NOT PROTECTIVELY MARKED

Public Board Meeting **27 May 2020**
Item No 04

THIS PAPER IS FOR DISCUSSION

BOARD QUALITY INDICATORS PERFORMANCE REPORT and TOWARDS 2020: TAKING CARE TO THE PATIENT

Lead Director **Author**	Pauline Howie, Chief Executive Executive Directors
Action required	The Scottish Ambulance Service Board is asked to **discuss progress** within the Service detailed through this Performance Report: - 1. **Discuss** and provide feedback on the format and content of this report. 2. **Note** performance against Annual Operational Plan (AOP) standards for the period to end April 2020. 3. **Discuss** actions being taken to make improvements.
Key points	This paper brings together measurement for improvement as highlighted by the Scottish Government's Quality improvement and Measurement for Non Executives guidance. This paper highlights performance against our AOP for Clinical, Operational, Scheduled Care and Staff Experience Measures. Patient Experience and Financial Performance are reported in separate Board papers. <u>Clinical Performance – April 2020</u> • Return of Spontaneous Circulation (ROSC) rates are returning to pre-pandemic levels at 44.2%. • We continue to reliably implement the pre-hospital stroke bundle. • Compliance with the recorded use of the PVC insertion care bundle continues to be above target at 96%. • Advanced Critical Care Paramedics are working within the National Tactical Command Cell to support our staff to respond to critically unwell patients. • Advanced Paramedic Practitioners are providing additional triage to support patients who can be safely

managed through alternative pathways of care. This includes self-care, face to face assessment and referral to COVID Hubs and Primary Care services.

Workforce

- In March 2020, the absence rate was 7.6%. The Once for Scotland Managing Attendance policy, guidance, processes and protocols have been refreshed to support delivery of attendance improvement.
- A Staff Wellbeing & Support group chaired by Director of Workforce has been set up to ensure we are taking all necessary steps to support the health and wellbeing of our workforce during the COVID-19 pandemic and progressing activity as appropriate.
- A Workforce Wellbeing Champions Network has been convened by the Scottish Government to promote and support the wellbeing of the Health & Social Care workforce with a national wellbeing hub launched on 11 May 2020.
- Significant effort has been made to attract additional staffing to support our COVID-19 response. Our workforce plans for 2020/21 are currently being reviewed as we move through the pandemic.

Enabling Technology

- The electronic patient record major incident module is undergoing trials by Specialist Operations Response Team (SORT) staff.
- Emergency Service Network (ESN) Programme – The revised Full Business Case (FBC) has been further delayed and there is currently no set release date.
- The project to provide an ESN compatible Integrated Communications Control System (ICCS) has been delayed due to the pandemic. Current indications are that this will push the Service go-live into 2021, requiring an extension to the current ICCS support contract beyond December 2020. Work is underway to arrange this.
- Defibrillator Replacement – The rollout was completed by the end of March as originally scheduled.
- The Patient Transport System Mobile Data Procurement Project is paused while the Scheduled Care Strategy is further developed. A business case is being developed to secure funding to keep the current system running.
- There have been a significant number of projects brought

	forward to support our response to Covid 19 e.g. Microsoft Teams, bot automation (voice recognition), additional business continuity sites, advanced practice triage.
Timing	This paper is presented to the Board for discussion and feedback on the format and content of information it would like to see included in future reports.
Link to Corporate Objectives	The Corporate Objectives this paper relates to are: 1.1 Engage with partners, patients and the public to design and co-produce future service. 1.2 Engaging with patients, carers and other providers of health and care services to deliver outcomes that matter to people. 1.3 Enhance our telephone triage and ability to See and Treat more patients at home through the provision of senior clinical decision support. 2.1 Develop a bespoke ambulance patient safety programme aligned to national priorities. Early priorities are Sepsis and Chest Pain. 2.4 Develop our mobile Telehealth and diagnostic capability. 3.1 Lead a national programme of improvement for out of hospital cardiac arrest. 3.2 Improve outcomes for stroke patients. 3.4 Develop our education model to provide more comprehensive care at the point of contact. 3.5 Offer new role opportunities for our staff within a career framework. 4.1 Develop appropriate alternative care pathways to provide more care safely, closer to home building on the work with frail elderly fallers - early priorities being mental health and COPD. 5.1 Improve our response to patients who are vulnerable in our communities. 6.2 Use continuous improvement methodologies to ensure we work smarter to improve quality, efficiency and effectiveness. 6.3 Invest in technology and advanced clinical skills to deliver the change.
Contribution to the 2020 vision for Health and Social Care	This programme of work underpins the Scottish Government's 2020 Vision. This report highlights the Service's national priority areas and strategy progress to date. These programmes support the delivery of the Service's quality improvement objectives within the Service's Annual Operational Delivery Plan.
Benefit to Patients	This 'whole systems' programme of work is designed to support the Scottish Ambulance Service to deliver on the key quality ambitions within Scottish Government's 2020 Vision and our internal Strategic Framework "Towards 2020: Taking Care to the Patient", which are to deliver safe, person-centred and effective care for patients, first time, every time. A comprehensive measurement framework underpins the evidence regarding the benefit to patients, staff and partners and supports the Service's transition towards 2020.

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

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

Control Charts

Rule 1: A single point outside the control limits

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

Rule 3: Six or more consecutive points increasing or decreasing

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

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

Run Charts

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

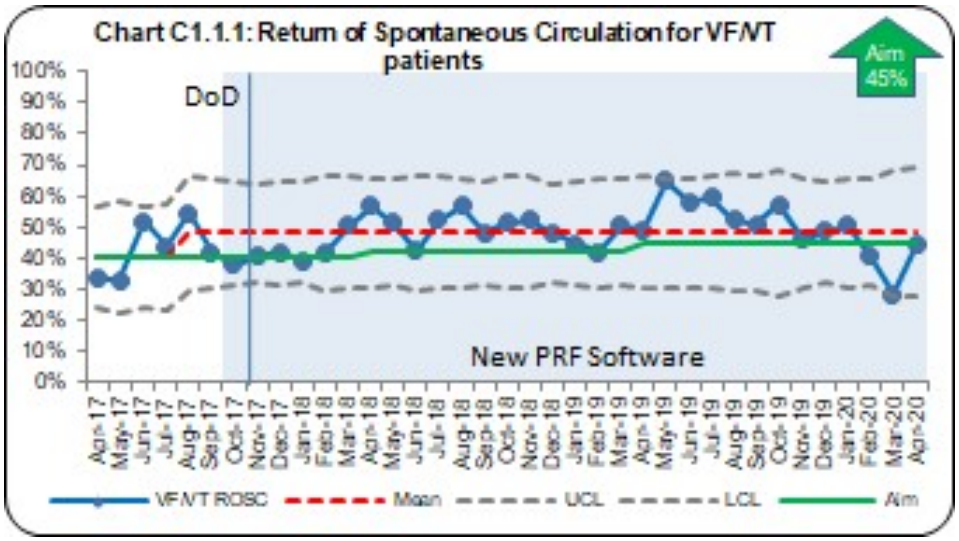
Rule 2: Five or more consecutive points increasing or decreasing

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

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

C1: Clinical Measures – Cardiac Arrest ROSC

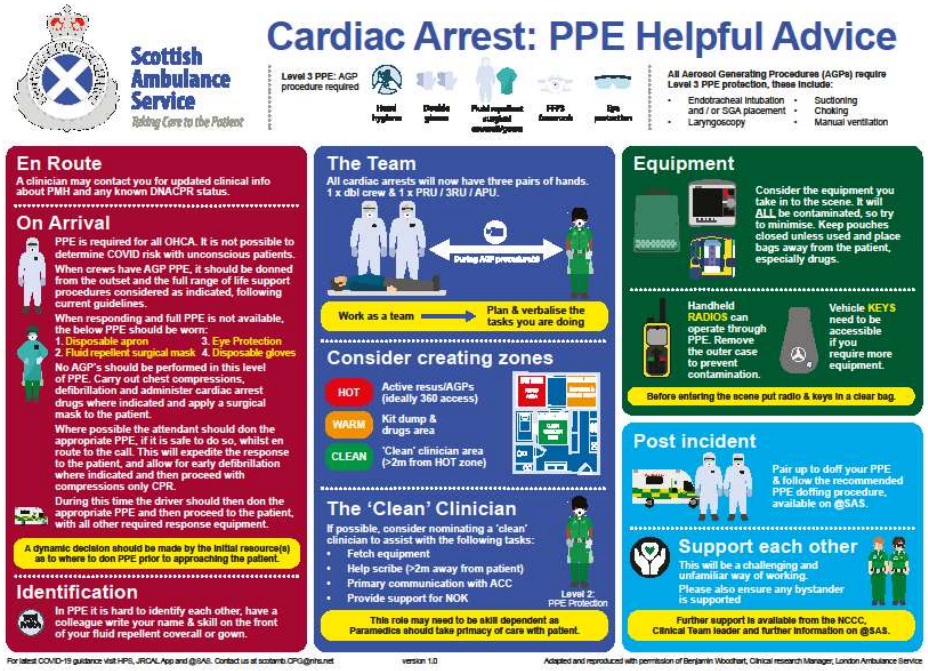
C1.1 VF/VT ROSC



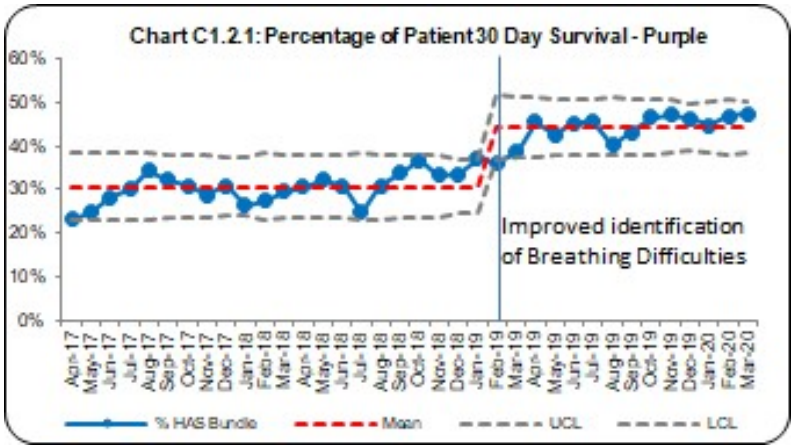
What is the data telling us? – The reduction in the VF/VT ROSC rate in March 2020 coincided with a series of changes in COVID-19 case definition and PPE guidelines which challenged the wider NHS system. Subsequently our OHCA and related PPE guidance has remained unchanged and this has allowed the position to become more stable. The data for April 2020 indicates that our ROSC rates are returning towards pre pandemic levels.

