NOT PROTECTIVELY MARKED

Public Board Meeting	**30 November 2022** **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 October 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 October 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 July 2022 at over 56% Work to improve OHCA survival rates in line with Scotland's strategy are described, with actions to increase community readiness in relation to bystander CPR rates and early use of defibrillators in our

	communities. An update on trauma and stroke care is provided, including for the first time publicly reporting on 999 to thrombolysis time. <u>Workforce</u> The Service's Equality Monitoring Report was presented to the Staff Governance Committee for approval at the September meeting, following consultation across the Service/ the report is due to be published on the Service's website over next few weeks. Our workforce plan for 2022/23 continues to be reviewed and monitored on a monthly basis and recruitment and training plans are being adjusted where necessary for the remainder of this year and 2023. 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. We are also entering into a difficult industrial relations environment with our staff side colleagues in light of the proposed industrial action. The successful decommissioning of our Mobile Testing Units (MTU) in line with Scottish Government direction to meet the deadline, required considerable resource, time and extensive consultation and engagement with over 800 staff, to ensure that the decommissioning has been in accordance with all relevant employment legislation as well as ensuring all staff are offered as much individual support as possible. The range of supportive measures included alternative tasking, retraining, up-skilling, careers advice and assisting with applying for other jobs.
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 amiable, 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, 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 January 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)

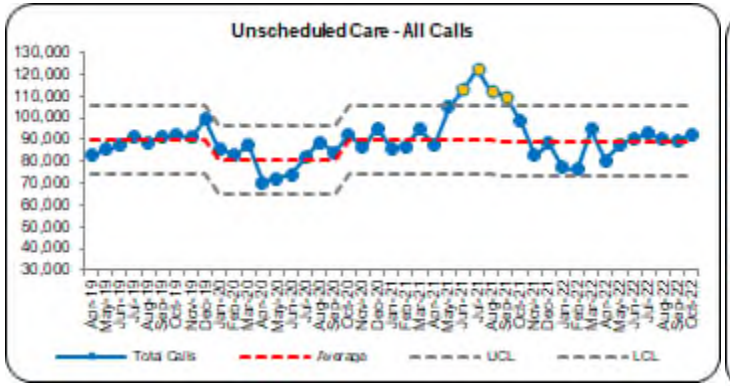
Run Charts

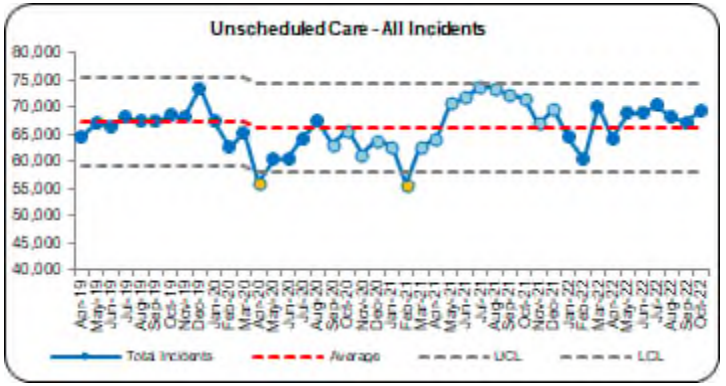
Rule 1: A run of six or more points in a row above or below the median (light blue)

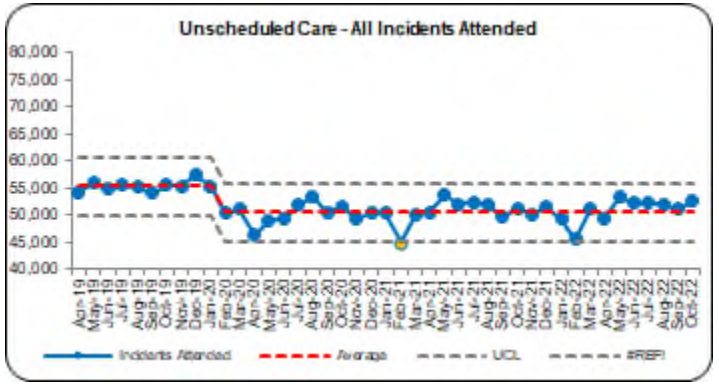
Rule 2: Five or more consecutive points increasing or decreasing (green)

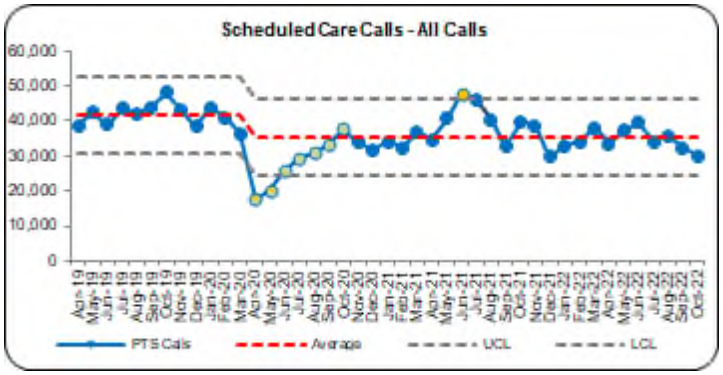
Rule 3: Undeniably large or small data point (orange)

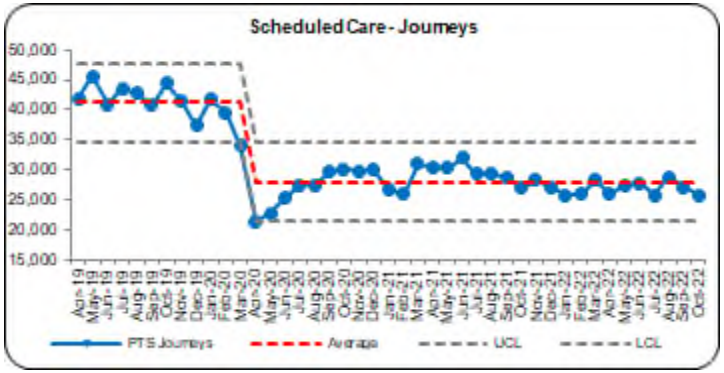
D: Demand Measures











What is the data telling us?

Unscheduled call demand has remained within the control limits in October 2022 with 92,647 calls. The volume of incidents has returned within control limits and is in line with pre-pandemic levels.

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.

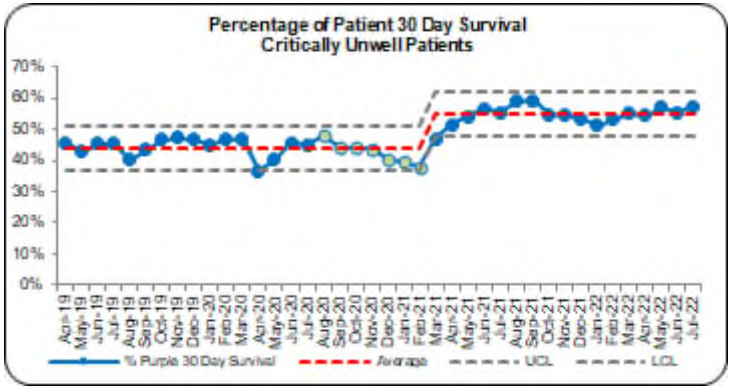
Our annual delivery plan this year is focused on those priority areas highlighted by Government that we can influence, which will reduce pressures on the wider Health & Social Care system, support the stabilisation of services, accelerate recovery and provide the most benefit to patients and staff.

