APPENDIX 2

A SERVICE STRATEGY & VISION

CONTENTS

1 Introduction

The publication of *"Taking Healthcare to the patient"*[1] places responsibility on Ambulance Services to review and re-engineer services to provide more appropriate care to patients in an appropriate setting in their home or community. There is also a major stress on improving response times as targets become more stringent.

There is a real opportunity for Ambulance Services to improve the clinical outcomes for patients by:

- Utilising the skills and capability of staff to provide a wider range of service provision and reduce the need for patients to go to hospital
- Maximising the use of despatch and communication technology and capability to improve response times and provide more convenient access to services for patients
- Maximise the potential for providing an enhanced range of accessible services by utilising the transport/communication capability of the Trust to provide more mobile facilities/services

The achievement of these aims will need to be done in the context of the needs of patients, the requirements of the various Primary care Trusts as the commissioners of health care services, and National targets and policy guidelines.

A significant part of the change process will be to involve the public, patients, carers and staff in developing the new service models.

The pace of change will also need to be carefully managed to ensure that standards of care are maintained and improved as the service changes are implemented.

A key element of the process will be to enhance the skills and capabilities of staff to perform a wider range of responsibilities. This will require a shift from the current training methodology to one of continuous professional education with an appropriate clinical accountability and responsibility for each member of staff. This will allow the real development of staff to utilise different skill sets from that currently in place, in line with the Knowledge and Skills Framework principles contained within Agenda for Change.

To plan the way forward the Trust is developing three main documents;

1. A Service Strategy and vision (this document) which will be the subject of extensive discussion and development. The Strategy will need to underpin the development of the Trust as an organisation.
2. An Operational Performance Plan which will outline how the Trust can maintain and improve performance as the new Service strategy is implemented.
3. A detailed Change Implementation Plan which will be developed to guide and monitor a wide range of initiatives and programmes required to implement the new Service Strategy

These will be further supported by a range of Strategy and Plan documents including Facilities Management, IMT, Workforce Changes and Communications.

2 The Service Strategy & Vision

The main elements of the strategy are identified in Figure 1.

