in place due to the COVID-19 pandemic, and as restrictions eased, hospitals have been operating at or near full capacity. In December 2022 this was further exacerbated by adverse weather, flu, covid and respiratory admission and significant numbers of delayed discharge patients. The situation remains particularly challenging in some hospital sites affecting ambulance response times, ambulance availability, staff rest periods and shift overruns.

What are we doing and by when?

Hospital Ambulance Liaison Officers (HALOs) have been deployed at the busiest hospital sites to ensure we are fully integrated in support of whole system hospital flow. HALOs are supported by managers.

Additional HALOs are now in place across the three regions funded by the unscheduled care and systems pressure money. There are now six additional HALOs in the West Region, three in the East Region, and two in the North Region. NHS Lanarkshire has also funded an additional HALO post to work in the Flow Centre. The Service now has 17 WTE HALOs in post covering the major Emergency Department sites.

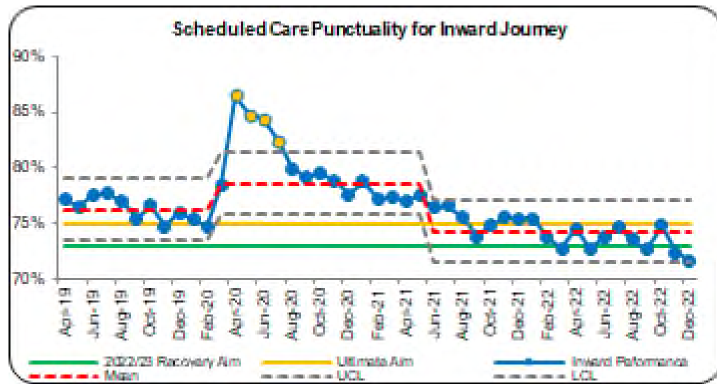
Other specific actions include:

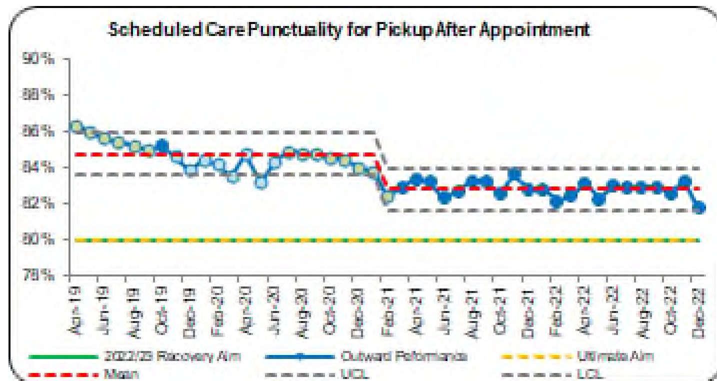
- Weekly or bi-weekly meetings between Chief Executives at the most challenging sites
- Increased use of 'safe to sit' practice to avoid patients waiting in ambulances where they can safely wait in COVID-19 compliant waiting areas.
- Hospital arrival screens available to Hospital teams to monitor ambulance patients who are waiting to be handed over and ambulance patients due to come into Emergency Departments and the hospital helping with managing flow.
- All efforts re safe alternative measures to Emergency Department admission described earlier in terms of the IUUC.
- Hospitals reviewing the principles of the Continuous Flow Model to ease the front door pressures primarily on Emergency Departments.
- Hospitals exploring development of temporary admissions units to support surge capacity.
- Escalation to Senior on Duty and On Call Teams as required.
- Involvement in Hospital Incident Team meetings.
- Cohorting guidance produced to allow regions to cohort patient (preferably post triage) at key sites at busy times.
- Review of joint improvement plans in place with acute sites is ongoing and this is being refreshed as part of our winter planning activity.
- Daily conference calls with our HALOs take place to ensure early escalation of issues but also to ensure support for the HALOs in engaging with sites.
- In Ayrshire there is a 24/7 Call Before Convey process which has been implemented which is averaging 10 patients per day referred through the Service and a non conveyance rate of 89%. Discussions are ongoing to further improve the process and refer higher volumes appropriately.
- East Region have been progressing call before you convey to reduce unnecessary conveyance to Emergency Departments. This is now in place in Tayside, Fife, and Lothian with testing in the early stages in NHS Borders area.
- In Lothian call before you convey is supported by APs embedded in the Flow Navigation Centre (FNC) and through prof to prof discussion, consideration is given to the Western General Hospital being used to receive patient where clinically appropriate i.e. not time critical and not major trauma.
- The Same Day Emergency Care pathway in Lothian has been extended to cover the full range of conditions accessible to General Practitioners providing an alternative to Emergency Department attendance. This is complimented by an increase in triage capacity within Edinburgh Royal Infirmary.
- The Service's clinicians are working in the Emergency Department at the Edinburgh Royal Infirmary between 0800 and 0100hrs to support the early handover of patients and to facilitate the early release of operational resources. This operating model allows full cohorting to be quickly implemented during times of greater pressure.
- Advanced Practice Practitioners in Aberdeen now rotate through the Aberdeen City H&SC Partnerships Hospital at Home project to reduce admissions and provide treatment in the home setting. With the assistance of the Service's