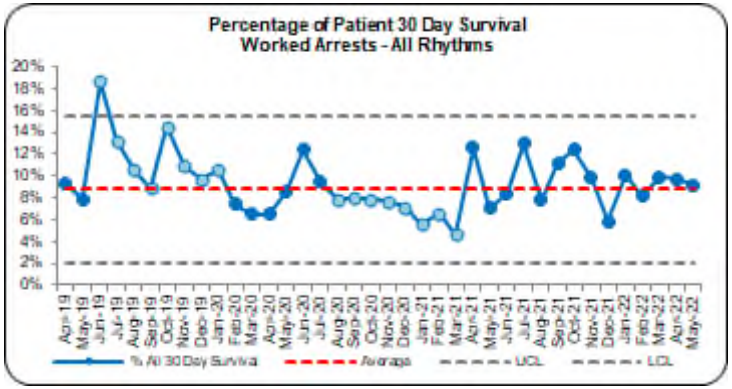
We have established a number of work streams to increase our workforce, improve demand management and increase capacity which include working collaboratively with our partners across the wider system to reduce unnecessary Emergency Department attendance by ensuring patients receive care that meets their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

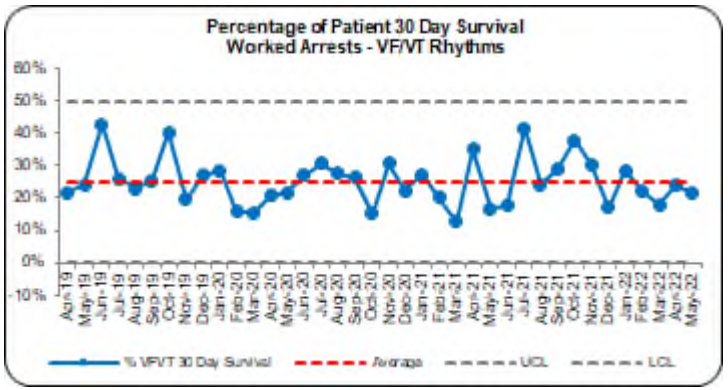
Significant work is being undertaken with hospitals to improve flow and reduce ambulance handover times. Details are included in the section of the paper specifically to Hospital Turnaround.

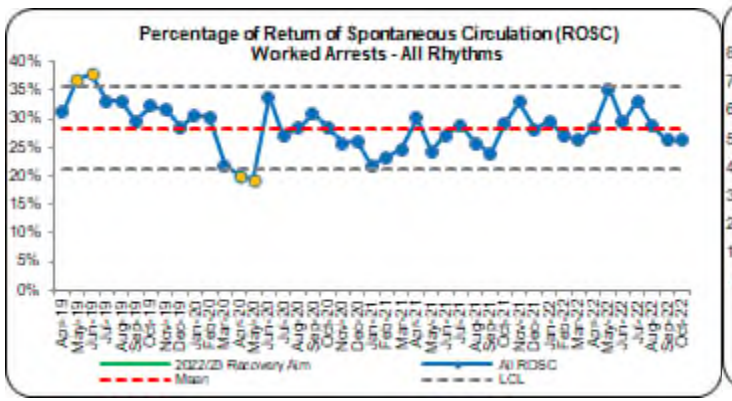
Our work to support staff health and wellbeing is also detailed in the 2030 Strategy Portfolio update.

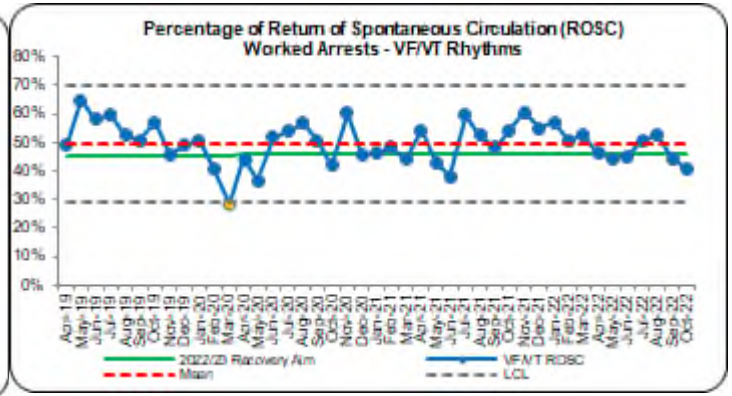
Purple Response Category: Critically Unwell Patients

