OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 23 May 2017

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 23 May 2017

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HEALTH AND SPORT COMMITTEE
14th Meeting 2017, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Clare Haughey (Rutherglen) (SNP)

COMMITTEE MEMBERS

*Tom Arthur (Renfrewshire South) (SNP)
*Miles Briggs (Lothian) (Con)
*Donald Cameron (Highlands and Islands) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Jenny Gilruth (Mid Fife and Glenrothes) (SNP)
*Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Maree Todd (Highlands and Islands) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Paul Bassett (Scottish Ambulance Service)
Dr Gareth Clegg (Scottish Ambulance Service)
Pauline Howie (Scottish Ambulance Service)
Gerard O'Brien (Scottish Ambulance Service)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 23 May 2017

[The Convener opened the meeting at 10:00]

Subordinate Legislation

National Assistance (Assessment of Resources) Amendment (Scotland) Regulations 2017 (SSI 2017/134)

The Convener (Neil Findlay): Good morning everyone, and welcome to the 14th meeting in 2017 of the Health and Sport Committee. I begin by expressing on behalf of the committee our deep condolences to the families and friends of those who lost their lives in last night's evil attack on Manchester. We wish all those who have been injured a speedy recovery, and we offer our thoughts and prayers to everyone who has been affected. We also express our solidarity with the people of the great city of Manchester at this dark time.

On our agenda, we have an evidence session with representatives of the Scottish Ambulance Service. It is only right that, at this time, we put on record our appreciation and admiration of the work of emergency services staff here and around the world.

The first item of business is subordinate legislation. We have two negative instruments to consider. There has been no motion to annul SSI 2017/134 and the Delegated Powers and Law Reform Committee has made no comments on it. I invite comments from members.

Clare Haughey (Rutherglen) (SNP): I note from our papers that there has been some delay in implementing the changes. They would normally be implemented from April, but the process has been delayed until the summer. I propose that the committee write to the Scottish Government to seek clarification on that, and on whether changes to payments will be backdated and so on.

The Convener: As there are no other comments, I ask members to agree that that is the way forward.

Members *indicated agreement.*

National Assistance (Sums for Personal Requirements) (Scotland) Regulations 2017 (SSI 2017/135)

The Convener: There has been no motion to annul SSI 2017/135 and the DPLR committee has made no comments on it. I ask for any comments from members.

Clare Haughey: I suggest that we write to the Scottish Government on this matter too, seeking the same information.

The Convener: Do members agree?

Members *indicated agreement.*

Scottish Ambulance Service

10:02

The Convener: Item 2 is an evidence session with the Scottish Ambulance Service. I welcome to the committee Pauline Howie, who is the chief executive; Dr Gareth Clegg, who is associate medical director; Gerard O'Brien, who is director of finance and logistics; and Paul Bassett, who is general manager. I ask Pauline Howie to make an opening statement.

Pauline Howie (Scottish Ambulance Service): The Scottish Ambulance Service touches the lives of almost everyone in Scotland at one point or another. Every year, we receive approximately two million calls for help. A very small proportion of those calls come from people who are in immediate need of our services—for example, those who are suffering from cardiac arrest.

The number of unscheduled care presentations is increasing. We have a range of different responses to patients in various circumstances, for example, elderly patients who have fallen. We provide almost one million patients with help in getting to and from their hospital appointments. We host the SCOTSTAR—the Scottish specialist transport and retrieval service—for the most acutely ill patients in Scotland who require to be transferred to specialist facilities.

We host the Scottish air ambulance service, and we have special operations teams that respond to tragic events like the one in Manchester last night. Like the convener, I want to place on record our thoughts for all those who have been affected by the tragedy in Manchester, and our thanks to our emergency services colleagues, especially those in the North West Ambulance Service.

The Scottish Ambulance Service is changing. Like the rest of the national health service, we operate in the context of increasing demand for healthcare services, public service reform, tight financial budgets, an increase in the elderly population and a workforce that is getting older. We have listened to our staff, to the public and to our partners, and we have embarked on a significant transformation of our service, which involves taking care to the patient. The reform programme means that we are basing our service on clinical evidence and on staff and patient experience. The aim is to provide care for patients where and when they need it, in the most appropriate setting, which might not be a hospital. Last year, we treated more than 100,000 patients where they want to be treated—at home or in a homely setting—and we saved more lives of patients who had had a cardiac arrest.

Our reform programme means investing in equipment and technology, but fundamental to everything is investing in our staff. We are developing our workforce through further education and the development, enhancement and addition of new roles and clinical skills for staff, and we will train 1,000 new paramedics by 2020. As we continue to introduce our new programme and the next phase of our clinical-based response model, we know that we still have a lot to do. We are only part of the way through the reform programme.

We know how valuable it is for members to see our service at first hand, and it was great to see so many committee members in ambulance stations and ambulance control rooms recently. We would welcome other committee members joining us to listen to staff and to hear and see for themselves at first hand the work that they do and the ideas that our staff have for further development of our services.

We will be pleased to answer your questions, and we seek the committee's support for further improvements in our service. We need to develop new models of care with and for communities. Those models of care must be sustainable, particularly in remote and rural locations. We need to provide alternative transport options for those patients who do not require the skills of ambulance staff, and we must continue to develop performance standards that matter to people. People tell us that what matters to them is improved positive outcomes and being treated with care and compassion.

The Convener: Thanks very much. In general, how do you think that the service is performing?

Pauline Howie: As I mentioned, we are part of the way through a significant reform of our service, based on the best clinical evidence that is available to us.

As I said in my introduction, we are saving more lives and we are developing our staff so that they can provide care in different settings. The experience of our staff and our patients is that a range of responses is required for people who phone 999. Sometimes, the response will not involve an ambulance—it might be referral to other parts of the health and social care system. That is why we are investing in upskilling the staff in our ambulance control centres and developing new roles there, as well as investing in the staff you see driving about our towns and cities. We want them to be able to take more care to patients.

There is always more to do. We have a very detailed corporate plan this year, which will involve our continuing to invest in the staff and to develop new care models and pathways with our partners.

Gareth, do you want to say a bit more about the evidence base for the changes?

Dr Gareth Clegg (Scottish Ambulance Service): Sure. There are two things that it would be good to say at this point about the performance of the service. The first is about out-of-hospital cardiac arrest, which Pauline Howie mentioned. Cardiac arrest is a good condition to use as an indicator, because it is at the top of the acuity pyramid. After someone's heart stops in the community, there are only a few minutes in which we can intervene to do something to save their life.

