



The Scottish Parliament
Pàrlamaid na h-Alba

Pauline Howie
Chief Executive
Scottish
Ambulance
Service

Health and Sport Committee
T3.60
The Scottish Parliament
Edinburgh
EH99 1SP

Via email only

Tel: 0131 348 5210
Calls via RNID Typetalk: 18001 0131 348 5224
Email: healthandsport@parliament.scot

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Dear Pauline,

Thank you to you and your colleagues for giving evidence to the Health and Sport Committee on [Tuesday 26 February 2019](#). The Committee found the session to be informative although they do have a number of follow up questions as set out in the attached document.

It would be helpful to have your response by Tuesday 16 April.

Yours sincerely

Lewis Macdonald
Convener
Health and Sport Committee

New triage system and response times

Dr Ward explained the new triage system, created in November 2016, “aims to put patients right at the centre of all the response decisions”. ([Official Report, Col 2](#)) The new system prioritises patients in accordance to their clinical need instead of categories A, B or C. In this present model, ‘immediately life threatening’ calls have a response time of eight minutes, which was previously associated with category A. The eight-minute response time remains the criterion to which the service is aligned to, yet Dr Ward stated that it has now “lost its relevance” ([Official Report, Col 13](#)) to clinicians in the system.

Tom Steele also reiterated the need for response times to be meaningful rather than target driven. He stated, “although we still look at the eight-minute response target, it is a bit of a sledgehammer to crack a nut”. He also outlined the target response times for each category. “On response times to purple calls, we have a standard of six minutes, which we are beating. For red calls, we have a standard of seven minutes, which we are also beating. Standards are in place for the amber and yellow categories too”. ([Official Report, Col 14](#))

Can you provide further information on the standards for the amber and yellow categories, what is their current target and how often is it being met?

Two examples were given in the Committee meeting of patients falling in the street or taking ill in a public place and having to wait three hours for an ambulance. Dr Ward stated that the reason for this delay is the prioritisation of resources. Patients receive a call back after 45 minutes of the initial call to check their condition has not deteriorated.

You stated that just before winter 2018, you looked at how to recategorise those patients who are particularly vulnerable and who may be outside with fractures. You said that “those types of patients have not waited as long as they did in previous winters”. ([Official Report, Col 6](#)) Can you elaborate further on this point. What does the Scottish Ambulance Service deem as an acceptable time for vulnerable patients to wait outside for an ambulance to arrive?

The Stirling Evaluation includes an analysis of average response times for each category of patient since the introduction of the new system. What is the longest time a patient with non-life-threatening injuries (amber and yellow category) has waited on an ambulance in each of the past three, six, nine and twelve month periods?

The evaluation does not cover the care experience or outcomes for people with non-life-threatening conditions beyond the impact on survival. Is the board planning to look at the overall care experience of people with non-life-threatening calls?

Who do you consider is responsible for taking care of patients when they are waiting up to three hours for an ambulance to arrive?

Classification of 999 calls

We understand there has been a 'bedding in period' with the new system, with changes to categorisation of 999 calls and method of responses. Dr Ward highlighted that data has been refined to ensure that patients are allocated to the correct response code. Between six and ten changes have been made to the new model in the past year. ([Official Report, Col 4](#))

Can you provide further information on whether changes to the new model have had a positive impact on response times and how incorrect classifications of patients are currently dealt with?

Dr Ward provided an overview of the 999 call process and how patients are currently categorised. He stressed that "all the delays we are talking about fall within our yellow category which is our biggest basket of calls. Over the whole year, we probably reach 50 percent of the calls in 15 minutes and 90 per cent of them in less than 50 minutes". ([Official Report, Col 9](#))

Therefore, 10 per cent of calls in the biggest category are not provided an ambulance within 50 minutes. Please provide further information on how long this substantial number of patients are waiting and detail on the steps taken to eradicate this figure.