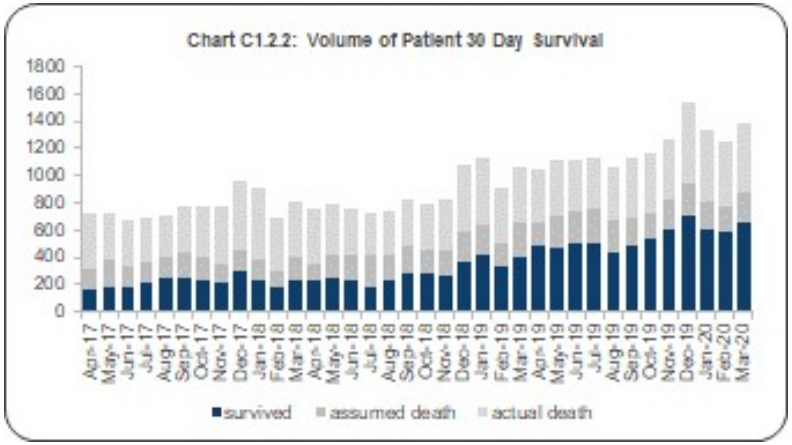
Why? – The Service continues to be a key partner in the delivery of the Scottish Government's Out of Hospital Cardiac Arrest (OHCA) strategy.

What are we doing to further improve and by when? – In relation to the COVID-19 pandemic the management of cardiac arrest in Personal Protection Equipment (PPE) represents a significant challenge to staff. Based on helpful feedback from staff, and involving frontline Paramedics, additional communication regarding practical advice to staff for management of OHCA safely and effectively utilising recommended PPE. This has been described and also communicated to staff via the infographic below.


Scottish Ambulance Service
Taking Care to the Patient
Cardiac Arrest: PPE Helpful Advice
Level 3 PPE: AGP procedure required
Hand hygiene
Double gloves
Fluid repellent surgical coveralls/gown
FFP3 facemask
Eye protection
All Aerosol Generating Procedures (AGPs) require Level 3 PPE protection, these include:
Endotracheal intubation and / or SGA placement
Laryngoscopy
Suctioning
Choking
Manual ventilation
En Route
A clinician may contact you for updated clinical info about PMH and any known DNACPR status.
On Arrival
PPE is required for all OHCA. It is not possible to determine COVID risk with unconscious patients.
When crews have AGP PPE, it should be donned from the outset and the full range of life support procedures considered as indicated, following current guidelines.
When responding and full PPE is not available, the below PPE should be worn:
1. Disposable apron
2. Fluid repellent surgical mask
3. Eye Protection
4. Disposable gloves
No AGP's should be performed in this level of PPE. Carry out chest compressions, defibrillation and administer cardiac arrest drugs where indicated and apply a surgical mask to the patient.
Where possible the attendant should don the appropriate PPE, if it is safe to do so, whilst en route to the call. This will expedite the response to the patient, and allow for early defibrillation where indicated and then proceed with compressions only CPR.
During this time the driver should then don the appropriate PPE and then proceed to the patient, with all other required response equipment.
A dynamic decision should be made by the initial resource(s) as to where to don PPE prior to approaching the patient.
Identification
In PPE it is hard to identify each other, have a colleague write your name & skill on the front of your fluid repellent coverall or gown.
The Team
All cardiac arrests will now have three pairs of hands. 1 x dbl crew & 1 x PRU / 3RU / APU.
During AGP procedures
Work as a team
Plan & verbalise the tasks you are doing
Consider creating zones
HOT
Active resus/AGPs (ideally 360 access)
WARM
Kit dump & drugs area
CLEAN
'Clean' clinician area (>2m from HOT zone)
The 'Clean' Clinician
If possible, consider nominating a 'clean' clinician to assist with the following tasks:
Fetch equipment
Help scribe (>2m away from patient)
Primary communication with ACC
Provide support for NOK
Level 2: PPE Protection
This role may need to be skill dependent as Paramedics should take primacy of care with patient.
Equipment
Consider the equipment you take in to the scene. It will ALL be contaminated, so try to minimise. Keep pouches closed unless used and place bags away from the patient, especially drugs.
Handheld RADIOS can operate through PPE. Remove the outer case to prevent contamination.
Vehicle KEYS need to be accessible if you require more equipment.
Before entering the scene put radio & keys in a clear bag.
Post incident
Pair up to doff your PPE & follow the recommended PPE doffing procedure, available on @SAS.
Support each other
This will be a challenging and unfamiliar way of working.
Please also ensure any bystander is supported.
Further support is available from the NCCC, Clinical Team leader and further information on @SAS.
For latest COVID-19 guidance visit HPS, JRCALA App and @SAS. Contact us at scotamb.CPG@nhs.net
version 1.0
Adapted and reproduced with permission of Benjamin Woodhart, Clinical research Manager, London Ambulance Service

C1.2 Survival at 30 days – Critically Unwell Patients





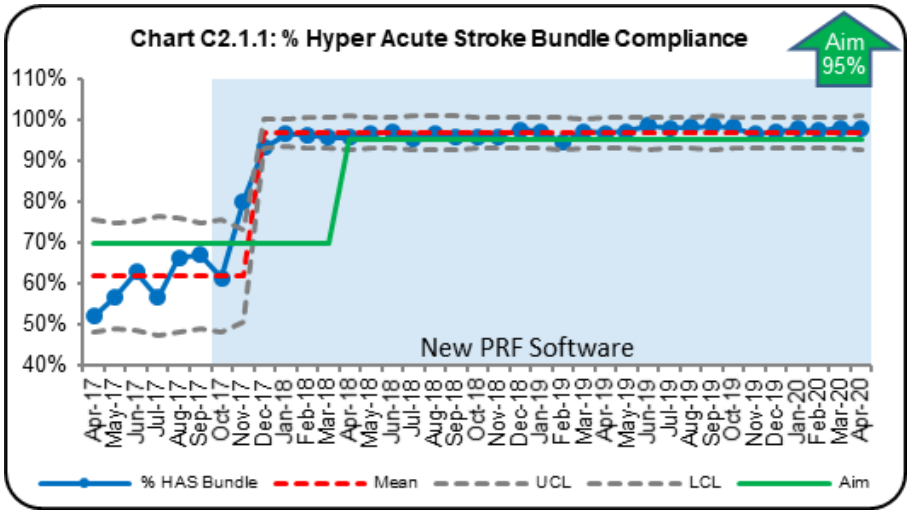
What is the data telling us? – The change in mean seen in chart C1.2.1 from January 2019 shows an increase in survival at 30 days of patients in the critically unwell category. In March 2020 47.5% of people in this category were still alive at 30 days compared with 38.7% in March 2019.

Why? - In November 2018, additional training was delivered to ACC call takers, to improve the identification of patients with severe breathing difficulty symptoms. This resulted in an improvement in the identification of patients with acute breathing difficulties at the time of triage which has led to an increase in the volume of patients in this category (chart 1.2.2). Analytical work is underway to understand various elements contributing to this observed increase in survival.

What are we doing and by when? – This category represents the group of patients where Service interventions can have the single biggest impact on survival. Further work is ongoing to understand more fully the clinical needs and associated interventions that can be improved to further increase survival.

C2: Clinical Measures – Stroke

C2. 1 Hyper Acute Stroke Care Bundle



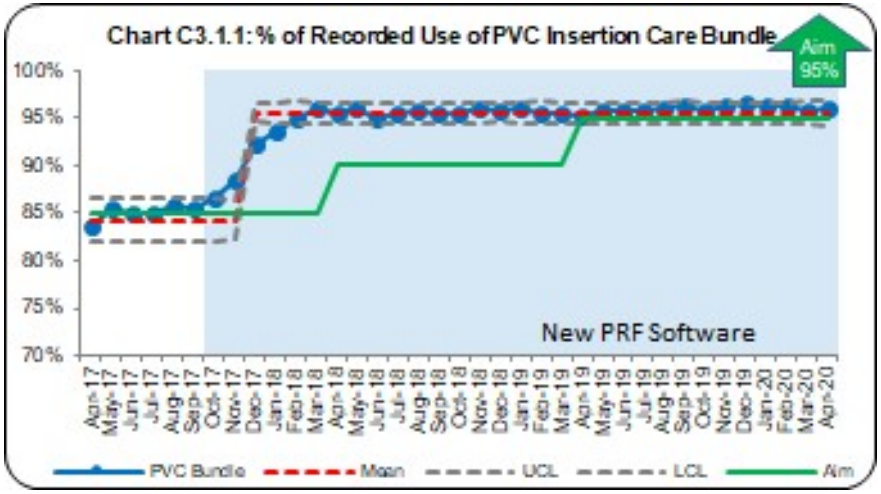
What is the data telling us? – During the last 12 months, on average we attended 320 hyper acute stroke patients per month. We are continuing to reliably implement the pre-hospital stroke bundle, with the data for April 2020 demonstrating 97.7% reliability.

Why? - The Service continues to lead on the pre-hospital recognition and intervention for stroke. This includes early recognition of stroke by the Ambulance Control Centre and the New Clinical Response Model approach to tasking for stroke patients. The introduction of the new PRF software has made it easier for crews to accurately record when they are providing the stroke pre-hospital care bundle.

What are we doing to sustain this level of implementation? – Implementation of the stroke pre-hospital care bundle will continue to be measured. A feedback system for crews and stations is being tested to support continuous improvement. The Scottish Government is leading a piece of work to revisit the national stroke pathway to include thrombectomy and the Service will play a key role in this future development, including updating how we measure the components of care for patients with a stroke therefore a dedicated Clinical lead has been appointed to lead this work.

