Ambulance Response Programme

Supporting early implementation

Ambulance Response Programme

- Sorted out all of our performance problems
- Everything has gone swimmingly
- Everyone is happy
- Game over
- What's next?

- Only joking!

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But let's reflect on what's been achieved…

- Successful lobbying effort by AACE
- Wholescale change in a difficult political climate
- Completely new operating system that's turned out pretty much as the sector proposed
- Excellent example of productive collaborative working with commissioners, regulators and others
- Moved from responding to circa 50% of incidents in 8 minutes to less than 10% in 7 minutes
- Sending the most appropriate resource rather than something to stop the clock
- Cleaned house on rules that just don't make sense anymore

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It's not perfect…

- Categorisation still needs work
- Took longer than we'd like but is based on strong evidence
- Still too many standards but at least they make sense
- Still very time based but with increased focus on clinical measures
- Still lots of unexplained differences between trusts but we have the tools to increase our focus on unwarranted variation

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Dispatch on Disposition

- Giving EOC staff enough time to make better assessment of the patient's needs.
- Allowing *up to* 30 seconds before starting the clock for Category 1 patients to ensure rapid dispatch of resources to the most seriously ill.
- Allowing *up to* 240 seconds before starting the clock for all other categories.
- Prevents immediate dispatch of multiple resources to incidents where that level of response is not required.
- Preserves fast response resources for those in greatest need.
- Preserves conveying resources for those who need transportation.

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Pre Triage Sieve and Nature of Call

- PRE TRIAGE SIEVE – new script for call handlers at point of answer:
- Before entering NHS Pathways or MPDS ProQA
- Q1 “Ambulance Service is the Patient Breathing?”
- Q2 - If Yes to 1 “Is the patients conscious?”
- Q3 - If No to 2 “Does the patient have noisy breathing?”

  If applicable (i.e. Patient is breathing and conscious or is unconscious without noisy breathing)
- Q4 – “Tell me Exactly what's happened” and select from potential NOC code
- Identifies up to 75% of Cat 1 patients within 30 seconds.
- On average 102 seconds saved compared to awaiting MPDS/NHS Pathways “codes”
- Having confidence that we’re catching a high proportion of Category 1 patients offers assurance around allowing up to 240 seconds to triage other patients.

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AACE "Nature of Call (NoC)" viewer

AACE Task and Finish Group

5 MPDS Trusts view

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AACE Nature of Call (NoC) Task and Finish Group Viewer

Welcome to the AACE Nature of Call (NoC) Task and Finish Group Viewer

This Viewer provides a reference for five of the English MPDS Trusts to support benchmarking of the key elements of the Category 1 patient response process. This Viewer was created in partnership by Lightfoot and AACE, to support the AACE / NHS England NOC in MPDS Task and finish group, and has also proved very useful for reflecting the wider Category 1 pathway.

Statistical Process Control (SPC) is adopted throughout using Lightfoot's improvement science platform signalsfromnoise® - to provide insight, highlight where change has occurred, and to show variation.

Each chart reflects the daily summary values as provided by the Ambulance Trusts covered in this work stream (NOC in MPDS).

Where appropriate a minimal level of data transformation has been applied, in order to maintain consistency and to meet specific reporting requirements of the NoC Task and Finish Group.

As such, this viewer should be used for benchmarking, shared learning and to support decision support rather than statutory reporting.

Should there be any queries regards the underpinning data within your Trust, in the first instance please contact your Business Intelligence department or AACE.

If you have any further questions regarding the Viewer please contact Lightfoot at: enquiries@lightfootsolutions.com or AACE at dan.gore@aace.org.uk

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EMAS | EoEAST | LAS | NWAS | YAS | Overall | National Benchmarking

Time Profile: By Day(wk) | Start Date: Inherit <none> | End Date: Inherit <none>

Welcome Page | Cat 1 Perf | Cat 1 Perf - Mean | Cat 1 Perf - 90th | Cat 1 Volume | % Call Answer | Cat 1 Early Identified | Clock Start Trigger | CPU to Early Predict | CPU to Final MPDS | T0 to 1st Alloc | CPU to 1st Alloc | Early Predict | Chief Complaint