It came to our attention a few years ago that Scotland does not do terribly well in the international league table on survival after out-of-hospital cardiac arrest. Only one in 20 of the 3,000 or so resuscitations that are performed every year in Scotland will result in a survivor going home to their family. That is in contrast to the situation in parts of Scandinavia, where as many as one in four people in that position will go home.

In recognition of that, last year Maureen Watt launched Scotland's strategy for out-of-hospital cardiac arrest. The Scottish Ambulance Service has been at the centre of the strategy. It has chaired the committee involving all the other emergency services, third sector organisations and people from academia that has put together a programme that includes aims, pledges and undertakings to improve matters over the next four years up to 2020. We hope to improve survival to the extent that we save an additional 300 lives a year after cardiac arrest.

That highlights some important points about the Scottish Ambulance Service. We are keen to be proactive and at the centre of changes that will result in positive patient outcomes. We are willing to engage with all the partners in the community who want to contribute to that, who include community groups, other emergency services, third sector organisations, academics and so on. We are willing to collect the data and the resource in order to push things forward. As things stand, and as Pauline Howie alluded to, since the launch of the strategy, we have seen an increase in the number of patients who get a pulse back before arrival in hospital.

The Convener: We would all welcome changes that improve outcomes for patients, but looking at the measurements and health improvement, efficiency and governance, access and treatment targets, we see that we are 9 per cent below the target to

"Reach 80% of cardiac arrest patients within 8 mins",

10 per cent below the target for category A incidents and 14 per cent below the target for category B incidents. There are also areas in which there has been significant improvement and the figures are above target. I did not hear you commenting on those areas.

Dr Clegg: I will hand back to Pauline Howie in a second. Time targets are very important; we need to get to patients in a timely way and with the right resource that the patient needs, but clinical outcomes are perhaps more important. From a medical perspective, my submission is that we need to get patients what they need. As Pauline said, that is the experience that people want from the Ambulance Service. They want the things that are important to them, but they also want good clinical outcomes. We want lives to be saved, we want stroke disability to be reduced and we want sepsis to be treated early. That does not always mean sending the fastest resource. Sometimes it means sending the best resource. A clinical example is stroke. It is sometimes very easy to send the nearest resource to a person who has had an acute stroke if that resource is a car, but of course, the patient will almost certainly need transport to hospital, so it is often better to send a marginally slower response that is able to convey the patient to hospital, where they need to be, rather than sending a car as an earlier response. The car will stop the clock and improve the target figures, but it might not improve the patient's clinical journey.

A lot of the thinking around the new clinical response model is not just about time. Time is important, but it is about getting the best resource—the right resource—to the patient so that we can improve their longer-term outcomes.

The Convener: Is there any time element within that?

Dr Clegg: Yes. The time targets are important.

The Convener: Do they remain in the new model?

Dr Clegg: They do.

The Convener: What about in relation to the overall review of targets that is being done by Harry Burns and others? Are you involved in that and will that change things again?

Pauline Howie: The new response model is being introduced in phases and the second phase will be introduced next month. As part of the introduction to the model, which was in November last year, we have developed more evidence-based performance standards. We want to continue to refine them as we go.

We have shared with Sir Harry Burns the work and modelling that we have done on the evidence. As part of our new response model, that will be independently evaluated by the University of Stirling. That is what the chief medical officer asked us to do.

Alex Cole-Hamilton (Edinburgh Western) (LD): I am proud to have in my constituency two centres of the Scottish Ambulance Service—the risk and resilience unit and the call handling centre.

I have a couple of questions, but first I will pick up on something that was said about cardiac arrest and the disparity between survival rates in Scotland and Scandinavia. As I understand it, cardiac arrest survival is so much better, particularly in Norway, because they have an educated population who know what to do in the event of someone having a cardiac arrest. They have mandatory training in schools, which does not need to be onerous, but it does happen.

I am aware that the British Heart Foundation is campaigning for an hour of first aid training to be given to all secondary pupils at some time in their school career, and I have lodged a parliamentary motion in support of that. Does your organisation support that kind of shift to training in schools so that people are equipped with the knowledge and skills to deliver such first aid?

Dr Clegg: That is a helpful comment. Bystander CPR, or cardiopulmonary resuscitation being performed by somebody who has witnessed a cardiac arrest, is crucial. Survival from cardiac arrest does not just depend on the Ambulance Service. A whole chain of events need to stack up, the first two of which are the call for help and then bystander CPR.

Anything that increases the proportion of bystander CPR that occurs after cardiac arrest will improve outcomes. In Scotland, bystander CPR happens only about half the time—it is less than half the time, in fact. The best centres are not just in Scandinavia. The west coast of the United States and many other places have good outcomes, and bystander CPR happens there up to 85 per cent of the time. That is what we are gunning for. We seriously need to overhaul the way in which we, as a community, view cardiac arrest. In places such as Denmark, that has been done by making CPR training in schools mandatory, but that is not the only way to improve things.

10:15

It is certainly something that we have looked at and discussed with the Scottish Government, but, at the moment, we are taking a different approach, which is to support a national organisation called Save a Life for Scotland. That is a collaboration of all the emergency services and a whole range of third sector organisations, such as the BHF, Chest Heart & Stroke Scotland, the British Red Cross and the St Andrew's Ambulance Association, to do CPR training in and with communities, including in a range of schools. One of the targets of Save a Life for Scotland, of which we are a member, is to give all schools in Scotland the opportunity to learn CPR over the next five years.

Alex Cole-Hamilton: As I mentioned, the risk and resilience unit is in my constituency. I have visited it a couple of times and am very proud to have it there and of the absolute heroes who work there. Given the events in Manchester, are we in Scotland prepared for any similar attack, as regards the response of the emergency services—and particularly of the ambulance services, as was necessary last night?

Pauline Howie: We work very closely with the other emergency services, including the ambulance services, across the United Kingdom. We always take on board any learning that we can from tragedies such as the one experienced in Manchester last night. We have already been in touch with the North West Ambulance Service this morning, to take on board any immediate learning that we can. We have a whole programme of planning, preparation, testing and training of our staff—not just our colleagues in the risk and resilience department, but across the whole service—in emergency preparedness.

Alex Cole-Hamilton: Great. Thank you.

