Norfolk Health Overview and Scrutiny Committee
26 October 2017
Item no 7

Ambulance response times and turnaround times in Norfolk

Suggested approach from Maureen Orr, Democratic Support and Scrutiny Team Manager

A report on the trends in ambulance response and turnaround times in Norfolk and action underway to improve performance.

1. Background

1.1 During 2012–14 Norfolk Health Overview and Scrutiny Committee (NHOSC) focused its attention on the subject of ambulance turnaround delays at the Norfolk and Norwich Hospital (NNUH), which appeared to be a significant contributor to the ambulance service's overall performance problems in Norfolk. In April 2014 the committee was reassured to see a sustained improvement in ambulance turnaround times at the NNUH.

1.2 NHOSC returned to the subject of ambulance services in February 2015 because it was aware that response times in Norfolk were still below locally agreed trajectory standards (which were lower than national standards) in some areas. At this stage NHOSC widened its focus to look at county-wide ambulance response times and the turnaround performance at the Queen Elizabeth (QEH) and James Paget (JPUH) hospitals as well as the NNUH and at performance against specific stroke standards (Stroke 60 and Stroke Care Bundle) which had been a matter of concern for NHOSC during its scrutiny of stroke services in Norfolk in 2013-14.

1.3 NHOSC received reports from The East of England Ambulance Service NHS Trust (EEAST), the NNUH and North Norfolk CCG in October 2015 and October 2016 about the continuing challenges facing the ambulance service, the urgent and emergency care system and the wider health and social care system and actions underway to address the issues affecting patient flow. The following link will take you to the 13 October 2016 report to NHOSC (agenda item 7, page 46)
http://norfolkcc.cmis.uk.com/norfolkcc/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/518/Committee/22/Default.aspx

1.4 The figures presented to NHOSC in October 2016 showed that a significant number of ambulance hours continued to be lost because of delays at the county's acute hospitals, particularly between arrival and handover of patients.

With regard to ambulance response times, EEAST was seeing a sustained recovery in performance from March to October 2016 following a challenging winter period.

It should be noted that EEAST is expected to meet the national response time standards on a regional level and not on a county or locality level, but CCG locality response time figures are available. In terms of the 8 minute (Red 1&2) response standard for potentially life-threatening emergencies the most challenged geographic areas were North Norfolk and South Norfolk:-

		Minutes to arrival on average (Sept 2015 – Aug 2016)
Red1 - cardiac arrest / not breathing	North Norfolk	10:07
	South Norfolk	09:50
Red 2 – all other potentially life threatening emergencies	North Norfolk	12:43
	South Norfolk	11:31

1.5 North Norfolk was also the most challenged area in terms of the Stroke 60 standard (the percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyper stroke centre (HASU) within 60 minutes of call). At the time of reporting in 2016 the latest figure showed less than 20% meeting the Stroke 60 standard in North Norfolk. Driving time to the nearest HASU was a major factor in this.

EEAST pointed out that the Stroke 60 performance figures could not tell us what the outcome was for patients. That also depended on the timeframe within which patients received the most appropriate treatment when handed over to the care of the acute hospitals. EEAST assured NHOSC that it meets monthly with the commissioners and discusses Stroke 60 misses in detail, specifically looking at why the miss occurred, if there was any patient harm and to look for any patterns that could result in actions to improve.

1.6 In October 2016 NHOSC also heard that:-

- EEAST was undertaking a sustained recruitment drive to increase frontline staffing. There were 180 trainee ambulance staff undertaking student placements at UEA and the first cohort were due to qualify in January 2017.
- Demand on the 999 service had continued to increase, with a 15.31% increase in Red calls (potentially life threatening emergencies) over the 12 months to August 2016.
- The NNUH was the busiest emergency department in the eastern region and one of the busiest in the country. Ambulance arrivals at the hospital from 3 April – 11 Sept 2016 were up 2.35% on the same period in 2015.

- EEAST was in the upper percentile of ambulance trusts in relation to the number of patients to whom it provided alternatives to transport to hospital.
- The project for an Ambulatory Care and Diagnostic Centre at the NNUH had been put on hold but increased assessment on arrival, ambulatory care and the availability of the Urgent Care Centre at the hospital had helped with a reduction in admissions to A&E.

The Committee considered that the closure of the NNUH's Henderson Unit (at the Julian Hospital site in Norwich) in October 2016 could have implications for ambulance turnaround and patient flow times through the NNUH during winter 2016-17.

Given the ongoing pressures on the ambulance service, urgent and emergency and the wider health and social care system, NHOSC requested to be updated on the ambulance response and turnaround situation in a year's time.

