HSJ LOCAL briefing

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AMBULANCE SERVICE PERFORMANCE

HSJ Local Briefing is our new in-depth analysis of the key issues facing the NHS's major health economies

In brief

Issue There is a relentless rise in demand for emergency ambulances. With no additional money available, improved performance and innovation is required.

Context Ambulance trusts that are planning radical changes to help them sustain performance are meeting opposition from politicians, the public and unions. They will also have to cope with the rollout of the NHS 111 non-emergency number, which may increase demand in the short term. There are longer term questions about how ambulance trusts fit into the whole urgent care framework.

Outcome In the short term winter pressures will increase demand and therefore hit performance. But bad weather also affects accident and emergency departments so handover difficulties are unlikely to be resolved in the next few months. In the longer term ambulance services would like to develop a "smorgasbord" of other urgent care services around their emergency response role, catering in particular for patients who call 999 but do not need to be taken to an accident and emergency department.

The difficulty of hitting targets when activity rises

Ambulance services face a rise in activity of around 6 per cent a year, says Heather Strawbridge, chair of both the Ambulance Service Network and South Western Ambulance Service Foundation Trust.

The rise for 2010-11 was 5 per cent, while a 2008 report for the network found that the annual rise had been between 5 and 7 per cent for the previous decade.

This reflects the ageing population and greater needs. But despite this increasing pressure ambulance trusts still have to meet national targets of getting to 75 per cent of the most urgent calls – category A – within eight minutes. They also must attend 95 per cent of all calls within 19 minutes.

They also must meet the needs of the difficult group of patients who call 999 but do not need to be taken to either a specialist centre or their local accident and emergency department. How they are dealt with is key to controlling demand at the front door of hospitals. This has implications for all NHS urgent care.

The problem of turnarounds

Many problems centre on turnarounds, the process through which ambulance crews hand over patients to accident and emergency departments. The impact can be serious in terms of availability of ambulances for other emergencies, as paramedics are forced to remain at hospitals. There is also an impact on patient care, as it leads to a delay in the patient seeing a decision-making clinician who can move on their care.

Delays in hospital turnarounds are not universal – some services seem to be barely affected. They may largely be a problem at certain hospitals in a region and at particular times of the day, reflecting pressure on A&E departments

For example, in the first week of November, 5 per cent of turnarounds in the East of England were over 60 minutes. At the Norfolk and Norwich Hospitals Foundation Trust, which is seen as having particular problems with turnarounds, 14 per cent took over an hour.

East of England Ambulance Service Trust's November board meeting heard that the average time had risen to 18 minutes and 21 seconds, with a warning that this "does not bode well" for the pressurised winter season.

A tripartite agreement on penalties is being negotiated between the ambulance trust, acute trusts and Norfolk and Waveney PCT cluster but the details of this have yet to be negotiated. It is likely to involve a penalty per hour if a baseline percentage of ambulance handovers within a specified time is not met. Delays over 60 minutes are already being treated as potential serious incidents, meriting investigation.

The issue of handover times may have been more prominent in the East of England but it is by no means the only ambulance trust suffering from this problem. In October, South Western Ambulance Service Trust had 4,432 incidents of delays over 15 minutes, with 10 of these lasting more than two hours. Total operational ambulance time lost was 729 hours – around a 16 per cent increase on last year.

The trust has had a system of penalties for delays in hospital handover for several years. This contract currently includes a sliding scale so that longer waits incur bigger penalties.

"Fines" for long delays can be significant – they have totalled more than £100,000 so far this year at Royal Cornwall Hospitals Trust.

A lack of enthusiasm for fines

The Ambulance Service Network will this week issue new guidance on reducing delays in hospital turnarounds.

The report draws from a series of regional summit meetings, and a national event last month, as well as interviews with ambulance service providers, commissioners, clinicians and hospital managers – and examples of good practice from around the country.

But even if penalties lead hospitals to focus on improving handovers, they are a long way from being a complete answer. Hospitals under pressure will still struggle to take patients promptly.

