HEALTH SCRUTINY COMMITTEE	AGENDA ITEM No. 6
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Report of:	East of England Ambulance Service NHS Trust	
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AMBULANCE SERVICE - AMBULANCE RESPONSE PROGRAM (ARP) AND THE IMPACT ON PETERBOROUGH

R E C O M M E N D A T I O N S
It is recommended that the Health Scrutiny Committee note the contents of the report.

1. ORIGIN OF REPORT

1.1 The report is being presented at the request of the Health Scrutiny Committee.

2. PURPOSE AND REASON FOR REPORT

2.1 This report has been produced at the request of the Health Scrutiny Committee to update the Committee on the NHSE Ambulance Response Programme and the impact on Peterborough.

2.2 This report is for the Health Scrutiny Committee to consider under its Terms of Reference Part 3, Section 4 - Overview and Scrutiny Functions, paragraph No. 2.1 Functions determined by Council - Scrutiny of the NHS and NHS providers.

3. BACKGROUND AND KEY ISSUES

3.1 **ARP**

Following the largest clinical ambulance trials in the world, NHS England implemented new ambulance standards across the country known as the Ambulance Response Program (ARP).

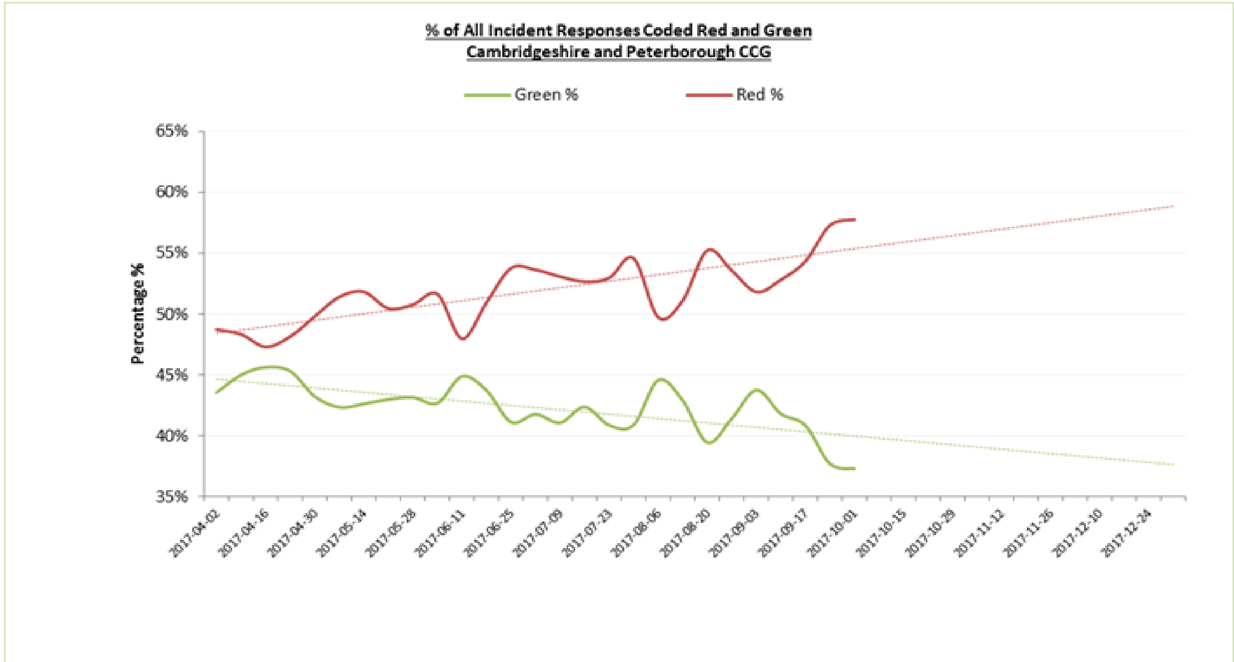
In a letter to Jeremy Hunt, Secretary of State for Health, Sir Bruce Keogh outlined why the results from the trial demonstrate that changes should be adopted nationally. The new system updated a decades old system that addresses the issue that most aspects of UK ambulance services have changed beyond recognition:

- a large number of responses now focus on the frail elderly rather than traditional medical emergencies,
- half of all calls are now resolved by paramedics without the need to take patients to hospital,
- for specialist care the focus of the ambulance service is increasingly on getting patients to the right hospital rather than simply the nearest.

