Foreword by Councillor Philip Allnatt
Chairman of the Ambulance Service Task Group

The Group was aware that morale within the Wiltshire Ambulance Service (WAS) had taken a knock as a result of recent adverse publicity. The Task Group wished to be supportive of the improvement programme in general terms and constructive in any criticism, whilst acknowledging the huge public confidence and support for the Ambulance staff at the frontline.

The Task Group also wishes to express it's confidence in the dedication of the men and women who work in the WAS.

The report also addresses the substantial work that is being done to make improvements within the Trust and the Task Group was pleased to note that the latest performance figures for November 2004 showed significant improvements. It should be noted that the role of the air ambulance was not included as part of this review.

Following the review being conducted but prior to publication of this report the Task Group members received the letter attached at 'Appendix H'. The Task Group would expect the Strategic Health Authority and WAS to consider how the recommendations made in this report fit in with the agreement to improve the Wiltshire Ambulance Service particularly when reviewing closer working and integration with other Ambulance Trusts.

The Task Group recommends that this report, *and its recommendations as set out on pages 24-25*, be submitted via the Health Overview & Scrutiny Committee to the Department of Health Ambulance Reference Group.

Finally, I wish to thank everyone who supported this review by giving up their time and effort.

Philip Allnatt

Philip Allnatt
Chairman

Introduction

1. This report provides a summary of the work undertaken by the Ambulance Service Task Group from August 2004 to January 2005.

2. The Task Group comprised the following Members (drawn from the County Health Overview & Scrutiny Committee):

   Councillor Philip Allnatt (Chairman)
   Independent Member for Chippenham Town

   Councillor Mrs Mollie Groom
   Conservative Member for Wootton Bassett North

   Councillor Mr William Moss
   Conservative Member for Alderbury

   Councillor Mrs Paula Winchcombe
   Conservative Member from Kennet District Council

   N.B. Initially, Councillor Mrs Kerrie Dixon (Liberal Democrat Member from North Wiltshire District Council) was appointed to be on the Task Group but withdrew for personal reasons. Councillor Mrs Mollie Groom was originally elected Chairman of the Task Group. However, due to involvement in a car accident, she was temporarily indisposed to undertake this role.

3. The Task Group was set up with terms of reference to:

   (a) Consider the reported poor performance of the Wiltshire Ambulance Service Trust and the reasons given.

   (b) Report back on the improvement plans of the Wiltshire Ambulance Service Trust and comment on its ability to improve the service and address local need.

   (c) Conduct the Review within a suitable time period.

4. The Task Group met on six separate occasions:

   (a) 12th August 2004
   To agree a scope of review, call witnesses, questions and review key background documents. It was agreed that a press release should be issued to engage with the public and correspondence be sent to Primary Care Trusts regarding GP Out of Hours provision.

   (b) 14th September 2004
   Members met to consider responses received from members of the public.

   (c) 16th September 2004
   Interviews conducted with witnesses:
   Mr T Skelton (Acting Chief Executive Wiltshire Ambulance Service)
   Ms D Elliot (Director of Commissioning Kennet & North Wiltshire PCT)
   Mrs G Holland and Mr R Jagger (Wiltshire Ambulance Service Patients' Forum Representatives)
   Members of the public

(d) 28th September 2004
Interviews conducted with external witnesses:
Mr G Reeves (Commissioner St. John Ambulance Trust)
Mr D Wilmot (Clinical Supervisor, Wiltshire Ambulance Service Trust)

(e) 4th November 2004
Visit to the Devizes Shared Control Centre
Interview with Mr R Ashton (Performance Improvement Manager, Wiltshire Ambulance Service).

(f) 15th November 2004
Meeting to agree outline final report.

(g) 31st January 2005
Final meeting to agree content of Task Group report and recommendations

N.B. Task Group Members also attended the 14th October, 2004 Wiltshire Ambulance Service Stakeholder Day at Chippenham Town Hall.

5. Evidence from external witnesses was collected in confidence and verified with them for accuracy. This report represents a comprehensive summary of the information received within the scrutiny review. Jo Naylor, Wiltshire County Council Health Scrutiny Officer, prepared the report.

OUTLINE OF REPORT

6. This report is divided into 7 sections, and subdivided where necessary, to fully address the issues as outlined in the terms of reference.

(1) BACKGROUND ON THE WILTSHIRE AMBULANCE SERVICE (WAS) TRUST

7. The Wiltshire Ambulance Service (WAS) covers an area of 3,553 sq. km serving a population of 626,159 people. The service is judged against performance standards for a rural area although it covers the urban areas of Swindon and Salisbury. The County of Wiltshire currently has 9 ambulance stations in the locations of Swindon, Marlborough, Amesbury, Salisbury, Chippenham (HQ), Warminster, Trowbridge and Devizes.

8. The Service has 300 members of staff. The Trust owns a fleet of 35 Accident & Emergency (A&E) ambulances, 15 solo response vehicles (Volvo cars and Honda CR-Vs), 4 motorcycles plus 15 vehicles used for non-urgent patient transport (PTS) and 1 air ambulance.

9. The crews available on a typical day are 21 crews during the day and 11 at night. With staff working a 12-hour shift, 4-days on (2-days, 2-nights) and 4-days off.

10. The Wiltshire Ambulance Service is commissioned by Kennet & North Wiltshire Primary Care Trust (K&NW PCT) which takes the lead for commissioning on behalf of patients in their own Trust as well as the West Wiltshire, South Wiltshire and Swindon Primary Care Trusts. The Service also responds to emergencies on the borders of the county in a reciprocal agreement with the neighbouring Ambulance Trusts.

11. The Trust received £12,382,000 in income to support its operations during 2004/05. The cost of running the service is £12,030,000. At the end of last financial year the Trust had a surplus of £368,000 of which £364,000 was required for repayment of Public Dividend Capital (i.e. interest on loaned money used for capital assets). This means the Trust is left with only £4,000 surplus from its activities. (Source: Annual Report and Accounts, 2003/04).

12. Staffing costs are also the highest single factor in the Trust, accounting for approximately 70% of running costs for the Trust.

(2) NATIONAL TARGET FOR AMBULANCE TRUSTS

13. The National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06 – 2007/08:

Key Targets for All Ambulance Trusts:
• All ambulance trusts to respond to 75% of Category A calls within 8 minutes • All ambulance trusts to respond to 95% of Category A calls within 14 (urban) /19 (rural) minutes • All ambulance Trusts to respond to 95% of Category B/C calls within 14 (urban)/19 (rural) minutes. • Ensuring that 95% of GP urgent calls arrive at hospital within 15 minutes of the time stipulated by the GP
N.B. From 1st October 2004 ambulance trusts will no longer be required to report on Category C calls. Performance should instead be measured through local agreements between ambulance trusts, SHAs, PCTs and emergency care networks.
Source: Department of Health Policy Information

Call Category Descriptions
Category A Patients who are or maybe life threatened and will benefit from a timely clinical intervention. **Category B** Patients who require urgent face-to-face clinical attention but are not immediately life–threatened. **Category C** Patients who do not require an immediate or urgent response by blue light and may be suitable for alternatives.

14. Behind each call category description there was a dispatch code description, which further defined the trauma, injury or accident.