Tom Arthur (Renfrewshire South) (SNP): I welcome the panel. I want to pick up on Pauline Howie's reference in her opening statement to the addition of new roles and skills. Will you outline what those will be?

Pauline Howie: The development is across our whole workforce. We know that enhancing the clinical skills of our staff can not only save more lives but also improve outcomes for patients. We have talked a little about cardiac arrest, but the most common reason for people phoning 999 is that an elderly person has fallen. We know that a lot of elderly people who have fallen are not injured and do not want to go to hospital, so we have been developing different skills for staff to be able to assess people and refer them to alternative, community-based pathways. For example, we have been developing a new specialist paramedic role. They have enhanced skills and can treat, refer and work as part of primary-care-based teams in communities. Paul Bassett might want to say a bit more about that.

Paul Bassett (Scottish Ambulance Service): We have a number of specialist paramedics who are already trained, with a commitment to have 240 of them by 2020. One of the key areas in which they can use their skills is the agenda on integration with primary care. The convener will be pleased to know that a trial is going on at Deans and Eliburn medical practice, where a specialist paramedic is based for 7.5 hours per day, doing

the mobile workforce, going out and visiting patients, and working as part of that integrated health system to try to stem demand for us and to treat patients more appropriately, at the right time and in the right place. Specialist paramedics do a lot more work on minor illness and minor injuries that is not part of the core paramedic curriculum, and has not been for a number of years, but, as we transform approaches to education and pathways, that will become more mainstream in relation to the demand increases that we have seen.

Tom Arthur: That is interesting. To what extent does the realistic medicine agenda inform your practice and approach? There seem to be some echoes of that in the taking care to the patient strategy, and it is also reflected in the latest statistics, from April, in which you are exceeding your target on reducing hospital attendances quite significantly.

Pauline Howie: Absolutely. It works both ways; we have been sharing our approach with the chief medical officer and her team. We know that those models work. We held our own evaluation of the model, based on the small tests that we did a few years ago. In March 2017, the Nuffield Trust reported that the model of community-based paramedics helps as regards keeping people at home and shifting the balance of care.

Tom Arthur: ISD Scotland states that, as of December last year, there were 1,385 allied health professionals—in essence, paramedics—employed in the service. I understand that there is a Scottish Government commitment to increase that number by 1,000 by the end of this parliamentary session. What impact will that have? Will it help to address some of the areas where you have fallen short of your targets?

Pauline Howie: It is fantastic news that we will be able to train that number of new paramedics in the service to work in our communities. We are an unscheduled care service. We are part of the health service and are community and primary care based. We will be able to offer a huge amount to patients in communities with the investment of 1,000 more trained paramedics.

The Convener: Mr Bassett, you mentioned the Deans and Eliburn practice. Is that the practice that, in effect, went bust recently?

Paul Bassett: The practice is certainly struggling and we are helping out where we can.

The Convener: Were you brought in to assist in the practice because of the fallout from the situation, or were you in there before it went bust?

Paul Bassett: It happened about the same time, but our involvement is part of our longer-term strategy. We have similar models in Kelso, Hawick and the north of the country where we are trying to integrate all the different aspects of primary care, to integrate our service in all the primary care work streams and to use all the available resources to best effect to address the patient's need at home.

Alison Johnstone (Lothian) (Green): Good morning. I, too, have had the privilege of visiting my local ambulance centre. It was certainly heartening to see the skilled workforce in action and to listen in to some of the calls. I understand the training that has gone into ensuring that calls are handled as appropriately as possible. Pauline Howie highlighted the number of calls that are related to old people and falls. Does the service liaise with Government departments that might assist in preventing falls in the first place? Does it have any input there?

Pauline Howie: We have been working with the Scottish Government's assisted living programme to try to prevent falls because we know that, if people become dependent on the health services, they quickly lose their independence and the return to independent living can be an uphill struggle for them. Through some of the work that we have been doing on, for example, alternative models of care for people who have fallen, we have been able to identify people who are more at risk of falling and put in place preventative measures such as housing adaptations or changes in the medicines management for those patients. We now work as part of a multiagency team to share learning and to try to put in place much more sustainable services that not only respond to but can anticipate and, ultimately, prevent falls.

Alison Johnstone: Are you seeing any improvement because of the work that is happening already?

Pauline Howie: The data that we collect relates to people who have fallen at home who are not injured and whether we are able to keep them in community settings. We are seeing a significant improvement in our contribution. It is too early to say whether it is having any impact on the wider prevention agenda.

Alison Johnstone: You spoke about the Minister for Public Health and Sport's commitment to training 1,000 new paramedics by 2020. Will that be possible? We have taken a great deal of evidence about recruitment and retention across medical professions. Who do you hope to attract to those roles?

Pauline Howie: We train a lot of people ourselves. People can join the Ambulance Service and be trained as ambulance technicians. That takes about 18 months and then there is a period of consolidation of the practice. After that, they can go on and train to become paramedics. We are

also introducing a degree course at Glasgow Caledonian University in September this year as a trial.

Across the country, the Ambulance Service remains an attractive employer. Last year, as part of the first phase of investing in new staff and new roles in the service, we attracted more than 5,000 applications for roles in our service. There are some pockets in remote and rural areas where it is harder to attract staff, so, last year, we developed a model that specifically tries to encourage people who already live and work in such communities to consider a career with our service because we know that they are more likely to stay in those communities once they are trained with us.

Alison Johnstone: I have a question on neonatal transport. You will be aware that the maternity and neonatal services review recommended reducing the number of neonatal units from 15 to five, and potentially to three, which will mean that more travel is required. How involved are you in those decisions? There will be implications for staff training.

Pauline Howie: We were a member of the maternity and neonatal programme board, which reviewed the existing arrangements. We will continue to work with the areas as we move towards the new model that the review sets out. We are at the very early stages, but the SCOTSTAR—Scottish specialist transport and retrieval—service includes the neonatal service and it provides a fantastic service every year.

Ivan McKee (Glasgow Provan) (SNP): I thank the panel for coming. I want to drill down a wee bit into some of your measures to understand how they fit together. If I read the data right, you handle about 600,000-plus incidents a year, with nearly 900,000 journeys. You mentioned that about 3,000 of those incidents are cardiac. There will be other serious issues that you deal with as well, but I reckon that the vast majority of cases will be less serious—perhaps you can confirm that. How effective are your call screening processes to understand at the start what is in front of your staff and what are the best resources to deploy? You clearly do not want to deploy resource to something when it could be better used somewhere else. Do you measure the effectiveness of the call screening? That is probably the most important metric, because if you get that right, everything else flows from it.