There is little support for penalties as the sole lever to tackle this complex issue. Ms Strawbridge says: "Fines don't solve the problem. It is a way of recognising that there is a problem."

Association of Ambulance Chief Executives chair Anthony Marsh echoes this, saying that joint working is what will bring improvements and that penalties alone will not solve the problems.

Real time information

Mr Marsh says that some acute trusts have been using predictive analysis of ambulance flow to ensure they are prepared for peak times. Real time information systems can also update trusts on the numbers of ambulances driving to them, their estimated time of arrival and basic information about patients.

Agreeing on the measurement of delays can be another issue: NHS Norfolk and Waveney is to fund radio "tags" at Norfolk and Norwich University Hospitals Foundation Trust, which would provide accurate information for any penalty regime.

There is also little evidence of Department of Health enthusiasm for fining. In the summer deputy NHS chief executive David Flory made it clear that there was an expectation that handovers would occur within 15 minutes of the ambulance's arrival at hospitals. He also said acute trusts and ambulance trusts should work together to overcome difficulties.

Meanwhile, Monitor has written to foundation trusts warning them about "gaming" to hit the four hour A&E target – the clock does not stop ticking until handover has occurred.

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Because the clock does not start until the hospital has taken over the care of the patient from the ambulance crew, hospitals under pressure on the four hour target could theoretically benefit from patients remaining in ambulances (even if only for a few minutes).

Changing pathways for care

Ambulance trusts also have to cope with changing pathways for acutely ill patients. Specialist stroke, primary angioplasty and trauma centres have been developed over the last five years in many regions, leading to longer ambulance journeys for some patients. Reconfigurations of children's, maternity and A&E departments are also likely to affect this in the next couple of years.

This is reflected in contracts from commissioners who recognise that ambulances can be tied up on a single transfer for much longer and may then have to be deployed in a different area.

But meeting some of the requirements for this – such as getting stroke patients to an appropriate unit within 60 minutes – can be affected by geography. In North Norfolk, for example, only 2 per cent of stroke patients reached hospital within 60 minutes in one month this year.

For Norfolk as a whole the percentage was in the 20s throughout the year. Local MP and health minister Norman Lamb described performance as "completely unacceptable".

Stroke services in the East of England are currently being reviewed – but the expectation is that the number of hospitals which can receive stroke patients will, if anything, be reduced.

The Impact of NHS 111

Ambulance services will also have to cope with the nationwide rollout of the NHS 111 non-emergency number next year. Some will be running the service themselves; others will have to work with new providers.

An emerging concern is the potential for increased demand because of NHS 111 calls which are triaged as needing an ambulance; the system will not allow ambulance services to re-triage patients, meaning they are dependent on the sensitivity of the NHS 111 software.

A review of pilot schemes by the University of Sheffield found an increase in emergency attendances by ambulances in the pilot areas. Ms Strawbridge says that some areas have experienced a 10 per cent rise in activity after the introduction of NHS 111. In the East Midlands, where some NHS 111 services are already running. In areas where NHS 111 is already operating, East Midlands Ambulance Service Trust is seeing up to 13 per cent of calls coming through NHS 111, depending on the time of day. Overall this is an increase in demand, says director of operations Peter Ripley.

The chief executive of North Eastern Ambulance Service Trust said recently there would be a lot of "inappropriate referrals for a considerable length of time". There is little time to prepare for this with most services expected to be live by April (a handful have been given an extension).

The controversy of reconfiguration

Ambulance services are responding to many of these challenges by looking at how they organise themselves and making changes. This can include a closer matching of supply and demand over the week – with consequent changes to rotas, staffing levels and the type of vehicle stationed in an area. This is being done in the East of England where the trust has ordered an independent review of capacity.

More radical proposals include closing ambulance stations and creating central hubs where staff start and finish shifts, while ambulances on duty are based at "tactical deployment points". Proposals around this in the East Midlands – which will reduce the number of ambulance stations from 65 to 13 – would increase the number of people reached within the target times, with A8 and A19 performance improved.

The region's Being the Best consultation on this ends on 17 December and the trust's board will make a decision on whether to go ahead with the plan in January.