Mean Cat 1 Performance Pre Triage Sieve

Mean Cat 1 Performance NOC

Mean Cat 1 Performance Key Words

Mean Cat 1 Performance No early predict

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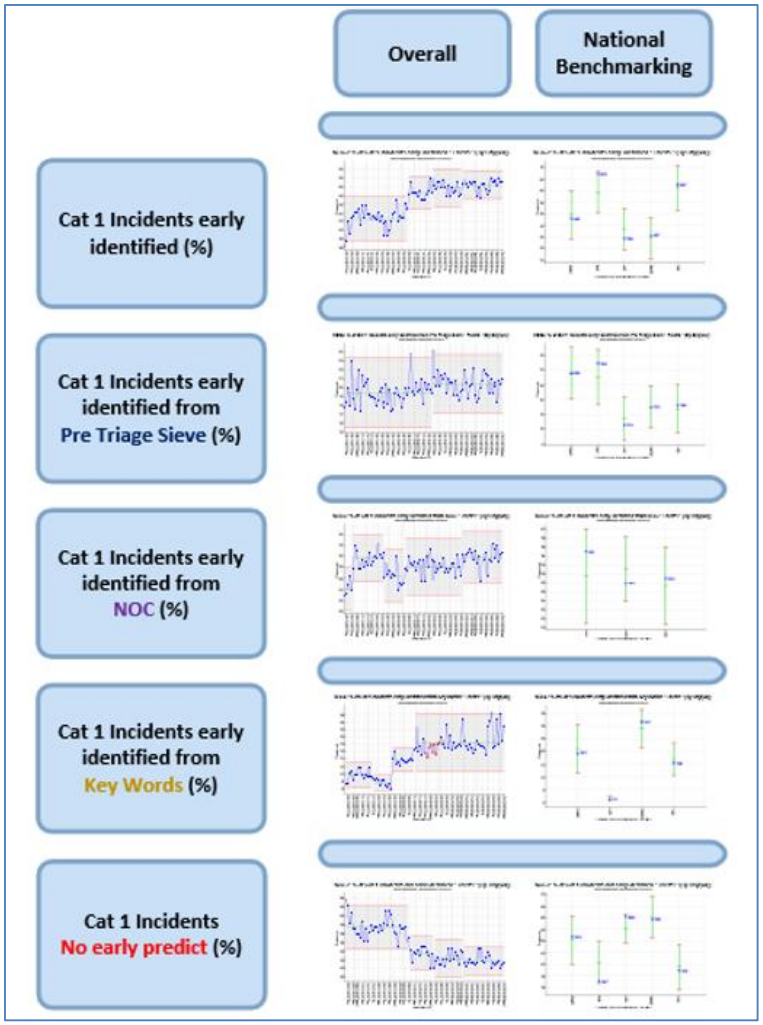

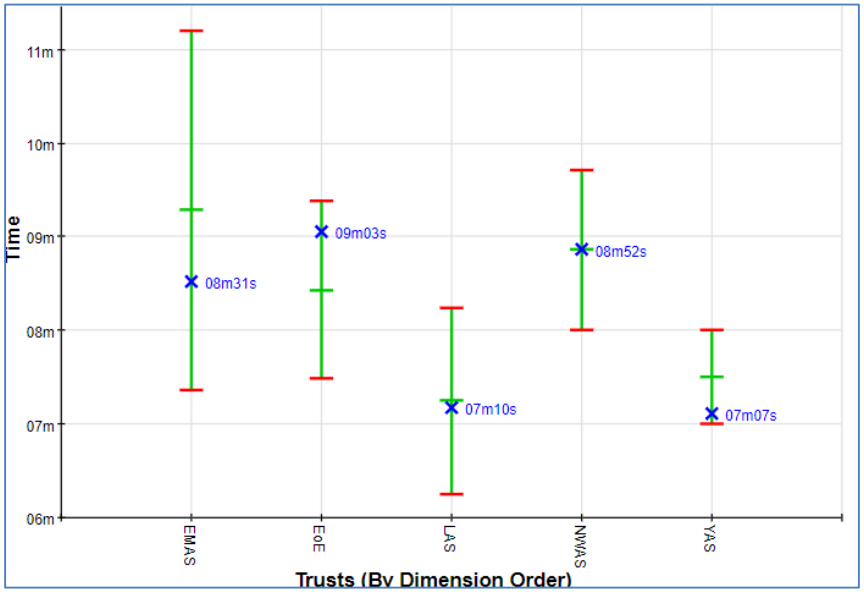

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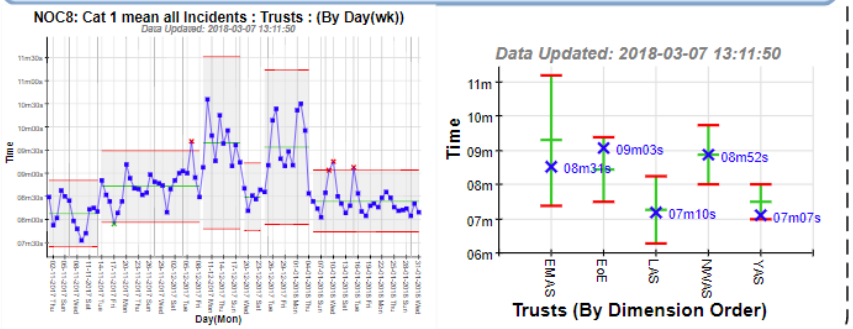
Bringing together skills, expertise and shared knowledge in ambulance services

Category 1 Performance

Please select one of the options below to view by "mean" or by "90th Centile"

Category 1 Performance

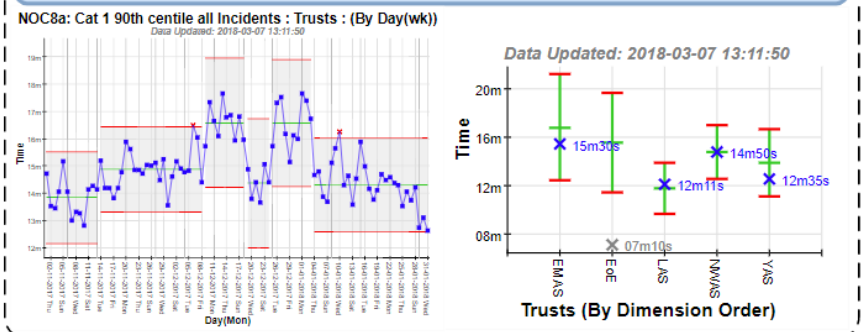
Mean



Category 1 performance – mean by Trust benchmarking

Category 1 Performance

90th Centile



Category 1 performance – 90th Centile by Trust benchmarking

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Insights from the early implementation of ARP

