

# 22 May 2003 Ambulance Trust Chief Executives

## 1. Update

It has been several months since we respectively took on new roles as the Head of Ambulance Policy, and the Chair of the Modernisation Agency Ambulance Group. We thought it was a good time to thank you for your support and provide you with an update on developments within the Department and the Modernisation Agency relating to ambulance services.

Our conversations with many of you over the past weeks have made us aware of the valuable work taking place across the country. It is clear to both of us that you are exploring and implementing alternatives to emergency admissions by providing more appropriate care for patients and relieving some of the pressure from A&E departments. This can only be a good thing for patients. Many of these new pathways of care require the involvement of Primary Care Trusts – only with their support will we get the important and necessary collaboration and potential integration with Walk-in Centres, Minor Injury Units, and NHS Direct. Your new ways of working have other benefits too – many of them help support the standards within the CHD NSF and towards OOH developments.

We all have a role to play in supporting and spreading these important and necessary developments in the ambulance service. But as you know, we also need to ensure that we don't take our eye off achieving and sustaining the Category A 8-minute target.

Historically, the months of May and June have always been a busy time for you with the publication of the Department's annual ambulance response statistics and the annual AMBEX Conference. What we hope will be different this year is the support and assistance available through two new joint initiatives between the Department of Health Ambulance Team and the Modernisation Agency.

## 2. Modernisation Agency Ambulance Group

The Modernisation Agency Ambulance Group, Chaired by John Wilderspin will be responsible for mapping good practice across ambulance services using information collated from trusts and from recent CHI clinical governance reviews.

The group draws together expertise from the ambulance services, the Modernisation Agency, the Department and other organisations. It will identify the best mechanisms to share good practice around ambulance services and emergency care together with providing support for local implementation.

The group will ensure that ambulance services are engaged in the wider modernisation agenda and have access to all available Modernisation Agency resources.

**Terms of reference and membership are attached at Annex A.**

## 3. Ambulance Category A Taskforce

The Taskforce (Chaired by John Wilderspin), will oversee all activity that is taking place within the Department (primarily the Emergency Care Strategy Team, Primary Care, Modernisation Agency and Directorates of Health and Social Care) on delivering the 75% Category A target to ensure that it:

- is properly co-ordinated
- is focused on delivery
- prioritises action to deliver maximum improvement quickly;

and most importantly, to ensure that all trusts can achieve and sustain performance above 75%.

Through its co-ordinated approach and links to other departmental initiatives, the Taskforce aims to raise the profile of the 75% Category A target at all levels of the NHS.

**Terms of reference and membership are attached at Annex B. ([click here](#))**

## 4. Patient Transport Services

A further group has been set up following the Social Exclusion Unit's final report on transport and social exclusion "Making the Connections" which was published earlier this year. As you will be aware, the report examined the links between social exclusion, transport and the location of services. It particularly focussed on access to those opportunities that make the most impact on life-chances, such as work, learning, healthcare and food shopping.

The group will be taking forward the report's recommendations in the chapter on access to healthcare which stated that changes will be made to specialist travel to healthcare services so that they are organised around the patient. The group will also look at widening the criteria for eligibility to PTS, fundamentally reforming PTS, and increasing the advice and information given to accessing healthcare.

Developments in this area are still at an early stage and we hope to be in a position to provide further information including terms of reference and membership shortly.

## 5. Central Policy Support

In addition to these three groups, we are pleased to advise that the central ambulance policy team within the Department will be strengthened over the next three months. We hope to announce

further team members who will be working closely with colleagues within the Emergency Care Strategy Team in the near future.

## 6. Emergency Care Networks

A fundamental part of Reforming Emergency Care was the development of emergency care networks. Many of you are already thinking about what would be an appropriate network and some networks are already being developed.

We thought it would be beneficial to bring to your attention a document which appeared in Issue 7 of the Emergency Care Leads Bulletin that states the aim of the network and provides suggestions for membership and terms of reference. As the document states, the network size/scale is for local determination, however, it is vital that ambulance trusts play a key role.

Attached is the hyperlink to the document <http://www.doh.gov.uk/eclbulletin/bulletin7ecn.htm> or it can also be found at Annex C.