15. The mechanism for categorisation of calls used by the Wiltshire Ambulance Service is a computer system (developed in the United States of America) called the '*Advanced Medical Priority Dispatch System'* (AMPDS).

16. The nature of the system instils a certain discipline. Calls handlers use a 'script', which cannot be deviated from, in order to assess a patient's condition. It was reported that call categorisation is always upwards to a more serious category if there is any doubt of which category the patient's condition falls under.

17. Following public concerns raised on the time taken to dispatch an ambulance after having made a 999 call, the Task Group enquired about the point at which the call taker requests an ambulance be deployed. It was found that at the Devizes Shared Control Centre, once determination of the location of the incident and the primary condition of the patient had been identified, the ambulance would be immediately deployed. This usually occurred within 30 seconds.

18. The information received indicates that an ambulance would be deployed before the call had finished and prior to call categorisation. After all questions from the script had been asked and should a call be deemed less serious in relation to its emergency status, an ambulance on its way to the scene may be diverted elsewhere to attend a more serious incident.

3. REPORTED POOR PERFORMANCE

19. The Commission for Health Improvement (CHI), an independent regulator of NHS performance, completed a Clinical Governance Review (CGR) of the WAS Trust in March 2003. On the basis of the evidence collected, CHI concluded that in relation to clinical governance the Trust showed "little or no progress at strategic and planning levels or at operation level".

20. A summary of conclusions of CHI (March 2003) for the Trust included:

(a) The need to develop an overall strategic direction for the organisation

(b) The need to develop a clinical governance strategy with clear lines of accountability

(c) The need to implement an effective internal and external communications strategy

(d) To develop and implement an involvement strategy for patients, service users, carers and the public

(e) To undertake a fundamental overhaul of human resources within the Trust

(f) The need to develop a comprehensive education and training strategy

(g) To increase medical input and effective functioning of the local ambulance paramedic steering committee (LAPSC)

(h) To develop an information strategy to be developed to define and audit the requirements of the Trust to support clinical governance activities and management decisions

21. In addition the Healthcare Commission (formerly CHI) re-inspected the service in order to issue a Star Rating for the Ambulance Trust in July 2004. The outcome of this inspection gave the Trust an overall zero (0) star rating. The definition of a zero star Trust is that the "Trust has shown the poorest level of performance against key targets or in implementation of clinical governance".

22. The Trust was grouped alongside 23 other rural Ambulance Trusts for comparison purposes. Of 4 key targets the Trust's performance was as follows:

Key Target	**Assessment**
Financial Management	Achieved
Category A calls meeting 14/19 minute target	Underachieved
Category A calls meeting 8 minute target	Significantly Underachieved
Improving Working Lives	Significantly Underachieved*

(*WAS Trust notified the Task Group that in fact no assessment of this function was carried out by the Strategic Health Authority for submission to the Healthcare Commission).

23. It is interesting to note that 71% of all rural Trusts surveyed were able to achieve on 'Category A' call responding within the 8-minute target. Also, 90% of all rural Trusts also achieved the 'Improving Working Lives' target set.

24. The Star Ratings assessment included an assessment of progress made since the original March 2003 Clinical Governance Review (page 19 refers). The Trust was still found to have significant areas of weakness.

25. Prior to the publication of the Star Ratings, the Healthcare Commission wrote to the Trust and the Strategic Health Authority about the conclusions they had made about the Ambulance Trust. The Trust was judged to have made significant progress in assessment components in relation to clinical audit and use of information. Progress had also been demonstrated in the areas of patient and public involvement, risk management, clinical effectiveness and staffing and staff management. However, this progress was not sufficient to move the trust into a higher band for performance overall, thus it still obtained a zero star rating.

26. The Healthcare Commission (HC) (formerly CHI) conducted a 'balanced scorecard' approach to assessing other areas of performance outside the 4 key targets. The Trust was found to be in the lowest band for both clinical focus and capacity and capability and in the middle band for patient focus (see full breakdown in table which follows):-

Table indicating the Healthcare Commission's 'Balanced Scorecard' Assessment (2002/03):

Description of Activity	Overall Scoring	Elements assessed in band	Band (1 - 5)
Clinical Focus	Lowest Band of Performance	Child Protection	1 (Poor)
		Clinical Governance Composite Indicator	5 (Good)
		Clinical Negligence	1 (Poor)
		Participation in selected audits	5 (Good)
		% Frontline ambulances with 12-lead ECG equipment	1 (Poor)
Patient Focus	Middle Band of Performance	Ambulance patient survey: access and waiting	5 (Good)
		Ambulance patient survey: better information, more choice	4
		Ambulance patient survey: building closer relationships	5 (Good)
		Ambulance patient survey: clean, comfortable, friendly place to be	5 (Good)
		Ambulance patient survey: safe, high-quality, co-ordinated care	5 (Good)
		Call answering time	1 (Poor)
		Category B/C calls meeting national 14/19 minute target	3
		GP Urgent calls meeting national 15 minute target	1 (Poor)
		Patient complaints	1 (Poor)
Capacity and capability focus	Lowest Band of Performance	Data quality of computer aided dispatch (CAD) data	4
		Staff opinion survey: health, safety and incidents	2
		Staff opinion survey: human resources management	3
		Staff opinion survey: staff attitudes	2
		Transport management	1 (Poor)

27. The Trust was assessed in the lowest band, in relation to the percentage of frontline ambulances with 12-lead ECG (electrocardiogram) equipment. **The Trust had only 29% of ambulances equipped in this way compared with the national average of 95%** at March 2003 *(N.B. Electrocardiogram - measures the electrical activity of the heartbeat).*

28. Transport management was a significant problem for the Trust with a score of 33.5 scoring well below the national median value of 82.9 in England. This relates to the environmental efficiency of fleet vehicles.

29. Poor performance was reported in relation to call answering time and the number of GP urgent calls met within the 15-minute national target.

30. The WAS Trust was reportedly poor at responding to GP urgent requests, which was echoed in a submission by a Wiltshire GP who felt that in relation to categorisation it was either 'immediate' or up to a 2 hour wait. There was a feeling that the presence of a GP with a patient was somehow 'downgraded the urgency of the call'.

31. In addition, in one extreme example, the Task Group received information from a member of the public who advised that his wife had died after waiting almost 3 hours for an ambulance following a GP request. This person was directed to the Independent Complaints Advocacy Service for advice on how to make a formal complaint and to initiate a more substantial inquiry into the matters surrounding this incident.

32. Interestingly, the Star Rating assessment records Wiltshire performance for GP urgent calls at 74%, this figure is close to the 78% average achievement for all ambulance trusts nationally. These figures show failure to meet the national 95% target, demonstrating a problem existed both locally and nationally (paragraph 13 refers).

> *N.B. The Health Commission states that the Star Rating regime indicators "do not necessarily reveal exactly why a Trust has done well, or in some cases not so well, in certain areas of performance". Instead they highlight certain areas for improvement and provide benchmarking data, to help share examples of best practice that are seen to be effective.*

4. REASONS GIVEN FOR POOR PERFORMANCE

33. The Task Group explored all areas of reported poor performance. This began by establishing if the inspection regimes had made a fair assessment of the Service. All interviewed acknowledged that the inspection ratings were fair. However, some felt that the huge efforts made to improve performance had not been acknowledged in the latest Star Rating (July 2004). **Inspectors of the service did not actually visit the Trust prior to compiling the data for the rating**.