Craig Harman
General Manager
London Ambulance Service NHS Trust
@CraigAHarman

2 Emergency Operations Centres

111 Services

Operating out of over 70 sites

Emergency calls

999

1.8 million

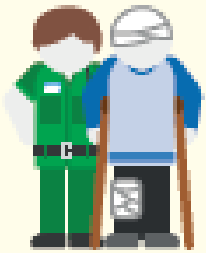
In 2016-17
(5,000 calls a day)

Population

8.7 million

a further 30m visitors each year

Time with patient
(Average)



47 minutes

5,251 staff

63% of which are frontline
Our staff are changing – more graduates, more women, higher expectations, no longer a "job for life"

Seat of Government & Monarchy

5
STPs in London

32
Clinical Commissioning Groups

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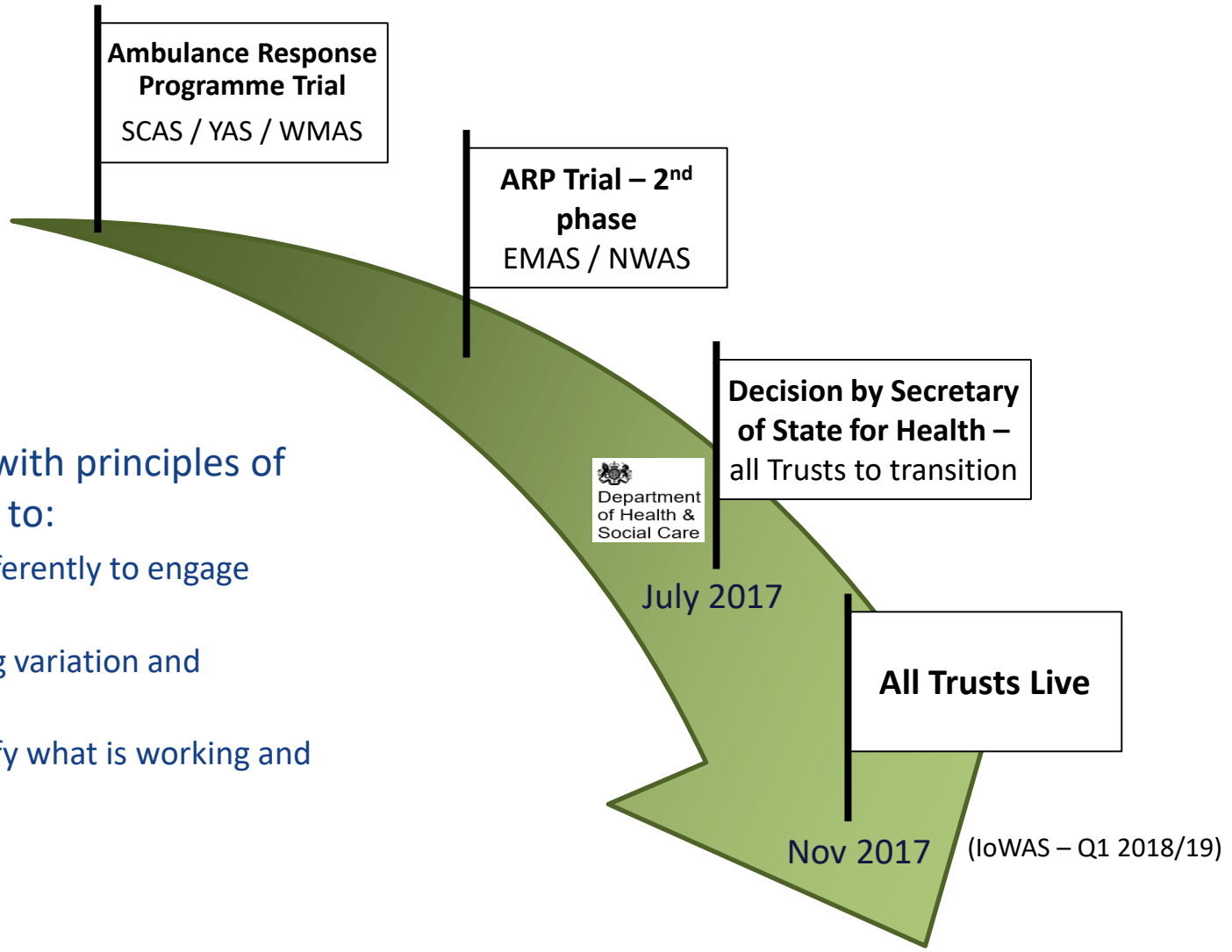
London's journey on the programme



- Vision aligned with principles of ARP and desire to:
  - Using data differently to engage staff
  - Understanding variation and bottlenecks
  - Quickly identify what is working and what is not