2. National ambulance standards – old and new

2.1 On 13 July 2017 NHS England announced **new** national ambulance standards (the Ambulance Response Programme (ARP)). All of the ambulance trust in England will be aiming to implement the new standards before winter 2017. The aim nationally is for:-

- Faster treatment for those needing it to save 250 lives a year
- An end to "hidden waits" for millions of patients
- Up to 750,000 more calls a year to get an immediate response
- New standards to drive improved care for stroke and heart attack

'Hidden waits' refers to the current situation where one in four patients who need hospital treatment undergo a wait after the existing 8 minute target is met because the vehicle dispatched, such as a bike or car, cannot transport them to A&E. Under the new system an emergency response will be expected to reach the most seriously ill patients (category 1) in an average time of 7 minutes. There is an additional category 1 transport standard to ensure that these patients also receive early ambulance transportation. For the three other categories, if a patient is transported to hospital, only the arrival of the transporting vehicle will stop the 'clock', rather than the arrival of the first vehicle.

Under the old system three or four vehicles could be sent to the same 999 call to be sure of meeting the 8 minute target and nationally one in four are stood down before reaching their destination. The new system should free up more vehicles and staff to respond to emergencies.

2.2 The changes also introduced mandatory response time targets for all patients who dial 999. Under the old system half of all ambulance calls nationally were classed as 'green' and not covered by any national target.

2.3 Condition specific measures are also being introduced which will track the time from 999 call to hospital treatment for heart attacks and strokes, where a prompt response is particularly critical. A new set of pre-triage

questions will identify those patients in need of the fastest response. By 2022 the aim is for 90% of eligible heart attack patients to receive definitive treatment (balloon inflation during angioplasty at a specialist heart attack centre) within 150 minutes. 90% of stroke patients should also receive appropriate management (thrombolysis for those who require it, and first CT scan for all other stroke patients) within 180 minutes of making a 999 call. Under the old system that happened for less than 75% of stroke patients nationally.

2.4 The **new response time standards** are:-

Call category	**% of calls in this cat-egory**	**National Standard**	**How long does the ambulance service have to make a decision?**	**How will this be measured?**
1 Calls about people with life-threatening injuries & illnesses	8%	7 minutes mean response time 15 minutes 90th centile response time (i.e. these type of calls will be responded to at least 9 out of 10 times before 15 minutes)	The earliest of:- • The problem is identified • An ambulance response is dispatched • 30 seconds from the call being connected	The first ambulance service-dispatched emergency responder arrives at the scene of the incident There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation
2 Emergency calls	48%	18 minutes mean response time 40 minutes 90th centile response time (i.e. these type of calls will be responded to at least 9 out of 10 times before 40 minutes)	The earliest of • The problem being identified • An ambulance response is dispatched • 240 seconds from the call being connected	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 ambulance service-dispatched responder at the scene of the incident counts
3 Urgent calls	34%	120 minutes 90th centile response time (i.e. these type of calls will be responded to at least 9 out of 10 times before 120 minutes		
4 Less urgent calls	10%	180 minutes 90th centile response time (i.e. these calls will be responded to at least 9 out of 10 times before 180 minutes)		

2.5 The link below will take you to short animations on the NHS England website which illustrate how the new standards work:-
https://www.england.nhs.uk/urgent-emergency-care/arp/

2.6 For **ambulance turnaround at hospitals**, the **current standards** (which have not been altered by the introduction of the new national standards) are:-

(a) 15 minutes - The time from ambulance arrival on the hospital site to the clinical handover of the patient (also known as 'trolley clear'). **The hospital is responsible for this part.**

(b) 15 minutes - The time from clinical handover of the patient to the ambulance leaving the site (also known as 'ambulance clear'). **The ambulance service is responsible for this part.**

2.7 For **ambulance response** to patients, the **old national standards**, which were applicable in the timeframe covered by EEAST's report (at Appendix A*)* were:-

Red calls (2 categories)

Reaching 75% of Red 1 and Red 2 calls within 8 minutes

Providing a transportable resource for 95% of Red 1 and Red 2 calls within 19 minutes of request.

Red 1 – patient suffered cardiac arrest or stopped breathing - two resources should be dispatched to these incidents where possible.

Red 2 – all other life threatening emergencies.

Green calls (four categories)

Reaching 75% of Green 1 calls in 20 minutes and 75% of Green 2 calls in 30 minutes.

Reaching 75% of Green 3 calls in 50 minutes OR a phone assessment from the clinical support desk[1] within 20 minutes

Reaching 75% of Green 4 calls in 90 minutes OR a phone assessment from the clinical support desk within 60 minutes.

Green – non life threatening emergencies

Both the Red categories were national requirements but the four Green categories are locally agreed.

2.8 In relation to stroke the applicable service standards for the period of EEAST's report (Appendix A*)* were:-

[1] A clinician calling back for a secondary telephone triage to establish the best pathway of care

Stroke 60 - The percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of a call. The compliance standard is 56%; i.e. EEAST strives to get 56% of eligible stroke patients to a hyperacute centre within 60 minutes from the time of the 999 call.

Stroke Care Bundle - The percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle. (As per National Ambulance Clinical Performance Indicator Care Bundle). The compliance performance standard is 95%.