Over the last four decades, however, ambulance services have had to remain organised around an eight minute response time target.

3.2 **Impact**

ARP has been trialled for about two years in three ambulance services – West Midlands, Yorkshire and South West. The learning form these trials are that the changes are safe for patients and better for the ambulance service and our staff. With half our calls previously being 'red', this has put a huge pressure on our service as we are held to account by commissioners, regulators, politicians and the public about how well we perform against this. Yet we know that the vast majority of these patients get no clinical benefit form an 8 minute response.



So, moving forward under the new standards we will be afforded more time to get to patients. That does not mean that we will plan to take longer, but the regulatory expectation based on clinical evidence means we can operate more efficiently and effectively for those patients not in the C1 category. This means that we will need to change how we operate and deploy our resources and importantly focus on more ambulance cover as we will need less rapid response vehicles given the extra time we will have for most patients. This ultimately is a good thing and has to be finely balanced with being able to increase ambulance capacity through improved commissioning.

18th October marked the start of ARP and we still have much to do over the next few months and even years. It will take us time to phase in the changes as we need to make sure we implement them safely for patients and in consultation with staff. At the same time we have an independent service review, commissioned by NHS England and NHS Improvement, to understand what funding and staffing we actually need to meet demand – we have been arguing for some time that we believe we need more staffing.

One important consideration we have right now is with increasing hospital handover delays; we will need to keep in place some additional solo responders to ensure safety of our patients in the community. We have been spending time with our stakeholders briefing them on what ARP means and why we need investment and real focus on hospital flow.

We have already been able to increase our ambulance cover and reduce some of our RRV numbers but our next step is to look at how we can further increase ambulance cover with a corresponding reduction in RRVs. We will do this in consultation with the staff affected and we will be discussing this with UNISON to agree the change management process, as it is absolutely vital we work in partnership to achieve the best for patients and staff.

3.3 **Issues**

Capacity Gap

We have been working with Commissioners and Regulators on the assertion that EEAST has a significant capacity gap compared to the demand on the service and pressures such as hospital delays. An independent service review (ISR) was commissioned by NHS England to independently recommend whether further funding to EEAST is required.
This report is due for release imminently and is expected to confirm that EEAST requires additional funding for several hundred more staffing positions in order to accommodate the growing pressure on the service

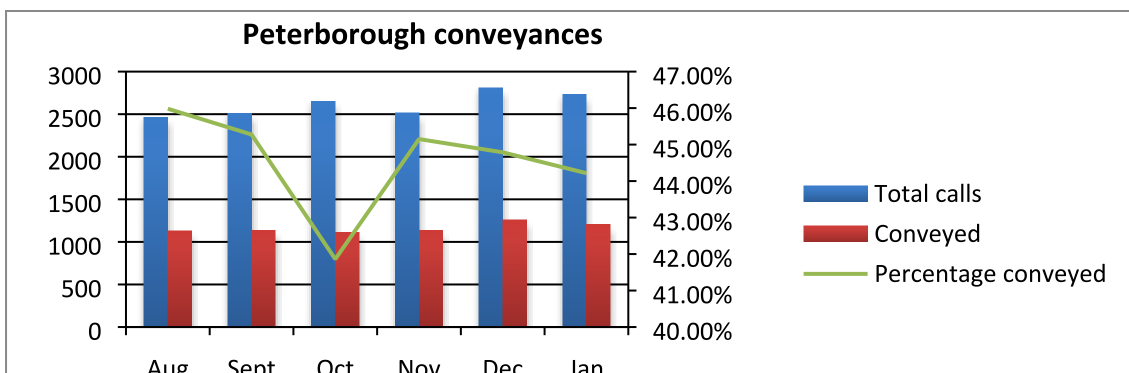
Demand/Performance

Cambridgeshire activity - We have experienced an increase in call volume every month except July when compared to 2016/17

