NHS
West Leicestershire
Clinical Commissioning Group

Paper D

WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP
BOARD MEETING
Confidential Session

Date 8th August 2017

Title of the report:	EMAS Ambulance Response Programme (ARP)
Section:	Confidential session
Report by:	Jackie Jones Director of Ambulance Commissioning, Hardwick CCG
Presented by:	Tamsin Hooton, Director of Urgent and Emergency Care WLCCG /Jo Clinton, Head of Contract and Provider Performance WLCCG

Report supports the following West Leicestershire CCG's goal(s):			
Improve health outcomes		Improve the quality of health-care services	
Use our resources wisely		✓	

Equality Act 2010 – positive general duties:
1. The CCG is committed to fulfil its obligations under the Equality Act 2010, and to ensure services commissioned by the CCG are non-discriminatory on the grounds of any protected characteristics. 2. The CCG will work with providers, service users and communities of interest to ensure any issues relating to equality of service within this report are identified and addressed.

Additional Paper details:	
Please state relevant Constitution provision	*6.5.1 (b) Joint Arrangements*
Please state relevant Scheme of Reservation and Delegation provision (SORD)	*n/a*
Please state relevant Financial Scheme of Delegation provision	*n/a*
Please state reason why this paper is being presented to the WLCCG Board	*To make aware all Governing Bodies covered by the East Midlands Ambulance Service (EMAS) an update on the Ambulance Response Programme in their **confidential** session.*
Discussed by	*CCG Governing Body Meeting – Confidential Session*
Alignment with other strategies	
Environmental Implications	*No environmental implications were reported by the Ambulance Response Programme (ARP).*

Has this paper been discussed with members of the public and other stakeholders? If so, please provide details	*This paper was presented at the ELR CCG's Governing Board Meeting on the 11th July 2017.*

EXECUTIVE SUMMARY:

N/A

RECOMMENDATION:

The West Leicestershire Clinical Commissioning Group is requested to note the following recommendations by the Governing Board:

- The inclusion of EMAS into the Ambulance Response Programme
- From the agreed 'go-live' date of 19th July EMAS will no longer be working to deliver current national constitutional standards, but will be working to a revised set of clinical standards monitored at both mean and 90th percentile
- Current reports will not be available for a period of time whilst new reports are developed
- There will be a period of 'bedding in' for the new ways of working
- The opportunities presented to develop a new clinical delivery model

RECEIVE/APPROVE ….
N/A as not open to negotiation at a local level.

WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP

BOARD MEETING

Ambulance Response Programme (ARP)

INTRODUCTION

The purpose of this paper is to provide all Governing Bodies covered by the East Midlands Ambulance Service (EMAS) an update on the Ambulance Response Programme (ARP) in their confidential session. As this programme is a national driver it is not open to negotiation at a local level.

Communications in relation to the programme is only to be provided by NHS England, but it was agreed at the recent Partnership Board meeting that all Governing Bodies should be made aware of the current position of the programme in relation to EMAS.

Background

The Ambulance Response Programme (ARP) is the largest prospective study of an ambulance system ever completed. More than 10 million patients have been studied and there have been no identified adverse incidents or associated patient safety concerns. The School of Health and Related Research (ScHARR) at the University of Sheffield is providing the academic analysis of the programme.

ARP has three parts:

- Dispatch on Disposition (DOD) including nature of call
- A new system of Clinical Prioritisation for all 999 calls
- A new set of ambulance service measures, indicators and standards

The demand for ambulance services increases year on year, putting huge strain on the system. The reasons are complex, but include a changing population with changing needs and expectations. Despite this, the way ambulance care is delivered has remained broadly constant.

Current ambulance standards

Since 1974 time-based ambulance response standards have been in place. However these have gradually led to a range of operational behaviours that undermine the effectiveness of the ambulance service and patient experience. Specific issues include:

- Sending vehicles to a 999 call, on blue lights and sirens, before the call handler has identified what the problem is, and whether an ambulance is actually needed;
- Sending several ambulance vehicles to the same patient, on blue lights and sirens, and then cancelling ("standing down") the vehicles least likely to arrive first;
- Diverting ambulances from one call to another repeatedly, so that ambulance clinicians are constantly chasing time standards rather than treating patients
- Use of response cars "to stop the clock", followed by long waits for the ambulance that actually takes the patient to hospital; this additional wait is hidden in the present system, and can be very long; and
- Very long waits for less urgent calls that nevertheless need assessment and patient transport.

To address these issues NHS England (NHSE) set out to review urgent and emergency care in 2013. This review set out five elements that are central to the development of a more responsive and effective system of which ARP is an integral part:

  - helping people to stay well and self-care;
  - providing the right advice or treatment first time;
  - ensuring urgent care is delivered close to home whenever possible;
  - developing hospitals as centres of expertise; and
  - creating networks to connect and coordinate services.