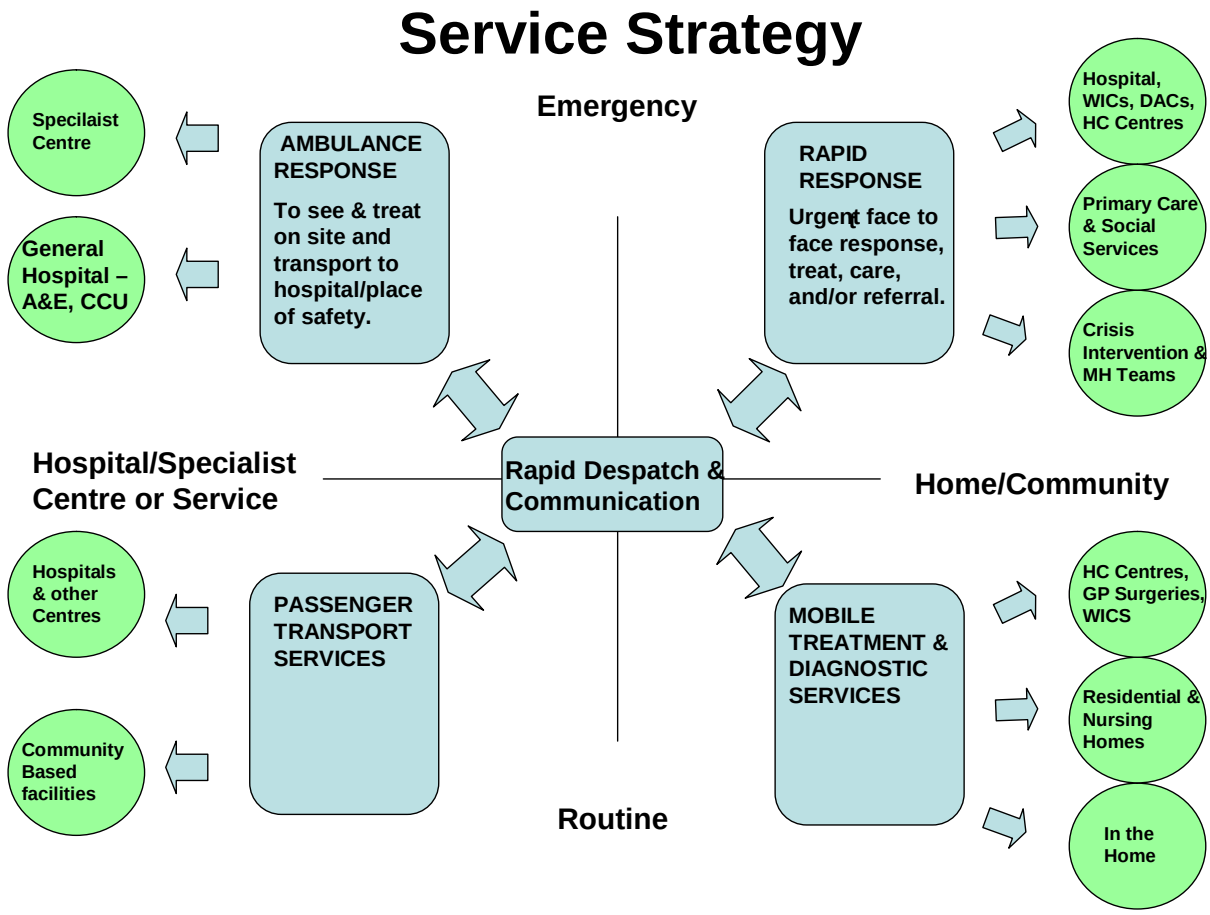

Figure 1. Service Strategy Model

There are five components:

1. The core despatch and communications capability. This aspect covers the Control Centres and the communications with individual vehicles/crew. This capability is central to the development of the new portfolio of service provision.
2. Ambulance response which will be required in particular types of emergency and inter-hospital transfers, and which will be increasingly despatched following assessment of patients by rapid responders.
3. The rapid response service which will take a variety of forms dependent on the needs of patients and the local geography. The rapid response crews will increasingly identify different forms of appropriate responses for patients and will be able to access support and care from a range of sources as well as the traditional journey to hospital.

4. Passenger Transport Services (PTS) which will continue to carry patients to more routine appointments and services.
5. Mobile treatment and diagnostic services will increasingly be developed to utilise the Trusts despatch and transport facilities to provide more convenient services in patients' homes or in local facilities such as the new diagnostic and treatment centres. This element will be developed within both the traditional Emergency and PTS streams.

The aim of the strategy is that the Trust effectively utilises all it' staff and physical resources to ensure that each patient obtains:

- the appropriate level of response, assessment and treatment within the specified time requirements
- appropriate access to routine/urgent/emergency care services
- appropriate services where possible in convenient settings outside hospital

There will need to be a wide ranging discussion on how the strategy can be developed within different areas across the Trust. There are a number of stakeholders who will wish to be involved and the Trust will develop a full communication programme to ensure that views, ideas and concerns can be collated and properly addressed.

The Trust will also need to ensure that performance standards are maintained and enhanced whilst the strategy is developed and change begins to occur.

3 Strategic Performance Plan

The standards expressed within *"Call to Connect"*[2] require the Ambulance Service to improve the delivery of the service from an operational performance perspective. The change in performance monitoring times commencing from the current point (after establishing name, location and key problem) to the point of connection to the switchboard in April 2008, will reduce the existing response time by approximately 50 seconds. The response comparison (Figure 2) from the available Manchester data shows an average 15% drop in Category A_3 response performance below the current threshold.

Looking back over the last ten years within the ambulance service, this level of performance increase has only been achieved with substantial additional income as well as fundamental change in service delivery models, such as the introduction of Rapid Response Vehicles (RRV)[4] and Intermediary Tiers[5].

The expectation for the future is that now the improvements will be made by redirecting existing resources into modernising the service. There will be a requirement to ensure that full engagement with the commissioners takes account of the reconfiguration of Primary Care Trusts and the reconfiguration work being undertaken within both Acute Hospital and Primary Care services.