34. Through the Task Group investigation key factors came to light in relation to why the Trust was categorised as 'poor performing'. These included:

(a) Location of acute hospital trusts in a rural county/Delays at A&E
(b) Lack of Automatic Vehicle Location System (AVLS)
(c) Rising demand on the service
(d) Inappropriate calls to service
(e) Vehicle Age
(f) Crew shortages at peak periods
(g) New GP Contract and impact of Out of Hours Cover
(h) Non-Urgent Patient Transport Service (PTS)

35. These will be covered in the following pages, describing the issue in more depth.

(A) Location of Acute Trusts in a Rural County/Delays at A&E

36. The rural nature of the county requires significant distances to be travelled to reach the scene of an incident. Concerns received by the public highlighted the problem. It was reported that it is physically impossible to reach certain remote areas in Wiltshire within the 8-minute target for Category A, should an ambulance be deployed from the Ambulance Station in Salisbury for example.

37. Furthermore, it was suggested that it could take as long to find an unnumbered house in a street as it does to get to the street. Similarly, some rural locations are inherently difficult to find. Attending remote locations also takes an ambulance out of general circulation for longer and thus unable to respond to other calls.

38. The locations of the acute hospitals on the periphery of the county, with no hospital centrally, exacerbate the problem. It takes a long time to reach the acute hospital, due to distance involved and traffic, resulting in slow turn-around times. It was heard that it could be a 2-2½ hour turn-around time to deliver a patient to the Bath Royal United Hospital (RUH).

39. The problem is further magnified by delays off-loading patients who are brought by ambulance. This is reportedly due to A&E units at full capacity or staff being stretched at their busiest periods. The hospital Trusts also have their own performance targets for patients to wait no longer than 4-hours at A&E. Delays in offloading patients at A&E has a knock-on effect on ambulance service performance measures. It was recently relayed to the Task Group that the situation of 'queuing of ambulances' still occurs at several Trusts within the AGW SHA area. This is also evidenced in the Fitch & Associates Europe Ltd demand analysis (November, 2004) which highlights delays at the RUH Bath as one factor in relation to 'lost unit hours'. (*n.b. A 'lost unit hour' is referred to as 'a unit hour, which is not available for immediate deployment or activation, for any of a range of reasons').*

40. It was felt that delays caused by other NHS Trusts should not be attributed to failures in responding time of the WAS. If necessary, some allowance for this should be factored into the response time reporting.

(B) <u>Lack of AVLS</u>

41. The CHI report identified that: *"The Trust's radio system is inadequate. This affects response time reporting and limits the ability of ambulance crews to communicate with the control centre in an emergency. The trust lacks an automatic vehicle location system (AVLS). This means that the Trust has no way of knowing accurately the nearest vehicle to an incident".*

42. The Trust's Acting Chief Executive estimated that response time performance could be improved by 5-6% through the introduction of this system alone. The Trust had not previously grasped the opportunity to acquire the system. This failing has now been recognised and the funding for the £450,000 system a one-off capital investment is being obtained from the Avon, Gloucestershire & Wiltshire (AGW) Strategic Health Authority (SHA). A preferred contractor will be selected in the next few weeks. It is hoped the system will be operational by March 2005.

(C) <u>Demand on the Service</u>

43. The Wiltshire Ambulance Service is under increasing pressure to respond to an increased volume of calls, which are up by approximately 10-11% yearly. This is similar to national findings, where emergency calls rose by 8% from 5.0 million to 5.3 million in the period between 2002-03 and 2003-04.

44. The number of Category A emergency calls responded to within target has also increased by 6%. Indicating both greater number of Category A calls and increased achievement of targets.

45. Historically it can be seen that by comparing data of all emergency responding from 2003-04 with that from 1993-94, over the decade demand has risen by almost 80%, with 4.3 million calls to respond to nationally, as opposed to 2.4 million in the nineties.

46. The challenge is to ensure a greater focus on the real life-threatening emergencies and finding alternative care pathways to treat those that fall into the non life-threatening category.

(D) Inappropriate calls to service

47. The Task Group heard some disturbing evidence in relation to inappropriate calls, which the ambulance crews ware dispatched to attend. One example of this was a crew being called out to carry an elderly person upstairs as their stair-lift had broken. In this scenario, assistance is undoubtedly required, but this should not have initiated an emergency response by the WAS. It was felt that better public information might be required to prevent unnecessary demand on the service. The issue of which service should deal with this type of incident is an issue, which needs to be addressed in a wider forum.

48. Other evidence heard of crews being called inappropriately at a GP's request, in order to provide patient transport for someone who is fit enough to travel by other means. This latter scenario was nicknamed 'the blue light taxi service'. The role of GP request for services is an issue currently being audited by the PCT commissioners, the WAS and the AGW SHA in an Ambulance Working Group meeting.

49. In addition, the Task Group was made aware of the Service's statutory responsibility to respond to all calls and the problems faced by hoax callers. The Task Group felt strongly that hoax calls to the service should have a raised status of being a criminal offence in line with legislation for the other emergency services.

50. In trying to determine the cause of the rise in demand, witnesses interviewed as part of the Task Group activity offered some suggestions. There was a feeling that generally there is a 'lack of community spirit', whereby people do not seek assistance from neighbours. Also that the NHS Direct service may have resulted in increased calls, due to the legal implications if failure to diagnose a life-threatening case occurs.

(E) Vehicle Age

51. Within the fleet some very old vehicles are still being used for frontline duties. This includes a P-registration ambulance with over 200,000 miles on the clock. The speed and reliability of such ageing vehicles is in danger of putting clinical safety at risk (See **Appendix A** List of age of A&E ambulances in the fleet).

52. The public perception was of a general shortage of vehicles within the fleet. However, the Task Group discovered that 35 A&E ambulances were within the fleet, but the actual number of crews gives a more accurate reflection of the vehicles available (21 crews on during day and 11 crews during the evening). Staffing requires careful demand analysis to ensure adequate crews and vehicles are available at high demand times.

53. Generally, it was heard that vehicles within the fleet were as well equipped as other trusts nationally. The WAS Trust has recently benefited from an extra 10 sets of portable ECG equipment with a total of 25 frontline ambulances with such equipment i.e. of the 21 vehicles involved on a daily basis in frontline activity all of these vehicles have access to such ECG equipment. This improves on the situation referred to in paragraph 27.

54. A number of witnesses were under the perception that the St. John Ambulances were better equipped to higher standards than the Wiltshire Ambulance Service vehicles. However, on further enquiry the Task Group was informed that the St. John Ambulance vehicles were newer and complied with international CEN-standards but were not necessarily better equipped. It was heard that WAS ambulances were actually fitted-out with more technical equipment.

55. In October 2004, it was relayed to the Task Group that the WAS has been awarded a funding from the SHA to procure seven new ambulances for the fleet. The Trust is also keen to adopt a 5-year replacement programme for vehicles, as opposed to the existing 7-year programme.

(F) <u>Crew shortages at peak periods</u>

56. The evidence supplied by the Trust (Fitch & Associates Nov 2004) indicates that ambulance crews were generally on-shift in accordance with demand patterns (see Figure 1 below). This, however, does not match the perception of many witnesses that there are inadequate crew numbers to cover the activity. The Fitch & Associates study however, did highlight the fact that the Swindon area was under-resourced and is likely to impact on resources from elsewhere in the county.