Established in January 2015, the Ambulance Response Programme (ARP) aims to increase the operational efficiency of ambulance services whilst maintaining a clear focus on the clinical need of patients. There are three main objectives for ARP:

- Prioritising the sickest patients, to ensure they receive the fastest response;
- Driving clinically and operationally efficient behaviours, so the patient gets the response they need first time and in a clinically appropriate timeframe;
- Putting an end to unacceptably long waits by ensuring that resources are distributed more equitably amongst all patients.

Dispatch on Disposition

- Call handlers were given more time to assess 999 calls that are not immediately life threatening before an ambulance vehicle is assigned. This makes sure that the right

response, which could be an ambulance, a paramedic in a car or a telephone call with a clinician, is allocated based on the needs of the patient.

- Three important questions were added to the start of a 999 call to ask about the patient's breathing and level of consciousness. This makes sure that immediately life threatening calls, particularly cardiac arrest, are identified very early in the 999 call.

Clinical prioritisation of calls

- Ambulance calls are prioritised according to urgency. The current system doesn't take account of the increasingly diverse and complex range of health problems that people have when they contact the ambulance service.
- A new evidence-based system to prioritise 999 calls was developed and tested to make sure the patient's urgency and clinical needs are matched to the best response to those needs.

Ambulance service measures

- Ambulance services are measured on the time between a 999 call being received and the time a vehicle arrives at the patient's location.
- For red calls (approximately 50% of 999 calls) the vehicle should arrive within 8 minutes 75% of the time.
- However, we know this doesn't reflect the needs of many patients. New measures should make sure the sickest patients receive the fastest response, that all patients get the best response allocated to them first time, and that no one is left waiting an unacceptably long time for an ambulance to arrive.

Ambulance measures proposals

Current standards apply to only half of the patients who dial 999, and are set at 75%; this means that 1 out of every 4 patients can miss the time target but still meet the standard.

- From now on the intention is to set the bar at 90%, rather than 75%, so 9 in 10 patients have to hit the target in order to meet the standard. For the first time NHSE propose to measure mean, rather than median, response times, so every single patient counts towards the time target.
- For the first time, a time standard will apply to every patient to whom a vehicle is sent, and when a patient needs to be transported only the arrival of the conveying ambulance will "stop the clock". This will reduce long waits for both a response and a transporting vehicle, which in the current system can sometimes be six hours or more.
- NHSE are also proposing a new set of clinical quality indicators, to measure the time between the 999 call and receiving life-saving treatment for heart attack and stroke, as well as cardiac arrest survival. These will be accompanied by new measures for patients with sepsis, and people who have fallen and are still on the floor.

Expansion of ARP Pilot

Since April 2016 there have been three English ambulance providers operating under revised response standards following the expansion of phase one of the ARP pilot (DoD) to all English Ambulance Providers: South West Ambulance Service (SWAS), Yorkshire Ambulance Service (YAS) and West Midlands Ambulance Service (WMAS).

Following agreement by the Chief Executive of NHSE and the Department of Health, an opportunity was created to expand the number of pilot sites to operate under the revised response standards.

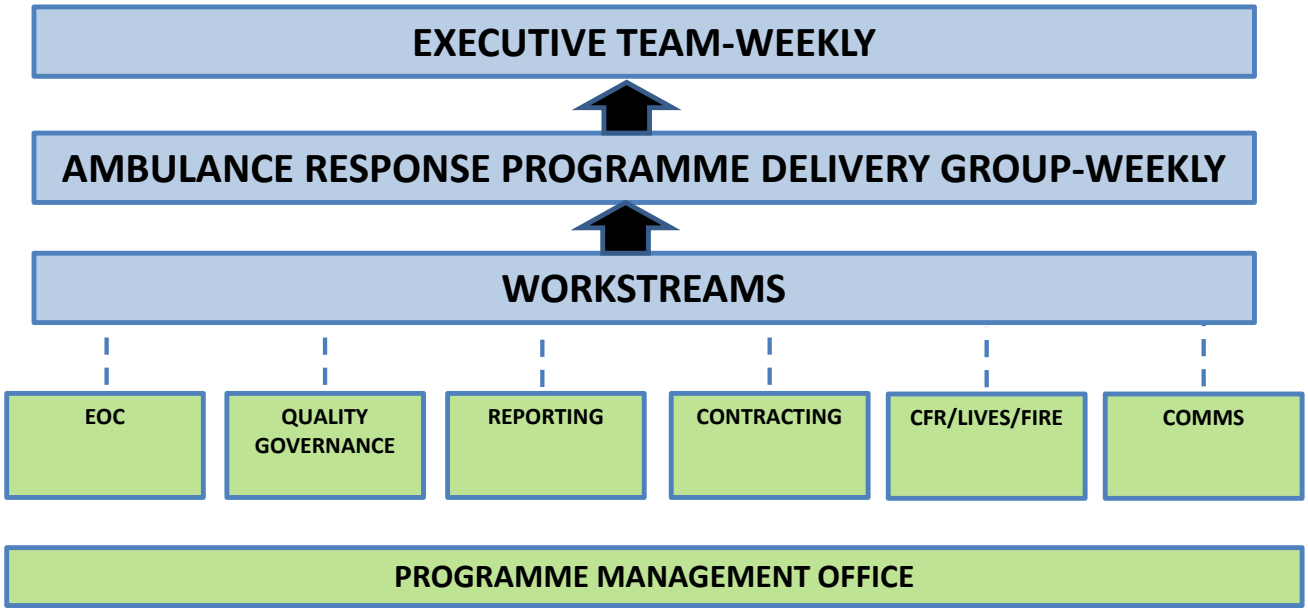
EMAS put forward an application to become an additional site for Phase 2.3 of the programme to test a revised call prioritisation set generated from 999 calls, and were informed on the 30th May 2017 that they had been successful and would participate in the trial commencing as soon as possible following the General Election. The Trust is currently working to a potential go live date of the 19 July 2017.