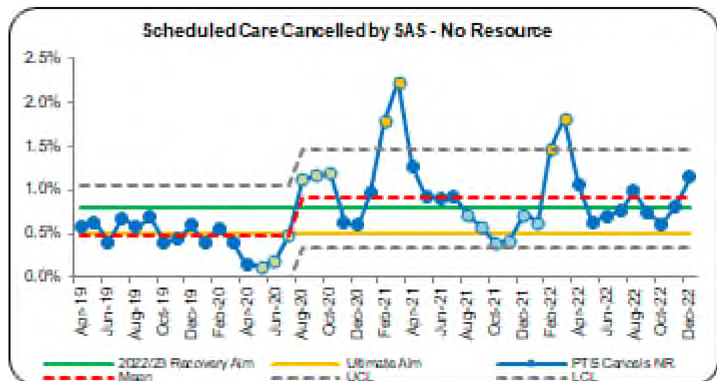
Advanced Practitioners (AP's) NHSG are now looking at increasing bed capacity within the Hospital at Home from 25 to 100 beds. This contributes to averting hospital admissions.

- Cycle 3 of the "Call Before You Convey" test of change commenced on 16 December 2022 running 0900-0700 Monday to Friday and 24 hours Saturday and Sunday. This Test of Change is to improve the use of the Flow Navigation Centre (FNC) within Grampian and to raise further awareness to frontline crews. This is led by a senior clinical/consultant assisting crews with decision making in relation to the best outcome for their patient. During the Test of Change, the Service's Advanced Practitioners will also be based in the FNC.
- We are participating in discussions and workshops in relation to the introduction of a "Continuous Flow Model" for ARIH which is to be implemented on 19 January 2023 once this has been finalised with medical staff.
- Low Risk Chest Pain Pathway introduced in December 2022 and Mental Health pathway being introduced w/c 15 January 2023 to look at diverting patients away from the Emergency Department.
- Cath Lab / PCPI at Raigmore now operating 24/7 as of 9 January 2023. Reducing the pressure on Emergency Departments at DGHH and RAIG.
- A revised Falls pathway has been introduced in Glasgow which has already delivered a 91% increase in referrals year to date.
- APs assisting Emergency Department staffing levels in Lanarkshire.

SC: Scheduled Care







What is the data telling us? – The number of Scheduled Care calls has remained stable since early 2022 and was 27,034 in December 2022 (see chart: Scheduled Care Calls – All Calls on page 8). Call demand between November and December dropped from 30,936 to 27,034 calls, which is a month on month decrease of 12.8% and follows an expected pattern for December.

Journey demand between November and December also decreased (by 10%), from 28,267 to 25,443 journeys. This is now the lowest level of journey demand since June 2020, and again in part a reflection of predicable seasonal variation.

Punctuality for inward appointments in December 2022 was 71.6%, which is within control limits but below the 2022/23 recovery aim of 73%.

Punctuality after appointment was 81.8% in December 2022, above the recovery and ultimate aim of 80% and within control limits.

The percentage of PTS cancelled by the Service in the "No Resource" category saw an increase to 1.1% in December, which is higher than the 2022/23 recovery aim of 0.8%.

Why? – While physical distancing measures relaxed on 14 April, we continue to maintain single journey arrangements for immunocompromised patients.

The increase in "No Resource" cancellations can be attributed to several factors. Operating at REAP level 4 in conjunction with raised levels of staff absence affected the number of resources available for general outpatients, with Scheduled Care also continuing to contribute resource to alleviate wider system pressures.