Secondly, I will follow up on Alison Johnstone's question on preventative measures. Work to prevent falls is a good example. If you work hand in glove with other parts of the health service that are engaged in the preventative agenda, you should see the total number of incidents going down. Are you tracking that figure to see the impact?

Pauline Howie: Investment in our staff includes a significant investment in the three ambulance control centres that work virtually as one ambulance control centre. We have established in the centres clinical hubs that are staffed by nurses, paramedics and doctors who can help staff to refine the triage and make sure that we direct ambulances to the most appropriate calls. When an ambulance is not required, the incident is referred to another part of the health and social care system. Our modelling in 2015 suggested that about 30 per cent of the demand at that time could be better served by another part of the health and social care delivery network. That is ultimately what we are aiming for over the five-year reform programme, and we have milestones along the journey. Paul Bassett looks after our ambulance control centres, so he can explain in more detail.

Paul Bassett: The processes and protocols of our call screening programme are internationally recognised. There is a standards council for them and they are constantly updated. Our staff are undertaking training to move to version 13, which is geared towards identifying life-threatening cases much more quickly. The process has also been changed to improve cardiac arrest survival and recognition by getting hands on chests much more quickly, which Gareth Clegg alluded to earlier.

Our call handlers are audited—up to 3 per cent of calls are audited—and we feed that audit back to the body with which we have our licence. We are working towards centre of excellence accreditation, which would mean that we are robust in our triage processes. We have to meet 20 standards and give evidence about those to the licensing authority. We hope to achieve the accreditation by March next year.

Ivan McKee: The question was whether you have a measurement of effectiveness. If you take 1,000,000 calls, you will know that, at the point where the person takes a call, they make a decision on whether it is coded A, B or C. When you have gone through that process and an ambulance has arrived, does anyone decide, "You called that a B, but it should have been an A," or vice versa? Do you have those numbers? Is there a feedback loop? What is the percentage of correct decisions?

Paul Bassett: The codes are generated by the system in direct response to answers by the patient to questions that are scripted. Much of that relies on the interpretation of the person who is with the patient and occasionally it is wrong—I am pleased to say that in most cases it is not. When our crews arrive on scene they complete a box in the electronic patient report form that confirms that the case was allocated to the right category and

protocol. I have not got an exact figure, but a high percentage are correct.

10:30

Variation between the codes can happen as the patient's condition may improve or deteriorate while we are en route. When we consider patients to be at risk, we stay on the phone with them and monitor the position throughout. We try to update the crews while they are en route.

Ivan McKee: You might want to come back to us on the number, because that measure must be absolutely critical to the health of the whole system and you should be tracking it week in, week out to see the trend. If you get that right, everything else will follow.

My second question was on the preventative agenda. Are you seeing any impact on the number of calls as a consequence of any preventative work that you are doing?

Pauline Howie: Our call volumes continue to increase, but the proportion that we are hearing, treating and referring is also increasing, and we are sending more to other parts of the health and social care system. As the most recent figures show, the proportion of calls following which we take care to patients in their own home is also increasing. Those are the two areas where we can shift the balance of care and keep people in community settings and out of hospital when they do not need to be there.

About 40 per cent of our activity requires getting someone to hospital, although perhaps not immediately—some patients might prefer to wait until the next day when the clinic is open. That is our focus in respect of differentiation and refining our triage arrangements. Gareth Clegg might want to say a little more on the evidence base for that.

Dr Clegg: There are a couple of interesting things. On prevention affecting the number of calls, there are lots of drivers that affect the number of calls that the Ambulance Service gets. It is not as though there is a fixed body of people who will call in any given 12-month period and so by preventing some of those calls we would reduce the number of calls overall, because the general trend is for an ever-increasing number of emergency calls. That trend reflects the change in the number of pre-hospital options that potential patients perceive that they have when something goes wrong. The tendency for our numbers to increase is partly due to demographics and partly a shift in the options for care in the community that people have.

Although we do our best to reduce that demand through preventative measures, we would not expect to see that thread through directly to the number of calls that we receive.

Ivan McKee: Is there an issue with people who do not understand what they should do and so call an ambulance when they should not? Is that part of the issue?

Dr Clegg: It is part of the issue, but it is complex. In part it relates to a change in the way in which other out-of-hours services are run and in part it is to do with people's changing perceptions of healthcare, their ability to manage their own health and their expectations of the health service.

I work in the emergency department in Edinburgh and we see the same pattern. The kinds of cases that are coming to us are shifting. We are getting older people, but we are also getting lots of younger people too—we have seen a spike in the 16-to-15 age group, as well as the older age group. That is not because those groups are getting sicker but because they are coming in with issues that previously they would have taken to other places.

Ivan McKee: Apart from the fact that the emergency department is not an appropriate place for them to go, that is also a non-effective use of resources across the health service.

Dr Clegg: Yes, it is a problem.

You asked about drilling down into the accuracy of diagnosis using the protocols in ambulance control. To demonstrate how proactive we are and how seriously we take it, I want to give an example of what we are doing in cardiac arrest. As you correctly identified, the triage point at ambulance control is the pivot for the whole system—if that does not work, then all sorts of other things will not work as well as they could. The service has spent a lot of time listening to individual cardiac arrest calls to see what gets in the way—such as linguistic barriers and misunderstandings—between the calls coming in and the response being sent out or someone being persuaded to do bystander CPR. We have published some work on that in collaboration with the University of Edinburgh.

The other big triage challenge is around major trauma. Again, if there is a big smash or accident, correctly discerning what resource needs to be sent and in what kind of timescale is very important, not only for saving lives but for saving money. We are right of the centre of the process that is examining how we best triage trauma across the whole country, as part of the trauma reconfiguration exercise. We take the area of ambulance control and triage very seriously.

Clare Haughey: I thank the panel for coming along this morning. From what I have been reading and hearing, the new model represents a

significant change and is very different from how the Ambulance Service was working before. You are asking Ambulance Service staff to do the job differently, whether we are talking about activity, judgment or risk assessment. What training has the organisation put in place for its current staff?

Pauline Howie: We have on-going annual training for our staff, which is refreshed each year, based on staff feedback. For example, last year, staff said that they wanted more training in obstetrics and paediatrics, so we put that into their annual programme of training. As part of the introduction of the new response model, we have been engaging with staff on what else they want to see in their training and development.