C3: Clinical Measures – Infection Control

C3.1 PVC Insertion Care bundle



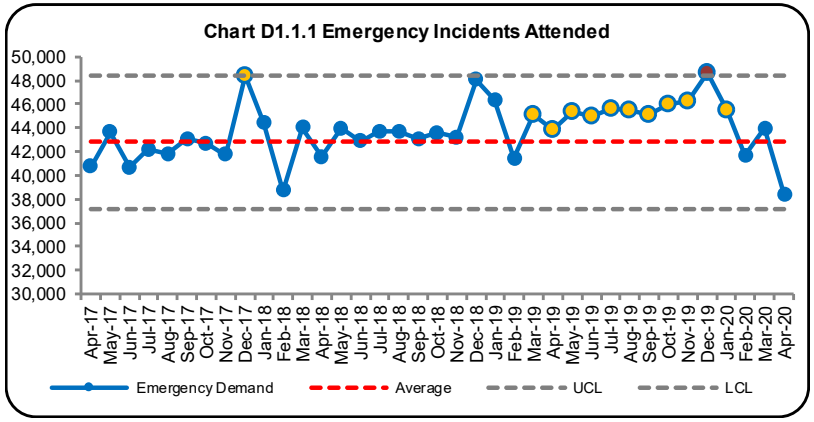
What is the data telling us? – Compliance with the recorded use of the PVC insertion care bundle is being consistently sustained above the quality indicator aim of 95%. Compliance for the months of January, February, March and April 2020 was 96.2%, 96.4%, 95.8% and 96% respectively.

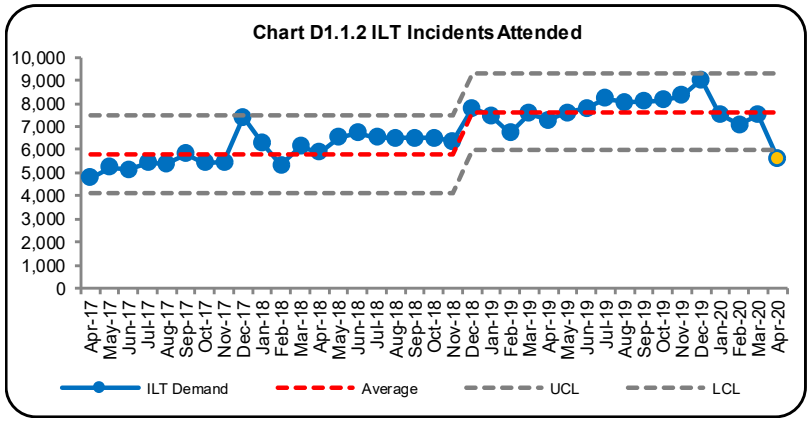
Why? – The accurate recording of compliance with the PVC insertion bundle continues to be supported by the software available in ambulances.

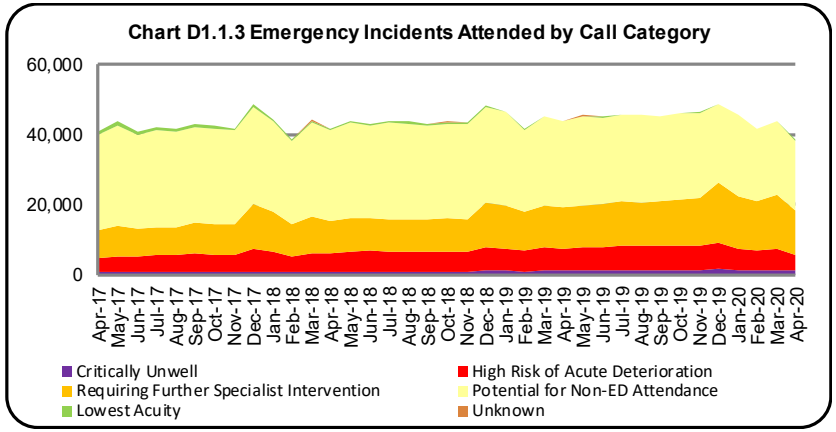
What are we doing and by when? – As well as recording and monitoring overall compliance for the Service the monthly compliance for each Region is monitored against the quality indicator aim.

D1: Demand

D1.1 Emergency Demand







What is the data telling us? – Emergency demand (chart D1.1.1) has shown a decrease in April 2020, this is directly attributed to COVID-19 restrictions. Critically and seriously unwell category demand (purple and red in chart D1.1.2) has shown a decrease of 22.76% in April 2020 when compared to April 2019 and overall Emergency Demand shows a decrease of 12.37% over the same period.

Why? – A reduction in the seriously unwell category has been seen during April 2020 as a direct result of COVID-19 restrictions. This is due to a significant reduction in Road Traffic Collisions, Industrial Incidents and Sporting/Leisure related calls. This reduction is not replicated in the critically unwell category where we have seen a 1.14% increase on April 2019, and this is in line with the increase we have seen throughout the previous year as a result of the improvement work in the triage of overdose patients and patients with breathing problems.

What are we doing and by when? – We continue to focus on a proactive management of demand in the Ambulance Control Centres which has been revised to meet the challenges of the COVID-19 pandemic. We continue referring appropriate patients to other providers, and pathways, including the 'COVID Hubs' within each territorial health board. We have also continued providing additional telephone triage by Clinical Advisors and more recently introduced a significant number of Advanced Paramedics to this cohort in direct response to the planning assumptions required for COVID-19.

Although demand overall is down, there are particular challenges seen in the North on increased numbers of longer ambulance journeys, in particular transfers from Caithness to Raigmore and Dr Grays to Aberdeen Royal Infirmary (ARI) owing to COVID status. There have also been patients admitted from Moray area to ARI and bypassing Dr. Grays at Elgin to maintain a 'clean status' as far as possible. This has increased service time and is often as a result of the community COVID hubs admitting patients 'virtually' from remote hubs.

SAS T1 Reduce hospital admissions - % of unscheduled

Chart T1.1 % Incidents with a Referral or Discharge Outcome

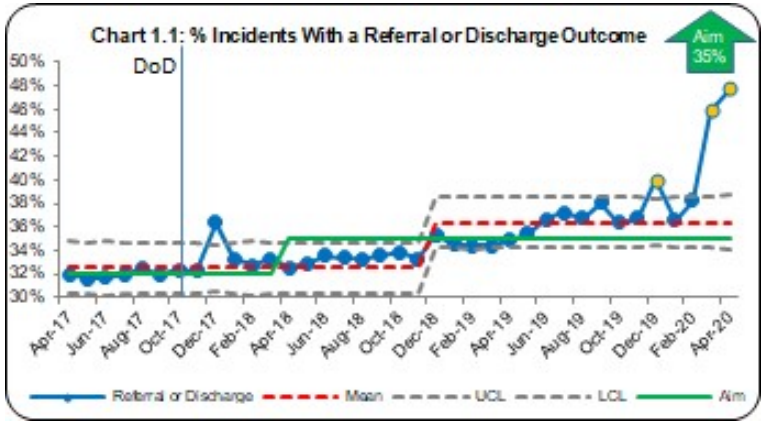


Chart T1.2 % Incidents with a Hear & Treat Referral or Discharge Outcome

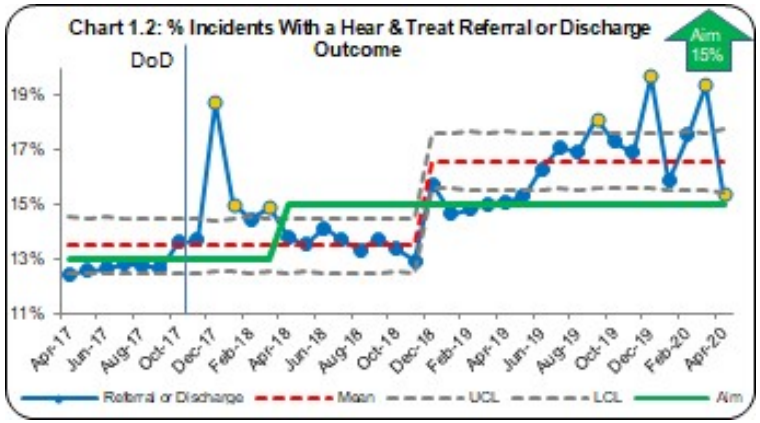
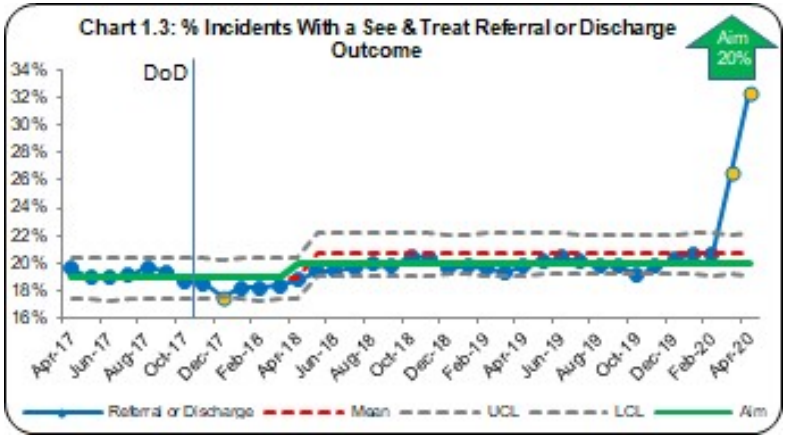


Chart T1.3 % Incidents with a See & Treat Referral or Discharge Outcome



What is the data telling us – Taking a whole system view of Charts T1.1, T1.2 and T1.3 we are able to review our progress against the aims associated with these measures and improve our understanding of the volume of incidents where a patient has received a referral or discharge outcome without the need to be conveyed to hospital allowing the patient to remain at home or in the community. The data for the months of March and April this year illustrate the impact of the COVID-19 pandemic on the system and will require further analysis and interrogation to help us understand the influencing factors and how these can be used to inform ongoing sustainable improvement.

Chart T1.1 illustrates the percentage of incidents with a referral or discharge outcome and the data shows we have continued to achieve the overall aim of 35% for the period June 2019 to April 2020. For the months of March and April 2020 there appears to be

a significant increase in non-conveyance with the data point sitting outwith the upper control limit (non-random variation) and warrants further investigation and an update will be included in the next Board report. This change is anticipated to be driven by the clinical interventions that have been introduced together with potential changes in public attitude to attending hospital where alternative pathways or clinical advice has been available during this pandemic.