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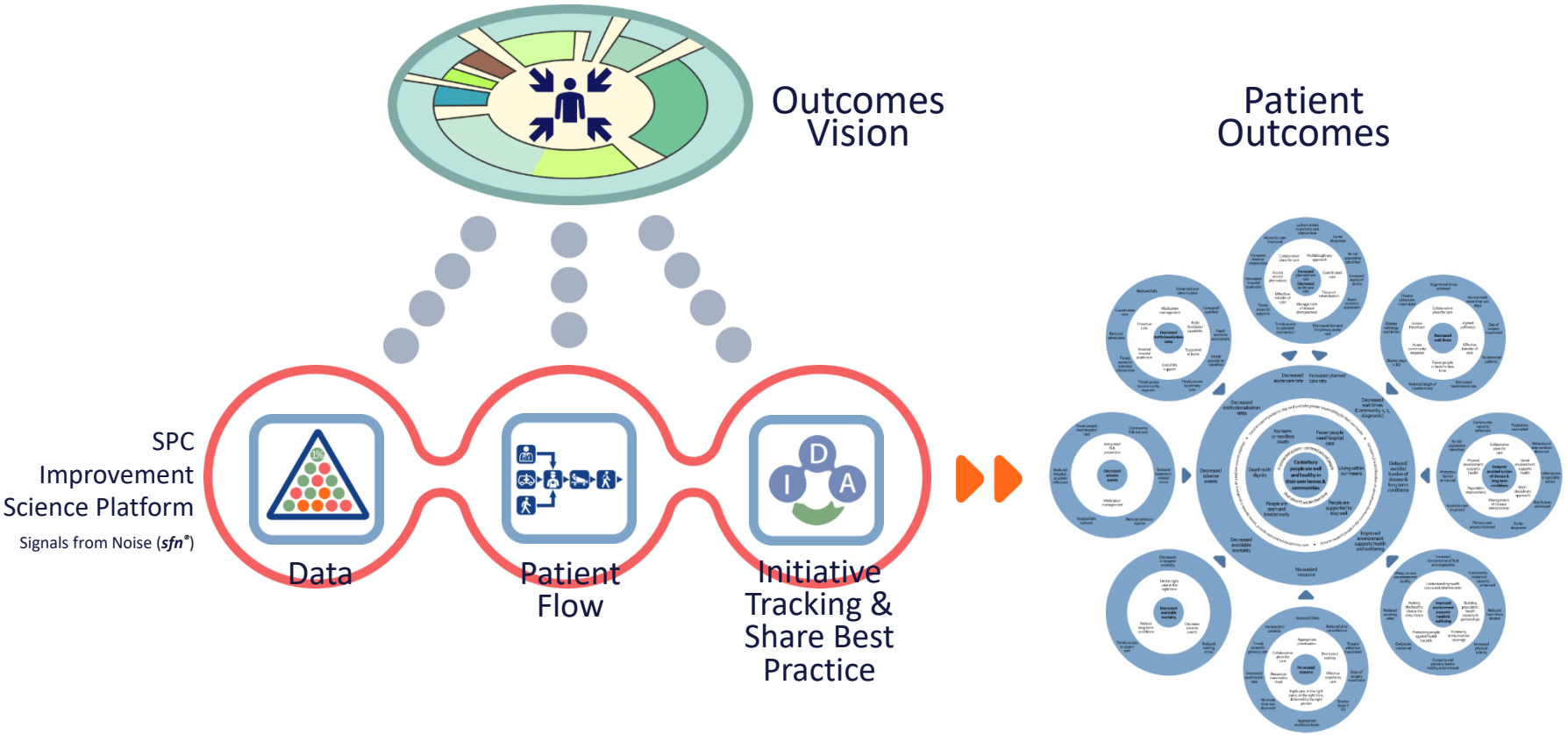
Key themes to delivering the new standards

Meeting the challenge through a patient-centric vision



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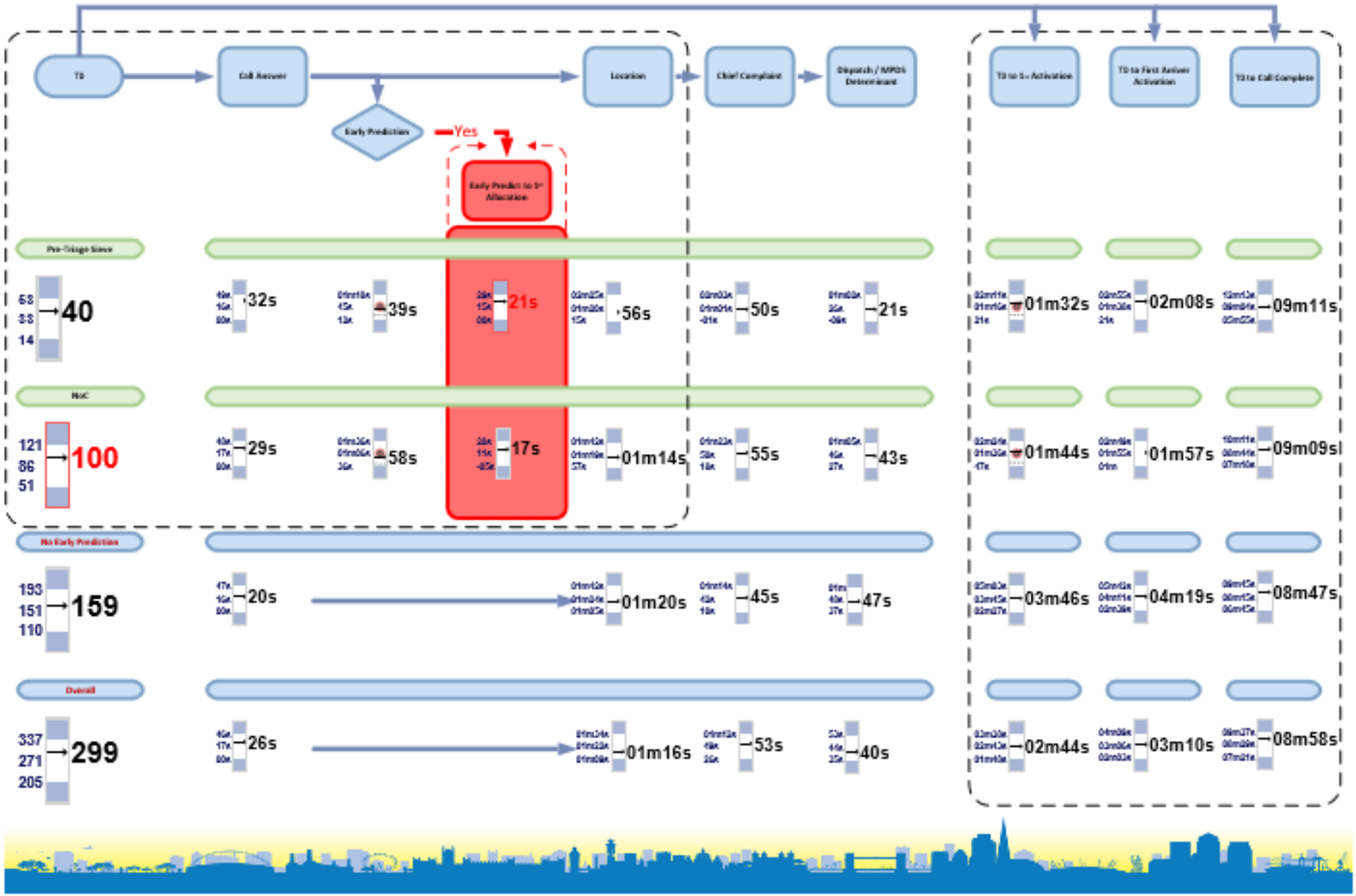
First stage getting the data and processes aligned