We talked about the 1,000 new paramedics who will be taken on. We are enhancing the skills of the new staff who come into the service and the skills of the ambulance technicians who are being trained to be ambulance paramedics.

There is a holistic training programme, which is for all staff. You are right to say that the new model is significantly different from the one that we previously operated and requires all staff to work differently. We have invested significantly in our practice placement educators, who work in our ambulance divisions and ambulance locations, as well as in the people who work for us at Glasgow Caledonian University to train new staff or upskill existing staff.

Clare Haughey: You mentioned training in specific areas of healthcare, such as obs and gynae, and it is fair enough that you provide such training as a result of feedback that staff have given you. However, how does that feed into the new model, which seems to offer a very different way of working? You do not have a huge staff turnover, so many people have been with you for quite some time; how are you supporting them?

Pauline Howie: The most significant change in practice is in the ambulance control rooms. Paul Bassett might want to talk about the intensive support that we have been giving those staff.

Paul Bassett: Certainly. We mentioned the clinical advisers. An in-depth process is going on to do with the triage system that we use and how we safely discharge patients or transfer them to other pathways of care. For staff in the field, there is documentation in that regard; there is also a patient safety manager, who has been looking at safe referral and discharge and what we need to do to ensure that patients meet the requirements.

In the Scottish Borders, in Kelso and Hawick, we have been trialling those models. In Hawick, specialist paramedics were embedded in general practitioner practices—we used all the paramedics at Hawick station to do that test of change. The approach was successful; a significant number of patients were able to be safely left at home or referred back to the GP community locally for appropriate care and support. Patients were also referred to avenues in social care, which involved bringing other people on board.

It is now about rolling out the approach across the country. As Pauline Howie explained, we run the learning in practice programmes every year—we are committing to two days this year—and the new models will be on the agenda. In addition, people can undertake other educational sessions via e-learning or any other portal that they want to use. That is a continuous process. There is also learning from good and bad experiences. We learn from complaints and concerns as well as compliments, so that we can hone best practice.

Clare Haughey: I am wondering about the new roles that have been developed in the Ambulance Service. We heard about practice placement educators and patient safety facilitators.

Paul Bassett: The patient safety manager sits in our clinical directorate, centrally, and does the horizon scanning, to ensure that across the Ambulance Service—

Clare Haughey: I do not understand the term “horizon scanning”. Will you explain it, please?

Paul Bassett: Yes. The patient safety manager looks at the national picture and everything that is going on, with a view to finding best practice. We undertake the improvement methodology through tests of change. There is therefore a central repository for looking at what works and what we need to revise or improve on.

In the context of the delivering future leaders and managers programme, team leaders and local managers are, through the staff engagement processes, doing local roadshows and local training, which they are well capable of doing.

There was a good example in Edinburgh recently, where a local team identified an issue. They got the training trailer to come in, and they spent time with all their staff going through things at a local level. We encourage all those different models of training. That is happening on some of the islands, too, where the team leaders take that responsibility, feeding into the centrally delivered syllabus and ensuring that, as far as possible, it is divested to staff locally.

Clare Haughey: That leads me to my next question, on the initial training that paramedics and ambulance technicians receive. Ms Howie, you said that a course is being developed at Glasgow Caledonian University. How are you inputting into that to ensure that the paramedics who are being trained now will be trained in the new model of working?

Pauline Howie: Our trainers and educators are based at Glasgow Caledonian University. They design the course, which is accredited. Other healthcare professionals based at the university are drawn in as necessary. There are benefits from that collaboration for other healthcare professionals based at GCU, and that has been helpful for learning from other professions as we develop paramedics within the Ambulance Service.

Clare Haughey: Have you had any feedback from the public, patients, service users or service providers about the new model, its roll-out, how well it is working or where the issues or difficulties lie with it?

Pauline Howie: We have been engaging with patient groups across the country to reassure them on the basis of the clinical evidence and to get their feedback as to what they would like to see in future. For patients, the issues are that we are able quickly to identify immediately life-threatening cases and to get the best ambulance response for them. There is also an issue around the ability to safety-net those patients who perhaps do not need that immediacy of response but for whom it is appropriate to get the conveying resource there in time.

We work with patient and public forums across the country, and they help us on the design of our services. For example, they have helped us to design new needs assessment models for the patient transport service, new vehicle designs and so on. That is an on-going engagement programme. Our service is very much based on patient experience and staff experience.

The Convener: Could you provide us with performance information based on the new system? The committee clerks wrote to you, and what we got was updated time information, rather than information based on the new model. If you could provide that for us, that would be very welcome.

Maree Todd (Highlands and Islands) (SNP): I represent the Highlands and Islands, so I am particularly interested to hear about provision of ambulance services in remote and rural areas. I visited the ambulance centre on Islay and was very impressed by the team there. Could you tell us a little bit more about the different types of service that are available in remote and rural areas?

Pauline Howie: We have a range of responders: there are more than 1,000 community first responders operating out of about 130 first-responder schemes who provide a really valuable service while the ambulance is on its way. You will be aware that the model on Islay is very much a partnership-type model: the SAS works very closely with the hospital and with the GPs on the island, as well as with the other responders there. In Grampian, we have recently introduced a new model called wildcat, whereby members of the community, nurses and doctors are trained to offer an immediate response to cardiac arrest.

We work with communities to design models that suit their local circumstances. As you will be well aware, rural communities and island communities are all very different in terms of their resources and the assets that are available to them.

Maree Todd: Could you tell me a little bit more about hospital transfers from islands—not the urgent transfers such as for cardiac arrests, but the less urgent transfers? I have heard anecdotally from people about difficulties to do with the number of ambulances that can go on a ferry, and to do with transferring people from ambulances on to ferries and then to an ambulance on the other side, because the service does not want the island ambulance to be away for a long time. Could you tell me a little bit more about the logistics of those challenges?

10:45

Pauline Howie: The situation is challenging because of all the different ferry arrangements across the country. We have the air ambulance service for patients who need to be moved by air transport: some of those cases will be emergencies and others will be more planned journeys or other urgent journeys. We work very closely with community hospitals, GPs and ferry companies to try to ensure that we can retrieve patients as smoothly as possible, based on their presenting need. We often try to keep island ambulances on the island and will send a mainland-based ambulance over to retrieve a patient and bring them to specialised care on the mainland.