Chart T1.2 which describes the percentage of incidents with a Hear and Treat referral or discharge outcome shows a relatively stable position between June to November 2019, potentially seasonal impact in December 2019 and some variation (random and non-random) in the early months of 2020 the data indicates that we are broadly in line with achieving the aim of 15%. This measure has been impacted by the way we report the changes to the NHS 24 stacker and the introduction of the Advanced Practice clinical triage from mid-April 2020. These changes are being closely monitored and further reporting will follow.

Chart T1.3 shows the percentage of incidents with a See and Treat referral or discharge outcome and describes the number of patients who were managed by our crews through face to face assessment without requiring onward transport to the Emergency Department. Over the months of January and February 2020 the data was above the aim of 20% however as we move into the months of March and April 2020 the data shows evidence of a significant change in the system (non-random variation) and further work is underway to better understand the influencing factors which are most likely to be directly linked to the COVID-19 pandemic.

Why – During this COVID-19 pandemic the Service continues to adapt its chain of response in line with its strategic intent with increasing awareness that timely meaningful interventions could mitigate the impact of the pandemic on our patients, our staff and other key stakeholders. During the time of the pandemic we have sought to safely manage demand through our Pandemic Escalation Plan and signposting appropriate patients to additional COVID and non-COVID related resources.

A key element of our ability to be so responsive has been the ongoing improvement work that has focussed on supporting staff to provide the most appropriate care for patients and building on the knowledge and skills of the Clinical Hub within ACC. During this pandemic we have deployed our Advanced Practitioners in an innovative way to provide additional clinical triage within the ACC and alternative pathways have been available locally for patients through the introduction of Board COVID Community Hubs.

The Service is both feeding into and learning from a whole system approach, for example in those high acuity non-COVID patient cohorts, and analysing the demand for STEMI patients and in non-high acuity mental health patients as we explore the opportunities for alternatives to traditional Emergency Department pathways.

What are we doing and by when –This ongoing pandemic and our learning from it will support us as we move into the Recovery phase and help inform how we can build sustainable improvement and inform our wider system understanding.

Clinical Services Transformation

The Clinical Services Transformation programme routinely reports progress across a range of projects however these have largely been paused as part of the Service's response to COVID-19.

Areas which we have been able to continue are:

1. End of Life Care – Our work in this area has helped inform clinical guideline development for crews managing end of life care and to provide them with support around symptom relief for patients being cared for in community settings. Through this work we continue to develop our professional network and stakeholder relationships to ensure a coordinated and joined up approach.

2. Scottish Trauma Network - Support NHS Scotland to deliver a high quality major trauma service.

The COVID-19 pandemic has seen a significant impact on our major clinical trauma volume and this has resulted in the deployment of our Advanced Critical Care Practitioners (ACCPs) to the national Tactical Cell at Newbridge where they are working on a 24/7 rota to provide real time decision support to staff on the ground by accessing patient records where available to determine:

- Do No Attempt Cardiopulmonary Resuscitation Status (DNACPR)
- level of frailty,
- pre-existing medical conditions; and
- presence of anticipatory care plans.

ACCPs have intervened in almost 60% of purple calls offering advice on Personal Protective Equipment (PPE) guidelines to ensure staff are adequately protected, supported with on scene decision making and clinical care and protecting additional staff from potential exposure to COVID-19 pathogen by standing down additional resources where appropriate.

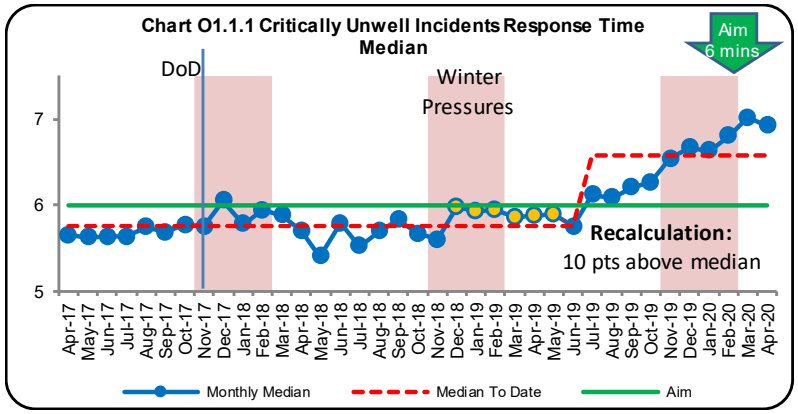
Work is progressing to incorporate these important interventions into a 'business as usual' approach by reformatting the SAS ACC 'Trauma Desk' to take on a broader 'Critical Care' function which would extend to critically ill non-trauma patients. This is one early example of where we are applying the learning from the pandemic to influence how we inform our future working.

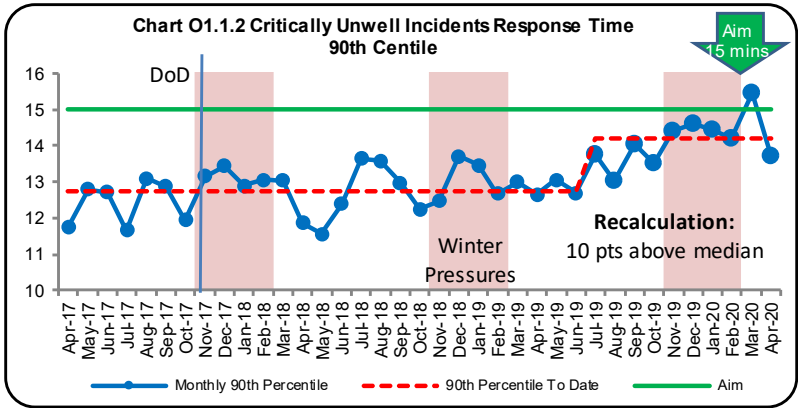
We continue to engage with the Scottish Trauma Network and have provided them with an update on our response to the COVID-19 pandemic and the impact on our internal operations.

Our understanding is that the planned opening of the Major Trauma Centres and units will proceed in 2021 and to this end we are looking to prepare for this development through engaging key stakeholders and using data to inform our understanding of operational demand and impact. It is anticipated that a further update will be available for the next Board meeting.

O1: Operational Measures – Unscheduled Care

O1.1 Critically Unwell Incidents Response



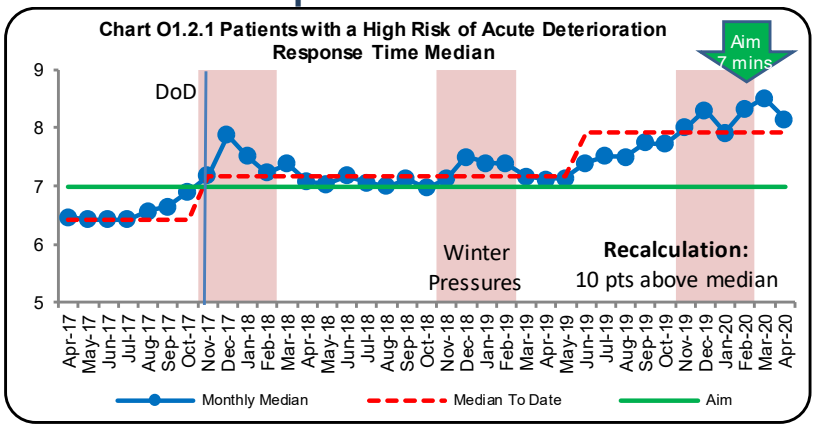


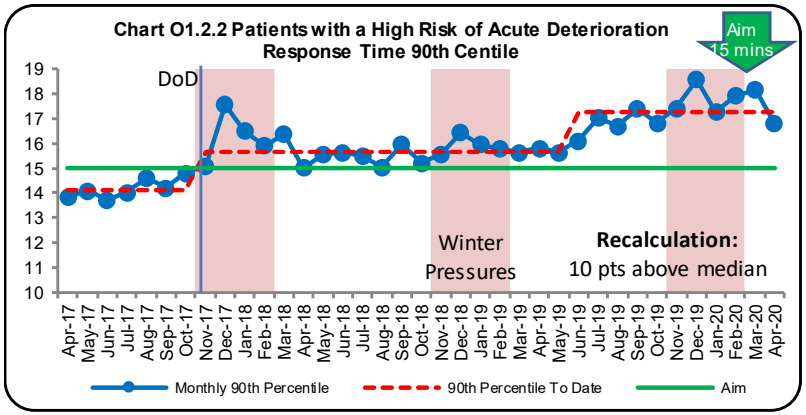
What is the data telling us? - In the last year on average we attended 1,213 critically unwell incidents per month; these are our highest priority calls to the most acutely unwell patients. In April 2020, we attended 1,187 incidents and the performance median was 6 minutes 55 seconds (against a standard of less than 6 minutes), with a 90th percentile of 13 minutes 43 seconds (against a standard of less than 15 minutes). Non-random variation can be seen in chart O1.1.1 highlighted yellow.

Why? – This is the highest priority call and identified early in line with the NCRM through the key entry questions. We send the nearest available resource which includes diverting them from lower acuity calls. This currently does not include volunteers (CFR's) due to the COVID-19 pandemic. We also send an additional resource (when available) to ensure we have 3 pairs of hands at the scene to improve the outcomes from Cardiac Arrest patients.

What are we doing by when? - We are seeing an increase in average time to scene due to not utilising CFR's as well as on scene times for both conveyed and non-conveyed patients due to COVID-19, the latter impacts on crew availability. Performance will improve through reductions in unscheduled demand and improvements in resource availability. We have placed our Advanced Critical Care Paramedics within the Tactical Command Cell to review our response to calls for our critically unwell patients and support staff who have to apply Level 3 PPE during the COVID-19 sustained transmission phase. Our work with the Unscheduled Care Collaborative Programme will help identify opportunities to reduce demand. To improve resource availability, we are progressing our recruitment and training plans as much as possible during the pandemic, working very closely with key sites which are experiencing delays in hospital handovers which have increased as physically distancing measures have been introduced in A & E departments.