		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD
Calls	2016	11,547	12,273	12,437	14,061	12,395	12,408	13,474	12,872	14,260	115,727
	2017	11,768	12,895	13,781	13,725	12,905	12,922	13,972	14,042	14,922	120,932
Conveyed	2016	5,736	6,214	6,128	6,428	5,962	6,155	6,395	6,203	6,651	55,872
	2017	5,968	6,188	6,007	5,999	5,814	5,734	6,204	6,093	6,443	54,450

Year	Breathing problems	Chest Pain	Falls	Sick Person	HCP admission
2016/17	7%	8%	13%	5%	7%
2017/18	10%	11%	15%	4%	10%

We are experiencing ever increasing demand, but conveying fewer patients to ED.



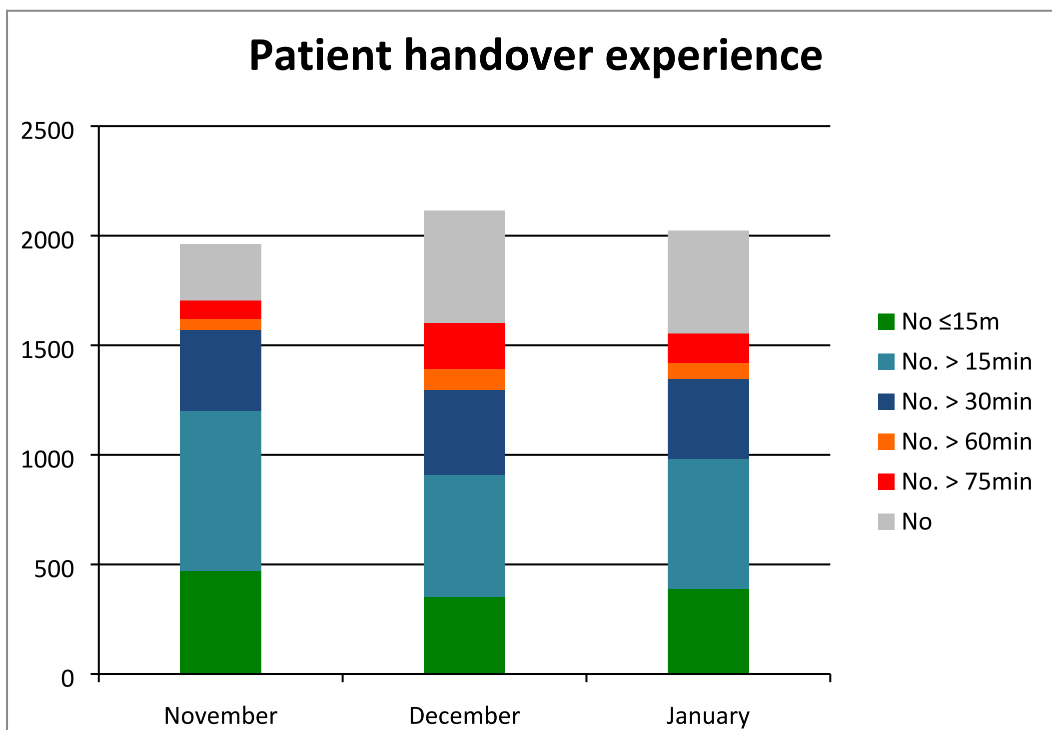
Handover delays

EEAST continues to experience the highest number of lost ambulance hours from hospital handover delays in England. This means that we are forced to 'stack' 999 callers who we are waiting to send ambulances to because they are waiting to offload their patients at hospitals. EEAST levels exceed every other service in England and have been higher than the national average for 5 years.