2.9 The ambulance service provided by EEAST for Bedfordshire, Hertfordshire, Essex, Norfolk, Suffolk and Cambridgeshire is commissioned jointly by all 19 Clinical Commissioning Groups (CCGs) in the area. Ipswich and East Suffolk CCG is the co-ordinating commissioner. EEAST has previously reported that it is not commissioned (i.e. not funded) to a level to enable it to deliver all the national standards. It has worked closely with commissioners to understand what level of funding would be needed at individual CCG level to meet mandated national targets. It reported to NHOSC in October 2016 that given the rural nature of Norfolk the gap between resources and what would be needed to deliver the national standards across this county is significant and that it actively engages with local schemes in rural communities to ensure that where a life is threatened a rapid response from within the community can occur.

2.10 On 18 August 2017 the Health Service Journal referred to an unpublished report by consultants ORH in August 2016 which highlighted a large gap between existing staffing capacity and the level needed if EEAST was to achieve the 2017-18 targets set out by commissioners. NHS England and NHS Improvement have commissioned an Independent Service Review (also by ORH) to understand what capacity and funding the trust requires to meet demand. The Independent Service Review is underway but may not be complete by the date of today's meeting.

3. Purpose of today's meeting

3.1 EEAST has been asked to report today with information on the past year in terms of:-

- Activity levels
- Handover performance at the three acute hospitals
- Developments in the Hospital Ambulance Liaison Officer role
- The impact of hours lost at the three hospitals on EEAST's wider performance in Norfolk
- Ambulance response times across the five CCG areas
- Performance against stroke standards
- Current numbers of vacancies and numbers of students compared to total staffing numbers
- Recruitment strategy
- The proposed reorganisation of depots and community bases and how it is intended to affect performance

- Policy on transport of mental health patients in crisis.

EEAST's report is attached at **Appendix A**.

3.2 Although ambulance turnaround figures for all three acute hospitals are included in EEAST's report, the NNUH has been invited to report and to attend today's meeting as the largest hospital in Norfolk and consequently the one where potentially the most hours could be lost in ambulance delays. The NNUH has been asked to update the committee on activity at the hospital in the past year to improve performance in terms of ambulance turnaround and patient flow through urgent and emergency services.

The NNUH's report is attached at **Appendix B**.

3.3 North Norfolk CCG has also been invited to today's meeting as the lead commissioner of the NNUH and one of the 19 regional CCGs who jointly commission the ambulance service.

North Norfolk CCG can answer the committee's questions on the success of the measures to tackle the causes of delay in all aspects of the urgent and emergency care system in central Norfolk.

4. Suggested approach

4.1 Members may wish to explore the following areas with the representatives at today's meeting:-

4.2 **East of England Ambulance Service NHS Trust**

(a) Are you satisfied that all the health and social care agencies whose co-operation is necessary to resolve the issue of ambulance delays at hospitals are actively and adequately addressing their part of the problem?

(b) In October 2016 EEAST reported to NHOSC about its sustained recruitment drive to increase frontline staffing and at that stage there were 180 trainee ambulance staff undertaking student placements at UEA. Has EEAST continued to be successful in recruiting trainees and experienced staff and what is the situation with staff retention?

(c) Is EEAST satisfied that the balance between experienced paramedics and trainees in the workforce is manageable in terms of providing satisfactory training and of delivering the service to meet rising demand?

(d) Given that fact that national standards cannot be met in some rural localities without significant additional funding, the work of community first responders is crucial (see paragraph 2.1 above). What does EEAST do to ensure that volunteers are properly supported?

(e) Presuming that the results of the Independent Service Review (see paragraph 2.6) are not yet available, what is EEAST's current plan for recruitment and retention of staff within current funding levels?

(f) What are the implications of the **new** national ambulance standards (the Ambulance Response Programme) in terms of resources required?

(g) The **new** national standards include an additional Category 1 transport standard to ensure that these patients receive early ambulance transportation. What is that standard?

(h) It appears that the new national standards for heart attacks and strokes will require measurement of the patient's pathway from 999 call to definitive treatment in the acute hospital. How will this measurement be arranged locally?

(i) What is EEAST's involvement in the transport of patients in mental health crisis to the acute hospitals and to acute beds at mental health hospitals after a Mental Health Act assessment? What criteria are used to assess the urgency of transporting a person in mental health crisis to hospital?

4.3 **Norfolk and Norwich University Hospitals NHS Foundation Trust**

(j) Are you satisfied that all the health and social care agencies whose co-operation is required to manage demand for acute care are actively and adequately addressing their part of the problem?

(k) What was the effect of the closure of the 24 bed Henderson re-ablement unit in October 2016 on the flow of patients through the NNUH's urgent and emergency care services?

(l) Now that the NNUH is no longer in special financial measures, will the project for an Ambulatory Care and Diagnostic Centre go ahead?

4.4 **North Norfolk CCG (commissioner of the N&N and with a role in regional commissioning of EEAST)**

(m) When do the CCGs expect the report of the Independent Service Review (see paragraph 2.10 above) to be available? Will the report be made public? Are there any early indications of the actions that the commissioners and EEAST will need to take in response to the findings of the review?

(n) What are the implications of the new national ambulance standards from the CCGs' point of view?

(o) Given the requirement for ‘parity of esteem’ between physical and mental health, what is the commissioners’ view on the way ambulance transport is provided for individuals in mental health crisis? (see 4.2(i) above)

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