O1.2 Patients with a high risk of acute deterioration Response



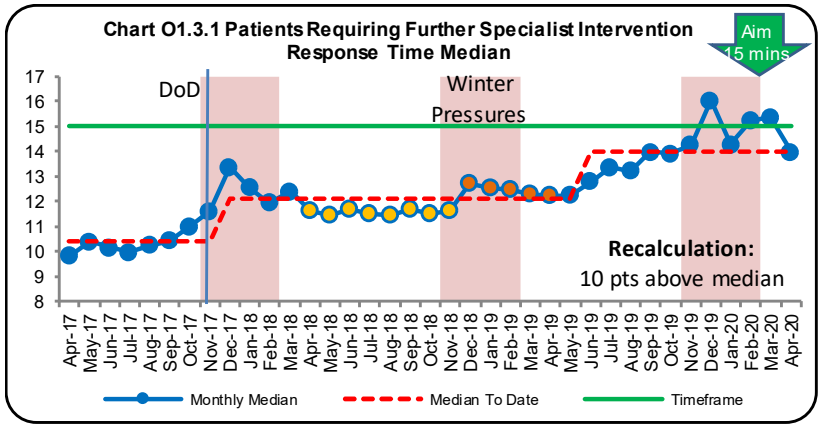


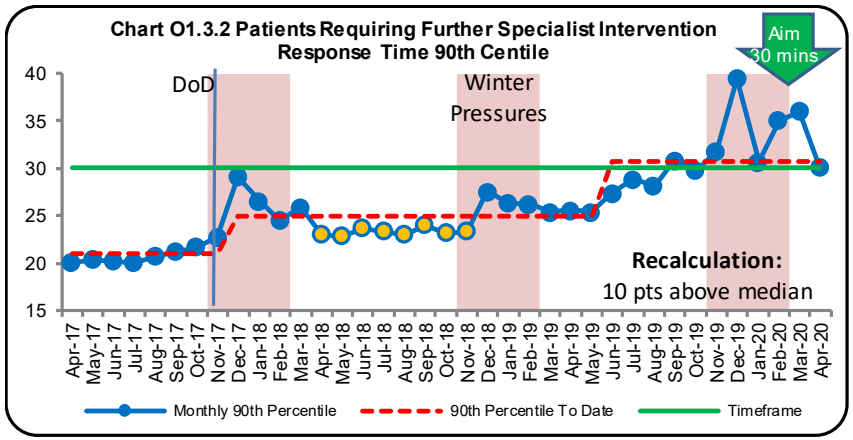
What is the data telling us? - In the last 12 months on average we attend 6,546 patients with a high risk of acute deterioration per month, these are our second highest priority calls to patients in an immediately life threatening situation. In April 2020, we attended 4,446 such incidents and the performance median was 8 minutes 09 seconds (against a standard of less than 7 minutes), with a 90th percentile of 16 minutes 48 seconds (against a standard of less than 15 minutes).

Why? - Performance within these areas remains outwith the standard despite a decrease of 28.93% in this category of incidents in April 2020 when compared to the same period last year. Community First Responders are no longer able to support response due to the COVID-19 pandemic.

What are we doing and by when? – We continue to focus on the pre-positioning of resources when available to reduce the travel time of ambulance resources arriving at the scene. This will include performance management and support of dispatch in areas such as use of social tactical deployment points; due to COVID-19 and social distancing requirements, unsocial tactical deployments have been suspended.

O1.3 Patients requiring further specialist intervention Incidents Response





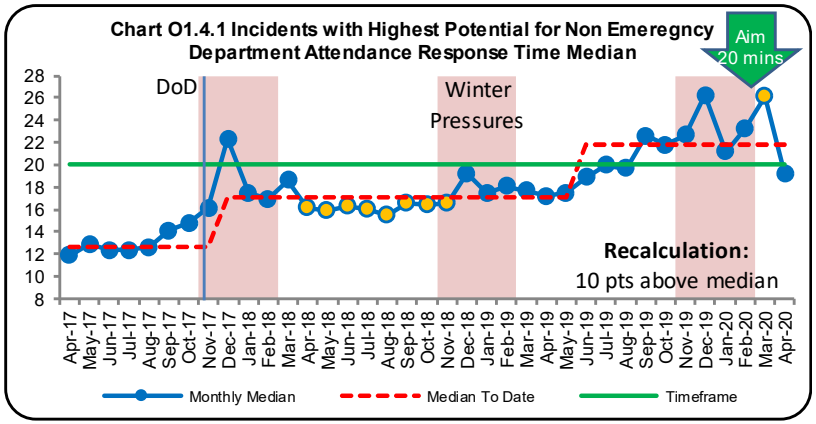
What is the data telling us? – In the last 12 months on average we attend 13,529 such incidents per month; these are patients who have a defined need for an acute care pathway. In April 2020, we attended 12,795 such incidents and the performance median was 13 minutes 58 seconds, with a 90th percentile of 30 minutes 7 seconds. Although there are no specific time standards for Amber calls indicative time frames for these calls are 15 minutes for the median response and 30 minutes for the 90th percentile response. Non-random variation can be seen in these charts highlighted yellow and orange.

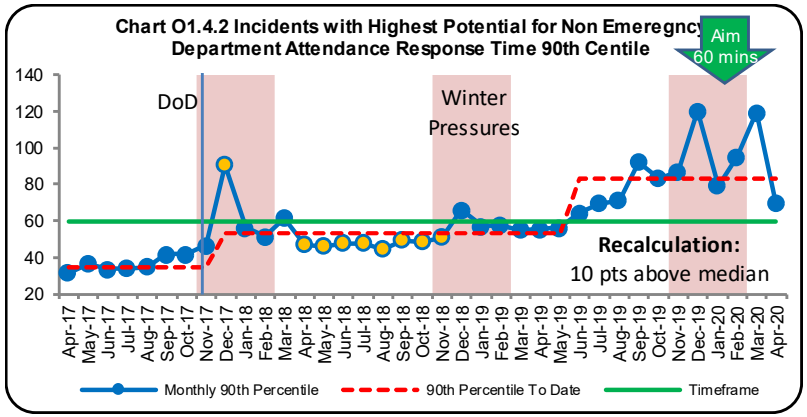
Why? – The introduction of Dispatch Prompts identifies that the most appropriate resource for these patients is an ambulance for transport. This ensures that patients who require a specific clinical pathway arrive at the destination location quicker.

What are we doing and by when? – We continue to review these Calls to understand the special causes behind the variation being seen. Where a transporting resource is not available within 25 minutes a Paramedic will be sent and backed up as soon as transport capable resource becomes available.

The regions continue to manage abstractions to maximise shift cover.

O1.4 Incidents with highest potential for Non-Emergency Department attendance



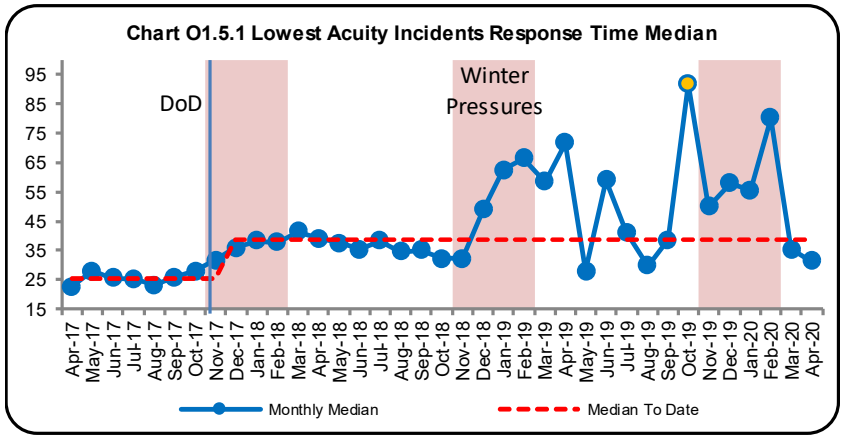


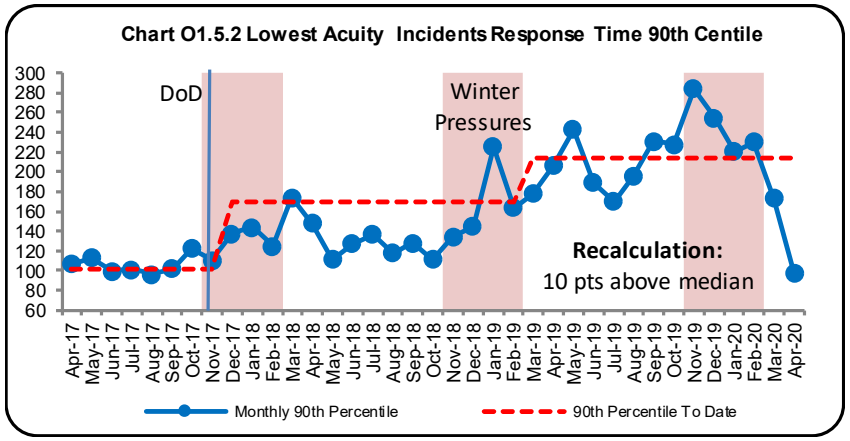
What is the data telling us? – In the last 12 months on average we attend 23,336 such incidents per month; these are patients with non-immediately life threatening presentations, and an associated high rate of non-conveyance. For April 2020, performance median was 19 minutes 15 seconds, with a 90th percentile of 1 hour, 10 minutes 7 seconds. Although there are no specific time standards for yellow calls indicative time frames for these calls are 20 minutes for the median response and 60 minutes for the 90th percentile response. Non-random variation can be seen in these charts.

Why? – Where demand exceeds resource provision, resources will be diverted to higher priority calls to enable us to prioritise critically unwell patients. Ambulance resources delayed at hospital directly impact on our ability to respond to these patients timeously.

What are we doing and by when? – We continue to review these calls to understand the variation being seen. A work programme of clinical risk and demand management, led by the Medical Director and the Director of National Operations has been developed in order to mitigate risk, reduce delays and improve patient experience for those patients in lower clinical acuity categories. This requires a whole system approach to matching resources to demand and continually considering the clinical acuity of patients affected. In cases of delayed response, welfare call backs are undertaken to ensure patient safety. Work has taken place to ensure that any calls that are delayed by more than 45 minutes receive a clinical welfare check. During the COVID-19 pandemic, Advanced Paramedics are undertaking additional triage to support patients who can be safely managed through alternative pathways of care. This includes self-care, face to face assessment and referral to COVID Hubs and Primary Care services.