Cambridgeshire Hospitals compared to Trust wide (December 2017)

Hospital	Patient Journeys	No of Patient Handover Times	No. > 15min	% > 15min	No. > 30min	% > 30min
Addenbrookes Hospital	2878	2717	1208	44	184	7
Barnet General Hospital	589	464	294	63	120	26
Basildon & Thurrock Hospital	2710	2385	1621	68	476	20
Bedford Hospital South Wing	1660	1406	582	41	169	12
Broomfield Hospital	2724	2291	1885	82	790	34
Colchester General Hospital	2993	2634	2238	85	753	29
Hinchingbrooke Hospital	1047	910	691	76	268	29
Ipswich Hospital	2565	2346	1760	75	550	23
James Paget Hospital	2055	2005	895	45	178	9
Lister Hospital	2687	2074	1221	59	340	16
Luton And Dunstable Hospital	2669	1875	964	51	240	13
Norfolk & Norwich University Hospital	4335	3600	2843	79	1645	46
Peterborough City Hospital	2115	1603	1251	78	693	43
Princess Alexandra Hospital	1911	1668	1284	77	510	31
Queen Elizabeth Hospital	1905	1669	1382	83	654	39
Southend University Hospital	2822	2256	1496	66	700	31
Watford General Hospital	2460	1920	1575	82	578	30
West Suffolk Hospital	1930	1730	1334	77	470	27

Patient handover experience at Peterborough City Hospital



4. CONSULTATION

4.1 N/A

5. ANTICIPATED OUTCOMES OR IMPACT

5.1 In its 18 month trial phase, the ARP covered over 14 million calls, testing a new operating model and new set of targets. In summary this new system would:

- change the dispatch model of the ambulance service, giving staff slightly more time to identify patients' needs and allowing quicker identification of urgent conditions.
- introduce new target response times which cover every single patient, not just those in immediate need. For the most urgent patients we will collect mean response time in addition to the 90th percentile, so every response is counted.
- change the rules around what "stops the clock", so targets can only be met by doing the right thing for the patient.

ARP is in 2 phases; phase 1 below relates to EOC process and phase 2 involves changes to the categories (code sets) that ambulance service triage 999 callers into.

In October 2016, EEAST joined a national pilot for phase 1 that aims to give patients a more clinically appropriate response to people who call 999 for help, implementing the following:

Dispatch on Disposition (DOD): Where a maximum clock start of 240 seconds for all calls except predicted or confirmed Red 1s (where we continue to dispatch as soon as possible). The additional time to triage 999 calls (compared to the previous 60 seconds) means they can be more appropriately resourced "first time" as it gives more time to find out the clinical need of the patient. New deployment guidelines were also introduced in line with this change to clock start for Red 2 and Green calls.

Changes to the opening call taking process for 999 calls to "predict" Red 1 calls before full coding:

- new "pre-triage questions" (PTQ) opening the call to assist with immediate identification of patients that are not breathing or have a potential airway problem.
- introduction of the Nature of Call (NoC) which allow selection of "key words" (for example "choking") based on the initial description of the problem by the caller. These key words cover the most likely conditions to result in a Red 1 and Red 2 coded call.

Phase 2 saw ambulance services move from having 6 triage codes (Red1,2 Green 1-4) to 4 that are outlined here:

Cat 1: Immediately Life Threatening
Response Time Standard:
Mean response time ≤ 7 Minutes
90th percentile ≤ 15 Minutes
Clock start Triggers the earliest of:
- The call is coded
- The first resource is assigned
- 30 seconds from call connect

Clock stop by:
- Trust resource arriving on scene including PAS/VAS deployed by Trust
- CFR, Co Responder
- HCP with a defib next to the patient

Cat 2: Emergency
Response Time Standard:
Mean response time ≤ 18 Minutes
90th percentile ≤ 40Minutes
Clock start Triggers the earliest of:
- The call is coded
- The first resource is assigned
- 240 seconds from call connect

Clock stop by:
If a patient is transported by an emergency vehicle, only the arrival of the *transporting vehicle* counts. If the patient does not need transport the first response arrives at the scene of the incident.