57. Furthermore, it was confirmed that high levels of sickness and absence hampered the Service (currently affecting 8% of the workforce). This reduces the capacity of the Trust to respond to emergencies. Fitch & Associates analysis (Nov 2004) took lost hours over a 2-week period and found that 390 hours were lost due to no crews being available. This was the most significant factor for lost unit hours. These figures are based on 2664 hours output each week.

58. The WAS Trust is hindered by the fact that the workforce is not big enough to provide adequate relief staffing. Currently the Trust operates at 26% relief staff; however, to fully cover demand 30% cover would be required. This equates to a further 8 staff required, to increase the total number of relief staff to 60, to support the 200 paramedic and technicians employed by the Trust.

59. Those interviewed at the Joint Control Centre in Devizes suggested that pressure points for the service occurred at night, particularly in response to recurring weekly alcohol-related incidents between 12 midnight and 2 am on a Friday, Saturday and Sunday. In part, this was reflected by the Fitch & Associates study, which commented that “there is a slight unit hour deficit on Thursday and Sunday between midnight and 0200 hours”.

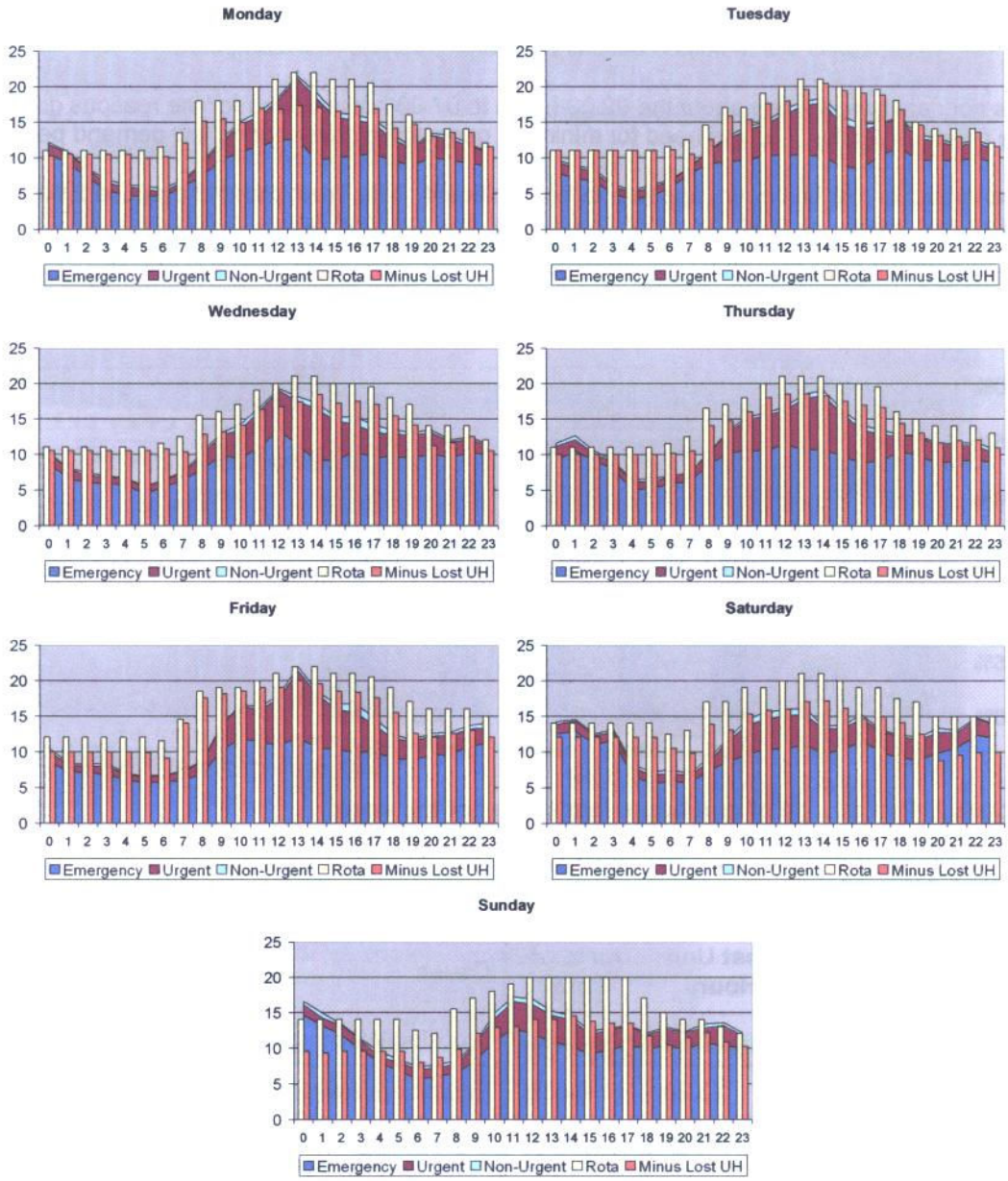


Figure 1: Whole service demand analysis

60. The Wiltshire Ambulance Trust is one of the smallest in the Country which results in difficulty in attracting qualified staff from other Trusts (i.e. at paramedic level) as Wiltshire is a relatively expensive area with high house prices. The Trust relies on training their own technicians to become paramedics at the Greenways Training Centre. A new batch of paramedics were fully trained in October 2004 in an attempt to increase the number of paramedics in relation to technicians.

61. The new 'Agenda for Change' policy guidance will reduce NHS staff hours to a 37.5 working week. WAS ambulance crews currently work between 40-42 hours per week. However, this policy will require the Trust to find a further 23 members of staff, to meet the new hours directive and scheduling of extra holiday entitlement.

(G) New GP Contract and impact of Out of Hours Cover

62. Many of those interviewed and evidence received, including that from a practising GP, highlighted that the new GP Out of Hours arrangements could potentially result in more calls to the emergency services. The Primary Care Trusts now responsible for this care were approached to assess their interpretation of the adequacy of the arrangements. Their responses can be found at **Appendix B.**

63. Concerns were expressed that one on-call doctor would cover a very wide patch and would not necessarily be able to reach the patient quickly. Concerned patients might not wish to wait and call the ambulance service instead.

64. If they do call the out of hours telephone number, their condition will be assessed by a triage nurse, who might advise an ambulance be called if there is any ambiguity or concern of the callers condition. It was cautioned that such arrangements might actually increase A&E admissions. There are currently no hard facts available as to whether there has been any detrimental impact following the introduction of the new arrangement. The Task Group however, was concerned that the PCTs should closely monitor the arrangements and ensure that additional workload burden was not being transferred to the ambulance service.

(H) Non-Urgent Patient Transport Service (PTS)

65. The policy document 'Driving Change' highlights that patient transport accounts for over 80% of all ambulance journeys in England. That equates to 30,000 people in England being conveyed to and from hospital every day. Despite this, this aspect of service has a much lower profile. It represents 20% of total ambulance service expenditure nationally which is an overall decrease since 1990's when PTS equated to over 25% of all expenditure. Interestingly, in Wiltshire spend is even lower with 16% of expenditure committed to PTS.