The reduction in PTS journeys is being driven by a range of factors. In addition to the expected seasonal fluctuation due to a reduction of outpatient clinics operating in December and the impact of 2 public holidays, the streamlined telephony booking process is now embedded and we continue to engage with NHS Boards to encourage appropriate booking and early cancellation of journeys.

In addition, an increase in cancellations from both Health Boards and patients was observed during December, together with a rise in aborted journeys.

What are we doing and by when?

We are updating our systems and reporting processes to enable us to accurately measure and understand the effect on Scheduled Care of wider system pressures.

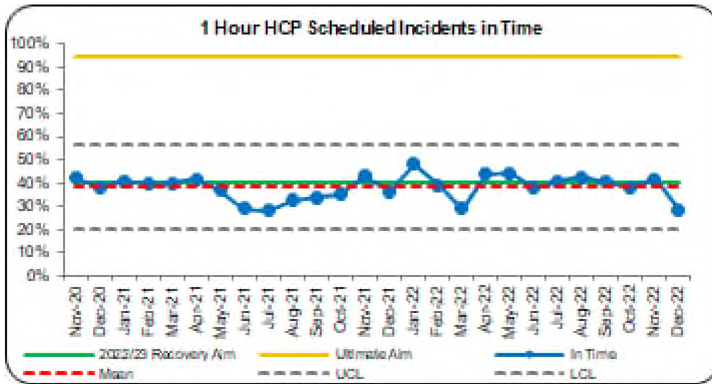
The updated Patient Needs Assessment is expected to be ready for testing by the end of January 2023 and it is anticipated this should result in a reduction of ambulance requests from patients with lower mobility needs.

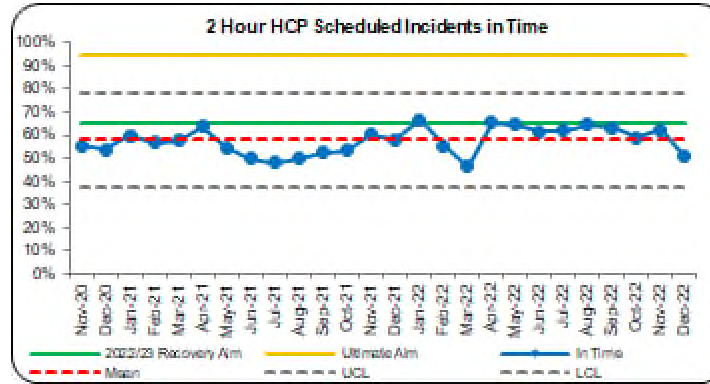
Our continuing engagement with NHS Boards and the Transport to Health team at Scottish Government about potential additional Scheduled Care demand through Planned Care activity and National Treatment Centres (NTCs) is assisting us to estimate potential additional Scheduled Care demand and cross boundary conveyance before they go live next year. This data is being shared with the Demand & Capacity project and we expect initial modelling to be available in the coming months.

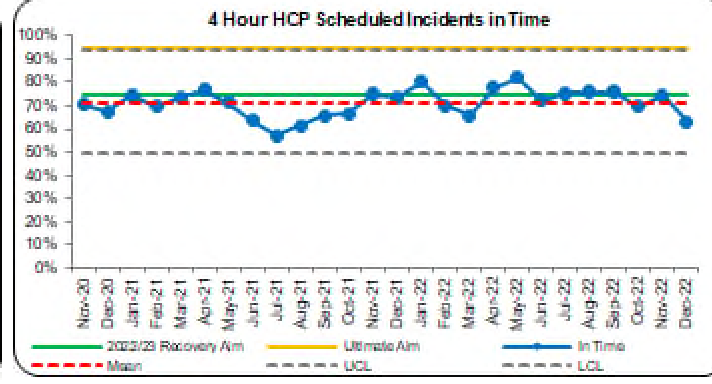
A test of change was undertaken in Tayside over 2 weeks where only inward journeys were pre-planned for a select number of outpatients with outward journeys assigned dynamically as patients became ready. Initial results appear to demonstrate a positive impact on punctuality after appointment times and we will be repeating this test of change with defined improvement measures and a larger volume of journeys before testing in further Health Board areas.

