Great Western Ambulance Service NHS
NHS Trust

Joint HOSC Meeting
To be held on Friday 14 October, 2011 at 11am
At Wiltshire Council Monkton Park offices, Chippenham

Key in title here

1 Purpose

To provide members with clarification of issues raised in a recent National Audit Office report looking at value-for-money within ambulance services.

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MEASURING COST-EFFECTIVE IN AMBULANCE SERVICES – UPDATE REPORT FOR JOINT HOSC

Background

In June 2011, the National Audit Office published *Transforming NHS ambulance services* – a report looking at the cost-effectiveness of ambulance trusts individually and collectively, in comparison with expectations on them in the form of performance standards and activity levels.

This brief update for Joint HOSC members highlights some of the NAO report's key findings and recommendations and provides an insight into some of the activity taking place within GWAS that address the issues raised.

Key findings and recommendations

- *Performance over the last decade has been driven by response time targets and not outcomes*

Prior to April 2011, the sole measure of ambulance performance was its speed of response. The category A 8-minute response time target – one of the most demanding in the world – has undoubtedly ensured more patients suffering life-threatening conditions have survived, while also meeting public expectations for a fast response.

However, it was recognised that speed of response in isolation of any measure of clinical outcomes created a narrow view of what constituted 'good' performance, while also led to ambulance services over-allocating resources to incidents – deploying multiple vehicles then standing down the surplus.

Therefore, the introduction in April of a new range of indicators is now starting to produce a better, more rounded picture of ambulance service performance. Members are receiving an update on these new indicators in another agenda item for this meeting.

- *There is scope for improved efficiency as evidenced by variations between ambulance services in costs per call, the way resources are deployed to meet demand, the take-up of different approaches to responding to calls and reliance on overtime.*

The report highlighted GWAS as having the highest cost per call at £216. Clearly an element of this is the fact that GWAS is the smallest of England's 11 standalone ambulance services (the Isle of Wight is part of NHS Hampshire) – the trust has to have the same level of governance and other 'fixed cost' items as

larger trusts. Also, in terms of cost per incident, GWAS sat more in the middle of the pack (less than Yorkshire, East of England and South Central) at £235.

The growing use of 'hear-and-treat' and 'see-and-treat' – assessing and treating patients over the phone or on scene without the need to convey to hospital – was identified by the NAO as a key area whereby ambulance services could help the NHS as a whole save up to £280million/year. This ability to provide care for patients without the need to take them to A&E is one of the quality indicators in place since April – for the April-July year-to-date data, GWAS was in the top three ambulance services, in that 43.5% of incidents attended did not result in the patient having to go to A&E.

One of the issues highlighted by the NAO report in identifying comparative cost effectiveness among ambulance services was the fact that there was often no consistency in the information requested/provided. An example of this was in the comparison of the percentage of incidents in which ambulance services sent more than one resource in response.

GWAS was identified as the trust most often dispatching dual or multiple resources to incidents (on 62% of occasions). However, the GWAS data included those incidents where a static defibrillator or community first responder was dispatched (and which would therefore have to include a professional ambulance clinician response as well). Other ambulance services only included data where two or more ambulance service vehicles were dispatched. Directly comparative data shows GWAS as far more in the middle of the pack.

In terms of extensive use of overtime, the NAO report identified that historically high sickness levels among frontline ambulance staff, as well as the ability to match staff availability with demand, meant ambulance services currently rely on overtime at a combined cost of almost £80million/year.

GWAS was identified as having the lowest level of frontline staff sickness – 5% - among ambulance services.

Also, in terms of matching staff resources to demand, the trust last year introduced a new operating model based on extensive analysis of 999 demand. This has allowed us to better match the level of resources to the level of demand – not simply in actual numbers but also ensuring more of the right resource is available in the right place at the right time.

In addition, the trust's continuing investment in paramedic training of its existing technician/practitioner level staff means it will soon be in a position to ensure a paramedic on every vehicle responding to 999 calls – thereby increasing the potential for treating more patients on scene.

- *A lack of alignment of objectives between urgent and emergency care providers, including ambulance services, means that work remains to achieve cost-effective integrated emergency care.*

The NAO identified that more than 20% of patient handovers at hospital A&E departments take longer than the recommended 15 minutes – resulting in more ambulances being unavailable to respond to 999 emergencies as they are queuing outside hospitals.

GWAS continues to work with its acute hospital partners to reduce handover delays within its areas – such as by the introduction of handover screens in every A&E department to give hospital staff a clearer picture of how many patients are currently waiting to be handed over from ambulance care and how long they have been waiting.

In addition, commissioners are now including financial incentives in hospital and ambulance service contracts to encourage smoother turnaround times.

- *The ability to improve performance is limited by a lack of data on patient outcomes and a lack of comparative information that can be used to benchmark performance.*

The new ambulance quality indicators include clinical outcomes – among them, for the first time, a measurement of the proportion of patients experiencing a cardiac arrest in a non-hospital setting who go on to survive and are ultimately discharged from hospital.

Other clinical measures give an indication of how successfully ambulance services are in responding to and treating patients suffering particularly clinical emergencies – stroke and STEMIs. For the first time, these are being displayed and updated monthly by all ambulance services in the form of a web-based clinical dashboard.

This dashboard shows activity and performance for all ambulance trusts – it is important to note that the majority of these new indicators (apart from the 8-minute and 19-minute response standards) – are not ‘targets’, in that they do not have a pass-or-fail threshold. Instead they will, over time, develop into a fuller picture of comparative information by which ambulance trusts can be benchmarked.