Governance and Reporting

EMAS have established governance and reporting structures to ensure a smooth transition from the current standards to the revised response codes.

The EMAS governance structure for the programme is detailed below. This shows an Ambulance Response Programme Delivery Group which will provide oversight and governance across the programme workstreams. The Delivery Group will meet on a weekly basis and provide a weekly report to the Executive Team; the Chief Operating Officer as sponsor of the programme will be delegated to make key decisions supported by the Executive Team.

A risk and issues log will be maintained which will record all risks and issues identified by the workstreams, ARP Delivery Group and Executive Team.



ARP Governance Structure

The ARP workstreams are as follows:

- **Emergency Operations Centre (EOC)** – responsible for the delivery of the required training packages to the different teams within EOC, updating the Standard Operating Procedures and upgrading & testing the systems used for the EOC and operational staff
- **Quality Governance –** The responsibility of this work stream is to ensure all the supporting policies and procedures relating to patient experience, patient engagement, and external letters are updated to reflect the national project. All external communications that are sent to MP's Ombudsmen, patient experience teams in hospitals and other service providers are informed.
- **Reporting** – The reporting workstream will be responsible for ensuring national and contractual returns are made; information is available internally to support performance; ensure AQI compliant; close off existing AQIs
- **Contracting** – The contracting workstream will ensure that the terms of the Trust's 2017/18 Urgent and Emergency Ambulance contract are reviewed in the light of the ambulance response programme, and that, by agreement with the Coordinating Commissioner, appropriate amendments (via Contract Variation) are made to that contract
- **CFR/Lives/Fire** – The purpose of this workstream to assess, analyse and communicate the outcome of the ARP introduction to EMAS direct CFRs, LIVES CFRs, EMAS MFR, LIVES Medics and all six FRS involved in the EFR project including the projected outcome/impact of the changes to the new National Response Model

- **Communications** – The Communications workstream is responsible for ensuring key ARP messages and corporate briefings are shared in a structured, consistent, timely and accessible manner to staff, volunteers and stakeholders. Together with NHS England, the Department of Health, and other Ambulance Service Communications teams, this work-stream is responsible for managing media interest in ARP

The programme will be managed through the Trust Programme Management Office; each of the work-streams outlined above will have delivery plans and will provide weekly updates to the delivery group and Executive team.

Indicative Standards

To date there are no definitive standards for ARP but EMAS will work to a set of indicative standards. The final agreed set will form part of the recommendations within the ScHARR final report for approval by the Chief Executive of NHSE and the Secretary of State for Health.

The indicative standards are set out in the table below, but it should be recognised that from commencement of the pilot EMAS will no longer be operating to the current national constitutional standards of Red1, Red2 and A19.

Category of call	The average (mean) will be less than	9 out of 10 will arrive in less than (90th percentile)
Life threatening Category 1	To be confirmed (likely to be 7 or 8 minutes)	15 minutes
Emergency Category 2	To be confirmed (likely to be 18 minutes)	40 minutes
Urgent Category 3	To be confirmed (likely to be 40 minutes)	120 minutes
Less urgent Category 4	To be confirmed (likely to be 60 minutes)	180 minutes

Next Steps

The inclusion of EMAS into ARP will result in significant changes to the way the service is delivered, but it also provides an opportunity to develop and deliver a new clinical delivery model. The service will no longer be 'chasing the clock' but will be able to respond in the most clinically appropriate and efficient manner, with all patients receiving a faster response than is currently achievable. Currently over 53% of all activity into EMAS requires an 8-minutes response. The recent demand and capacity review modelled activity against the anticipated standards and it was shown that approximately 7% of all activity will require an 8 minutes response.