Breaking down the process to visualise variation and bottlenecks

Where on the
patient's journey is the problem

Triangulated with Other Data Sets

Granularity

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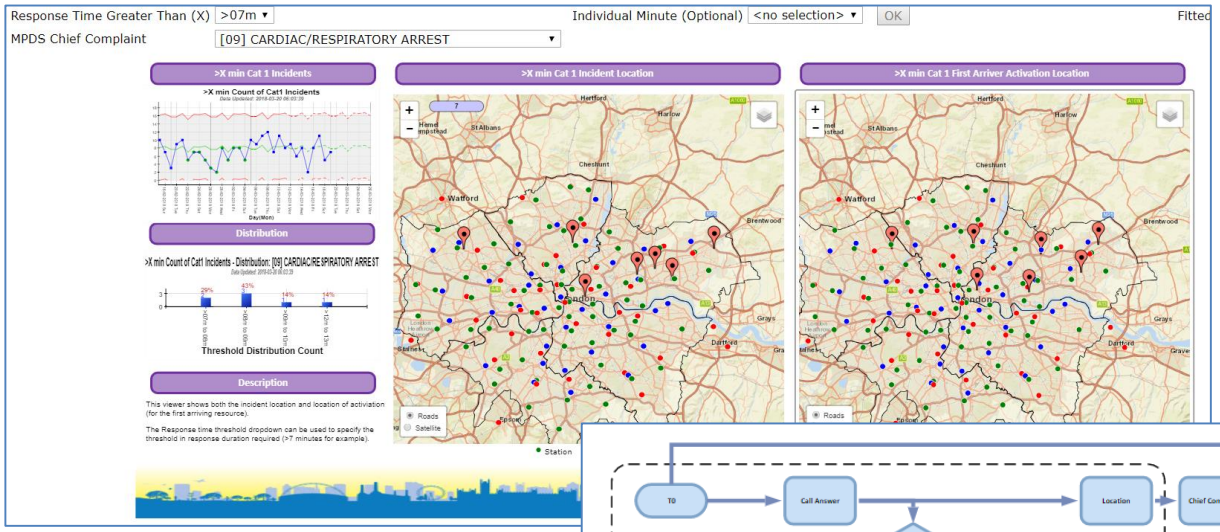
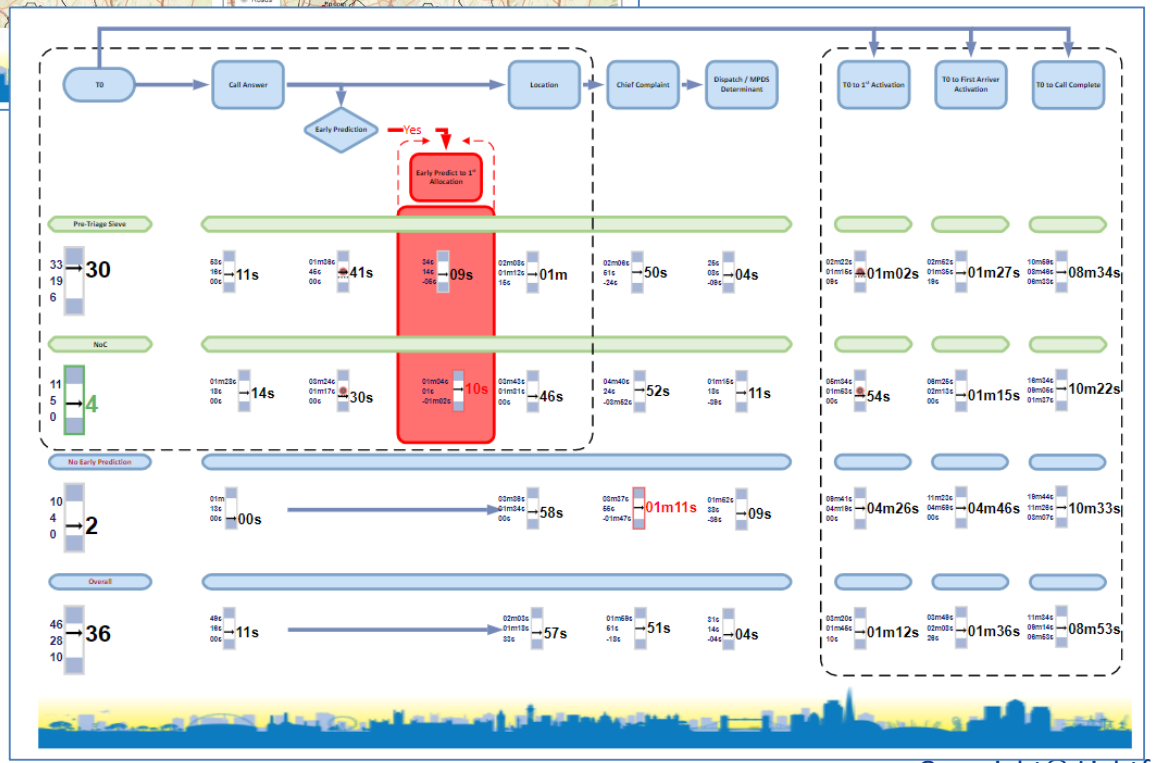
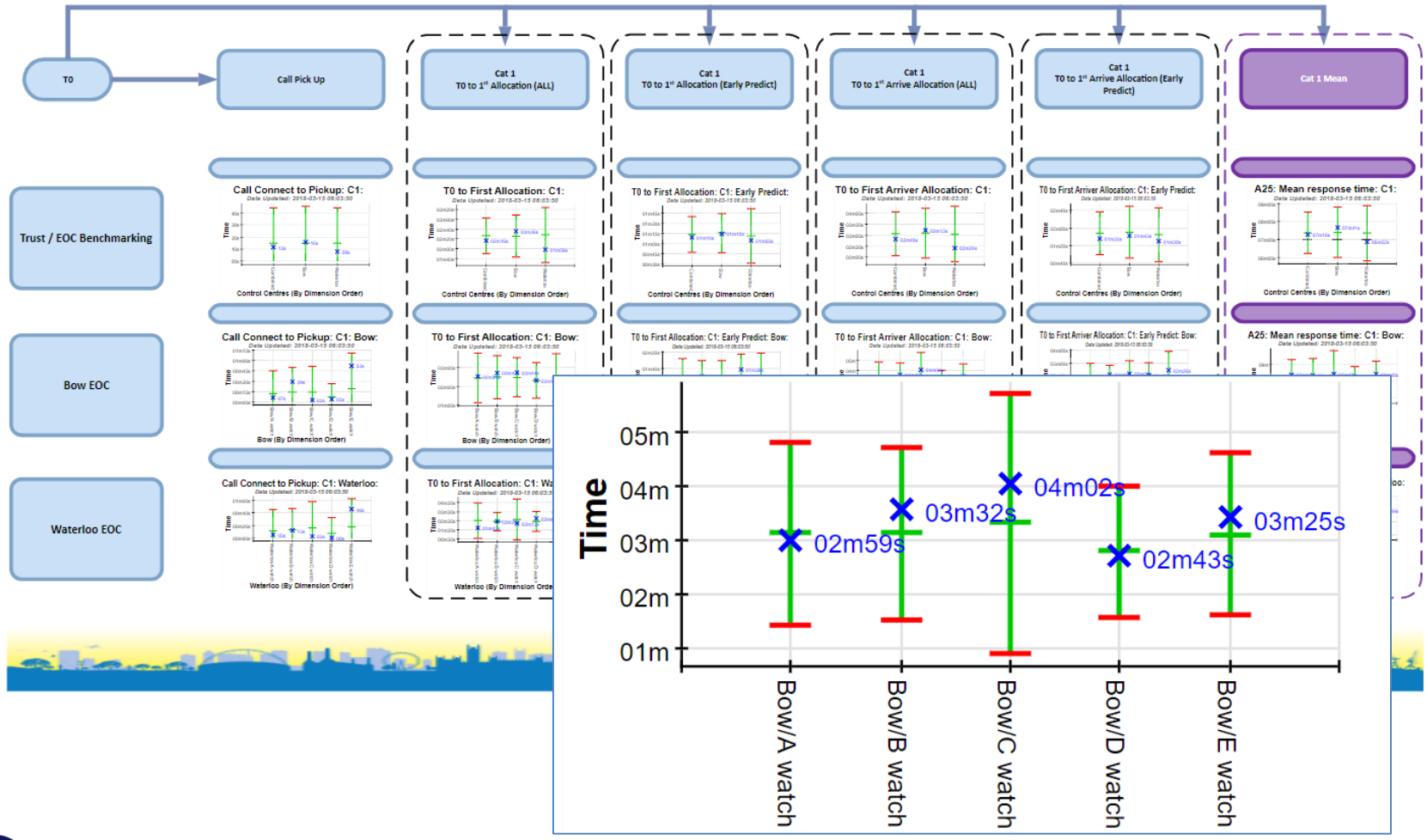
Making it real – Cardiac Arrest