## 7. Future developments

Over the next few months, we are planning a series of initiatives aimed at the ambulance service. The first of these initiatives will be a checklist of modernisation actions. This checklist is intended as an aide to all NHS ambulance Trusts and their staff to ensure that all possible steps are being taken to improve and streamline the care of patients presenting to emergency care.

Other initiatives planned for later this year include a sharing good practice workshop and a myth-busting event.

We hope that the steps we have set out above show that the Department is committed to supporting you to further improve ambulance services nationally. Please do not hesitate to contact us if you would like to discuss any of these issues further.

**With best wishes,**

**Daniel Scheffer,**

Head of Ambulance Policy Improvement,  
Emergency Care Strategy Team,  
020 7210 5126

**John Wilderspin,**

Director of Performance, Modernisation  
Agency

cc Emergency Care Bulletin, Chief  
Executives Bulletin, Ambulance Service  
Association

# Annex A: Terms of Reference for Modernisation Agency Ambulance Group

## Background

As identified in Reforming Emergency Care, the delivery of emergency care relies on all professional staff working in different ways to improve the patient experience of emergency care and to improve waiting times..

Of particular relevance to the ambulance service are the following:

- By the end of 2004, no-one to wait more than 4 hours in an Accident and Emergency department from arrival to discharge, admission or transfer to another service;
- By the end of 2002, 75% of Category A ambulance calls to be reached within 8 minutes. Clinical evidence indicates that achievement of the 75 per cent milestone could save 1,800 lives each year in people under 75 years of age suffering heart attacks;
- 70% of patients receive thrombolysis within 60 minutes of calling for professional help by 2006 representing a 10 percentage point increase per annum nationally as set out in the Priorities and Planning Framework for 2003-6
- 95% of Category B Calls to be reached within 14 minutes for urban services and 19 minutes for rural services;
- 95% of Category C Calls to be reached within 14 minutes for urban services and 19 minutes for rural services;
- Ambulance services are required to take patients to hospital where the need is identified by a doctor as urgent and these patients should arrive at hospital within 15 minutes of the arrival time specified by the doctor in 95% of cases.

## Purpose

Specifically the Group will:

- Ensure the work is patient focused
- Ensure the work has a whole system approach
- Be focused on operational issues
- Complete a mapping exercise of good practice/systems/processes/ management across ambulance services.
- Identify the best mechanisms for spreading good practice / systems / processes / management
- Offer support and guidance to ambulance trusts
- Support the spreading and sustaining of good practice/systems/ processes/ management in the Ambulance Service and offer support to Learning Workshops
- Ensure that ambulance services are engaged in the wider Modernisation Agency agenda and have access to all available modernisation resources.

## Function

It is proposed that:

- The meeting is chaired by the Director of Performance Improvement, John Wilderspin
- The group meets monthly for the first 6 months. Frequency of meetings will then be reviewed
- 'Chatham House' rules are observed

A list of the Group members is attached.

## Membership of the Modernisation Agency Ambulance Group

Mr John Wilderspin, Director of Performance Improvement, NHS Modernisation Agency;

Mr Martin Reddy, Associate Director - Emergency Care, NHS Modernisation Agency;

Miss Victoria Swaile, Business Manager – Emergency Care, NHS Modernisation Agency;

Ms Elizabeth Bradbury, Associate Director – Emergency Services Team, NHS Modernisation Agency;

Mr Richard Wells, Business Manager – Emergency Services Team, NHS Modernisation Agency;

Ms Catherine Guelbert, Associate Director, Leadership Centre, NHS Modernisation Agency;

Ms Judy Hargadon, Director, New Ways of Working, NHS Modernisation Agency;

Ms Tracey Cooper, National Clinical Governance Support Team, NHS Modernisation Agency;

Mr Matthew Cooke, A&E Advisor, ECST, DoH;

Mr David Carson, Primary Care Advisor, ECST, DoH;

Mr Gary Fereday, Policy Manager, NHS Confederation;

Mr Jo Setters, Commission for Health Improvement;

Mr Simon Featherstone, Chief Executive, North East Ambulance;

Mr Hayden Newton, Chief Executive, Kent Ambulance;

Ms Anne Walker, Chief Executive, Bedfordshire & Hertfordshire Ambulance;

Mr Roger Thayne, Chief Executive Staffordshire Ambulance;

Mrs Taymar Thompson, Chief Executive, Hereford & Worcester Ambulance;

Mr David Radbourne, Assistant Director – Performance & Modernisation, South West London StHA;

Mr Mark Davies, Branch Head, ECST, DoH;

Mr Daniel Scheffer, Head of Ambulance Policy, ECST, DoH.