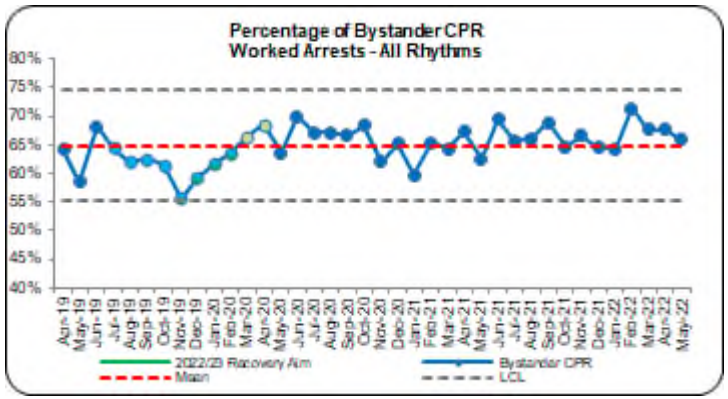


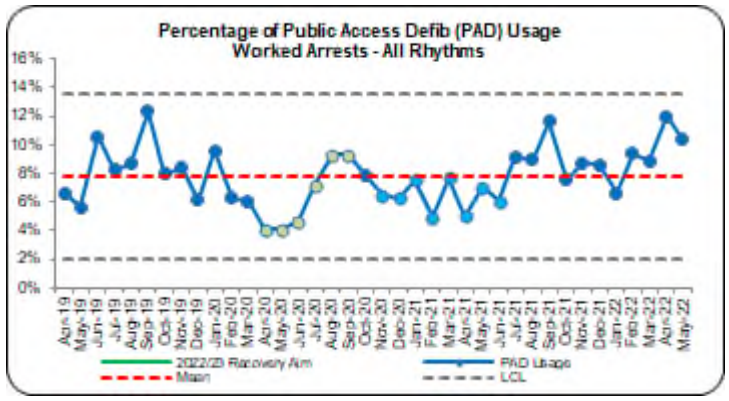


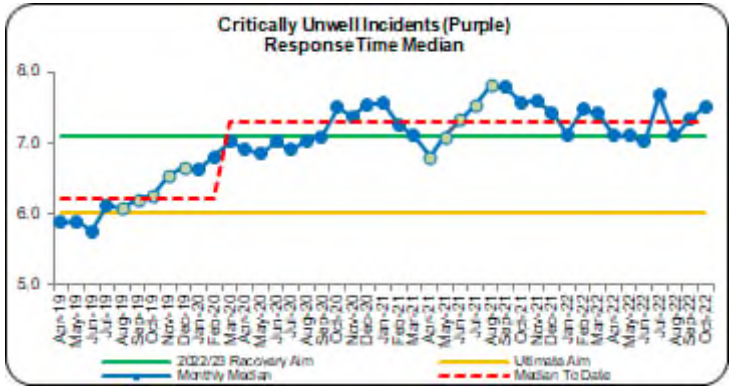


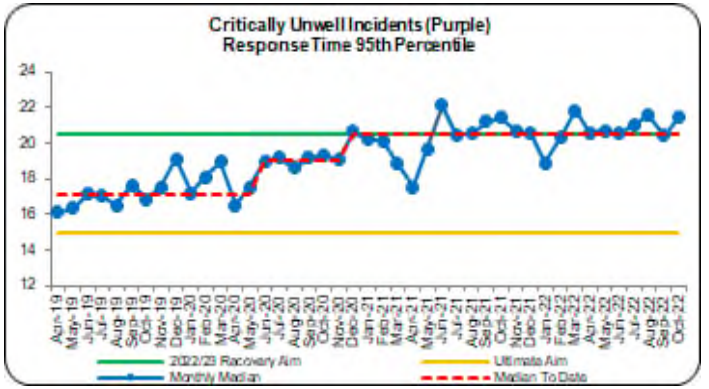












What is the data telling us?

Purple Category 30-day survival data is collated three months in arrears in order to validate the figures. The 30-day survival rate for these patients at end July 2022 increased to 57.3%, it remains within the control limits with no evidence of impact for seasonality that we have seen in previous years. This will continue to be monitored closely to allow us to better understand any influencing factors.

Out of Hospital Cardiac Arrest (OHCA) - the Return of Spontaneous Circulation (ROSC) for VF/VT patients had been maintained within the control limits with 40.8% being achieved in October 2022.

Patients within our 'purple category include those patients who have experienced an Out of Hospital Cardiac Arrest (OHCA). We are presenting data regarding our performance for this subgroup of patients within the 'Purple Category. The aim of Scotland's 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%.

In order to achieve this ambitious aim we (the Service and Scotland's Communities) will need to improve every part of the chain of survival and some of the new metrics introduced into this paper illustrate some examples. These include rates of Bystander CPR, we know the earlier we can get 'hands on chest' the better the chance of survival, and rates of use of Public Accessible Defibrillators (PADs) prior to the Service's arrival.

Despite slight lengthening in response times, all of the outcome metrics described for patients remain within control limits and the following narrative describes actions that we are taking organizationally to progress against the ultimate aim of improving survival.

International 'Restart a Heart Day' took place on 16 October 2022 and the Service used this date to launch the use of the GoodSAM app for the public in Scotland with excellent media coverage across multiple platforms including social media resulting in around 1200 people signing up as potential responders. The GoodSAM app is used in many systems to alert responders where there is a patient in cardiac arrest nearby and offers the potential to increase rates of CPR prior to the arrival of the ambulance. We will continue to promote the ability to become a responder and monitor the impact of the GoodSAM app on our system.

Scotland's Out of Hospital Cardiac Arrest Annual Report will be 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.

The Service continues to work with multiple partners with one recent example a collaboration with the Save A Life for Scotland partnership supporting the development of cardiopulmonary resuscitation (CPR) tools for those with disabilities. This has included training materials with sign language and for those unable to perform CPR how they can instruct other bystanders to perform it.

The Service now has over 4500 PADs mapped on our system. This is more than double those registered in 2019 and we continue to work with communities to further increase the availability of PADs, as well as using historical data to optimise PAD placement in communities.

Research and innovation remain an important element of our OHCA work. The OHCA team continue to engage with the research community and partners in Global Resuscitation Alliance to find new

and innovative ideas, solutions to the challenge of improving survival from OHCA with several high-profile research projects underway. There are also early discussions about how to best research the use of drone technology and how to better access PADs.

Purple Median Times

Median response times to purple in October 2022 was 7 minutes 31 seconds. We reached 95% of these patients in 21 minutes 27 second in October (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

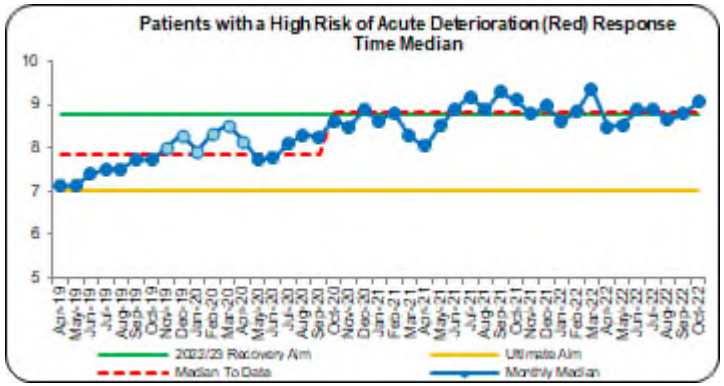
1) Reducing service time (through auto-allocation, new static sites for ambulances, reducing hospital turnaround times and timely access to professional-to-professional support).
2) Reducing the number of Accident and Emergency unit dispatches (through Advanced Paramedic clinical assessment, alternative 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).

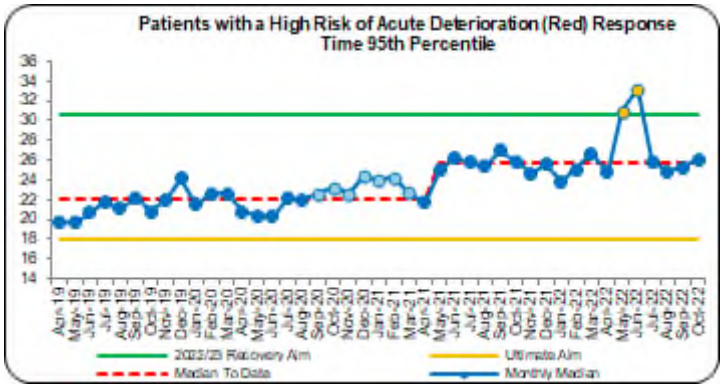
We have increased ambulance resources and are implementing new rosters through the demand and capacity programme. We are focused on working to maximise shift coverage, support abstractions for paramedic training and managing sickness absence levels.

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.