O1.5 Lowest acuity Incidents Response



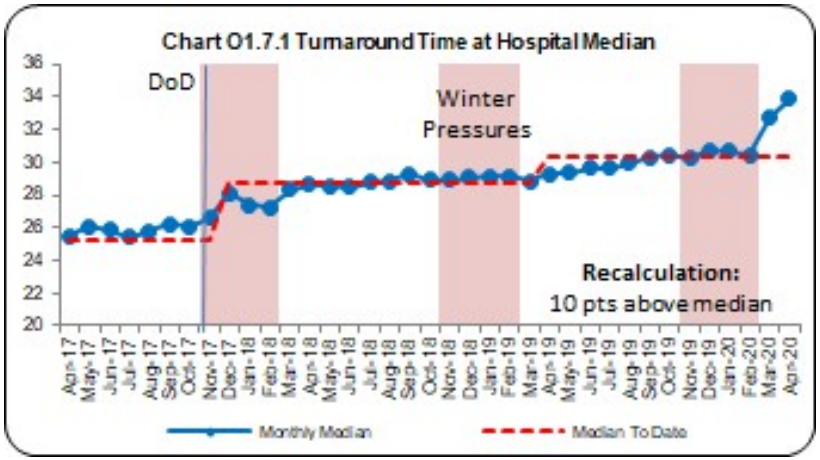


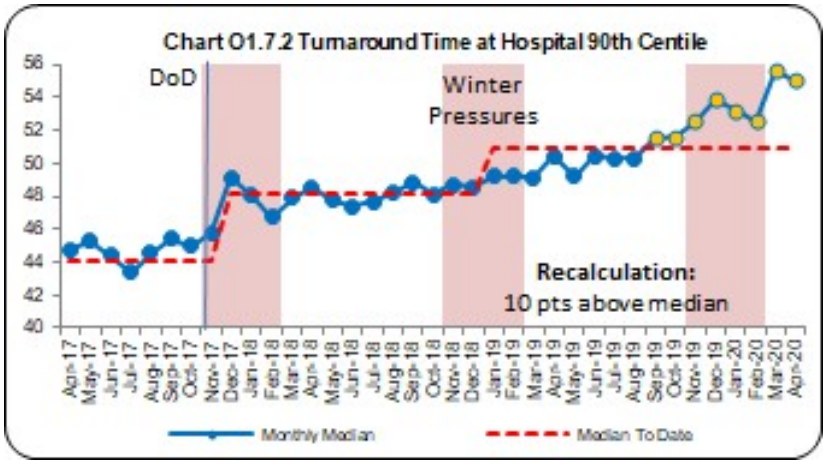
What is the data telling us? – In the last 12 months on average we attend 93 such incidents per month; these are non-immediately life threatening patients who have the potential for additional clinician led telephone triage or face to face assessment when required. For April 2020, performance median was 31 minutes and 24 seconds, with a 90th percentile of 1 hour, 37 minutes 17 seconds. Non-random variation can be seen in these charts highlighted yellow.

Why? – Where demand exceeds resource provision, resources will be diverted to higher priority calls to enable us to prioritise ILT the sickest patients. Ambulance resources delayed at hospital directly impact on our ability to respond to these patients timeously.

What are we doing and by when? – We are reviewing these Calls to understand the cause of the variation. In cases of delayed response, welfare call backs are undertaken to ensure patient safety as detailed in the work programme mentioned at O1.4.

O1.7 Turnaround Time at Hospital





What is the data telling us? – On average we transport 30,798 (61.2%) unscheduled care patients to hospitals per month; these are patients who present through the accident and emergency service. For April 2020, we transported 21,817 (52.2%) patients with a median turnaround time at hospital of 33 minutes 52 seconds. Non random variation can be seen in these charts highlighted yellow.

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

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

- Introduction of red and green zones within hospitals for COVID and non-COVID. This has seen different entrances and procedures for patients and ambulance crews attending hospital sites. Initially this changed frequently however now seems to have settled into set procedures for each hospital site. It should be acknowledged that each hospital has different processes so crews from different areas may not know what the specifics are for each site. Donning and Doffing of PPE has added time to staff procedures along with undertaking processes like completing the EPR as this cannot be undertaken whilst the highest level of PPE is worn and has to be undertaken once the patient is off loaded. There is also an acknowledgement that undertaking physical effort

within the PPE does increase staff requirement for hydration and rest after each event.

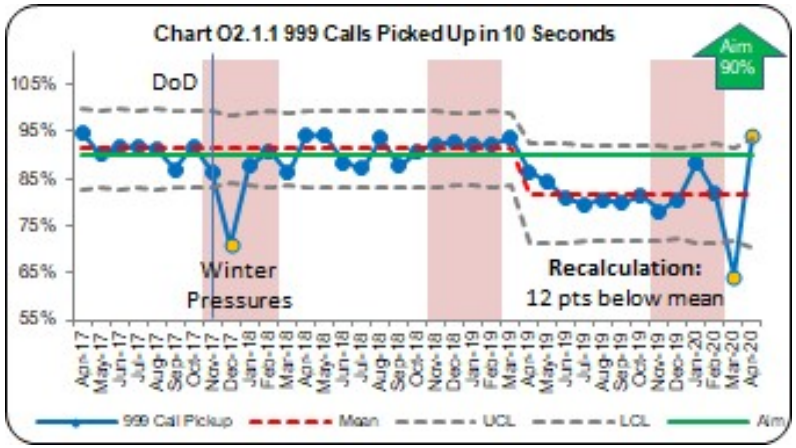
- Cleaning - there has been increased time as staff must ensure that the vehicle has been thoroughly cleaned to ensure there is no cross infection. Although staff would have generally undertaken infection control procedures they are being more cautious with this and taking longer to undertake this.

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

Within the West of Scotland there has been a dedicated Area Service Manager and HALO specifically aligned to both QEUH and Ayr to provide local leadership and engagement to reduce hospital turnaround issues. In addition to this there are up to three conference calls daily with senior hospital managers, SAS Heads of Service and Deputy Regional Directors attending the hospital sites, and Operational Director along with Medical Director meeting regularly with QEUH to discuss solutions to decrease turnaround times.

O2: Operational Measures – 999 Calls

O2.1 999 Calls Answered in 10 Seconds



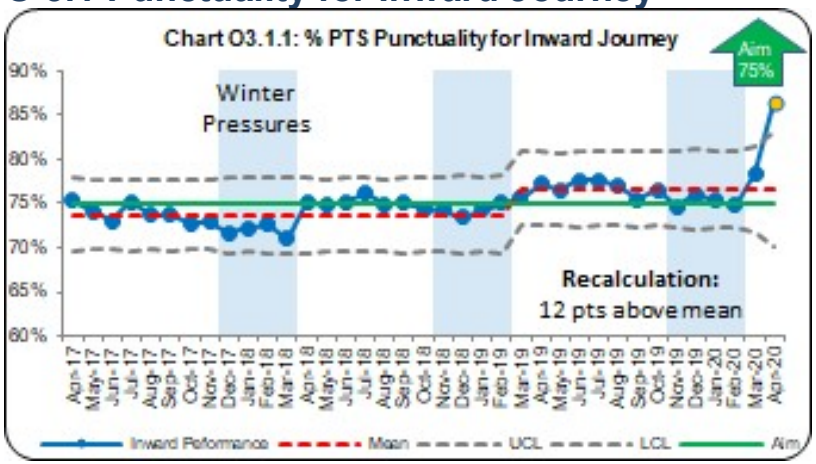
What is the data telling us? – In the last 12 months on average we answer 49,528 emergency 999 calls per month. For April 2020, we answered 39,470 emergency 999 calls with 94.4% picked up within 10 seconds (against a standard of 90%). Call demand has decreased by 11.7% when compared to the same month last year. This pattern is in line with similar patterns across the UK ambulance sector. Non-random variation can be seen in this chart highlighted in yellow.

Why? – Call demand fluctuates by hour of the day. When incidents occur in public places, we sometimes see a sudden spike in call demand due to multiple calls for the same incident. Whilst this is not uncommon, where we see a number of these across the country in quick succession demand exceeds capacity.

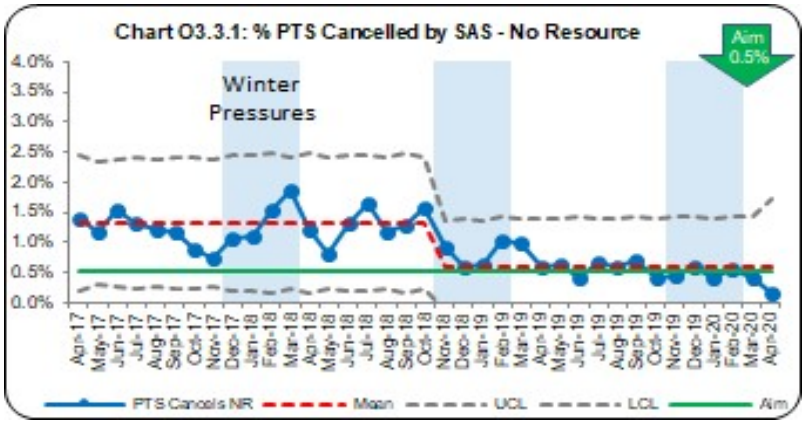
What are we doing and by when? – We are reviewing call pick up performance to identify the special cause of this variation. We regularly review patterns of call demand to ensure that we have sufficient resources to answer 999 calls as soon as possible. We have recruited 60 additional call handlers in line with our mobilisation plans relating to COVID-19. The reduction in call volume and the additional call handling capacity has enabled the improvement in the percentage of calls answered in 10 seconds.

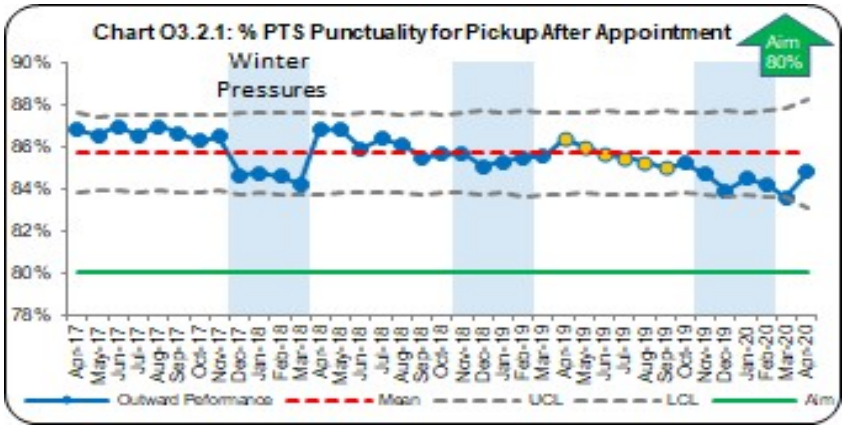
O3: Operational Measures - Scheduled Care

O 3.1 Punctuality for Inward Journey



O3.3. Cancelled by SAS No Resource





What is the data telling us? - Punctuality for Inward Journey (O3.1) was above the target of 75% for March 2020 and finished above the Upper Control Limit in April. This reflected the reduction in PTS demand in April due to Health Boards suspending non-essential clinical activity including the majority of outpatient services.

