DEPLOYMENT MODEL REVIEW

NEWBURY RACE COURSE

21ST JULY 2010

NOTES

This is the feedback from the Deployment Model Review on 21st July @ Newbury Racecourse. The notes below are from 2 discussion sessions. Each table was asked the same questions:

1) **What should the ambulance service look like in the future?**
2) **Partnerships "How can we work together to deliver services that drive cost efficiencies and deliver highest quality outcomes for patients?" (White Paper 12th July 2010)**

Notes taken by Ian Ferguson – Table 1

- Network with rest of Health Service
- Expand into some areas
- Community Support and Public Education to reduce demand
- Need to be clear on role of SCAS
- GP OOH, urgent community response, specialist support.
- Life threatening fast and effective
- Co-ordinate other activity
  - in house
  - or out house
  - Possibly SPOC – we could run that
- Targets need to be patient focussed and outcome based not time target.
- More sophisticated triage system
- SP commissioning offers OOH opportunities
- Single point of contact/ access
- Service redesign / pathway inclusion
- Time targets patient focused
- Triage re visit to be more efficient
- GP commissioning – OOH opportunities for SCAC

Notes taken by Isabel Wroe – Table 2

What should ambulance service look like in future?

- Partners need to be ready for different model, so all work together
- People go to A&E in ambulance who could take themselves, SCAS need to be empowered to refuse to convey
- Need to work with GPs to prevent inappropriate urgent admissions
- Need to analyse volume of calls by time of day, as suspicion that evening call volume has gone up since April (as GPs incentivised to avoid emergency admissions, but patients call in evening when still feel ill, or worse told by GP to do so to avoid them being charged for admission)
- People need alternative to 999 – lots of discussion about single point of access and improved 24/7 GP services
- Critical that we modify expectations of NHS and emergency services, otherwise our actions will just move demand/expectations around the system

- GPs not doing so many OOH shifts any more (something to do with the tax rate above £150,000 income)
- Need to work as whole system
- Need to look at proactively at care plans for elderly
- Need to support individual clinicians in making decision not to treat (e.g. at end of life, or when clinical treatment not beneficial, support individuals opting to leave a patient at home)
- We need data/information at GP and commissioner level to inform decisions.
- We need outcome of SCAS conveyance to A&E – A&E Consultant from Royal Berks offered to start sending electronic discharge/referral letters automatically to SCAS (already doing this for GPs, so not complicated) … *my comment: we need system for handling / distributing these letters to relevant clinicians / analyzing data*
- Greater use of Adastra would help to share care plans and records for patients already in system
- Need to direct patients at point of entry: single point of access and GP front door to A&E
- SCAS needs to be consulted early on service change (e.g. trauma networks)
- Critical that we all work together and with social care
- Community services need to be in place 24/7, in order to make effective difference to acute/emergency services
- Portsmouth have 24/7 district nursing service in place and their 999 volumes have reduced (unlike Hampshire which doesn't have 24/7 district nursing)
- Need to work together to develop and implement care plans for high intensity users
- Need to look at managing entry points, and realize risks of making it easier to access care (i.e. increased demand)
- Non elective transfer for G.P.
- Health economy integration
- Modification of public's expectation
- Issues appertaining to access to Patient care records

And lastly, someone from Berks PCT said that she found conversation very useful - thanks

Second Question

- Get input from each of the stakeholders
- Safeguarding boards
- Local economy
- Showing of patient information and calls to G.P's/Social Services
- Insufficient technology
- Specific care pathways