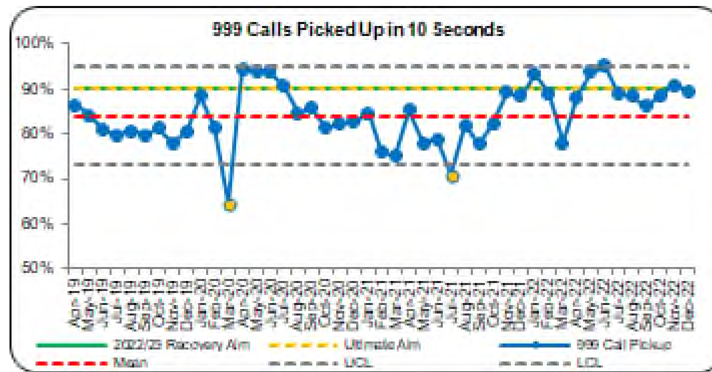
We will monitor the effects of our ongoing work with Health Boards, in particular discharge lounges to identify further opportunities for improvement.

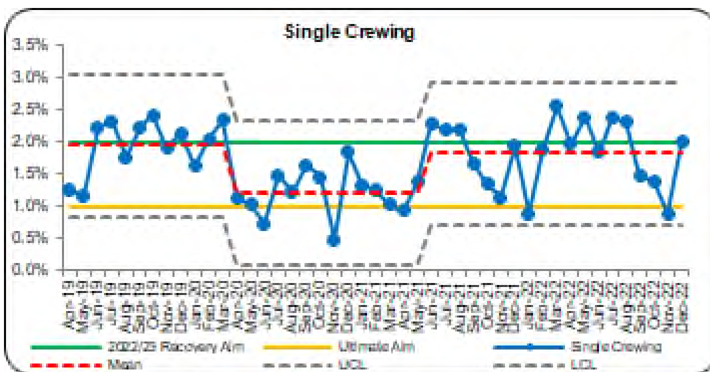
Other Operational Measures











What is the data telling us?

The proportion of scheduled incidents from Health Care Professionals (HCP) fall into 3 categories which are defined by the requested timeframe of attendance.

As with responses to emergency incidents, response to these incidents is heavily influenced by the increased time experienced at the handover of patients. In all of these timeframes there has been an improvement since the summer of 2021 and the proportion reached within the timescales remains within the control limits at 28.6%, 50.7% and 63.1% for 1 hour, 2 hour and 4 hour scheduled incidents respectively.

The proportion of 999 calls answered in 10 seconds has seen improvement and stability in the last 9 months with 89.4% being achieved in December 2022 against an aim of 90%.

What are we doing and by when?

HCP Scheduled Incidents in Times

The Regions are working closely with the Ambulance Control Centre to maximise availability and tasking of low acuity ambulance resources to appropriate ambulance calls. This is focused on sending the right ambulance resource to the right place at the right time with an appropriate skill level. This has a positive impact on HCP calls where an emergency ambulance may not always be required to convey a patient to hospital. Through the Service's demand and capacity programme, we are seeing the benefits of aligning the right ambulance resources to ambulance demand through the Ambulance Control Centre Clinical Hub, rostering and additional ambulance resources. Extended Hospital turnaround times continue to impact on ambulance service time and ambulance availability.

Scheduled Incidents 1, 2 and 4 hours – attending incidents within their allocated time remains the main priority within the Timed Admissions Hubs within the Ambulance Control Centre. This test of change across all Ambulance Control Centre sites and regions allows for dedicated clinical and dispatch focus to maximise the use of our dedicated Scheduled Care vehicles freeing up critical A&E capacity where it is safe and appropriate to do so. The Ambulance Control Centres and Regions have individual improvement action plans being progressed through the Service's Planning & Performance Steering Group to improve this overall performance.

Single Crewing

Staff abstractions for COVID-19 seasonal influenza and other non COVID-19 reasons have impacted on the percentage of single crewing. Every effort is made by the Regions to avoid single crewing through maximising relief cover and covering shifts in advance where single crewing is anticipated.

Other specific actions include:

- Single crewing is reviewed daily as part of the Regional management call to minimise occurrences.
- Local Operational Managers will review the available shifts and redeploy staff where possible to reduce the potential for a single crew, such as changing shift times or locations, usually the day before the shift takes place.
- ACC with discussion from the local management team may decide to move a Paramedic from a PRU to double up with a

single crewed Ambulance, depending on the prevailing demand in the area at that time.