Specialist Paramedic, Donna Hendry, spoke about the problems encountered with patients when they have been categorised incorrectly and there has been a long delay in receiving treatment. Patients can often be distressed and angry by the time the ambulance arrives. How many front-line staff have experienced aggressive and abusive behaviour from patients and members of the public following a lengthy wait for an ambulance in the past reporting year? Do the figures vary across the regions?

What training and support mechanisms are in place for front-line staff experiencing this type of behaviour?

Public engagement

Tom Steele discussed the new triage model and the re-categorisation of calls. He advised, "in the future, it will be our collective interest for the public to understand how we are operating the new model. It is effective and we are keen to publicise that". ([Official Report, Col 10](#)) Can you provide further information on the current engagement strategy to communicate the new model to members of the public?

Do you believe members of the public are likely to understand the process when they call 999 and are they aware they may not receive an ambulance in eight minutes?

What is the level of public acceptance and satisfaction with the new protocol?

How does the future engagement strategy address this?

Response times in rural areas

You will note the [BBC article](#) on 6 March 2019 regarding ambulance response times for the most life-threatening callouts in more than 2,700 local communities across Britain.

You mentioned in the evidence session that in remote and rural areas, there is a network of first responders who work closely with ambulance crews and are a vital resource. “Our new wildcat responders for patients who have had cardiac arrests have been in place for more than a year. That programme has been evaluated as doing “very well”. ([Official Report, Col 15](#)). You confirmed that this is part of a five-year programme of investment and reform. Can you further elaborate on “very well” and provide further evidence from this evaluation? Is there a target for the five-year programme?

Given that the eight-minute target for immediately life-threatening cases is still used, can you provide further evidence on how this target is reached within large rural areas and provide a regional breakdown of response times across Scotland?

Are there particular postcode areas where response times are often missed and if so, which ones?

Police Scotland

Recent press reports state a significant proportion of Police Scotland’s resource is being taken up by Officers escorting patients with mental health and other issues to hospital. Vice Chairman of the Scottish Police Federation, David Hamilton, was quoted as saying,

“Our Members are telling us that they are now regularly left escorting people to hospital or waiting around because there is nobody else to do it.”

We are unclear how this is occurring and what categorisation is given to such patients. Are the claims of the Scottish Police Federation borne out by the experience of the ambulance service?

Has the new response system inadvertently had a detrimental effect on the Police Service?

You mentioned a pilot scheme in Lanarkshire with Police Scotland and NHS 24, stating that “research around the UK has indicated triage from police and ambulance into more appropriate and robust referral pathways is sustainable and evaluates well”. ([Official Report, Col 11](#)). The Committee are concerned to ensure successful pilot schemes are rolled out. Please provide further detail on the evaluation of this pilot and provide a date for implementation across the country.

Number of inappropriate calls

We understand the Scottish Ambulance Service receives calls which are then re-directed to NHS24 and vice versa. Please provide statistics on the number of inappropriate calls received out of hours in the past three years and the impact this has on the overall service.

Staffing

The Scottish Government has previously monitored the experiences of the NHS staff through various means including the annual staff survey, IMatter and the Dignity at Work survey.

Over the years, the Scottish Ambulance Service has consistently had some of the worst scores within these measures, often ranking the lowest out of all the territorial and special health boards. The [2017 Dignity at Work Survey](#) showed the lowest score in the following domains:

- Proportion of staff experiencing unfair discrimination from their manager
- Proportion of staff experiencing unfair discrimination from other colleagues
- Proportion of staff experiencing bullying and harassment from their manager
- Proportion of staff experiencing bullying and harassment from other colleagues
- Proportion of staff who believe it is safe to express concerns about quality, negligence or wrongdoing by staff
- Proportion of staff who felt they could meet all the conflicting demands on their time
- Proportion of staff who felt there were enough staff for them to do their job properly.

What measures are being taken to eradicate bullying from the organisation and how are staff being encouraged to communicate their concerns?

How is progress being monitored by the Scottish Ambulance Service?