The two drivers in the strategy outlined above are to deliver a response to each patient as quickly as possible and deliver the most appropriate care to the patient. These two drivers can be difficult to reconcile and are dependent on effective and efficient delivery systems and clinically competent staff educated to appropriate levels of skill and competency.

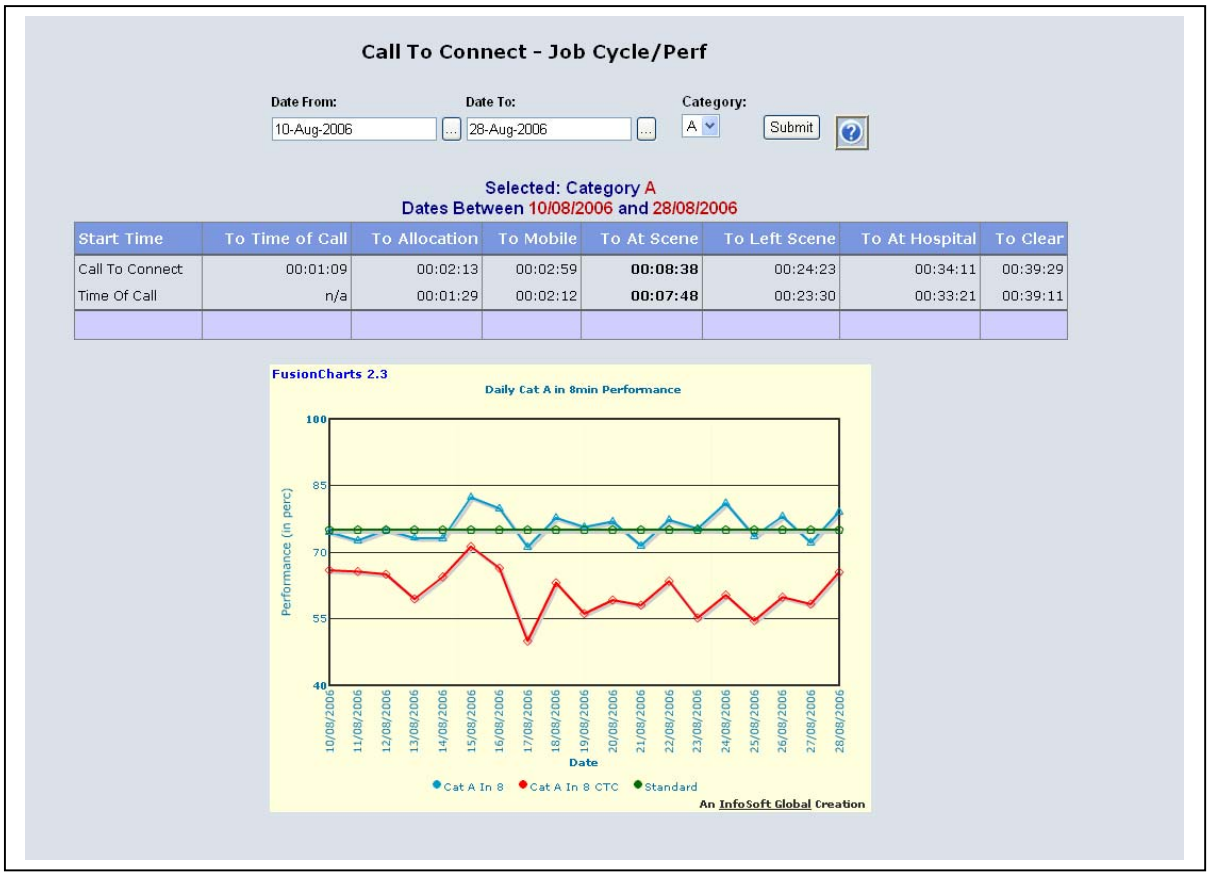

Figure 2 – Manchester performance comparison

4 Enhancement of the Rapid Response Capability

The emerging model identified by the Bradley report and by consultancy firm Operational Research in Health, is that the only viable solution is to develop a more 'front-end' orientated model with a Rapid Response capability enabling staff available to attend and assess patients quickly. The ability to respond quickly on a consistent basis with more emphasis on assessment and access to a range of services will require fewer double crewed ambulance vehicles.