## Annex B: Ambulance Response Time Taskforce

### Terms of reference

The Ambulance Response Time Taskforce will oversee all activity that is taking place within the Department (primarily the Emergency Care Strategy Team, Primary Care, Modernisation Agency and Directorates of Health and Social Care) on delivering the 75% Category A target to ensure that it:

- is properly co-ordinated
- is focused on delivery
- prioritises action to deliver maximum improvement quickly;

and most importantly, to ensure that all trusts can achieve and sustain performance above 75%.

The Taskforce will use the weekly ambulance data to monitor the performance of each trust against its own performance trajectory agreed between the trusts themselves, SHAs and PCT commissioners.

The taskforce will be report to David Fillingham, Director of NHS Modernisation Agency and the Director of Access & Choice/Director of Delivery on a monthly basis with details of current performance and action being taken to improve inadequate performance on a sustainable basis.

### Membership

**Chair:** John Wilderspin

**Ambulance Adviser:** Gron Roberts

**Emergency Care Adviser:** Matthew Cooke

**Primary Care Adviser:** David Carson

**NHS Direct:** Paul Jenkins

**Ambulance Service Representative:**  
Paul Sutton (East Anglian)

**StHA Representative:** Jo Franklin  
(West Yorkshire StHA)

**DHSC Representative:**  
Lynne Hodgson (DHSC North)  
Christian Hamilton (DHSC South)  
Mike Hellier (SW London StHA  
Representing DHSC London)

### (DHSC Midlands & East of England)

**Central Management Team:**  
Daniel Scheffer (DoH Policy)  
Mark Davies (DoH Policy)  
Martin Reddy (Mod Agency)  
Victoria Swaile (Mod Agency)  
Tracey Cooper (Mod Agency)

### (Emergency Care Collaborative) Timetable

The taskforce will meet on a fortnightly basis (Monday's) and aims to transfer its role and responsibilities to the Modernisation Agency Ambulance Group by the end of June 2003.

### Objectives of the Group

1. Ensure that the activity of NHS bodies is co-ordinated to improve the performance of ambulance trusts in achieving the Category A target in a sustainable fashion.
2. Raise the profile of the 75% Category A target at all levels of the NHS.
3. To monitor weekly ambulance performance of each trust against its own performance trajectory agreed between the trusts themselves, StHAs and PCT commissioners. The taskforce will report to David Fillingham, Director of NHS Modernisation Agency and the Director of Access & Choice/Director of Delivery at the Department of Health on a monthly basis with details of performance and action being taken to achieve, and sustain performance against the target.
4. Ensure that best practice on the delivery of sustainable performance against the 75% Category A target is spread throughout the NHS.
5. Ensure that the delivery of the 75% Category A target is integrated with the delivery of other key ambulance and NHS objectives.
6. To provide regular communications in the form of team briefs to ambulance trusts, PCTs and StHAs on the work of the Taskforce.

## Annex C: Networks for Emergency Care

### Introduction

Emergency care networks are a vital part of Reforming Emergency Care. This framework aims to clarify their purpose and makes suggestions for membership and terms of reference.

It must be emphasised, however, that the network size/scale is for local determination. These are suggestions only, the important thing is that the network makes sense locally and enables local delivery.

### Aim:

- (a) to optimise the emergency care of all patients in the locality
- (b) ensure that the patient perspective and quality of care are the priorities in planning emergency healthcare in the local health and social care community
- (c) to ensure ease of access to appropriate services at the appropriate time without unnecessary duplication for the patient and in line with national standards.
- (d) to co-ordinate emergency health care across all organisations in a community
- (e) to ensure the engagement of external organisations whose services contribute to the effective delivery of emergency care
- (f) to work with health and social care commissioners to determine priorities in emergency care
- (g) to promote knowledge of developments in emergency care amongst health and social care professionals and users
- (h) developing and maintaining improvement work including that initiated by the Emergency Services Collaborative
- (i) to agree and develop local standards and protocols to facilitate comparative audit and training.