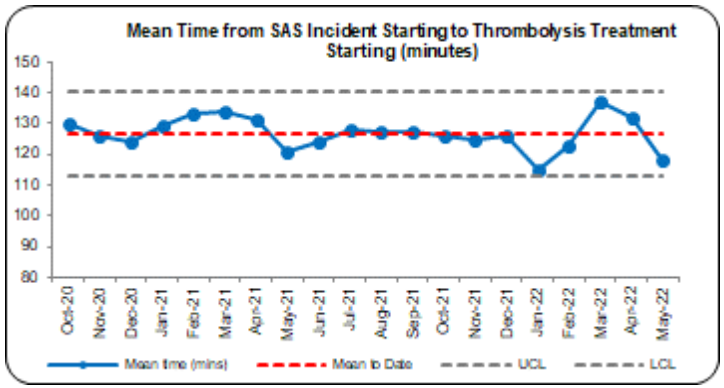
We are continuing to see extended hospital turnaround times in many hospital sites. This remains an area of significant concern. Extended hospital turnaround times are affecting staff rest periods, ambulance availability, ambulance response times and shift over runs. Health Boards have been working with 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.

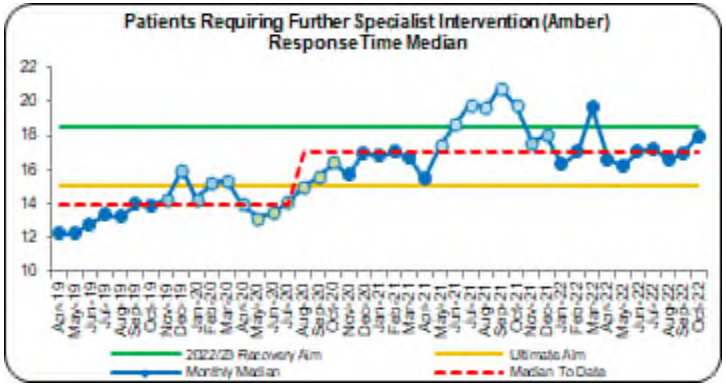
Red Response Categories: Patients at risk of Acute Deterioration

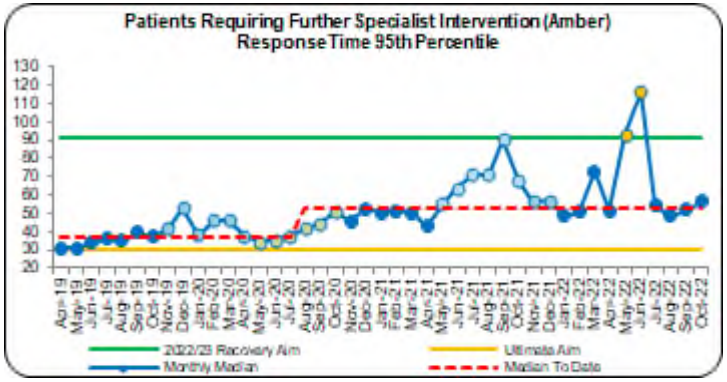




Amber Response Categories: Patients requiring Further Specialist Intervention







What is the data telling us?

The median and 95th percentile response times for both red and amber categories of call remain stable however rose above the average in October 2022. In October 2022, we attended 50% of red category incidents within 9 minutes 7 seconds and amber within 18 minutes.

The clinical detail around the red category of call relating to Major Trauma response is under development and will be played in from 2023. In the last quarter we have seen a review of our Critical Care Desk implemented with more senior clinical staff available to co-ordinate response and provide support to front line crews at scene. Use of our triage tool continues to improve, allowing effective decision making re optimal patient flow for those affected by trauma, and we are feeding back more information to front line clinicians regarding their care at scene.

The clinical condition used to illustrate patient care in our Amber Category is stroke. Stroke is a common condition and a significant cause of death and disability. When a patient has a stroke, it is crucial to identify and confirm this, and to take patients to definitive care so that those who are suitable for thrombolysis (treatment to dissolve the clot that has caused the stroke) can receive this treatment as early as possible. By linking the Service's data with data sets across the NHS we can now report on the time it takes from 999 call to this definitive intervention.

Stroke incident start (call coding) to thrombolysis data is collated three months in arrears in order to validate the figures. In May 2022 this was an average of 1 hour 58 minutes.

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 has stabilised following a peak in March 2022.

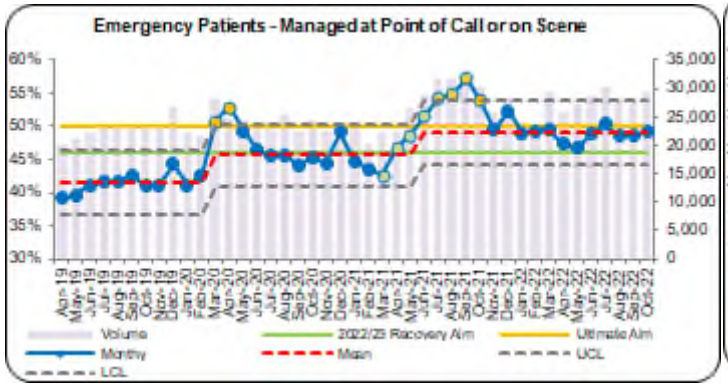
What are we doing and by when?

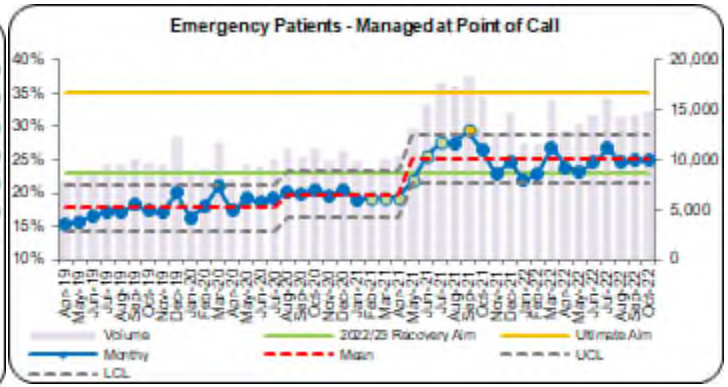
In terms of stroke care improvement a number of work areas are progressing.

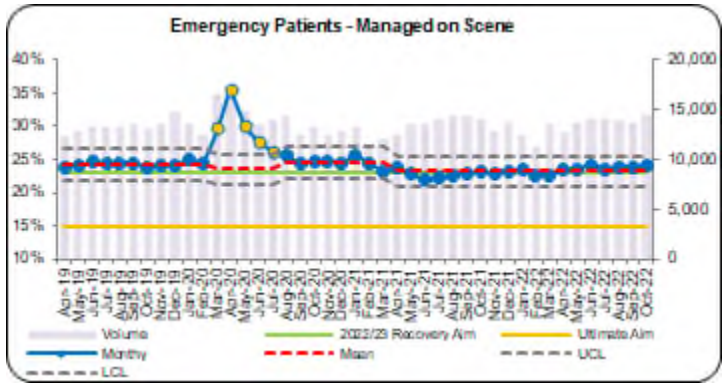
- Improved recognition of stroke at point of first contact within the Ambulance Control Centre
- Optimise dispatch arrangements and understand variation in practice where observed
- FAST – improve recognition of hyper-acute stroke through utilisation of FAST (face to face)
- On-Scene times – improve 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.