Miles Briggs (Lothian) (Con): Good morning, panel. The weekend before last, the Scottish Ambulance Service, along with all the health boards apart from NHS Lothian, experienced the ransomware cyberattack. Will you update the committee on what changes you have put in place since then and any additional IT capacity needs that you have identified?

Pauline Howie: Before I hand over to my colleague, Gerry O'Brien, I would like to say that the malware attack a couple of weeks ago had no operational impact on service delivery.

Gerard O'Brien (Scottish Ambulance Service): The service was made aware of the ransomware attack at 15:45 on that Friday afternoon. By 16:30 we had identified that 14 personal computers and a laptop had been

infected by the attack. The majority of the PCs were located on our Aberdeen network, so we took immediate steps to isolate it from the national network, purely as a precautionary measure. By 17:30 we had updated our monitoring software and our Sophos software to protect against any future ransomware attack.

Pauline Howie said that the attack had no impact—I am very pleased to continue on that theme. No patient data was impacted by the attack. The 15 devices that we identified—which have now all been replaced—were all providing admin and back-office functions. We were a little bit puzzled as to why those 15 devices were affected, out of our estate of more than 1,500 PCs. We have identified that it was because of a patching issue. We take a very robust approach to patching PCs: we always insist that we have the most up-to-date software versions, and we do the same with our major business-critical systems. We work very closely with Paul Bassett's team on bringing systems down and moving back to analogue and paper during patching, to ensure that we have the most up-to-date software.

Our remedial action is to review our patching arrangements to ensure that they are up to date. We have everything set to update automatically every two hours. We are working through why those 15 devices were not picked up by that process, which the attack has led us to reinforce.

I am pleased to report to the committee that there was no impact on patient data.

Miles Briggs: Thank you for that update.

My second question is on pressures on maternity units. I have had a number of cases in which expectant mothers have presented at an NHS Lothian maternity unit and been sent home, only to go into labour and have to call for an emergency ambulance to attend. Are you seeing an increase in those kinds of incidents? Sadly, I am being told quite regularly that they are happening in NHS Lothian. The committee has met, under Chatham house rules, a number of maternity nurses who have highlighted that problem.

Pauline Howie: We have not seen any spikes in our patient-related data for maternity cases. I do not know whether colleagues have any other intelligence on that.

Paul Bassett: No. We know that only a proportion of expectant mothers travel with the Ambulance Service to hospital, so we would not see the true effect of those sorts of situations. We are more likely to be called to imminent births, complications, or situations in areas where there is no transport available. As Pauline Howie said, the data shows no indication of a significant increase in those in any part of the country.

The Convener: Were there any missed or delayed appointments because of the malware attack?

Pauline Howie: No

The Convener: Thank you.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): Pauline Howie said earlier that the ambulance service remains an attractive employer, but a couple of worrying things came out of the 2015 NHS staff survey. For example, only 39 per cent of ambulance service staff agreed with the statement:

"I am kept well informed about what is happening in my health board",

and only 42 per cent agreed that

"My line manager communicates effectively with me".

Those were the lowest percentages for all the national bodies in the NHS. Can you account for why that might be the case?

Pauline Howie: We are a unique service, when compared with other bodies in the NHS. We have a distributed workforce that is mobile and which works in communities 24/7. Further to the staff survey, we have been implementing the "I matter" staff experience tool. I am pleased to say that that is now fully rolled out across the Ambulance Service. Our employee engagement score, which measures how engaged people are within their workplace, is 67 per cent. That is much better than we were expecting. The participation rates were 70 per cent: we have had much higher participation in "I matter" than we had in the previous staff survey.

However, we are never complacent. We have a range of channels through which we engage with staff, and that communication is two-way. For example, a couple of weeks ago I did a quarterly webcast, which allows anyone in the service to ask of me or the senior manager team any question at all. I have a weekly bulletin that includes three hot topics of the week. We always highlight fantastic examples of the good practice that goes on in the service so that we can share that learning, as well. We have station meetings across the service, and we use social media and a range of other opportunities for staff to engage. We have been enhancing and developing front-line leaders and managers through our programme called developing our future leaders, and we are giving them more dedicated time so that they can help to develop their teams and the areas that are important to them.

Jenny Gilruth: I will pick out another couple of points from the staff survey. Only 20 per cent of your staff agreed with the statement:

"When changes are made at work, I am clear how they will work out in practice",

and only 53 per cent agreed that they had had a knowledge and skills framework development review in the past 12 months—nearly half your staff had not had a staff review in the previous year. I appreciate that you have put changes in place on the back of that staff review, but those percentages do not match up to other NHS boards nationally, so I wonder why. Did you involve staff in the move to the new clinical response model? It seems that there is a disconnect between how staff on the ground are feeling and what is happening at corporate level on the board?

Pauline Howie: Some of the key differences arise because we are a mobile workforce so we need to use different channels for engaging staff. Certainly, the new response model was based very much on staff feedback. Staff were concerned that they were blue-lighting to incidents that did not require that level of response and were frequently being stood down once there was more intelligence from the caller about the presenting condition of patients. The new model has been co-designed with our staff and we continue to adapt it, based on staff feedback.

The Convener: To follow up on that, I say that I get the impression that there is a bit of not wanting to face up to difficult things that are going on. If we look at the section of the survey concerning staff satisfaction and absence, only 13 per cent said that they felt that they were consulted about changes, 34 per cent would recommend their workplace as a good place to work, 39 per cent said that they were kept informed, only 15 per cent said that there were enough staff to do the job, and 29 per cent said that they could meet all conflicting demands. If we compare that with the staff survey in Wales, it is significantly different. We have already looked at the performance data, and I do not think that you have said much about areas where performance was failing. There has been no mention of sickness absence or anything like that. There seems to be a disconnect between what your staff are saying and the impression that you are giving us, which is that everything in the service is going along swimmingly.

Pauline Howie: As I said, we are part way through a significant reform of our services and there is much more that we want to do. We want to continue to develop staff, we want to continue to put in place opportunities for them to be further engaged in the development of our service, and we want to listen to and take on board their ideas. That is why we have invested in front-line leaders and managers.

We are a very distributed service—we cannot do it all from the centre. We want to empower local staff to develop services with and for local communities, within a safe and effective governance framework that is based on the work of our clinical governance team.

We are absolutely not complacent. We have been looking at our staff health and wellbeing strategy. You will be aware that our staff put themselves in very challenging situations and sometimes see the most horrific scenes, so we have support mechanisms in place for them. We recently conducted a stress audit and are also training our staff to use individual stress-assessment tools. There is a range of opportunities for further support mechanisms for staff as part of our health and wellbeing strategy, which our staff partners have been designing with us.