- Demand & Capacity recruitment/funding has provided additional relief capacity across the North Region which should assist with the reduction of single crewing.
- All opportunities are explored when covering shifts and mitigating single crewing including the use of Bank staff – clinical staff and trained emergency drivers.

999 Calls picked up in 10 seconds

In November 2022 we achieved our target of 90% of 999 calls answered within 10 seconds. We saw a slight downturn in 999 call volume with 54,222 calls in November compared to 58,230 in October, a reduction of around 70 calls a day which is seasonally expected. We also saw a similar reduction in volume in our non-public emergency and HCP demand.

In December 2022 we did not achieve our target of 90% of 999 calls answered within 10 seconds coming at 89.5% for the month. We saw the expected upturn in call demand throughout December peaking at over 17,000 999 calls in the week commencing 17 December 2022.

Overall there was 14,000 more 999 calls offered in December compared to November. Overall we saw an increase of just under 15,500 calls from November 2022 across all call types in November.

The Service maintained a good standard against the other UK ambulance services for 999 call metrics where we had the least number of 2-minute delays (374) and maintained the fastest call answer for all services at 8.92 seconds.

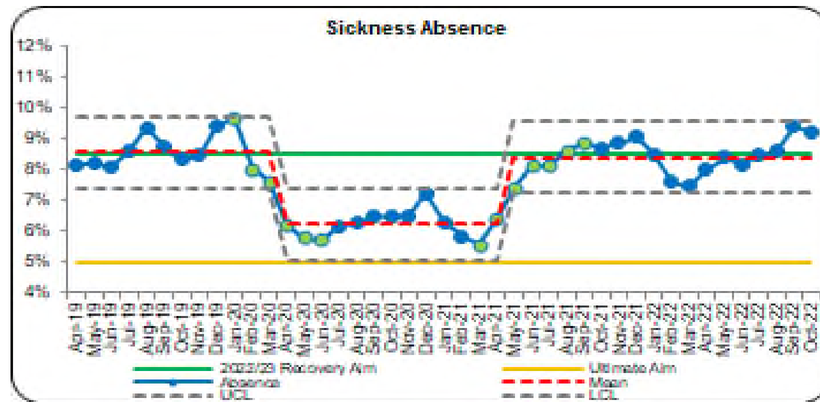
We only had one buddy call during December and only two calls recorded that were 5 minutes or over call answer.

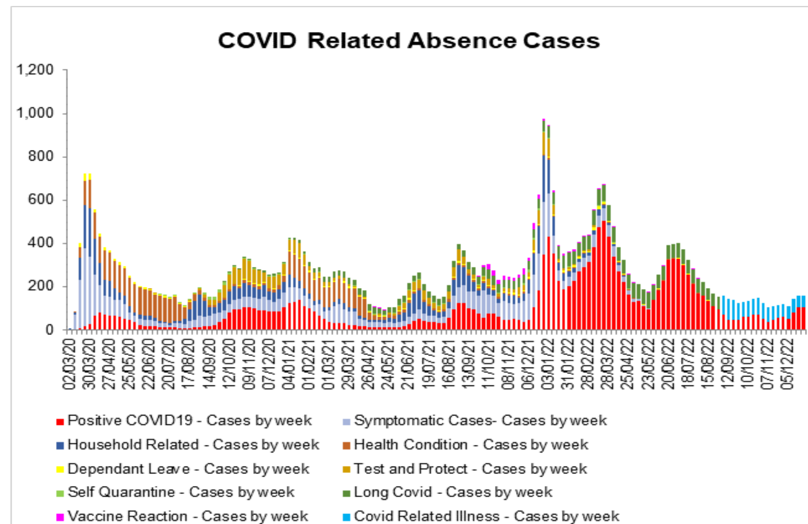
Due to pressures across UK ambulance services we took calls to assist all other 12 services at some point through December.

From a performance and patient safety perspective this is the best performing December in call handling for the ACCs and Service in at least the last 8 years however the utilisation of our calls handlers has been continuously high due to both demand and staff availability impacted by absence.

Delays and risk to patients have been mitigated by our forecasting, planning and live day management of calls by our analytics teams, workforce planning teams and live time supervisors and managers and our success is due to the work undertaken by those teams in the wider system.

Sickness Absence





What is the data telling us? – The latest sickness absence data to end November 2022 had not been received when this paper was published and an update will be provided to Board members when this is available.