66. The witness statements suggest that PTS was not being delivered timely to patients who were eligible for this service, with long delays for pre-booked appointments and long waiting times for return travel from hospitals. Others suggested it was detracting from the Trust's ability to respond to frontline emergencies.

67. In Wiltshire, there are multiple contracts for PTS crossing PCT boundaries and matching acute hospital demands, all requiring management. The Audit Commission's, (2001) 'Going Places' report noted that; "Most ambulance services have many different agreements, some are worth less than £50,000 a year, and each of which will have its own contract terms, quality standards and managerial overheads".

68. There is certainly scope for working with commissioners to review contractual agreement for PTS especially in light of new policies to drive change and not least the forthcoming 'payment by results' (PBR) arrangements designed to standardise levels of service.

69. An innovative approach to tackling PTS was initiated by Nottinghamshire County Council (NCC) to maximise the use of social services vehicles during quiet periods. They entered into a contract with East Midlands Ambulance Service to relieve some pressure on providing non-urgent patient transport. This both assisted the ambulance service and increased the turnover for NCC.

(5) ABILITY OF THE TRUST TO IMPROVE PERFORMANCE AND ADDRESS LOCAL NEED

70. Evidence was received which suggested that the Trust had made some significant changes following the CHI Review (March 2003). A comprehensive Action Plan with key actions against target dates was prepared to address all aspects of this review.

71. The Task Group were notified that the WAS Trust Board and the SHA are both monitoring the implementation of this Action Plan including with the latest update provided in April 2004. The Task Group suggested that Section 8, Strategic Direction of the Trust was absent from the most recent update report and should be monitored by the Trust Board and SHA.

72. Key improvements have included:

(a) Appointment of a Medical Director, in order to improve clinical effectiveness who has produced a draft Clinical Governance Strategy for the Trust.
(b) Appointment of a HR Director
(c) Ongoing work around improving flexible working, childcare arrangements etc. in order to obtain recognition in relation to 'Improving Working Lives' initiatives.
(d) Demand Analysis Survey completed in November 2004
(e) Consultant advice in relation to opportunities for merger with other Trusts.

73. In addition, further improvements have been implemented and will be expanded upon in the following sections:

(a) Adoption of First Responding Schemes to improve response times including strong partnership working with St. John Ambulance (SJA)

(b) Reported improved response times for October 2004 compared to October 2003 figures

(c) Move to Devizes Shared Control Centre with other emergency services and improved call handling management

(d) New future models of care in the community to reduce hospital admissions and demand on the service

(e) Better dialogue and co-operation with commissioners to address treatment of Category C patients

(A) First Responding Schemes

74. The Star Ratings review flagged up key concerns about response times and showed the Trust's lack of achievement even within a rural peer group of similar Trusts.

75. In April 2004 the Trust adopted 'First Responding Schemes'. Throughout the Review different individuals referred to these responders by different titles, showing some lack of consistency naming the scheme, which should ideally be qualified. However, the basic tiers are as follows:-

(a) Community Paramedics attached to GP Surgeries
These schemes operate out of GP surgeries in Wootton Bassett and Highworth where a member of WAS staff provides Category A responding in the local areas and carries out a wide range of care in conjunction with the GP Surgery.

(b) Community Paramedics Working From Home
The Trust is introducing a scheme in Westbury and Calne where a paramedic will operate in an emergency response service from home and work with the local community to develop voluntary schemes to cover out of hours.

(c) Military Schemes
There are good relations with the military and several schemes operate in Tidworth, Bulford, Boscombe Down and Colerne areas.

(d) First Responders (Neighbourhood Volunteers)
Training and organisation is carried out in partnership with the St. John Ambulance Service. First Responders are trained volunteers who can provide immediate life saving care whilst an ambulance is on its way. These schemes operate out of Market Lavington, White Parish, Ramsbury, Pewsey and Highworth. These neighbourhood responders notify the Control Centre that they are on duty.

"Another way of reaching patients within the critical 8 minute period necessary to save life is through the first responder schemes, which are in wide use in North America and other parts of the world".
Source: The NHS Executive Steering Group 'Review of Performance Standards' (1996)

76. All responders are equipped with an Automated External Defibrillator (AED) used to restart a heart in the event of heart failure. They are backed up by an Ambulance, which is simultaneously deployed, from the Control Centre.

77. Evidence however was received that some areas of the county might still be at risk, i.e. the area of Mere, which is on the edge of the county boundary. There is a need to continue to enhance the provision and number of first responders (in all tiers of responding) in order to ensure there is adequate cover for the whole of the county.

St. John Ambulance (SJA)

78. A strong partnership arrangements exists between the WAS and the St. John Ambulance (SJA). SJA do the training for 'neighbourhood responders' including 6-monthly refresher courses and payment of allowances to volunteers. This scheme is delivered at no cost to WAS. The SJA are soon to be included on the WAS radio system.

79. It was clarified that the SJA would not be called upon to attend a Road Traffic Accident (RTA) as the majority of its activity is pre-booked events or sporting events. In the event of a serious traumatic incident where there are a huge number of hospital admissions and SJA would be called to deal with discharged patients e.g. in a plane, train or other incident.

80. SJA supports the WAS in relation to patient transport and is occasionally called in relation to the GP urgent referrals. They are also used for long-distance transportation of patients, which prevents the WAS loosing a crew. Hospital transfers may take a whole day to deliver a patient to a specialist unit e.g. in London or Southampton. Patient transport is charged to the WAS using a formulae based on distance travelled.

'Standby Points'

81. The Trust has used historic patterns of incidents plotted to determine areas, which represent accident 'hotspots'. The maps at **Appendices C-F** demonstrate density of accidents occurring at certain geographical locations at certain times in the day. This is the basis for a Deployment Plan, which aids dispatchers in the positioning and deployment of resources.

82. The majority of standby points are not facilitated, as they do not afford the full range of rest or toilet facilities. In general crews should be rotated every hour from standby points.

Current Standby Points within Wiltshire
Westlea Standby Point (Facilitated standby point) ASDA, North Swindon (Facilitated standby point) Stratton St Margaret, Swindon Chippenham Community Hospital Melksham Community Hospital Bradford-on-Avon Community Hospital Westbury Police Station Salisbury Fire Station

83. The Task Group considered the rationale behind standby points. In an article published on the Internet called "Ambulance Standby points – The way to faster response" (Staffordshire Ambulance Service & ACTIVE Solutions Europe Ltd) describe the advantages of this approach. It states that: "In a perfect standby and dispatch system, the ambulance will constantly move to the place where the calls are coming from, enabling it to respond immediately to the accurately predicted requirements for emergency care". It is worth noting that the Staffordshire Ambulance Service NHS Trust is a 3 Star rated Trust as audited by the Healthcare Commission.

84. A structured analysis of historic data (via incident records) can provide essential planning information. Statistics in relation to call volume by time are valuable when used in conjunction with geographical variation in call volume. These demand patterns can help assist not only in identifying accident hotspots but also in relation to improving resource levels to match the demand pattern.

85. Such demand analysis can be used to shape shift patterns to ensure optimum staffing levels.

86. The WAS Trust vision is to increase the number of standby points to 12-13 to increase capacity of the fleet to respond and reduce the overall reliance on stations, with a possible reduction in the number of stations from 9 to 3 or 4.