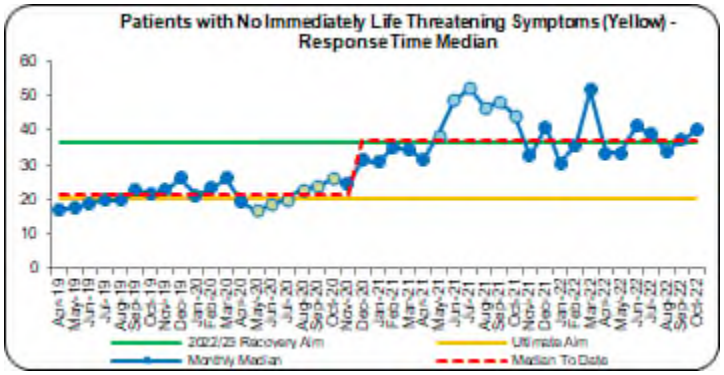
The Service's Research and Development Group were presented with three external proposals for research and development opportunities within the Service to improve stroke diagnosis and pathway optimisation.

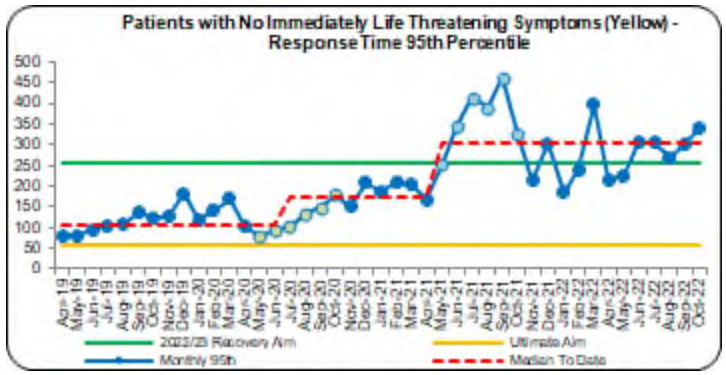
Yellow Response Category: Patients with Highest Potential for Non-Emergency Department Attendance











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. In October 2022 it was 49.1%, made up of 24.9% of patients managed at point of call and 24.2% 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.

As part of the national Urgent and Unscheduled Care Collaborative we have created our strategic improvement plan with a focus on our Clinical Hub development, increasing our role in Flow Navigation Centres and also other new models of care including Same Day Emergency Care and ensuring that the Service delivers its role in supporting discharge without delays from secondary care.

The Service's central Pathway Navigation Hub continues to increase the volume of calls that it manages, referring and connecting patients to services and communicating pathway information to crews across the country. We also have regional pathway teams who are focussing on clinician engagement and education, promoting the use of alternatives for patients where it is safe and appropriate to do so and promoting the use of clinician feedback. This is resulting in increased numbers of patients being connected with for example, falls referrals, alcohol and drug partnerships and public protection.

Work to develop and deliver our Clinical Hub within the Ambulance Control Centre continues with recruitment of multidisciplinary roles including additional GP Advisers and Advanced Practitioners to support remote clinical triage and assessment.

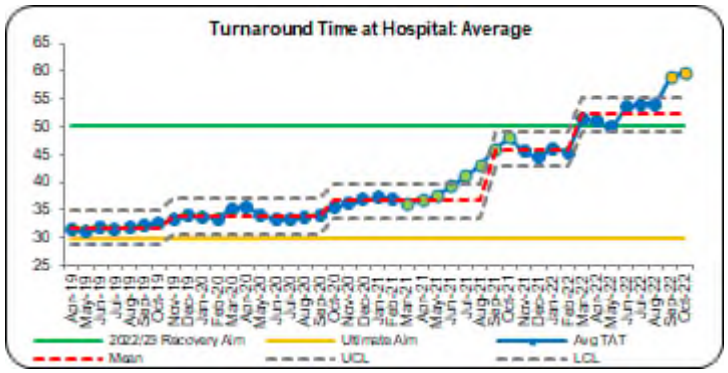
It is likely that as we strengthen and develop our remote clinical triage and assessment of patients utilising both telephone and video calls that this may influence the numbers of patients who we attend and subsequently manage out with an ED setting. As we develop our Integrated Clinical Hub within our Ambulance Control Centre our ability to access a range of referral options and end points for patients is increasingly important.

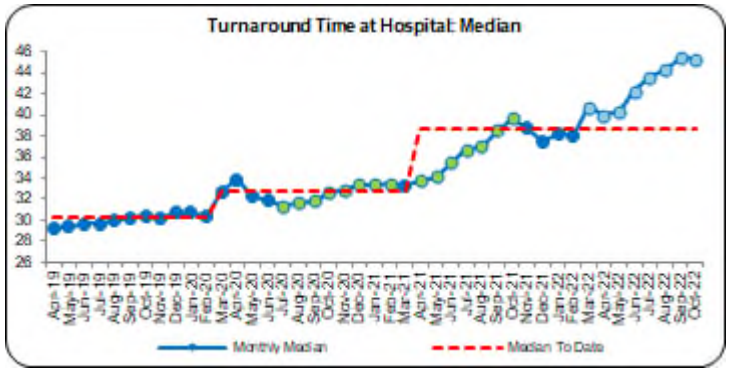
Clinical guidance for ambulance clinicians who are now having to look after patients in ambulances outside hospitals for prolonged periods is being updated.

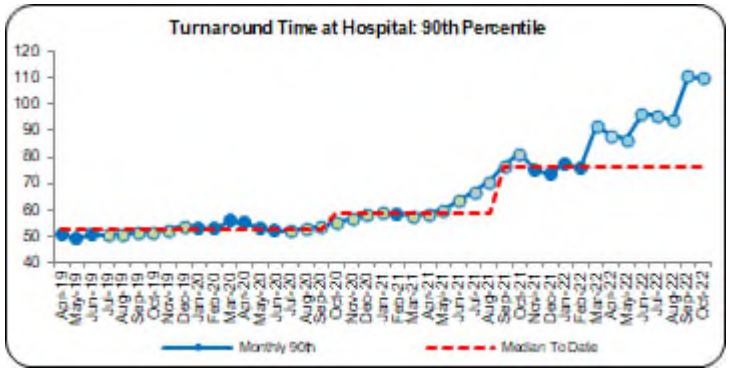
What are we doing and by when?

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 October 2019 and October 2022 the average turnaround time increased from 32 minutes 47 seconds to 59 minutes 52 seconds. This means our crews are, on average, spending 27 minutes 5 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 have eased, hospitals are operating at or near full capacity. 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.