Punctuality for Pickup after Appointment (O3.2) also improved in April 2020 having dipped slightly in March.

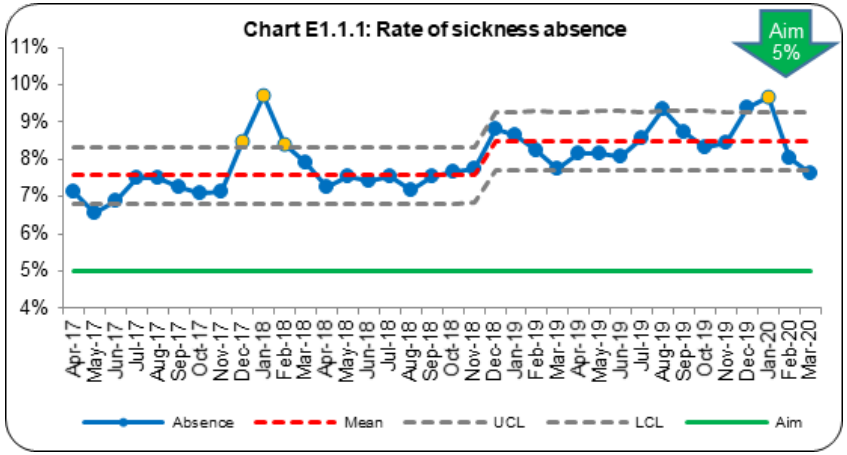
Journeys Cancelled by the Service – No Resource (O3.3) maintained the good performance trend of recent months; achieving the target of less than 0.5% in March 2020 and improving on it still further in April at just over 0.1%.

Why? – The suspension of non-essential activity including elective procedures and outpatient clinical services by Health Boards as part of the COVID-19 contingencies significantly reduced the demand on PTS in late March and in April. Despite some reduction in staffing due to the requirements for shielding staff with underlying health conditions, this allowed the remaining resources to deliver improvements in punctuality for the remaining, life-supporting patient demand such as renal dialysis and oncology. This also resulted in an improvement in Punctuality for Pickup after Appointment and reduced the level of PTS Journeys Cancelled by the Service due to No Resource.

What are we doing and by when? – Discussions are ongoing with Health Board partners to utilise transport capacity to assist with some patient journeys. This will allow PTS resources to focus on providing more dedicated, responsive support to Boards as they resume routine activity in addition to freeing resource to underpin A&E activity in the event of an increase in COVID related demand.

E1: Staff Experience

E1.1 Sickness Absence



What is the data telling us? -

In March 2020, the absence rate was 7.6%, this is a 0.1% reduction on the same month in 2019.

Why? – Absence cases for Stress/Anxiety/Mental Health related conditions have increased, resulting in long term absence causes which continue to require significant attention. We have, in some service areas, also seen an increase in short term intermittent absence.

What are we doing and by when? - Actions introduced to address absence rates are continuing as we focus on reducing absence and keeping people at work where appropriate.

- The E.A.S.Y. absence management model, a new Wellbeing and Case Management model, which the Service introduced in November 2019, has enabled a more focussed and targeted support to staff who are absent from work with a mental health, stress or anxiety related absence.

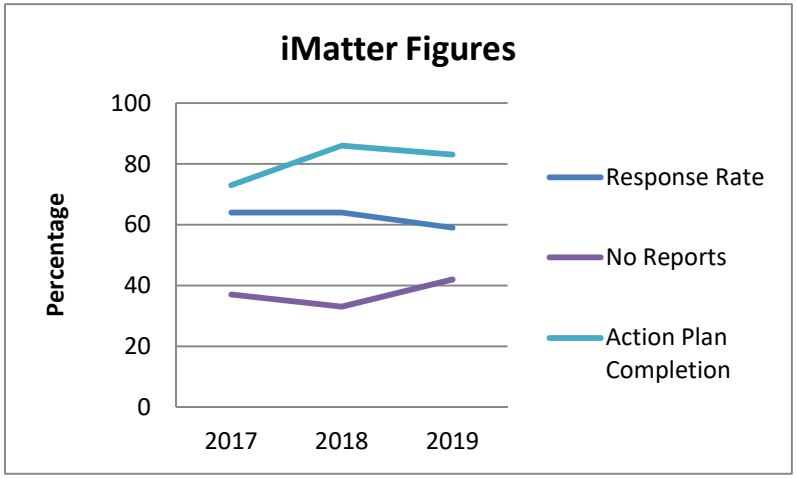
- The group established by our Executive Team to focus on absence on a weekly basis have introduced a number of health and well-being initiatives to support staff in looking after their mental health, stress and anxiety.

- Although revised Attendance Management policy and processes were introduced from 1st March 2020 as part of phase one of the national Once for Scotland policy implementation, all Boards have had to suspend or adjust normal operational management activity as we prioritise the COVID-19 response. All Regions/Directorates are reviewing case handling arrangements and we are having ongoing partnership discussions to identify how we can use a person centred approach to handle specific staff situations.

- Development work with regard to consistent use of GRS, tracking and reporting of absence is ongoing.

- All training and development materials are being updated in line with recent developments, using external bench marking of practice including Public Sector Wellbeing Group and NHS Employers.

E1.2 Employee Experience



COVID-19 Pandemic Implications
The COVID-19 global pandemic has required us to refocus our approach regarding employee experience. Maintaining positive employee experience remains at the heart of our organisational priorities with the current focus on ensuring we are doing all we can to support our staffs' health and wellbeing throughout the crisis.

Whilst we are focusing on our organisational response to the pandemic the Staff Experience group and associated activity has temporarily been postponed. This means initiatives such as iMatter will not run according to schedule but will recommence as the situation permits.

What are we doing and by when?
A Staff Wellbeing & Support group chaired by the Director of Workforce has been set up with the purpose of ensuring that all necessary steps are taken to support our staff and their health and wellbeing throughout the crisis. There is wide representation from across the Service and expertise on the group to enable this to happen.

A summary of the work that has been completed with some of it implemented on an ongoing basis is:

- Health & Wellbeing is featured in staff communications and briefs every week, signposting to resources available through @SAS and other sources of help
- The CEO weekly bulletin is focusing on a different wellbeing theme each week with resilience, physical activity, culture & behaviours and social connections themes in the month of May 2020
- Wellbeing videos are being developed for a continual promotion of staff health & wellbeing – the first two featured were on themes of mental health and promotion of our Chaplaincy service
- We are posting clips received from well known Scottish personalities thanking our staff and providing encouraging messages to help boost morale
- We are constantly asking for staff feedback regarding what else we can do to support their health and wellbeing with feedback captured online
- A Wellbeing Pack is being produced for staff and printed copies will be distributed to stations as an easy access reference guide
- The Wellbeing section on @SAS has been updated to streamline resources and signpost staff appropriately with guidance and resources that reflect additional needs and requirements during the COVID-19 pandemic

- Regional Leadership Teams are encouraging local managers and team leaders to be in regular communication with their teams to ensure they are supported and in particular those who are off sick or shielding who may feel more isolated
- We are currently progressing the introduction of staff welfare vehicles with one in each region for the provision of refreshments to staff similar to Ambulance Trusts in London and East Midlands that have had a very positive impact on staff wellbeing and morale
- Two staff members have started a blog to help support and start a conversation amongst staff about wellbeing and will align with the weekly wellbeing themes in the CEO bulletin
- A peer support initiative is going to be trialled based on the critical incident stress management model. Interested staff will form a peer support team (in particular staff who are shielding will be invited to participate) and following virtual training will provide support initially to our Paramedic Practitioner cohort

It is worthy of note the support and donations that the public, local businesses and companies have generously given the Scottish Ambulance Service at local, regional and national level. Their kindness and words of encouragement have proved to be a real boost to staff morale at this difficult time.

Whilst the activity that the Staff Wellbeing & Support group is taking forward has been set up in response to the COVID-19 pandemic, it is important to note that we are also looking to see how it can be sustained in the long term. The intent is to continue to build on our staff wellbeing and support provision that enables the continued success of our organisational priorities.

The Scottish Government has been considering what they can do to support efforts at this time as well as outlining the role and responsibilities of Boards as employers. We have mapped out the actions we are taking to ensure we are compliant with the employer's duty of care during COVID-19 as set out by the Scottish Government DL (2020)8 14 April.

We are represented on the Workforce Wellbeing Champions Network that the Scottish Government has convened across Health & Social Care to promote and support the wellbeing of the workforce through this unprecedented time. This group is meeting weekly with the intention to pull collective efforts and enable mutual aid. For example, we have gained agreement from Directors of Psychology in Lothian, GGC and Grampian with respective Chief Executive support to open up their help lines on a regional basis for Service staff. The help lines are for early intervention for psychological distress that is based on psychological first aid and are staffed by psychologists. We will be reviewing this after 6 weeks to see what the demand has been and negotiate a longer term more sustainable solution if appropriate.

As part of this work a national wellbeing hub is being launched on 11 May 2020 as a single access point with a number of resources available to the Health & Social Care workforce for health and wellbeing. The intent is that this is complementary to what local Boards provide and links will be provided on the national hub to signpost to local Boards' service provision too.

Workforce Development

1. Employee Resourcing

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

Status – On track to deliver 2020-21 plans based on continuing strategic direction of travel.

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

As a consequence of the current COVID-19 situation the current Dip HE in Paramedic Practice courses have been temporarily suspended due to the closure of Glasgow Caledonian University, lack of access to the Academy teaching facilities and the return of Associate Lecturer secondees to frontline duties. The July 2020 cohort is likely to commence in August 2020 which has been communicated to students who this has affected. It is proposed that GCU will remain closed until the 6th October and will be carrying out online learning. Discussion is currently underway with the university around access to the academy facilities prior to this time.