Sickness absence, as at October 2022, was 9%. This is a slight decrease on September's figure. There were 189 cases of COVID-19 special leave during the month of October. Concerning sickness absence, the majority of COVID-19 related illness during October was long-term (86%).

Current local data is indicating an increase in sickness absence across the organisation.

For continuity of trend analysis relating to covid absence, COVID-19 sickness is included in the chart. COVID-19 related absence levels during week commencing 07 November 2022 were at the lowest level seen since May 2021. 105 staff were absent from work with covid related illness, 1.8% of staff, 68 of these staff were due to COVID-19 related sickness and 37 as result of asymptomatic positive test. Cases have increased throughout the remainder of November and December, by week commencing 26 December, 160 staff were absent, 2.7% of staff, with asymptomatic cases contributing most to the increase.

Why? Our increase in COVID-19 related absence was in line with forecast modelling carried out by our business intelligence team.

During the month of October, absence decreased in the majority of regions and departments across the organisation with the exception of ACC and NRRD.

What are we doing and by when?

Current local data confirms that anxiety/stress/depression remains the top reason for absence, Secondly Cold/flu and the third reason is covid related sickness. We have continued to see an increase in short-term absence related to cold/flu. Cold/flu features in the top three reasons for absence across every region/department in the organisation.

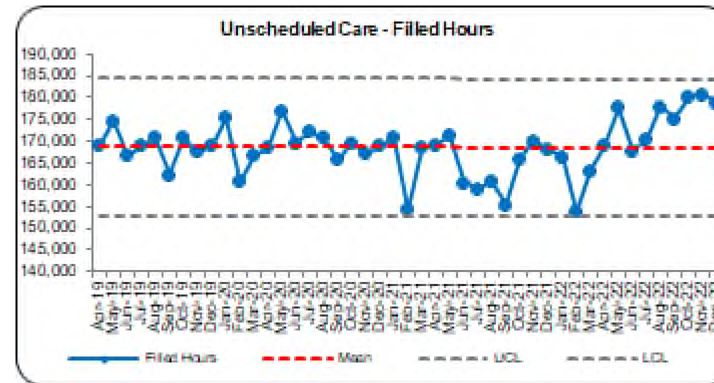
Managers continue to manage attendance in line with the Attendance Policy. Attendance has remained a key priority for line managers during severe operational pressures.

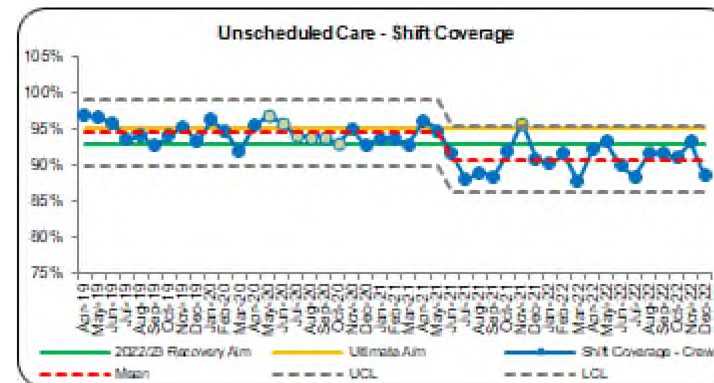
We continue towards our strategic aim, agreed with the Service's Staff Governance Committee, to further reduce absence, with a national target to reduce absence by 1% by the end of March 2023.

The Regional and National HR teams continue to support managers to manage attendance cases and levels in their area. The National Attendance Lead continues to focus on attendance action plans with each region/department.

Absence reporting is available on a weekly and monthly basis. A report continues to be produced for the Service's Performance and Planning Steering Group, which sets out the position for each region and service area broken down into long and short term sickness absence. Local managers provide a supporting narrative, which gives local information and specific action being taken.

SE1.2 Shift Coverage





What is the data telling us?

As a result of the implementation of our demand and capacity programme, hours of shift coverage have been increasing and this is planned to continue in the following months whilst the final tranche of the additional staff complete their training and start on shift. (The percentage of accident and emergency shift coverage has seen a drop resulting in a mean and control limit recalculation in June 2021. In the months to March 2022 this was caused by increased COVID-19 related absence. From April 2022 new rosters have been introduced and new staff have been recruited in a phased approach across the Service, this has resulted in an increase in the number of filled hours. However as the denominator (required hours) has also increased the percentage shift coverage remains similar to previous months)

Best practice for UK ambulance services is no more than 55% utilisation, our utilisation rates in November and December 2022 were 62.5% and 70.6% reflecting the continued shortfall in capacity versus demand which is being progressed through our demand and capacity programme and work to reduce ambulance handover times.