Such hubs are already used in some parts of the country, such as the West Midlands. Mr Ripley argues they will help East Midlands Ambulance Service to provide appropriate facilities for the crews, and are part of a package of measures that will help the organisation improve. Other parts of the East Midlands' plan include a roster reorganisation to reflect demand, the introduction of urgent care ambulances to take some patients seen by paramedic-staffed ambulances to hospital; and more emergency care practitioners.

But changes such as these are almost as inflammatory as A&E closures. The East Midlands proposals were described as "absolute madness" by one MP, who talked of "devastation". A furious response met the East of England proposals in many areas, with a 6,000-signature petition in North Norfolk opposing the changes. It has also looked again at the data underlying its proposals.

Unions have also been active in opposing the changes. The GMB has attacked plans for both EMAS and the East of England. A vote of no confidence in the East of England chief executive was followed by the announcement that he was taking early retirement.

Ms Strawbridge insists that "ambulance stations don't deliver care" but concedes there is still a selling job to be done with the public about what response is most effective.

The problem with targets

And nuanced critics have asked whether meeting the A8 and A19 standards was enough to improve outcomes for patients - especially if it meant more responses were being made by one person vehicles which could not convey patients to hospital. Theoretically two vehicles could then be tied up by one call and, although responses might meet target times, there could then be a delay before transport to hospital arrived.

There has been speculation that targets for the most serious calls – red 1s – could be raised from 75 to 80 per cent reached within eight minutes. The number of patients involved is tiny – the percentage of patients treated as red 1s varies between trusts but it would certainly be below 5 per cent of calls – but meeting a tougher target would still be a serious challenge, suggests Ms Strawbridge. She says it could only be achieved at enormous cost in some areas.

Prioritisation and specialisation

And cost is a consideration which has to be balanced with meeting targets and improving outcomes. London has an ambitious scheme to manage demand by greater prioritisation of calls (which can mean less urgent calls have to wait longer for a response). However, London Ambulance Service Trust's board papers reveal concerns that there is a

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"significant level of clinical risk" associated with the stages of this demand management plan being implemented. The directors "cannot support a further reduction in clinical headcount until systems and processes have been maximised". In the capital 999 calls were up 9.3 per cent year-on-year in October; the trust had to use 6,585 hours of private ambulance cover (last year it announced it wanted to reduce staff numbers by more than 800).

But one of the challenges for ambulance trusts is not the patients who obviously need to go to a specialist centre or to the nearest A&E unit: it is dealing with those patients who need care but not necessarily in a hospital. This "see and treat" and "hear and treat" approach perhaps offers the area where ambulance services can add most value – by keeping people out of hospital. Mr Marsh sees this as a real opportunity. Some ambulance services are already involved in GP out-of-hours cover and have even run minor injuries units.

Conclusion: a smorgasbord is being created

Parts of ambulance services' business could be whittled away. Primary care trusts took over commissioning of many services in 2009 but clinical commissioning groups are now getting engaged, and a number are using European-wide tender processes. East Midlands Ambulance Service Trust lost a major patient transfer service contract this year, representing around £20m a year in income, to private providers. North West Ambulance Service Trust has also lost the Greater Manchester PTS contract from next April.

The danger of the loss of significant chunks of work is it reduces the size of the organisation and therefore economies of scale it may be undermined.

In the future ambulance services could look more varied with emergency response as a core offering but then a "smorgasbord" of other urgent care and transport services, depending on local needs and CCGs' approach.

But all of this is being played out against a background of organisational uncertainty. Only four of the 12 ambulance services are currently foundation trusts. Great Western Ambulance Service is going through a merger process with South Western.

Others are going through the FT process. East Midlands was recently pushed back by three months although Mr Ripley says it is putting measures in place which will ensure it can deliver long term. Mr Marsh expects all the trusts to ultimately gain foundation status, pointing to the key A8 and A19 targets being achieved last year.

But this year seems tougher than last: for example, London is slightly below target on its A8 performance so far this year and East of England is below on A19. At the back of ambulance trusts' minds must be the potential for takeovers should FT applications fail.