There has been a significant amount of work on defining the future workforce model based on the future work patterns. This suggests a fundamental change in staff methodology and skill sets from the current position. In addition, there is a growing recognition both amongst the organisational managers and within some of the staff groups themselves that the ambulance service will have to change to a clinical professional model. This change can only occur over time and will require adjustments at all levels of the organisation. For example, a change in culture and attitudes from operating within a hierarchical command and control structure, to a more devolved model.

The new Trust has an opportunity and a requirement to establish a new strategic framework for shaping and delivering best practise patient care pathways to become a truly world class service. It is easier to set those goals and targets at the outset of the new organisation with

realistically achievable timeframes, rather than trying to introduce them as potentially disjointed incremental changes later.

In essence, the service will operate in the following way:

1. A 999 call is connected to the NWAS switchboard (which has a router over a 'virtual network'[7] to every call handler in the different communication centres) and allocated to the next available call handler who picks the call up within 5 seconds. If the call is not answered within 10 seconds, 'call line identification'[8] creates an address and the nearest response unit is automatically responded pending a category determinant[9].

2. The call handler uses a rapid clinical protocol[10] (such as NHS Clinical Pathways[11]) to determine whether the call is an emergency (Red) or not, within 30 seconds. If the call determinant is Red, then the nearest Rapid Response Vehicle (RRV) with a level 5 practitioner (bulk of RRV's) would be responded via the local dispatch centre. If an Urgent (Amber) call determinant that requires a face to face assessment then the nearest Rapid Response Vehicle with a level 6 practitioner would be responded. Alternatively, the call could be determined Non-urgent (Green) and passed to the clinical advisor (level 6 practitioner) within the local communications centre to assess and process.

3. Once a clinical assessment of the patient has been undertaken and an outcome determined, any transport requirements would then be undertaken by a crew consisting of a level 3 driver and level 4 attendant.

This model would be the predominant model in urban areas with appropriate variations designed for more rural areas. In rural areas, it may be better to have more ambulances with a level 3 driver and level 5 attendant acting as response and transport, with only level 6 practitioner solo responders for the non Red calls. These would then be supported by a more robust community responder scheme network for the very remote and rural locations.

5 Change Implementation Plan

To deliver the strategy outlined above and to take forward the requirements contained within *"Call to Connect"* and enabling the provision of *"Taking Healthcare to the Patient"* six streams of work have been identified:

- Technology,
- Communication Centres,
- Response Capability,
- Transport elements,
- Clinical competency
- Organisational structure and effectiveness.

All these streams of work will need to be carefully phased and monitored for delivery against agreed targets and plans. Regular reports to the Programme Board and trust Board will be prepared to ensure that the timescales and resource allocations are adhered to.

The changes will also have implications for the Knowledge and Skills Frameworks within the Agenda For Change framework. Some staff and organisational restructuring for managers will be required to provide a professional basis for the clinical services in the long term. It should be recognised that these changes may well be unsettling in the immediate future.

The fundamental concept expressed in figure 3 below, shows how both drivers for the future service delivery can be met. The individual elements within each of the work streams will be addressed slightly differently and at a potentially different pace within each of the local Areas.