In addition, discussions have commenced with the HCPC regarding an extension for the delivery of the Dip HE programme to enable us to meet our planned intake numbers.

Recruitment to the 2020/21 VQ Ambulance Technician courses will continue with the next course set for July 2020.

11 Advanced Practitioners commenced training in January 2020 which increased our overall Paramedic numbers. An additional 4 are still awaiting confirmation of start dates. The 2020/21 campaign for Advanced Practitioners has also been put on hold due and a launch date is still to be confirmed to meet the September 2020 intake.

Planned Activities Include – With the suspension of the recruitment to the 2020/21 training groups for the Paramedics programme, the target date of having all places filled by April 2020 is currently being revised and the recruitment process will reconvene when new cohort dates are confirmed. However, a total of 156 applications were shortlisted and OSCE's will re-continue when safe to do so. who re-submitted a CPD statement will also progress to the OSCE stage when recruitment reconvenes.

The recruitment team will continue to liaise with regional workforce leads throughout the process. The allocation of places for VQ Ambulance Technician and Ambulance Care Assistant roles continues in line with Regional workforce plan requirements. 2020/21 advertising for qualified Paramedic recruitment is on hold and will re-continue once a launch date is agreed.

Other Considerations – Resourcing model developments will support continuing target delivery over the next three years as we prepare for changes to the Educational Model to align with the introduction of degree level HCPC registration requirements in 2021. This will build on the

external pipeline which was expanded in 2017 with commencement of the first full-time degree programme in Scotland (first graduates in 2020). The degree programmes will commence in August/September 2020 pending successful validation by the universities and HCPC approval.
We continue to be actively engaged as one of the 6 Boards in the East Region Recruitment Transformation Programme Board to inform the development of the Recruitment Shared Service. Part of the strategic proposal has been the implementation of the National Recruitment IT system, Jobtrain, which went live in December 2019. Core Scottish Government funding is in place for Jobtrain until the year 2022/2023.

2. Employee Development

Aim - To identify the employee development requirements arising from workforce modelling which will underpin the delivery of our Workforce Plan and ensure we have developed a workforce capable of delivering our strategic aims.

Status – Planning (review of work to date and response to workforce re-modelling activity) and implementation of changes arising from development needs assessment.

Improvement – An organisational learning needs analysis, overseen by the Capable Workforce Group, was undertaken at the end of 2018. A variety of learning needs from across Directorates were raised and the Group committed to supporting a number of these financially in order for development of staff to take place. It was acknowledged that the tool used potentially did not fully capture learning needs of the Service's staff, and will be developed iteratively through future cycles to align with strategic developments and embedded within directorates' annual activities.

Planned Activities Include –

The Service's processes for Talent Management and Succession planning was published in November 2019 and will be the basis for further embedding the cycle at Directorate level in 2020. Due to COVID-19, plans to commence the process in March 2020 have been postponed.

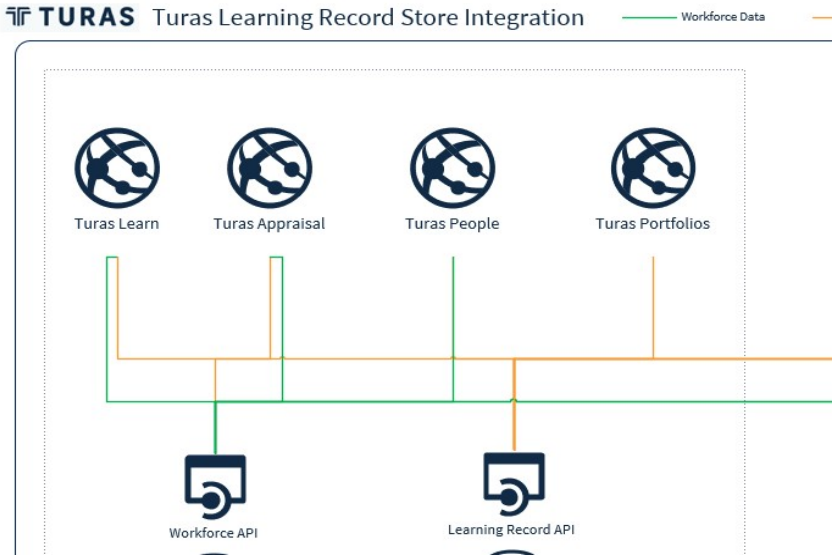
To support our Talent Development, SAS New Horizons is aimed at new and emerging leaders and managers from the Service in all professions to support their leadership capabilities by developing a leadership approach which emphasises compassion, collaboration and a desire to serve the Health and Care system in Scotland. The content is being developed in partnership with NHS Education for Scotland (NES) and is underpinned by the Health and Care Leadership and Management Development Framework. It offers a foundation for leadership based on the six Health and Care Leadership Capabilities. Candidates will be sought from those identified through the Project Lift processes who are not currently invited onto the national programme on offer through NES and from our internal Talent Management and Succession planning processes and procedures. The programme will take place over a period of eighteen months and is made up of four modules that take place over two days each, supported by pre-work and reflective learning. The first module was scheduled to take place over the 25th and 26th June 2020 at the Improvement Academy, Ninewells Hospital, Dundee. This is currently postponed with a view to potentially running in September 2020.

Plans were in development for the transition of all NHSScotland "Once for Scotland" statutory and mandatory training to be available through Turas Learn to all staff groups. As previously stated, these plans have been paused due to COVID-19. As we move to the recovery phase we will be seeking to reinstate scoping meetings with NES Digital that were planned for February 2020 to discuss the Service fully adopting Turas Learn as its primary Learning Management System. This will include adopting the Turas Learning Record Store (LRS) as the Services' means of reporting on all staff learning and training activity. Features of the Turas LRS:

- Creates a centralised, standards compliant learning record store

- Applications can create, read, update and delete records from the LRS
- Learners can have a unified, portable learning record - regardless of which system they completed the learning on
- Integration with Turas Learn, Turas Appraisal and other Turas Products, including assigning learning to teams.
- Integration with LearnPro
- Ability to link Turas and LearnPro accounts, including transfer of historical data

This is achieved by NES Digital creating an Application Programming Interface (API) or "digital handshake" between Turas and existing Workforce (eESS, SWISS) and Learning (LearnPro) data.



Our initial scoping had been to establish the business case in February 2020 with a view to commencing transition in June/July 2020. Tentative rescheduling of this move would be scoping June/July 2020 with transition in November/December 2020, this is highly dependent upon the availability of internal resources and NES digital who are currently deployed supporting the COVID-19 response.

The COVID-19 pandemic has initiated the adoption of Microsoft Teams and Office 365 for a number of Boards, including the Service, at a much faster pace. Microsoft Teams in particular has enabled a digital alternative to face-to-face meetings with virtual and remote meetings and collaborative working taking place on-line. Learning resources to support staff and teams in getting started with Microsoft Teams have been made available through our Intranet systems and also supported by NES. The NHSScotland Organisational Development (OD) Leads meetings have become "drop-in" meetings held on Microsoft Teams. With the postponement of the majority of national face-to-face programmes of

Leadership and Management Development sponsored by NES, a work-stream is being developed by the group to look at New Modes of Design and Delivery for learning and development activities, particularly virtual classrooms and remote collaborative working. The Service will be participating in this work-stream and look to implement best practice going forward.

Other Considerations – The Clinical Service Transformation (CST) programme leads on developing advanced practice within the Service, and close working arrangements between Clinical Services Transformation and Workforce Development are required and in place to manage interdependencies.

Benefit Realisation/Return on Investment – To support the delivery of the Service's strategic workforce development targets, for delivery of See and Treat and Hear and Treat aims, with greater integration of health and social care, managing patient care at home, supporting anticipatory care planning for patients with long term conditions, prescribing and referring directly to clinical services. In addition, this work will ensure that leadership & management and support function needs are incorporated into our development planning, ensuring that priority development needs are identified and supported.

Enabling Technology

1. Electronic Patient Record
The electronic patient record major incident module is still undergoing trials by Specialist Operations Response Team (SORT) staff.

1. Emergency Service Network (ESN) Programme
The revised Full Business Case (FBC) has been further delayed and there is currently no set release date. A revised high level integrated programme plan was released at the beginning of March 2020, however there is a lack of user confidence in the timescales and this has been fed back to the programme. More detailed level 2 and 3 plans are being developed and further scrutiny will be applied to these when they are released.

2. Integrated Communications Control System
The project to provide an ESN compatible Integrated Communications Control System (ICCS) has been delayed due to the COVID-19pandemic. Testing has been halted and the Ambulance Radio Programme (ARP) are looking at ways to complete some testing remotely. Current indications are that this will push the Service go-live into 2021, requiring an extension to the current ICCS support contract beyond December 2020. Work is underway to arrange this.

3. Defibrillator Replacement
The rollout was completed by the end of March as originally scheduled. The project team have begun to close down the project. The team has collected the majority of legacy MRx units and prepared them for auction, or distribution to assist with the COVID-19 contingency in the Service and the wider NHS in Scotland.

4. Patient Transport System Mobile Data
The Patient Transport System Mobile Data Procurement Project is still paused while the Scheduled Care Strategy is further developed. There are increasing operational, cyber and financial risks involved in delaying the replacement of the current solution as it relies on out of date hardware and software. A business case is being developed to secure an extra £48K pa to keep the current system running.

5. Fleet
The 2019/20 fleet replacement programme is managed within the Fleet Department and has been completed. The 2020/21 programme is now underway and SG approval has been received for our Initial Agreement. We are now proceeding to develop the Full Business Case for Board and SG approval.

6. Other Projects
The scope of the Enabling Technology Programme currently extends beyond the programmes and projects already covered in this section. It also includes a number of projects related to the delivery of the Service eHealth Strategy. Planning is underway to bring Telephony and Digital Workspace (Office 365) projects directly under the governance of Enabling Technology. The Digital Workspace Project in particular will require a large focus for the team as it is a national, time-bound project. The first phase requires the Service to have migrated off NHSMail, implement a new intranet, move to a new SharePoint site and move to a cloud based technical infrastructure by October 2020.These timescales will be reviewed as part of recovering from the pandemic.