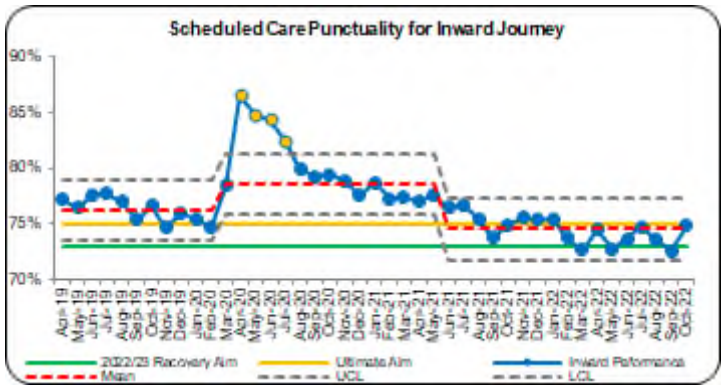
Additional HALOs are now in place across the three regions funded by the unscheduled care and systems pressure money. There are now six additional HALOs in the West Region, three in the East Region, and two in the North Region. NHS Lanarkshire has also

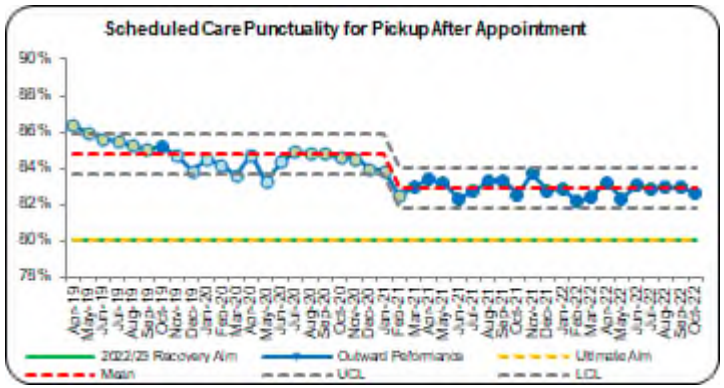
funded an additional HALO post to work in the Flow Centre. The Service now has 22.5 WTE HALOs in post covering the major Emergency Department sites.

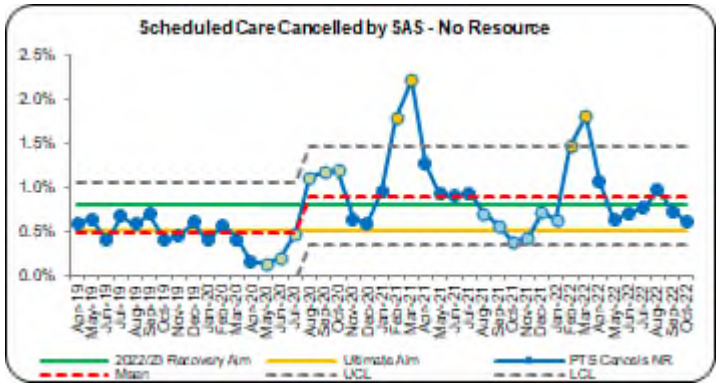
Other specific actions include:

- 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 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.
- Across East Region we have been progressing call before you convey to reduce unnecessary conveyance to E.Ds. This is now in place in Tayside, Fife and Lothian.
- An increased co-horting area at QEUH will be online before end of November 22 which will double the capacity to improve ED flow.
- 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 APs NHSG are now looking at increasing bed capacity within the Hospital at Home from 25 to 100 beds. This contributes to averting hospital admissions.
- A four week Test of Change "Call Before You Convey" commenced on the 24th October running 0900-2400 7 days a week in Grampian. 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 ToC the Service's Advanced Practitioners are based in the FNC. Experience so far is that this is reducing handover times.
    - A revised Falls pathway has been introduced in Glasgow which has already delivered a 91% increase in referrals year to date.
    - SDEC is now live in both Forth Valley and Lothian.

SC: Scheduled Care







What is the data telling us? –The number of Scheduled Care calls has remained stable since early 2022 and was 30,027 in October 2022 (see chart: Scheduled Care Calls – All Calls on page 8). Call demand between September and October fell from 32,439 to 30,027 calls, which is a month on month decrease of 7.4%. Journey demand between September and October also decreased by 5.4%, from 27,230 to 25,754 journeys. This is the lowest level of journey demand since June 2020.

Punctuality for inward appointments in October 2022 was 74.8%, which is above the 2022/23 recovery aim of 73% and is within control limits.

Punctuality after appointment was 82.6% in October 2022, above the recovery and ultimate aim of 80% and is within control limits.

The percentage of PTS cancelled by the Service in the “No Resource” category saw a further slight decrease to 0.6% in October 2022, which is below the 2022/23 recovery aim of 0.8% and approaching the ultimate aim of 0.5%.

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

The reduction in call volumes and PTS journeys is being driven by a range of factors. For example, there has been a reduction in sickness absence and an improvement in call handling performance. A new streamlined telephony booking process means callers are directed through a series of telephony messages and options to the best person placed to respond to their enquiry and we have also begun enhancing digital access to booking for hospital staff, through hubs and some hospital discharge lounges. In addition, we now also offer a call back service. Members of the public are now able to

complete a simple online form on our website, requesting a call back from a PTS call handler for appointments within a timeframe of up to 10 days in advance.

The reduced number of PTS journeys follows a similar pattern last October and other seasonal holiday periods earlier in the year. The October school holidays took place at different times across regions, with staff on leave across the heath and care system and some outpatients potentially requesting a later date for their appointment in order to accommodate the holiday period.

A number of improvement projects are underway to help optimise scheduled care productivity, including targeted work on reducing “No resource” cancellations in the North Region. The region’s October performance has improved, which in turn is supporting improved National performance against this metric.

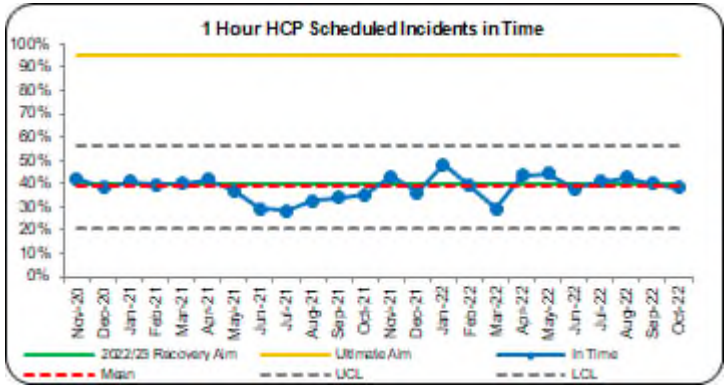
What are we doing and by when?