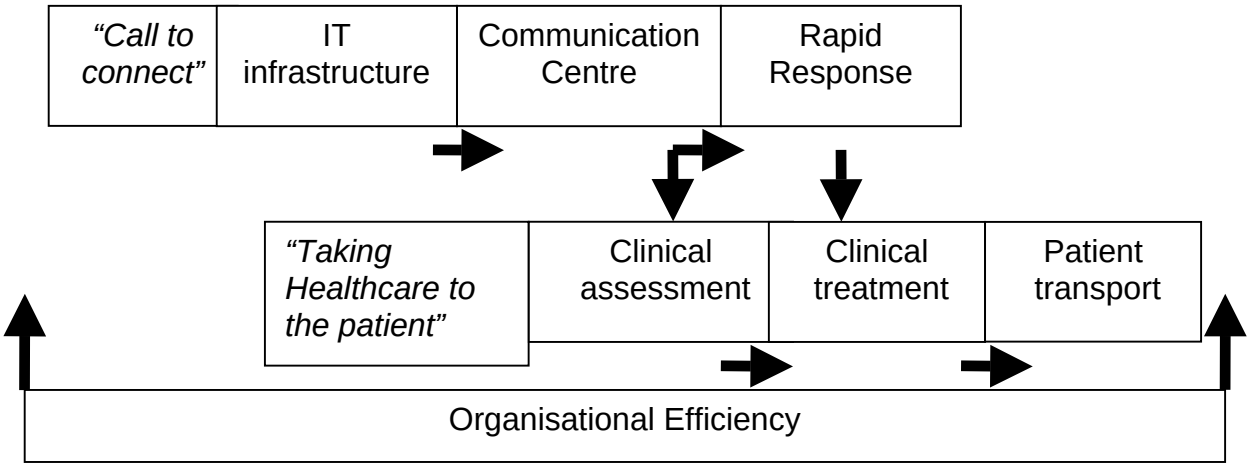

Figure 3 Performance Model

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he principle elements of change in each of the work streams can be summarised as follows:

- **Technology:**

A. The Ambulance Service nationally has procured a new digital radio system that is being implemented in all Ambulance services over the next 2 years. The Trust is responsible for ensuring the infrastructure is in place and the technology will work effectively once implemented.
B. A regional procurement within the National Programme for Information Technology[13] framework will implement a laptop within the vehicles for the clinicians to record assessments and treatments and create and send an Electronic Patient Record[14].
C. There is a need to ensure that the infrastructure within the separate control rooms is common to enable resilience and allow economies of scale from the merger to be realised.
D. In line with the implementation of the National Digital Radio and the Electronic Patient Record as well as delivering against the "call to connect" targets, the Trust needs to ensure that all vehicles have the correct and common AVLS (satellite tracking) and data capabilities.

- **Communication Centres:**

A. The communication centres need to be reconfigured to provide optimum resilience and cost efficiency in line with the introduction of National Radio Project, electronic Patient Record. The rationale for the change is supported by the independent Capita report[15] commissioned by the four previous Trusts. They then need connecting through a virtual network to enable distribution of 999 calls to the next available call handler wherever they may be sited.
B. Advancing from the above, standardisation of software systems and the ability to view all areas deployment screens would allow for resilience and a more 'Trust wide' resource and deployment plan to be effected.
C. The utilisation of appropriate hospitals depending on bed states and the co-ordination of transfers between hospitals need to be consistent across the Trust sites, utilising Health Information desks[16].
D. In order to reduce admissions and deliver most appropriate care to the patients, the greater utilisation of Practitioners within the Communications Centres needs to be enabled.

- **Response elements:**

A. The change to a 'front end' model will require the implementation of significantly greater numbers of RRV's with different profiles for the different practitioners that would be responding to the appropriately graded calls.
B. In order to ensure effective response coverage, a complete active standby deployment plan[17] for all areas will need to be implemented so that resources are held where the need is predicted rather than on ambulance stations.
C. An education programme to take existing Paramedics and future staff to level 5 practitioner against the new KSF[18] framework (likewise current ECP's[19] to level 6) will need to be developed and implemented.
D. Workforce resource profiles need to be more flexible to meet daily, weekly and seasonal variations in the demand patterns. This may require a move away from the 12 hour shift rota's to a more individual annualised hours style of working.

- **Transport elements:**

A. An education programme to take existing Technicians and future staff to level 4 practitioner will need to be developed and implemented, along with a programme to create level 3 dedicated driver assistants in order to implement dedicated transport crews (fewer than current ambulance fleet) for 999 incidents.
B. The current model for separate 'high dependency' or 'intermediary tier' vehicles and crews needs to be expanded and made consistent for General Practitioner and 'out of area'[20] transfers. It also needs incorporating with the other resource profiles to enable a rotation of staff through different working.
C. Use of active standby model. The same principles of utilising these resources most effectively should apply, with crews held where the demand is predicted not left on ambulance stations.

D. Workforce resource profile to be more flexible to meet daily, weekly and seasonal variations in the demand patterns. This may require a move away from the 12 hour shift rota's to a more individual annualised hours style of working.