Sharing best practice



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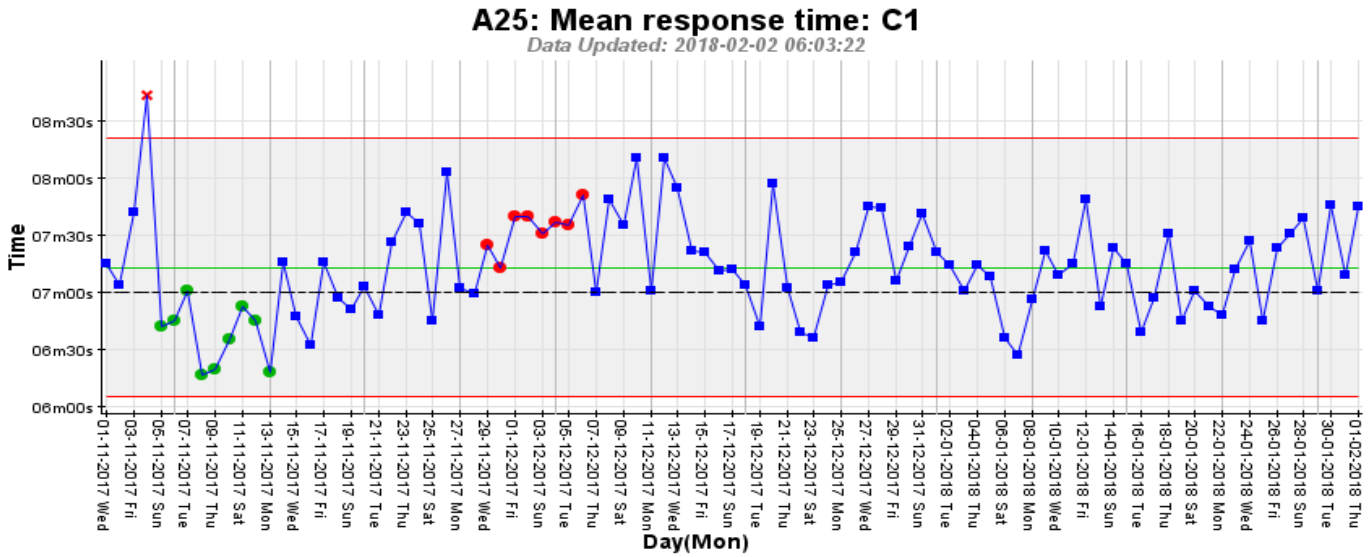
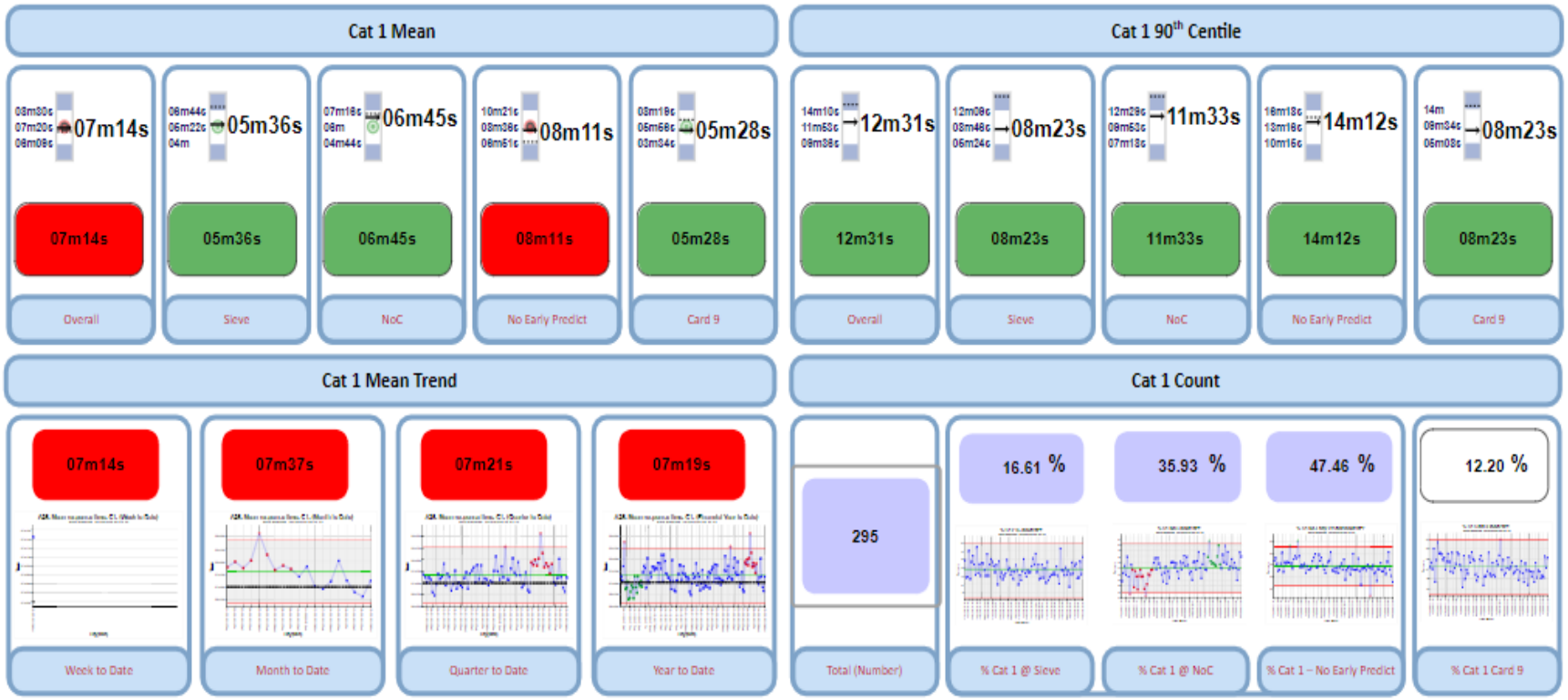
What have we seen….