87. There was some discussion over the benefits of using leased premises on industrial estates, to reduce the overhead costs of a station but to provide staff with some rest facilities. These sites also have the advantage of frequently being located on the edge of towns, providing access to ring roads and good road networks. This could also aid speed of responding. The Task Group further discussed the need to bear in mind staff comfort, morale and safety when considering standby points.

88. Standby points enhance response times by reducing 'activation time', that is the time required to mobilise an ambulance from a station.

(B) IMPROVED RESPONSE TIMES

Summary of Activity	Oct 2003	Oct 2004	Nov 2004	Figures from Apr – Oct '04
Total No. of All Emergency Responses	**3323**	**3680**	**3490**	**24560**
The Category A Standard				
Target 75% Reached within 8 Minutes				
% Reached in target	51.92%	69.56%	72.88%	64.60%
The Category B/C Standard				
Target 95% Reached within 19 Minutes				
% Reached in target	88.40%	83.48%	86.22%	84.69%
GP Urgent				
Target 95% arrive at hospital within 15 Minutes of the time stipulated by the GP				
% Reached in target	70.93%	86.34%	95.52%	77.98%

89. It is clear from the table above that some marked improvement in performance has been made in relation to Category A responding, especially for the latest figures for November 2004. Category A call responding is now almost reaching the national target of all calls to be reached within 8 minutes. When this is compared to October 2003 response time achievement is up 20.96% for all Category A calls. This actual change in performance from the baseline of 51.92% in October 2003, equates to 40% improvement in performance.

90. However, when looking at the average for the 6-month period (March-October, 2004) the Trust is still well below national targets. With attention and resource being focused on Category A the most life-threatening cases, response performance against Category B calls still is well below target and has declined since October 2003.

91. On the 4th November at the Task Group's visit to the Control Centre response time performance for Category A, calls had reached 80% within target, exceeding national targets. The Control Centre Performance Manager also reported that GP Urgent admissions were at 100%, exceeding the target and 95% of Category B calls met the target.

92. The latest figures show response to GP urgent calls dramatically improved in November 2004. However, using averages taken over 6 months (March-October 2004) figures do not show a marked improvement from the CHI (March 2003) rating when performance was at 74%.

(C) Devizes Shared Control Centre

93. The move to a new Devizes Shared Control Centre, combining the Ambulance, Police and Fire services call centres under one roof, was achieved in August 2003. The WAS Trust would not have been able to afford this centre without joint resources of all emergency services. Having a new building has improved both morale and performance. The Centre provides an advanced IT systems and essential back-up provision.

94. Within the CHI Review (March 2003) the Trust scored highly for its use of the Computer Aided Despatch (CAD) programme in operation at the Trust. Within the Shared Control Centre in Devizes, The CAD system allows for the electronically transfer of information obtained in a call to be routed to other emergency services.

95. Four emergency call takers sit next to the two dispatchers. Deployment areas are split into north and south, which allows for the dispatchers to focus attention on a particular area and develop greater local awareness.

96. CCTV of Salisbury town centre is also visible within the Control Centre enabling information on potential deployment and dangers to staff. Performance targets are clearly visible on a large screen for call takers. CCTV is increasingly being used across the county and could be linked particularly bearing in mind joint interest of emergency services that share the Control Centre.

97. The Trust is also in the process of budgeting for a new post of telephone triage nurse/ paramedic based within the Control Centre to advise and provide sign-posting for treatment of Category C calls. They will assist with the interrogation of the condition, identification of symptoms and providing the best advice in relation to self-care and alternative treatments.

(D) New Models of Care (Community Based)

98. The Task Group heard that the Service requires expenditure of approximately £1 million dedicated to supporting a new model of care within the community. The aim is wherever possible to treat Category C calls and other minor medical procedures within the community appropriately, either at minor injury units (MIUs), doctors surgeries or within peoples homes. This will be beneficial in order to release valuable emergency crews and relieve pressure at A&E departments.

99. The new models of care will include training paramedics in advanced skills and techniques of care in order for them to become “Emergency Care Practitioners”. Major benefits rest in the authority of these advanced paramedics to treat and refer. The Westcountry Ambulance Service has adopted this approach and an example of the functions of the ECP is listed in the table below.

Role of the Emergency Care Practitioner (ECP)
Improved clinical examination skills Neurological assessment Upper and lower limb assessment including tendon and nerve function ENT Advanced eye irrigation techniques Advanced wound care including suturing gluing and steristripping Plastering techniques Referral to fracture clinics Ordering X-Rays (some areas) Wider range of drugs Advice leaflets
Source: Extract from the Westcountry Ambulance Services NHS Trust Presentation (14th October 2004)

Statistics for ECPs in Exeter between January and March 2004 resulted in a 46.67% reduction in those requiring transporting to hospital (Source: Westcountry Ambulance Service figures for non-conveyed patients).

100. Evidence suggests that improved access to primary care in this way, plus the management of patients with chronic diseases requiring long-term care in the community could relieve a huge burden on the emergency services (see Modernisation Agency's 'Driving Change' document 2004).

101. This model of care has been adopted by Wiltshire's 'NHS family' of commissioners and the Ambulance Service is viewed as being the most effective way for the future delivery of emergency care.

(E) <u>Better Dialogue with Commissioners</u>

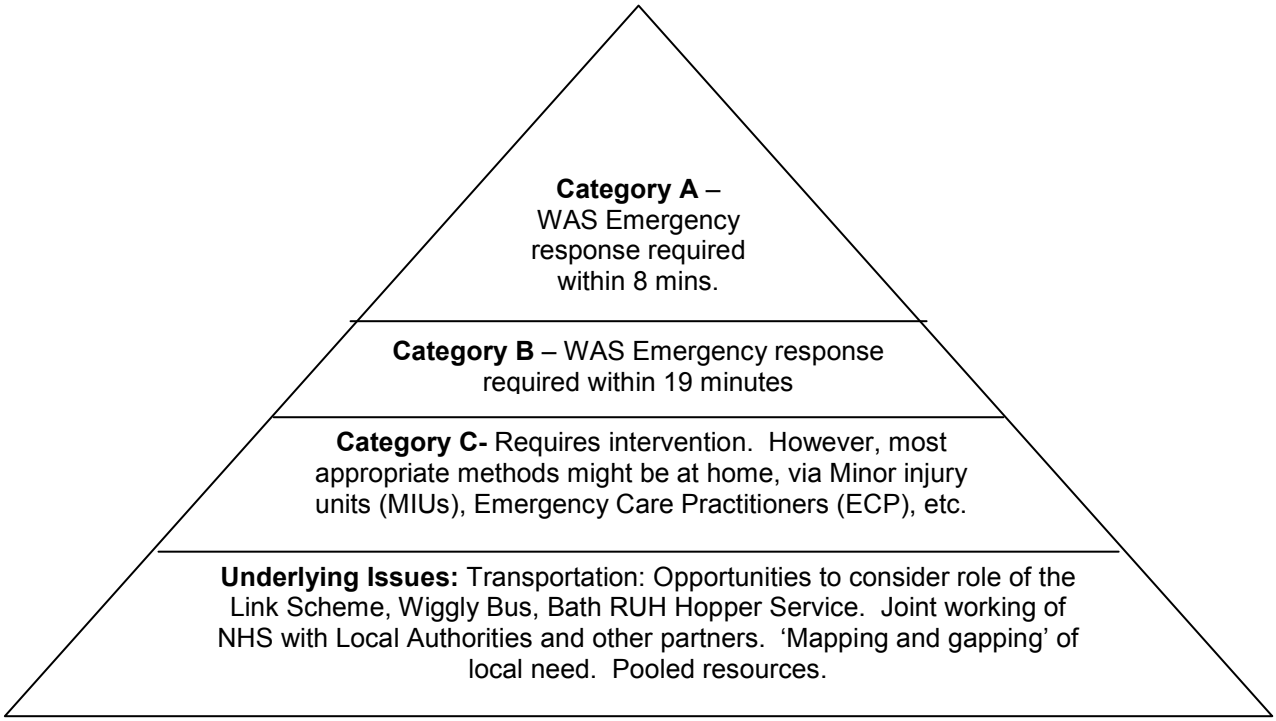
102. There is a need to focus on breaking down the traditional boundaries between Ambulance Trusts and the rest of the NHS to ensure they can make their full contribution to the delivery of the NHS (See 'Driving Change' Modernisation Agency, 2004 document).