Is this issue consistent nationally or specific to certain regions?

What support is available for staff if they are being bullied or experiencing harassment in the organisation?

Sickness levels

Reviewing the Dignity at Work Survey, the employee engagement index score and accounts of bullying in the organisation, it is evident there remains an ongoing issue with staff sickness levels. You confirmed in the evidence session that the Scottish Ambulance Service staff sickness rate is unchanged at 7.6% for the past two years, above the target of 5%.

You also highlighted the top two reasons for sickness absence in the Scottish Ambulance Service; musculoskeletal illness and mental health illnesses including anxiety, stress and depression. Can you provide a breakdown of what proportion of sickness absence is down to musculoskeletal problems and what proportion is accounted for by mental health?

In the evidence session, you advised that there has been investment in new equipment, policies and procedures in order to alleviate concerns. For example, an ergonomics adviser to offer advice on equipment/manual handling and greater support for staff regarding their mental health and wellbeing. ([Official Report, Col 19](#))

With the sickness rate remaining at 7.6% for the second year running, it would appear that new initiatives are having minimal impact on reducing staff sickness levels. What further measures are you undertaking to address this important issue? Are you introducing any initiatives to address mental health and wellbeing?

You also agreed staff sickness has impacted on your budget. Please provide the Committee with the accurate figure for this additional cost.

In addition, Tom Steele advised that “all ambulance services in the UK and abroad have significantly higher levels of sickness absence than the rest of the healthcare systems”. ([Official Report, Col 18](#)). Please provide details of the comparative sickness rates for the other organisations mentioned. Has any investigation been undertaken to understand why this is the case?

Staff turnover

Statistics obtained from the [ISD Workforce Data](#) indicate that staff turnover in the Ambulance Service was the second highest of all specified staff groups in 2017/2018 (10.9%). However, in the evidence session, you stated that “staff turnover was 4.1% with 25 vacancies”. ([Official Report, Col 17](#)).

Can you provide statistics to confirm the staff turnover for the Ambulance Service and explain this discrepancy? Also, is staff turnover linked to specific regions across the country?

What steps are you taking to retain staff, particularly those most affected by turnover, and ensure they feel valued?

Primary Care

At the evidence session, there was discussion about Primary Care. Donna Hendry explained there are specialist paramedics assisting GPs out of hours, making home visits and treating illnesses such as chest infections and abdominal pains.

When asked if treating patients at home instead of hospital is cost effective, you stated, “for every £1 that is invested in community paramedics and the wider reform programme, there is a £4 return to the wider health and social care economy.” ([Official Report, Col 22](#)).

Can you provide the committee with further information on how this evaluation is made and to whom the benefits accrue? Please also indicate, if possible, how this is reflected in budgeting across the NHS.

Tom Steele also reiterated the need to “start working closely with the integration joint boards and the health and social care partnerships as they are increasingly developing new pathways for patients”. ([Official Report, Col 23](#)). He also indicated that the Scottish Ambulance Service is in early discussions with IJBs in that regard. Can you provide any further detail on the areas covered by those discussions, progress being made, and if any targets have been established?

What are the benefits you see for the Scottish Ambulance Service from such close working and can you identify any areas where they are already being realised?

Financial sustainability and performance

At the meeting, you stated that whilst there has been significant investment in the organisation, significant cost pressures and challenges remain. You confirmed that due to an intensive efficiency identification programme the organisation is on track to achieve its financial targets this year. ([Official Report, Col 28](#)).

Information obtained from Audit Scotland illustrates that the organisation continues to rely on recurring savings to meet financial targets and the Board recognises that this is not a sustainable position. It has been forecasted that recurrent savings of £27.299 million are required by 2022/23 to continue to operate in a financially sustainable way.

We also understand that in October 2018, the Board reported an overspend of £1.3 million and that overtime payments for staffing reached over £6 million. What is the current figure for overtime?

Given the scale of the financial challenges outlined above, what enables you to provide reassurance that core services will not be affected?