Colin Smyth (South Scotland) (Lab): The proposal to recruit an additional 1,000 new paramedics over the next five years was mentioned earlier. That would be a substantial increase in the current workforce. The staff survey results have also been mentioned. The survey showed that 15 per cent of staff believed that there were enough staff to do the job—which was half the national average across all boards—and there has been a high level of staff absences, as the convener has just mentioned, so at what point was it noticed that the service was so understaffed?

Pauline Howie: As we developed the new model and the proposals for the new model in 2015, we underpinned that with a five-year workforce plan and a five-year financial plan. We have secured the Scottish Government's commitment to invest in the service over the coming five years based on that new model and the benefits that we could demonstrate for patients. Gerry O'Brien can say a bit more about that investment.

Gerard O'Brien: We have worked very hard over the past couple of years with Scottish Government colleagues to develop the financial plan, which is entirely driven by our workforce model. Committee members have noticed the significant increases in staffing levels that are coming: there is a significant increase in staffing levels in the control room and there is investment in additional training, which my colleagues have spoken about.

Over the past couple of budget-setting rounds, we have also tried to make sure that our front-line provision is adequately resourced in terms of what we call relief cover, which is about making sure that the staff are covered for annual leave, sick leave and so on.

Part of the overall workforce plan is about saying "This is where we are today and that is where we want to move to", and building towards that based on appropriate utilisation levels and

allowing for appropriate time off the road for training, continuing professional development and so on. That is what leads to the overall investment portfolio that is required over a range of headings.

As Pauline Howie indicated, we have recruited a significant number of new staff last year and this year and we are moving towards achieving the balance by 2020, when we will have implemented the full strategy. We have all the elements pulling together now, but as Pauline Howie said, it all commenced with the design of the new clinical response model back in 2014, moving into 2015.

Colin Smyth: There is a substantial change to the current levels of staffing. How can we be reassured that the workforce planning will work? It clearly has not worked up until now, because you are significantly understaffed, with high levels of stress and high absence rates. You have a plan to increase substantially the number of staff, so clearly the workforce planning has not worked up until now. How can we be reassured that the workforce planning that you are putting in place will work in the future? The NHS does not seem to be particularly good at planning workforce levels.

Pauline Howie: We undertook a resource modelling exercise in order to understand all the variables that impact on staffing requirements—not just the number of staff, but the skills mix that is needed based on the new clinical model. We will continue to refine that as we progress towards 2020.

We have been successful in recruiting the staff that we have needed up to now, but they are not yet all doing the things that we need them to do because there is a period of induction, training and development for them. As we move through to 2020, we will start to see more of the benefits coming through in the performance measures that we mentioned—more lives being saved from cardiac arrest, more patients being safely and appropriately cared for in community settings and improving outcomes for other patients.

11:00

Colin Smyth: How many of the 1,000 new paramedics and technicians were recruited in the past year?

Pauline Howie: We recruited more than 200 paramedics and more than 200 technicians last year, and we are on track to recruit the same numbers in the current year. Some of those technicians backfill for people who train as paramedics and some paramedics go on to be trained as specialist paramedics, so people embark on a career pathway. Of course, some people want to step off the pathway at various points.

Colin Smyth: You say that some of the paramedics are current technicians who are being trained up as paramedics, but it was reported recently that many technicians are being replaced by technicians on a lower band—I think that it was level 3—who have a lower skills level. Is that the case?

Pauline Howie: No. We have different types of ambulance response depending on the clinical acuity of the patient, so you might be referring to the introduction of what we call low-acuity ambulances to deal with patients who do not require the skills of paramedics. Those are staffed by ambulance care assistants. However, we continue to invest in the double-crewed accident and emergency vehicles. The skills mix for those includes paramedics and ambulance technicians.

Colin Smyth: You talked about backfilling the technicians who are being trained as paramedics. Are they backfilled by technicians who have the same level of skills?

Pauline Howie: Yes. We are enhancing the skills of our technicians, as well.

Colin Smyth: Obviously, it takes time to train people to the required level, so what plans are in place to mitigate the current pressures on staff as you train new technicians and paramedics? There will be a substantial gap between their starting to train and becoming fully qualified.

Pauline Howie: It is a matter of constantly striking a balance throughout the country and at local ambulance station level to ensure that we can balance people's desire for career development and training with the need to maintain services. There is a comprehensive workforce plan that covers the whole country. The service is split into five operational divisions, which determine what they need locally based on their expected turnover and progression towards the workforce model that we have set out in the 2020 strategy. We host different training opportunities in different locations throughout the country each year.

Donald Cameron (Highlands and Islands) (Con): I will ask about cybersecurity. I refer members to my entry in the register of interests and the fact that I am on the board of two companies that invest in healthcare technology.

As has been discussed, the Scottish Ambulance Service was one of the health boards that was hit by the recent cyberattack. Pauline Howie and Gerard O'Brien said that there had been no operational impact and that no patient data had been affected. Are they able to tell us categorically that no patient data was lost or compromised in the Scottish Ambulance Service following the attack?

Gerard O'Brien: Absolutely. No patient data was lost or compromised as a result of the cyberattack on 12 May.

Donald Cameron: I turn to the well-documented issues that have occurred in the north-east, Moray and the north. They have become evident in the past six months and encompass a number of different problems, some of which have been reflected in our discussions this morning. For instance, there have been reports of insufficient numbers of paramedics in Aberdeen leading to a shortfall in staff; there have been reports of too many long-distance journeys for non-emergency patients; there are issues with staff fatigue, caused by overwork, and staff having to take time off, which has effects on the service; and, lastly, when the Unite union had a ballot, 95 per cent of its members placed a vote of no confidence in the management of the north division of the Scottish Ambulance Service. What have you done to address those serious issues?

Pauline Howie: There is no doubt that our staff are working harder than ever before. As we said at the beginning of the meeting, emergency and unscheduled care demand is increasing and the nature of services is changing. We are working closely with health board partners to understand the changes and to put in place safe and effective models of service delivery. For example, you will be aware that we have announced investment in Caithness through additional transfer resources. We are also working closely with NHS Grampian on changes in service provision in Moray. At the staff partners' request, we have established an on-call working group, chaired by our employee director—who is a member of Unite—so that we can look at issues of fatigue and try to minimise on-call working in remote and rural areas wherever possible.