What are we doing and by when?

Regions continue to maximise all recruitment opportunities and use of bank staff. They are exploring the best way to optimise shift uptake by bank workers ahead of the winter pressures. Weekly reviews of all absences continue to take place to ensure early support and intervention for all cases and minimise abstractions.

Shift core coverage continues to be an issue for West Region particularly in Lanarkshire. 15 new Technicians were introduced to Lanarkshire in October and a further 38 will be introduced following the course end in March 2023. Forecasting indicates that when the new staff go live and the final demand and capacity rosters are implemented, West Region will have a much more sustainable coverage platform for 2023/24.

48 students Technicians became operational in the East Region from 24th October, which allowed additional Demand and Capacity rosters in Tayside, Fife and Lothian to go live. Through November, an additional 15 NQPs and 2 qualified Technicians also took up posts within the East. A further 42 Students commenced Technician training on 14 November and will return to the region for induction and operational duties from 13 March 2023. Bank staff, both clinical and emergency drivers, support shift cover across all regions.

Within the North Region they seek to maximise recruitment and training opportunities to fill vacancies. 41 students completed their training and commenced frontline duties at the end of October, 6 qualified Paramedics from NHS England completed their Clinical Induction Module and commenced Frontline Duties. 27 candidates were recruited to the November VQ Course to fill the final vacancies in the North Region leaving just four vacancies unfilled. Recruitment of all grades of staff continues (NQP, QP, Trainee Technician) with the latest campaign commencing on the 6th January 2023. Planning and forecasting is being undertaken along with gathering intelligence for forthcoming vacancies in the Region to carry out proactive recruitment to these areas.

Workforce Development

Employee Resourcing

Aim – To recruit and retain staff ensuring that the Service has the skills to deliver its 2022/23 workforce profile and improve staff experience.

Status – Plans are in place to deliver the 2022-23 workforce requirements although adjustments have been, and will continue to be made, to respond to the challenges identified below.

Improvement – We are on track to deliver the 2022/23 workforce plan and are actively pursuing opportunities to go beyond our initial aims, given the system challenges, with support from Scottish Government.

Planned Activities Include – The recruitment team will continue to liaise with regional workforce leads to deliver workforce intake targets. The allocation of places for VQ Ambulance Technician and Ambulance Care Assistant roles continues in line with regional workforce plan requirements.

Other Considerations - Resourcing model developments will support continuing target delivery over the next three years as we transition from our academy training to the new Educational Model to align with the introduction of degree level qualification requirements for HCPC registration in 2022. This will build on the external pipeline, which was expanded in 2017 with commencement of the first full-time degree programme in Scotland (first graduates in 2020). This year the intake for the undergraduate programme is 335 entrants and the support infrastructure is continuing to be refined to meet the needs of the undergraduate cohorts. The work continues with the transition to support for Newly Qualified Paramedic (NQP) and will continue to evolve over the coming years. The VQ programmes have increased in the last year to meet the requirements of the demand and capacity programme of work. The Education and Professional Development team have worked flexibly and collectively to meet the additional demands required both for demand and capacity planning, as well as supporting the development of external partners during the most recent challenges impacting on the workforce in relation to the pandemic and whole system pressures.

We continue to be actively engaged as one of the 5 Boards in the East Region Recruitment Transformation Programme. The formal transition to the new East Region Recruitment Service has now been completed and the Regional Shared Service is now live across all 5 participating Boards. A service level agreement has been agreed with all the Boards in the consortium. A new Oversight Board is due to be established early in 2023 which will have corporate oversight of all of the business as usual activity of the Shared Service.

The South East Scotland Payroll Consortium is also in the process of transitioning to a new shared service arrangement and is due to come into effect on 1 February 2023.

We are also exploring opportunities to develop a multi-professional workforce and transition requirements are being explored to a pre-hospital clinical setting, this work is at an early stage.

We are also applying for accreditation to the UK Home Office to become a Visa Sponsor which will open up significant opportunities for the Service to attract candidates internationally.