### Membership of EC Network

Suggested membership – For local determination/agreement:

- Acute Trusts
- Ambulance Services
- Community Paediatric Services
- Dental Services
- Other networks/collaborative leads
- Intermediate Care
- Local council
- Mental Health Trusts
- Minor Injury units
- NHS Direct
- OOH Providers
- PCT
- Pharmacy (NHS and retail)
- Social Services
- Independent Sector – nursing and residential care homes

- Strategic Health Authority
- User representation (or a patient/carer forum that feeds into this group)
- Nursing/Residential Home Representation
- Older People's Champions
- Police (e.g. mental health issues, security issues)
- Walk-in Centres
- Workforce confederation

Membership should include clinical and managerial staff and represent a broad spectrum of disciplines.

### Example of Terms of Reference

The Network will specifically look at standards in the NHS Plan and develop whole systems solutions to achieving these standards. In particular the following standards will be considered and monitored at each meeting:-

- ambulance response times
- ambulance turnaround times
- primary care access (including OOHs)
- total time in A&E
- thrombolysis
- delayed transfer of care rate in acute Trusts

In order to achieve these the following measures may also be considered at each meeting:-

- service usage (PC, Ambulance, A&E)
- bed occupancy in acute Trusts
- capacity plans
- breaches of local and national standards within the local community
- untoward incidents

The network is responsible for issues across existing organisational boundaries. (The ECL is responsible for issues within an organisation).

Networks should ensure that if a patient presents at a location that currently does not provide the required services that the user can be transferred to the appropriate carer without unnecessary delay or duplication of work.

### Network Checklist

The network will refer to the A&E target checklist issued in January 2003 and each organisation will report to the network meeting on any areas within this that are not undertaken by the relevant organisations. <http://www.doh.gov.uk/emergencycare/aetargetchecklist.htm>

An algorithm of actions to solve specific problems is available at <http://www.doh.gov.uk/emergencycare/aetargetalgorithm.htm>

1. Direct access from primary care, ambulance services and A&E to the following services are available:-
  - Community nursing
  - Community nursing and therapy services
  - Rapid assessment teams (particularly for older people)
  - Social care support in the home
  - Intermediate care - residential

- Intermediate care – rapid response service
  - Mental health services
  - 24 hour pharmacy
2. Primary care have direct access to:-
    - Urgent senior medical opinion from secondary care
    - Social care assessment & services
    - Urgent diagnostic services with same day reporting
    - Minor injury units and W/Cs

3. A&E should have direct access to:-
  - Urgent appointments in primary care
  - Outpatient appointments within 72 hours
  - Respite nursing home and residential beds
  - Emergency social care access

4. Ambulance services have direct access to:-
  - Primary care centres and OOH centres
  - Urgent appointments in primary care
  - Senior medical opinion
  - Minor injury units and walk-in centres
  - Rapid assessment team for older people
  - Night sitting services

5. Bed management systems cover all beds in primary, secondary and continuing care. Systems should prevent delays in transfer between any of the beds. Capacity is planned to match expected emergency admissions (predicted on a daily basis) with elective and respite activity.

6. Residential and nursing home bed availability is mapped against expected hospital, primary care and community requirements.

7. Systems are available to allow appropriate distribution of emergency care workload taking account of clinical need, system workload and time constraints. Capacity can be managed in a dynamic operational way as well as strategically.

8. Systems are present, wherever possible, to achieve referral via guidelines rather than via traditional gatekeeper roles.

9. Documentation (paper and electronic) assists in avoiding duplication.

10. Data transfer is optimised between organisations. Information is shared to the benefit of the users, including outcome data to allow effective audit.

11. Patients not registered with a GP can initiate their registration from all sources of emergency care.

12. Users and carers are involved in all stages of planning and provision of emergency care.

13. Facilitate development of new working practices including looking at how individuals and groups can work across organisational and professional boundaries. Encourage autonomous practise rather than increase restricted and protocol bound practise.

14. Facilitate development of guidelines and care pathways that work across the whole network.

15. Ensure that any developments by one organisation do not adversely affect patient experience in another organisation or affect another organisation's ability to provide quality care. Ensure that delays are not occurring at interfaces.