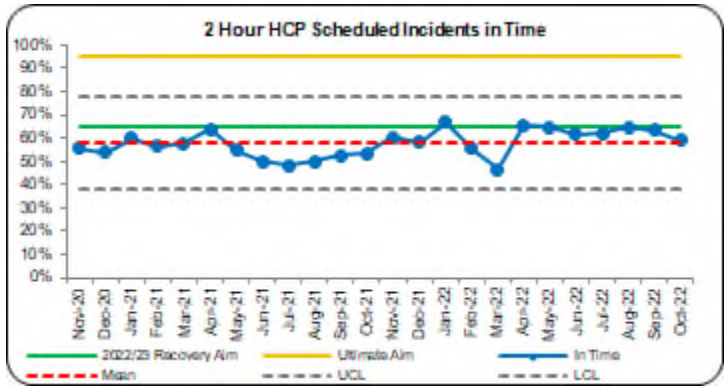
We will monitor PTS call demand to build a more complete picture of the impact on call volumes through the streamlined telephony booking process and access to online booking to identify further opportunities for improvement.

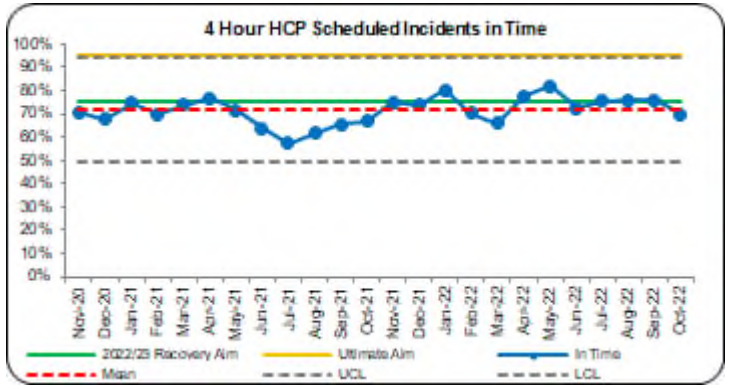
Systems testing of the revised Health Board Patient Needs Assessment is due to complete mid-November, followed by a planned roll-out of staff training before going live. This will be followed by testing of the Patient Needs Assessment for patient discharges and for bookings by members of the public to help to ensure that our scheduled care resources are focused on those patients who require ambulance care and conveyance for discharges, inter-hospital transfers and for travelling to hospital outpatient appointments.

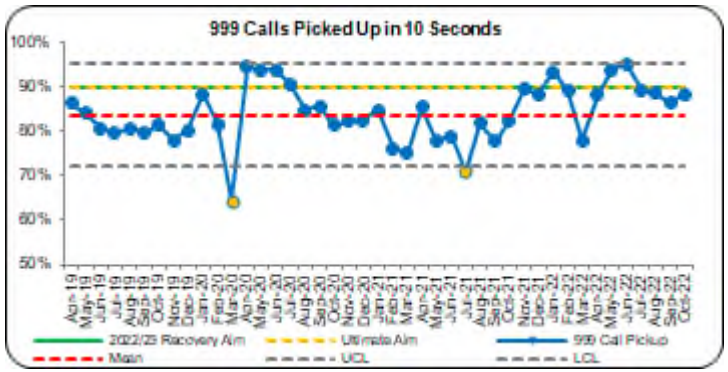
In addition, our engagement with NHS Boards and the Transport to Health team at Scottish Government about potential additional scheduled care demand through Planned Care activity and National Treatment Centres (NTCs) is giving us access to allocation data for the number of patients who will be offered elective treatment in another Health Board area and who may need support from the Patient Transport Service. The data is helping us estimate additional PTS demand and the volume of cross boundary conveyance for some patients before the NTCs begin to go live next year. The data is being shared with the PTS Demand and Capacity Project.

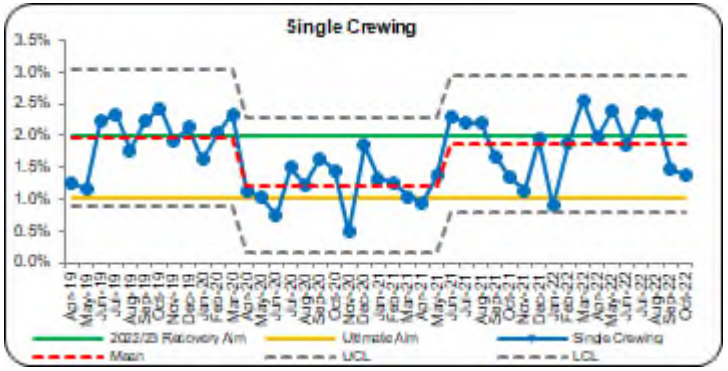
Other Operational Measures











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 stable and within the control limits at 38.3%, 59.1% and 69.8% 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 4 months with 88.4% being achieved in October 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 both COVID-19 and 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.

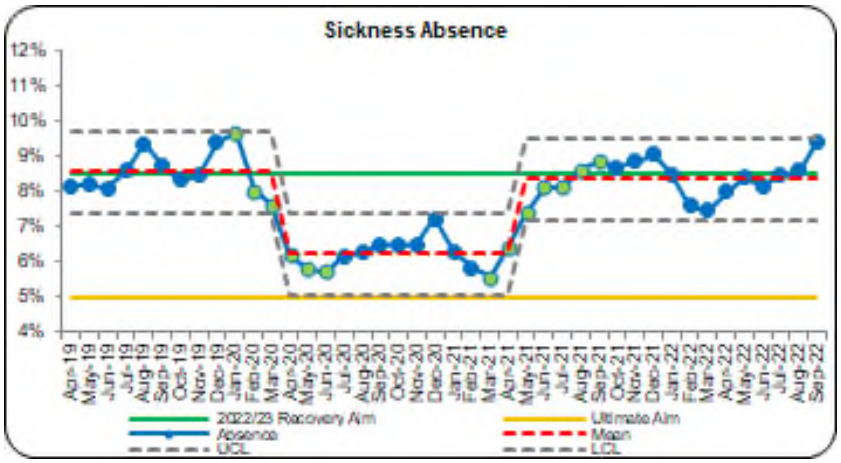
999 Calls picked up in 10 seconds

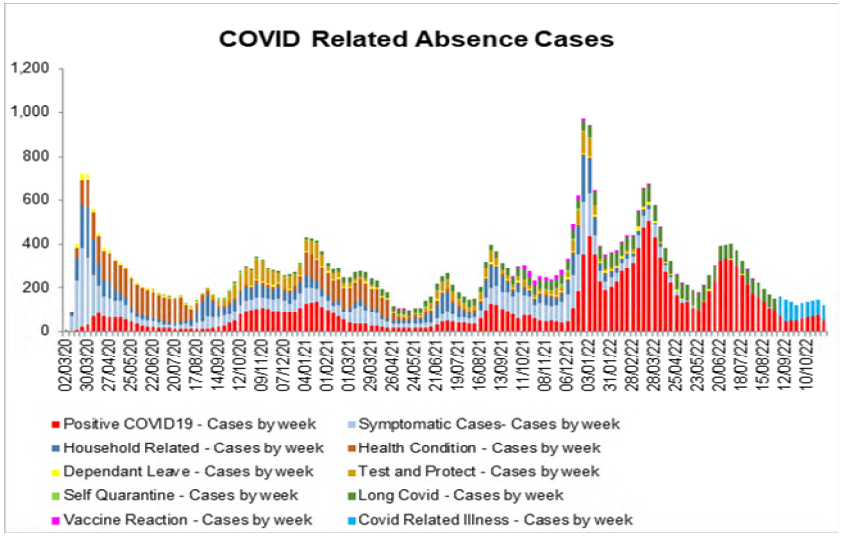
October 2022 reached our aim of 90%. This is an increase of 3.7 percentage points from September. October, saw a further increase in the number of 999 calls offered from September (57,535) with 58,501 offered. An increase of 966 calls.
Our (HCP) non-emergency calls demand were also up by 16 percentage points with 17,288 calls received compared to 14,919 last month and non-public emergency demand totalled 18,011.