- 8.5% of incidents are Category 1
- 43% were early identified
  - 12% PTS
  - 31% NoC
- The average response time for Category 1 incidents is 7m13s, 13 seconds above the ARP standard
- Those incidents that received an early identification (either PTS or NoC), had an average response time of 5m43s (1m30s quicker)



Our progress since go live



Opportunities

By modelling changes to these key indicators, we have identified a potential 65 second improvement in the overall Category 1 mean response times

- Call Answer Mean
  - A reduction to a 5 second mean will save 12.4 seconds
- % Early Identification
  - An increase to 65% (from the current 42.9%) will mean an additional 22.1% of Category 1 patients will receive a quicker Category 1 identification.
  - The impact of this additional 22.1% of patients receiving a faster allocation has the potential to improve the overall Category 1 mean by 29.8 seconds
- Call pick up to PTS time
  - Currently the average time to achieve PTS (for those it triggers a Category 1 response) is 44.8s
  - If this can be achieved in 30s, this has the potential to reduce the overall Category 1 mean by 1.8 seconds
- Call pick up to NoC time
  - Currently the average time to achieve NoC (for those it triggers a Category 1 response) is 1m06s
  - If this can be achieved in 45s, this has the potential to reduce the overall Category 1 mean by 6.4 seconds
- Call pick up to Chief Complaint
  - Currently the average time to reach Chief Complaint is 2m05s
  - If this can be achieved in 1m40s, this has the potential to reduce the overall Category 1 mean by 14.2 seconds

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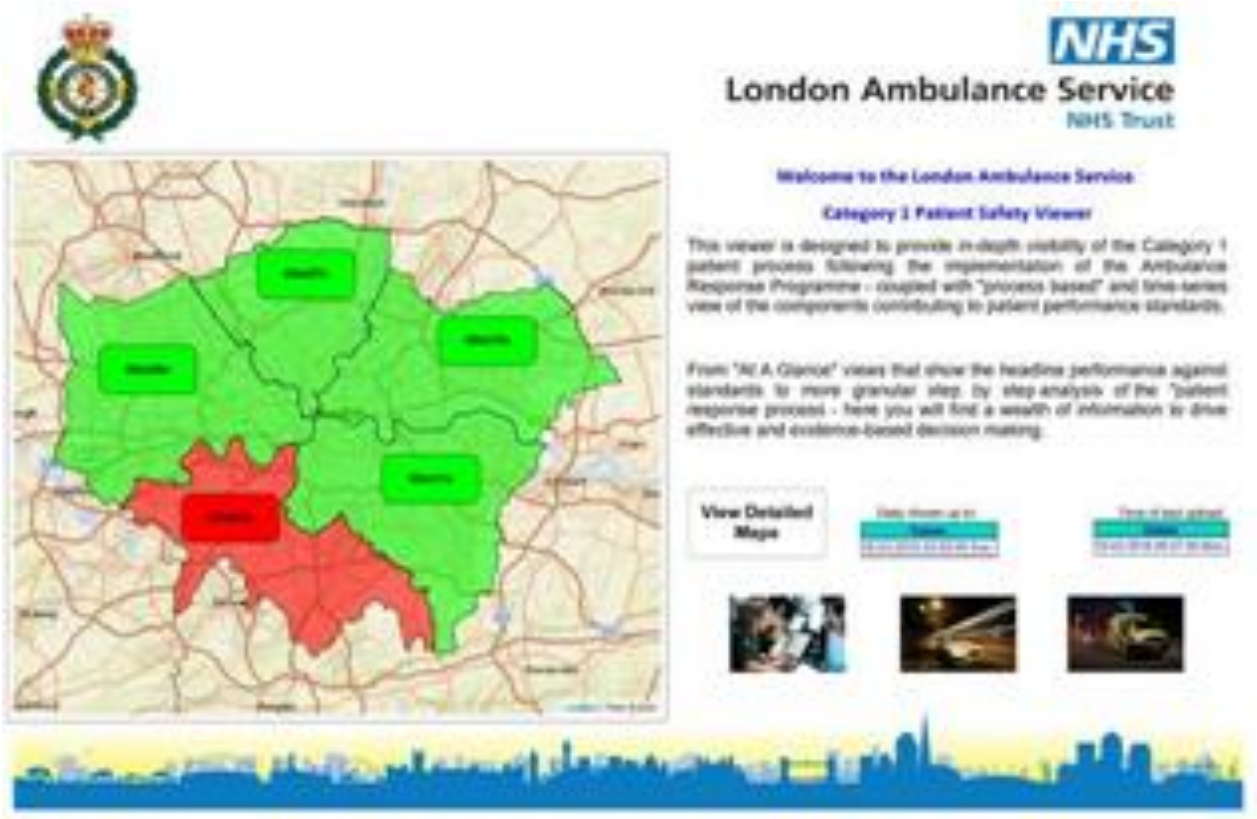
In Conclusion



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