Donald Cameron: Can you point to any concrete changes that have occurred?

Pauline Howie: In the past year, we have introduced what we call urgent-tier ambulances in Moray. We have also introduced hospital-ambulance liaison officers to ensure that all transfers are appropriate and so that we can task the most appropriate ambulance resource that is available to meet the presenting conditions of the patient at the time. We have also introduced specialist paramedics in the Moray area. As we demonstrated earlier, those paramedics are able to see, treat and keep people in their communities unless they need to be transferred to hospital or transferred from one hospital to another.

Donald Cameron: I believe that there is also a logistics co-ordinator. Can you explain their role?

Pauline Howie: They are based in divisions and help by ensuring that consumables, vehicles and other equipment that people need to do their job are in the best place.

Paul Bassett: In relation to things such as restocking systems for stations, we try to minimise costs by ordering supplies in bulk, having them delivered centrally and then cascading them out in each division. Edinburgh is the central point for Lothian and we have a logistics man in a van who then takes orders from the various stations and delivers them, ensuring that stocks and cleaning facilities are in place and checking the level of medical gas and so on. If anything needs to be taken away, he does that too. Therefore, rather than have ambulances travel from A to B with paramedics and technicians on board to carry out such admin tasks, we have logistics personnel who underpin the system, supporting it to maximise the availability of our ambulance resources.

Donald Cameron: Thank you.

The Convener: I have some specific questions. I understand that the board has a paper on the future of the patient transport service. Can you make that available to the committee?

Pauline Howie: Yes.

The Convener: Can you describe briefly your plans for the patient transport service?

Pauline Howie: The patient transport service is skilled by ambulance care assistants, who are able to care for patients to and from their hospital appointments. We have been refining that service over the past five years as part of a significant change programme, and we have been identifying alternative providers for those patients who do not need the skills of ambulance care assistants. We have been working closely with transport authorities, such as Strathclyde Passenger Transport.

We continue to refine the model. As the committee will be aware, the modern out-patient programme anticipates different models of out-patient appointments in the future. We will work closely with health boards to understand what that will mean for the patient transport service. That is the thrust of the paper; it considers what we will need to deliver in future.

We have also introduced more discharge ambulances, which help patients to get back from hospital after they have been admitted for a stay. The nature of the service is changing and we need to ensure that we develop it as we anticipate those future changes.

The Convener: Ok, thank you for agreeing to provide us with that paper.

Has the long-running saga about meal breaks been resolved?

Pauline Howie: Several years ago, we introduced a new Scottish system for ensuring that staff could have meal breaks. As we have introduced the new model, we have continued to refine the arrangements for disturbing people during meal breaks. It is important that staff get their meal breaks and that we minimise disturbance when someone is on a meal break, so that the person can be appropriately rested. We have been working with our trade union partners and staff over the past few weeks to try to refine the arrangements, as we have introduced the new model.

The Convener: That sounds like the matter is not resolved.

Pauline Howie: It is work in progress. Everyone understands the need to ensure that we can respond to life-threatening situations when such calls come in.

The Convener: You mentioned the skills mix. I understand that a paramedic should be present on every ambulance call. Does that happen?

Pauline Howie: We will develop the skills mix as we introduce the new clinical model. You will see in our strategy that different levels of skill are required, depending on the nature of the call. For example, the low-acuity vehicles that I mentioned often respond to GP requests for people to be admitted to hospital. The approach will continue to develop.

If, because of a short-notice call-off or another reason, we cannot get a paramedic on a particular vehicle, we ensure that the vehicle is tasked to appropriate calls that match the skills of the crew. We have paramedics in the ambulance control centres who can offer advice and ensure that resources are appropriately backed up. There is safety netting in place.

The Convener: Under the current operational arrangements, is there supposed to be a paramedic on each call?

Pauline Howie: As I said, we have introduced the first phase of the new ambulance response model—

The Convener: Sorry. Was that the previous situation?

Pauline Howie: That was the previous situation.

The Convener: Are you saying that we are now in a different situation and it might not be the case that a paramedic must be present, depending on the call?

Pauline Howie: It will depend on the presenting conditions. As Gareth Clegg said at the beginning of the meeting, the approach is based on the best evidence that we have.

The Convener: Finally, we have seen media reports of ambulances being forced to stay off the road, with ambulance crews saying that they have been stranded at hospitals because there were no emergency staff to receive patients, leaving ambulances stuck with patients in them who had nowhere to go. Has the situation been resolved? Was it a one-off, or is that a regular occurrence?

Pauline Howie: Hospital ambulance turnaround times are closely monitored, because it is important that we can hand patients over to clinical staff in hospitals and get back out to respond to emergency calls when they come in. I said earlier that we have invested in hospital-ambulance liaison officers, who are ambulance staff who work closely with the site management team, trying to pull patients through into the hospital and discharge patients as effectively as possible.

Hospital-ambulance liaison officers operate in a number of the larger sites in Scotland. There are different models and they are securing improvements in hospital turnaround times. An example is the work of the NHS Lothian flow centre, in Edinburgh. The flow centre is a multi-agency hub that ensures that we can get patients to the right place as effectively as possible. Paul Bassett might say more about the centre.

Paul Bassett: The approach has been a number of years in the making. The centre started off as a transport hub, which did really good work in the context of the integrated transport agenda. It saves ambulance resources because they go only to patients who absolutely need them. A paramedic is embedded in the flow centre, to ensure that there is a multi-agency approach, which gives us an early heads-up on where patient flow and additional discharges need to be facilitated. The pull-through from A and E means that there is a local focus on not delaying ambulances and on offloading as soon as possible.

We are seeing the benefits of the approach in Edinburgh, and colleagues from other health boards have come to visit the flow centre. We are working with local management teams in different areas to replicate the approach to see how we can continue to improve turnaround times where we need to do so.

The Convener: If there is data to back up the approach, it would be helpful if you would provide it to us.

Miles Briggs: In response to questions from Donald Cameron and me about the cyberattack, Gerard O'Brien said—I wrote down the responses—that no patient data was lost following the attack. Can you clarify that no patient data was lost or compromised during the attack?

Gerard O'Brien: Yes, sorry. During and following the attack, no patient data was lost.

Miles Briggs: Thank you.

The Convener: I thank all the witnesses for their evidence. As agreed, we now move into private session.

11:15

Meeting continued in private until 11:27.

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