103. Ambulance Crews are already being trained in order to assist in meeting targets in relation to thrombolysis, thus they will have additional responsibilities to deliver 'clot-busting' injections for those suffering heart attacks. This coupled with ECG scans transmitted to hospitals in advance of arrival can do much to enhance the patient's chances of survival.

104. Following evidence received the Task Group was concerned that ambulances could be held at the scene of accidents waiting for the Police Service to arrive and conduct blood-alcohol level tests. Joint working between the services on this issue could alleviate patient discomfort in terms of difficulty of being breathalysed in the event of sustaining chest injuries and also provide a key example of a holistic approach of joint working, ensuring Police and Ambulance Service resources are also preserved.

105. The Trust's Medical Director has produced a draft Clinical Governance Strategy which will continue to be updated in response to advancing clinical outcomes.

Figure 2: Methods of Intervention to treat Emergency & Non-Urgent Calls



Source: Information supplied by Commissioning Authority for WAS

106. This information (Figure 2) offered by the commissioners' highlights the joint role of primary care providers to support change and modernisation of the Ambulance Service by providing effective, alternative treatments in the community (see also **Appendix G**). It also highlights the role of local transport authorities in their 'mapping and gapping' exercises, which emphasises the importance of accessibility to healthcare centres.

107. Better joint co-operation between commissioners and the local authorities to tackle the issue of transport in rural areas should also be encouraged as best practice. This subject is covered in greater depth within the document 'Driving Change' (Sept 2004) whereby; mapping of the accessibility of local health care services are now integral to the latest transport plans (2006/07 – 2010/11).

108. The role of Minor Injury Units (MIUs) in supporting the Ambulance Service and reducing pressure on A&E units has also been identified, and was highlighted at the Trust's Stakeholder event on the 14th October 2004. It is crucial that The Primary Care Trusts communicate effectively with the Ambulance Service to ensure that reduction in MIU units and other service reconfigurations such as maternity do not negatively impact on the Service.

Other Key Issues Emerging within the Review

109. Although not strictly within the Task Group's terms of reference some significant concern was expressed in relation to staff welfare.

110. It was suggested that high sickness and absence rates might be a consequence of the stressful nature of the role and the long 12-hour day shifts.

111. Interestingly an indicator of the stress experienced by ambulance crews is reported in the National NHS Staff Survey. Where "ambulance technicians and paramedics reported low levels of support from supervisors and high levels of violence from patients".

112. The Task Group felt that in order to address the high levels of sickness and absence a greater amount of flexibility in working hours should be explored. This is in line with initiatives such as 'Improving Working Lives'.

113. In addition members wanted reassurance that the efforts made to improve response times through the use of facilitated standby points were not to the detriment of staff welfare. The Task Group strongly felt that a greater focus on facilitated standby points, with access to restroom facilities would be preferential.

(6) CONCLUSIONS

114. The Wiltshire Ambulance Trust has made significant attempts to improve performance over the last 18 months and some change in response time performance is being seen.

115. The Trust is hindered by a number of factors, not least the lack of some basic navigational equipment (AVLS) on the fleet of vehicles which is currently being addressed with additional funding from the Strategic Health Authority.

116. It has the challenge of reaching a dispersed rural population and has embarked on significant change with the adoption of First Responding Schemes and designated Standby Points in order to meet the challenge of reaching individuals within the 8-minutes required to save lives.

117. Income for the Trust does not match the ever-increasing demand on the service. The Trust is attempting to address concerns by changing the model of care it delivers in order to free-up resources. This includes greater attempts to care for those non-life threatening cases within the community working alongside those responsible for delivering primary care.

118. Plans have not yet been fully formulated but the Trust is considering merger opportunities to increase the size and viability of the service and reducing some of the overheads and duplication. Merger opportunities may cut out some of the tiers of management at operational and Trust board level to provide a more streamlined service, however, the Task Group would not wish to see local knowledge and experience being diluted as a result of merging operational services. Early engagement with the public and key stakeholders on this possibility has already been started. Procurement in particular is one area that could benefit from more sizeable 'buying power'. Regional or national procurement consortiums should be considered in the future. This developing work programme is to be monitored by the Strategic Health authority and Primary Care Trusts.

(7) RECOMMENDATIONS

RECOMMENDATIONS TO THE COUNTY HEALTH OVERVIEW & SCRUTINY COMMITTEE AND OTHER AGENCIES:

1. **To request the Wiltshire Ambulance Service (WAS) Trust to provide a progress update report to the County Health Overview & Scrutiny Committee in 12 months time highlighting the CHI recommendations and Task Group recommendations that have been implemented.**

2. **Trust Board and Strategic Health Authority continue to monitor the implementation of the CHI Action Plan and to ensure the Trust's "Strategic Direction" section continues to be monitored.**

3. **For the Primary Care Trusts in Wiltshire to report back to the Health Overview & Scrutiny Committee in October 2005 to assess the impact of the GP Out of Hours (OOH) arrangements and calls to the WAS Trust.**

4. **That the commissioners of the service undertake an evaluation of the current non-urgent patient transport (PTS) requirement for the county and the best way of meeting this need and improving standards.**

5. **The Department of Health consider undertaking a full analysis of inappropriate calls made to the service and whether there are grounds for a national public education campaign to prevent unnecessary demand on the service.**

6. **That the Secretary of State for Health be asked to change legislation to ensure it becomes a criminal offence to make hoax calls to the Ambulance Services.**

7. **The Task Group recommends to the Ambulance Service Association (ASA) that there should be lobbying for a minimum requirement for essential equipment on frontline ambulances.**

8. **Adequate funding of the service is necessary and there should not be an over-reliance on voluntary groups to support a professional and national funded service.**

9. **Opportunities for merger with other Trusts should be looked at thoroughly for the advantages and disadvantages of gaining greater size and reducing management overheads, especially noting the value of joint procurement consortiums.**

10. **The WAS Trust improves the dialogue with local GPs and Commissioners to address how to improve performance in response to GP Urgent Calls targets.**