Standard	% of activity (ORH Modelling)	Av number of responses per day (based on 1808 responses)
Category 1	7%	127
Category 2	53%	958
Category 3	35%	633
Category 4	5%	90

There are expected to be a number of operational efficiencies released through the new model of delivery to support the aspiration to provide a faster response to all patients, for example a reduction in the number of 'stand-downs' by not having to dispatch a vehicle to stop the clock.

The Director of Ambulance Commissioning within the coordinating commissioning team meets with the Programme Lead at EMAS every two weeks to receive an update on progress, and members of the coordinating commissioning team are members of two of the workstreams; reporting and contracting.

The coordinating commissioning team will provide updates to commissioning colleagues on a regular basis via the normal governance route of Partnership Board and the monthly county contract meetings. There is also a stakeholder meeting on the 6th July 2017 to share the elements of the Ambulance Improvement Programme, of which ARP is one element.

Quality

As part of the planning EMAS are required to have in place a process for rapid reporting of Serious Incidents, which could be due to the revised response standards. There is also a need to have a 'roll-back' procedure should a serious clinical risk be identified and they need to revert to the current standards and way of working. This will be monitored by the national ARP team and it will be the clinical leads for the programme, Keith Willets and Jonathan Benger, in conjunction with the ARP Development Group, who will make the decision to suspend EMAS from the pilot if necessary.

Reporting

As a pilot site there is a requirement for EMAS to submit detailed weekly monitoring information to the national ARP team, with the information analysed and reported on by the NHSE ARP team and will be used by ScHARR as part of the overall academic assessment of ARP.

As a result of ARP there will be a need to completely re-write all performance reports, therefore for a short period of time there will be no reports distributed to commissioners, which Governing Bodies need to be made aware of.
The reporting schedule within the current 2017/18 contract will need to be reviewed and amended to take account of the draft standards, and any revisions made to the current Ambulance Quality Indicators (AQIs).

Conclusion

The introduction of ARP into all English ambulance providers was indicated in the refresh of the Five Year Forward View. The inclusion of EMAS into the pilot phase of the programme is a positive move forward and provides an opportunity for EMAS to work with commissioners to design and introduce a new model of care that supports the ambitions of the system.
ARP has been clinically developed with all current codes being mapped to the revised standards based on clinical need and to support patient outcomes. The expectation is that EMAS will dispatch the most appropriate vehicle and staff member aligned to the patient's condition. For example a stroke patient will not have a Rapid Response Vehicle dispatched to stop the clock, but a Double-crewed ambulance (DCA) that can transport the patient to the stroke centre.
This change in dispatch behaviour should support a reduction in the number of stand-downs, and greater efficiency of the vehicles and staff available. There will be a requirement to amend the current Card 35 (Healthcare Professional requested transports), and further information will be sent out to Primary Care advising of the changes.

Feedback from the staff working within the three pilot sites has been extremely positive, but it needs to be recognised that the full impact of ARP will take time to be realised as this is the biggest change project to be introduced into the ambulance service for many years.

There will be a need to review the current mix of vehicles and there is likely to be a reduction in the number of cars and an increase in the number of DCAs, as the cars are primarily used to 'stop the clock' rather than deliver the most appropriate clinical care.

This is a significant change for all stakeholders to understand, as for a number of years the focus has been on delivering Red1 and Red2 in 8 minutes and A19 in 19 minutes which has been a challenge for EMAS for many years.

The National Ambulance Commissioners Network (NACN) has commissioned South West Commissioning Support Unit (SWCSU) to undertake an impact assessment to attempt to quantify the impact of ARP, including the financial impact. It is hoped that this will form part

of the final report and is being reported into the ARP Development Group. It is expected that this exercise will need to be undertaken locally to attempt to quantify the impact across the East Midlands.

RECOMMENDATION:

The West Leicestershire Clinical Commissioning Group is requested to note the following recommendations by the Governing Board:

- The inclusion of EMAS into the Ambulance Response Programme
- From the agreed 'go-live' date EMAS will no longer be working to deliver current national constitutional standards, but will be working to a revised set of clinical standards monitored at both mean and 90th percentile
- Current reports will not be available for a period of time whilst new reports are developed
- There will be a period of 'bedding in' for the new ways of working
- The opportunities presented to develop a new clinical delivery model

RECEIVE/APPROVE ….
N/A as not open to negotiation at a local level.