Cat 3: Urgent
Response Time Standard:
90th percentile ≤ 120 minutes
Clock start Triggers the earliest of:
- The call is coded
- The first resource is assigned
- 240 seconds from call connect

Clock stop by:
If a patient is transported by an emergency vehicle, only the arrival of the *transporting vehicle* counts. If the patient does not need transport the first response arrives at the scene.

Cat 4: Less Urgent
Response Time Standard:
90th percentile ≤ 180 minutes
Clock start Triggers the earliest of:
- The call is coded
- The first resource is assigned
- 240 seconds from call connect

Clock stop by:
If a patient is transported by an emergency vehicle, only the arrival of the *transporting vehicle* counts.

Impact on Peterborough

We continually look to improve patient care and patient outcomes, often through innovative schemes or pathways.

Currently in Cambridgeshire:

- We are providing Hospital Ambulance Liaison Officers at both Addenbrookes and Peterborough City Hospital

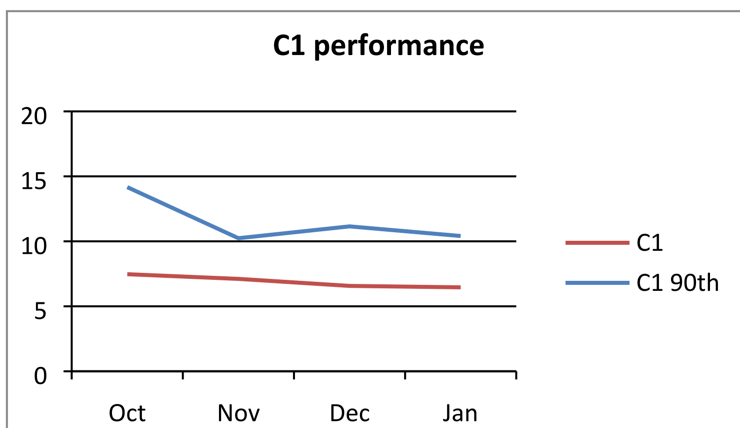
- We have introduced a Patient Safety Intervention Team to work closely with the Hospitals to keep patient safety as the highest priority whilst working to release our queuing Ambulances to respond to those patients in the community who are at risk

- We are providing an Urgent Vehicle; a dedicated response for the increased HCP demand

- We are in talks with commissioners to provide an Early Intervention Vehicle (EIV) to respond to the many elderly fallers in a collaborative and integrated way.

- We are discussing with Cambridgeshire Fire and Rescue Service to provide a joint response to the elderly non-injury fallers in the community, where EEAST will provide a clinical oversight and CFRS will provide a community Fire safety check.

- We are exploring a possible collaboration with First Response Service to provide a joint emergency Mental Health response service.



Performance is expected to improve as the recommendations from the ISR are introduced and the Handover delays are reduced.

EEAST continually work with system partners through external groups and meetings such as:

- Health & Care Exec
- System Delivery Board
- Clinical Advisory Group
- Joint Strategic Operability Board
- Cambridgeshire & Peterborough Local Resilience Forum
- Urgent & Emergency Care Delivery group
- A&E Delivery Boards
- JET steering group

To provide a collaborative approach to delivering the best possible health and care to the communities of Cambridgeshire and Peterborough.

Our biggest challenges remain:

- Historical under funding and investment with more demand and unmatched funding
- Loss of ambulance capacity with delayed handover at hospitals locally and regionally. This displaces resources, introduces long distance travelling and longer waiting times
- Demand increases on 999

6. REASON FOR THE RECOMMENDATION

6.1 In its 18 month trial phase, the ARP covered over 14 million calls, testing a new operating model and new set of targets. In summary this new system would:

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- Introduce new target response times which cover every single patient, not just those in immediate need. For the most urgent patients we will collect mean response time in addition to the 90th percentile, so every response is counted.
- Change the rules around what "stops the clock", so targets can only be met by doing the right thing for the patient.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 N/A

8. IMPLICATIONS

Financial Implications

8.1 N/A

Legal Implications

8.2 N/A

Equalities Implications

8.3 N/A

Rural Implications

8.4 N/A

9. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

9.1 None

10. APPENDICES

10.1 None

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