Overall we saw an increase of 4,335 calls from September 2022 and the hard work of the call handlers, supervisors and duty manager teams is testament to our success across the month.

SE: Staff Experience

Sickness Absence





What is the data telling us? – The non COVID-19 Sickness Absence level as at September 2022 was 9.4%. As of the 1 September 2022 Covid absence is recorded in sickness absence leading to an estimated 1% increase in absence levels.

Removal of temporary COVID-19 Policies has resulted in changes to how we record COVID absence. As of 1st September 2022, covid positive is the only covid absence reason recorded under the special leave category. All other reasons for covid related absence are now recorded as sickness.

For continuity of trend analysis relating to covid absence, COVID sickness is included in the chart. COVID-19 related absence levels during week commencing 26 September 2022 were at the lowest level seen since summer 2021. 123 staff were absent from work with covid related illness (1.9% of staff) , 75 of these were due to COVID related sickness and 48 as result of asymptomatic positive test. Cases rose slightly throughout October 2022 before dropping to 146 staff, week commencing 24 October.

Why? Our decrease in COVID-19 related absence was in line with forecast modelling carried out by our business intelligence team. Absence has decreased in the majority of regions and departments across the organisation. There has however been a very small increase in NRRD and a more notable increase in ACC.

What are we doing and by when?

The top 3 reasons for absence across the organisation remain consistent with last month. Anxiety/stress/depression is the top reason, followed by covid sickness absence and other musculoskeletal problems.

Over the last few months, our managers have been dealing with a range of attendance issues. These have involved undertaking regular welfare checks with staff, managing short and long-term abstractions, and undertaking detailed risk assessments for staff with long-term underlying medical conditions. All interventions are in line with the Once for Scotland Attendance Management policy,

The strategic aim, agreed with the Service's Staff Governance Committee, was to further reduce absence with a national target for reducing non COVID-19 absence by 1% by the end of March 2023. Whilst the same target reduction figure remains in place for this year, the challenge will be to maintain and increase the focus on reducing staff absence levels across all areas of the Service. A close and continued focus remains on maintaining an overall downward trajectory. In the last quarter, the focus has been on resolving complex long term absences across the Service and these efforts are now reflected in improving long term absence rates.

The Regional and National HR teams continue to proactively support frontline managers to manage attendance levels in their area. The National Attendance Lead who has been in place since January 2022 has overseen the development of regional and departmental action plans, focusing on improved management of sickness absence and looking proactively at ways of encouraging greater improvements in attendance levels generally. This has been supported by regular training and coaching sessions as well as ensuring that problematic cases are dealt with timeously, fairly and sympathetically. All of this positive action has to be viewed in the context of an organisation whose staff are genuinely fatigued, under significant pressure and understandably anxious about what is happening the country at the moment. As a consequence, personal resilience levels may be considerably lower than in previous years.

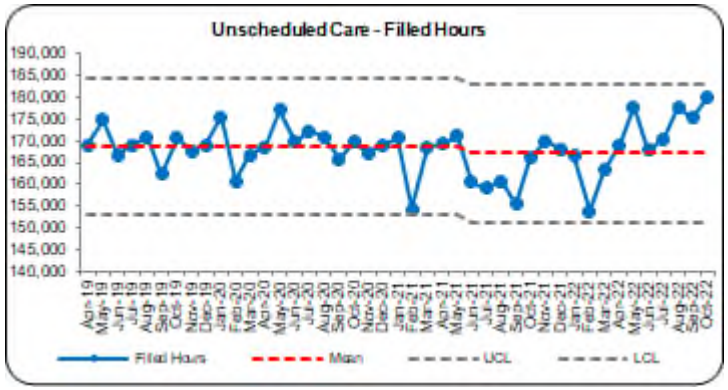
Every month a detailed report is produced for the Service's Performance and Planning Steering Group which sets out the position for each region and service area broken down into long and short term sickness absence. A supporting narrative is provided by local managers which gives local information and specific action being taken including a breakdown of the top five reasons for absence. Through the Service's Health and Wellbeing Strategy and the Occupational Health service a wide range of interventions are available to facilitate recovery and return to work.

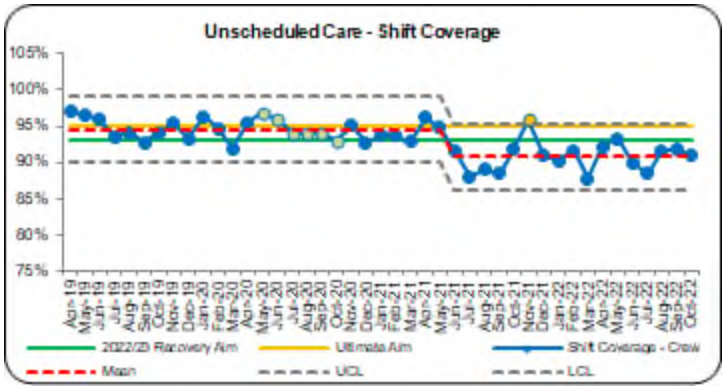
These reports are broken down into daily and weekly charts covering all operational regions and sub regions and National operations.

We will continue to assess attendance management handling arrangements, taking national direction as appropriate in a fast-changing situation.

The Service's Health and Wellbeing Strategy sets out a wide range of actions and programmes aimed at supporting staff and managers to look after their mental and physical wellbeing, recognising the unique stresses of the emergency responder role. A separate Board paper providing a Health and Wellbeing update is now a standing item on the Board agenda.

SE1.2 Shift Coverage





What is the data telling us?

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 September and October 2022 were 65.3% and 65.9% 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 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 Technician's were introduced to Lanarkshire in October and a further 23 will be introduced following the course end in March 2023. There are also a number of NQPs who are currently being recruited which will improve the regional vacancy level. Early forecasts indicate 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.

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. 27 candidates have been recruited to the November VQ Course to fill

the final vacancies in the North Region leaving just four vacancies unfilled. Offer bespoke recruitment campaign for qualified staff is now at the interviews and assessments stage working towards recruitment being complete and offers being made for Clinical Induction Courses in October for commencing duties in November 2022.

Workforce Development

Employee Resourcing

Aim – To recruit and retain staff ensuring that the Service has the skills to deliver its 2021/22 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 1st 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.