11. **Delays at acute hospitals should not impinge upon the Wiltshire Ambulance Service's response times. The AGW Strategic Health Authority should investigate the issue of delays occurring at acute hospital trusts and find solutions to this problem.**

12. **To ensure that Automatic Vehicle Location System (AVLS) becomes standard equipment for the fleet of Wiltshire Ambulances.**

13. **To provide optimal number of vehicles within the fleet to meet demand peaks and to decommission vehicles that are 5 years or older. New vehicles should adhere to CEN-Standards (European Standards for Efficiency) wherever possible.**

14. **The First Responding Schemes should be rolled-out across the County to ensure that the entire County is covered and can be reached within 8 minutes for 'Category A' calls.**

15. **The naming of the tiers of First Responding Schemes requires better clarity and adoption of the same terminology in order to ensure the Service and the public understand the schemes in operation and to provide public reassurance as to the level of training of the attending responder.**

16. **The use of standby points supported as based on historic accident data but the staff facilities at such sites needs to be enhanced.**

17. **To pursue at the earliest possible opportunity the appointment of a triage nurse/paramedic based within the Control Centre to advise and provide sign-posting for treatment of Category C calls.**

18. **The WAS Trust considers:**

- **The use of leased premises on industrial estates as possible facilitated standby points**
- **More innovative partnership arrangements with large employers operating 24hour working arrangements to provide standby points on-site**

19. **Consultation is required to establish the causes of such high-levels of sickness and absence particularly, looking at the existing shift patterns.**

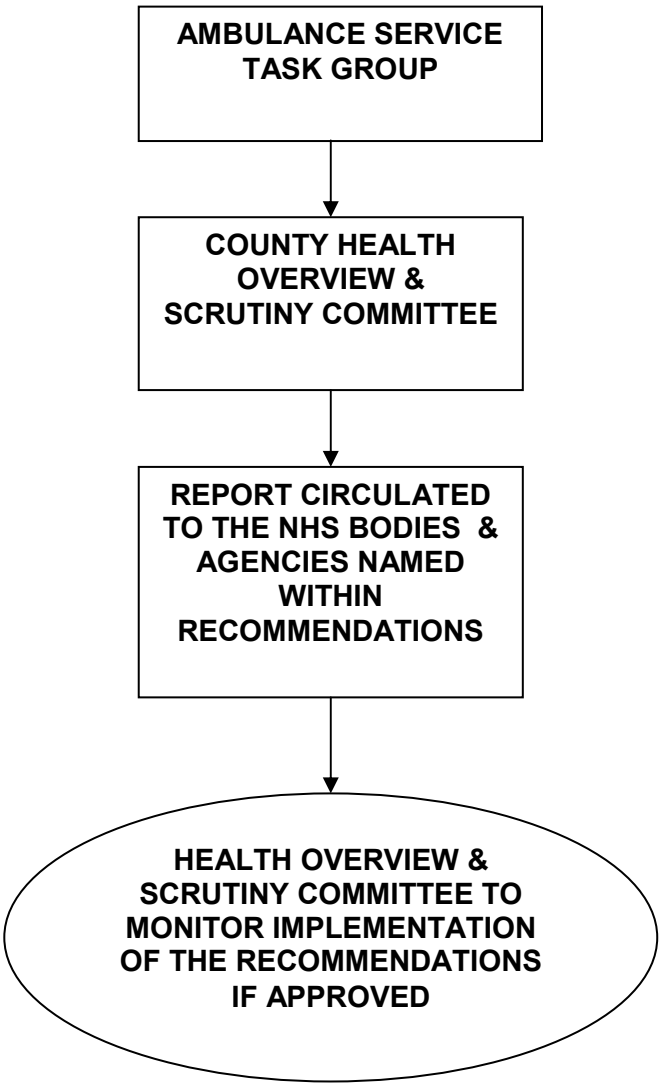
20. **Wiltshire's Town Centres, which have CCTV cameras, should be linked to the Shared Control Centre to assist with monitoring potential incidents and safety for paramedics and technicians sent to attend these incidents.**

ACTION REQUIRED:

By Wiltshire Ambulance Service Trust (Operational & Board Level), Avon Gloucestershire & Wiltshire Strategic Health Authority, Kennet & North Wiltshire PCT (Commissioners of service), Wiltshire's Primary Care Trusts, Department of Health, Association of Ambulance Services and the Home Office.

Decision Making Process, Implementation and Monitoring of Recommendations

119. This Task Group report will be submitted to the Health Overview & Scrutiny Committee in March 2005 for endorsement. This Committee will monitor the implementation of the recommendations in 12 months time.



References:

1. The Commission for Health Improvement (CHI) Clinical Governance Review – Wiltshire Ambulance Service NHS Trust (March 2003).

2. Wiltshire Ambulance Service NHS Trust - Action Plan to the "CHI Clinical Governance Review (June 2003)

3. Wiltshire Ambulance Service NHS Trust – "Commission for Health Improvement Progress Update - April 2004".

4. Wiltshire Ambulance Service NHS Trust Principal Objectives 2004/05 and Risk Area Action Plan (Submitted to AGW Strategic Health Authority in August 2004).

5. Wiltshire Ambulance Service NHS Trust Annual Report and Accounts 2002/03

6. Wiltshire Ambulance Service NHS Trust Annual Report and Accounts 2003/04

7. Healthcare Commission NHS Performance Ratings (2003/04) Wiltshire Ambulance Service NHS Trust Detail Report (Star Ratings)

8. Wiltshire Ambulance Service NHS Trust presentation slides – delivered on 14 October 2004 Stakeholder Event.

9. Wiltshire Ambulance Service NHS Trust – "Way Forward" presentation (Two Versions from 2004).

10. "The Unscheduled Care System – Effective Delivery Requirements" Model of Care presented on 14th October 2004 (Stakeholder Event).

11. Presentation by Peter Bradley (Department of Health Ambulance Advisor) - Ambulance Service Review, 14 October 2004

12. Presentation by Michael Willis, Chief Executive of the Westcountry Ambulance Services NHS Trust, 14th October 2004.

13. Finamore Management Consultants – Presentation to Wiltshire Stakeholders 14 October 2004 – Wiltshire Ambulance Services – Scoping study to inform the best configuration for future service delivery.

14. Written Testimony from all external witnesses (confidential records).

15. 'Driving Change' – Good Practice Guidelines for PCTs on Commissioning Arrangements for Emergency Ambulance Services & Non-Emergency Patient Transport Services, NHS Modernisation Agency (Improvement Partnership for Ambulance Services) (Sept 2004)

16. National Standards, Local Action – Health and Social Care Standards and Planning Framework (2005/06-2007/08)

17. Ambulance Improvement Checklist

18. Thayne, R. & Smith, P. "Ambulance Standby Points – The way to faster response", published on the www.activesol.co.uk website.

19. Department of Health website; Policy & Guidance - "Modernising Emergency Care Article"

20. A Demand Analysis for the Wiltshire Ambulance Service NHS Trust - Fitch & Associates Europe, Ltd (November 2004)

21. "Going Places: Taking people to and from education, social services and healthcare", Audit Commission 2001.

22. Correspondence from Healthcare Commission to the AGW Strategic Health Authority, 28 June 2004, Re: 2004 Clinical Governance Action Plan follow up for Wiltshire Ambulance Service NHS Trust