- **Clinical competence:**

A. There is a requirement to move from traditional ambulance training to continuous education for the new skill set levels outlined above based on clinical assessment and treatment.
B. There is a need for every Individual practitioner to take ownership of their own clinical competence, audit and development.
C. Supporting the development of the new clinical workforce will require the utilisation of level 7 and 8 practitioners for supervision, incident management and further advice. The clinical workforce will then be managed by senior operational managers for each sector area supported by general managers undertaking the logistics and administration duties.

- **Organisational effectiveness**:

A. A review of the current estate, fleet and supply facilities compared against the strategic service delivery for the future will inevitably result in the Rationalisation of logistical resources.
B. The Operational Performance Plan will set the framework for Local variation dependant on Area topography, demographics and health system infrastructure.
C. Sector Managers to be responsible for managing the operational function of a designated geographical area on an 'office hours' basis. They, along with the senior Control Manager, would report to the Head of Service responsible for the delivery of the operational service within the local Area. A separate 'general manager' could be assigned to each sector for the administrative and logistical control of non-clinical operational resources Operational managers within the existing structure could be redeployed into the various roles.
D. The concept of matrix management to be fully incorporated into the operational structure with, for example, each Sector having an Emergency Planning Officer who is responsible for ensuring the local plans through the Sector manager are in place and tested, but would also report to the Assistant Director for Emergency Planning to ensure consistency across the Trust for the function of Emergency and Business Continuity planning.
E. A complete review of the current estate and fleet requirements and infrastructure. The changing workforce skill mix and resource profiling will undoubtedly result in a rationalisation of the estate.

6. Summary

The Service Strategy for the Trust outlined in this paper is required to meet the National policy requirements, local service changes and the need to enhance performance and standards. This document contains a broad outline of how the change process can commence together with a major exercise to discuss issues with patients, carers, local communities and all staff.

The development of the implementation plan for this Strategy and the more detailed proposals required to make the necessary changes in the different work streams will continue and a range of further documents will be prepared to support the process, that will include:

- Operational Performance Plan
- Control Room Strategy
- Support Services Strategy
- Communications Strategy
- Finance Strategy
- Workforce Change Strategy
- ICT Strategy

As with all change management programmes there are always differences in performance whilst any individual change element is introduced. With a change programme on the scale of that outlined in this paper, it is essential that the performance trajectory is reviewed over the long term as variations will be experienced as individual elements are realised. Performance management of the implementation plan will need to be robust in order to ensure that the implementation of the individual elements do not negatively impact on each other, and this will be monitored within the remit of the Trust's Programme board.

GLOSSARY OF TERMS

1	*Taking Healthcare to the patient*	Department of Health document mandating the transformation of Ambulance Services
2	*Call to Connect*	Department of Health document stipulating the change in performance reporting measures
3	Category A	999 calls coded as Life threatening following categorisation (also known as Red call)
4	Rapid Response Vehicles	Vehicles operated by a single member of staff for response and assessment
5	Intermediary Tier/High Dependency	Ambulances with non-paramedic staff utilised for GP urgent calls and transfers
6	Agenda for Change	NHS pay and modernisation framework
7	virtual network	Technological connection between different control centres
8	call line identification	Software that identifies the location of a caller from a landline to the operator
9	category determinant	The coding of the potential severity of a caller's problem (e.g. category A, B or C)
10	clinical protocol	Software system designed to question a caller to determine the potential severity of their problem
11	NHS Clinical Pathways	New NHS developed clinical protocol software system
12	make ready bays	Bays on large ambulance stations that clean and restock ambulances with support staff
13	National Programme for Information Technology	NHS programme for implementation of the national patient care record
14	Electronic Patient Record	Electronic record for each patient that should be linked through all stages of care
15	Capita report	Independent report into the potential configuration model for control centres for NWAS
16	Health Information desks	Desks within the control centre that co-ordinate and monitor the bed state of hospitals in order to best utilise ambulances and A&E units
17	active standby deployment plan	Vehicles deployed to standby points in the community or roadside where activity predictions are high based on historical data
18	KSF	Knowledge and Skills Framework for career and pay progression within the NHS
19	ECP	Emergency Care Practitioner (current skill grade above Paramedic)
20	out of area	Transfers between hospital units across Trust boundaries