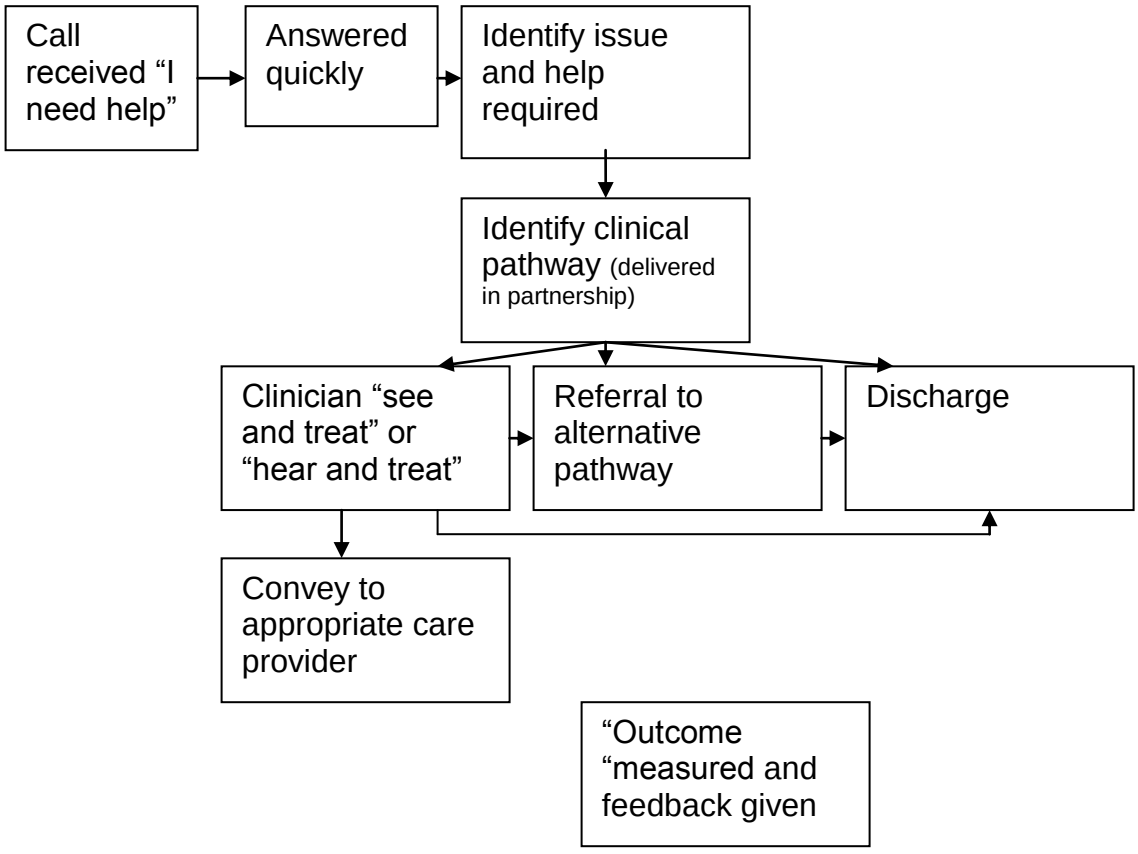
Notes taken by Phil Pimlott – Table 3

Full notes not yet available.

- 360 degree approach to partner working
- Review of current service delivery and adaptation
- Review challenges

Notes taken by John Nicholls – Table 4

- Very rigid front end to current model
- Should be focused on getting the patient to the appropriate place as quickly as appropriate – dependent chief complaint, e.g. STEMI time targets may be different from diabetic emergency time targets
- Need better triage at call handling stage
- Targets should be focused on outcomes – need to define what a 'good outcome' is and find a measure which is meaningful
- The four steps in the clinical strategy should not be seen as sequential as they may be parallel (a range of options to choose from)
- Need to give feedback to crews so they know how they are doing and the impact they have had and to improve decision-making on treatment pathways initiated
- Need access to effective pathways and services which reflect the 24/7 nature of emergency services
- The service of the future should offer a simple pathway which delivers rapid response at call handling and clinical intervention stages appropriate to nature of call.



- Cross organisational case conferencing – who is responsible for repeat callers/frequent users – providers or commissioners?
- Need to ensure that locally agreed pathways are delivered and complied with
- Local authority and NHS pressure to improve premises e.g. care homes
- Improved discharged planning (prior to admission) – e.g. patient held records working more effectively and more accessible to ambulance clinicians. Need to ensure handover includes social element (could they return home) but who is responsible for actioning this?
- Simpler forms which quicker and easier to use to encourage usage. Thresholds for other services need to be easy to understand.
- Better sharing of information between providers – and how can staff share information directly with other clinicians or social care providers?
- Need to ensure that changes in one area do not adversely affect another
- Small improvements can make a big difference
- Can SCAS support the delivery of community based care which currently provided in the acute setting e.g. IV therapy at home?
- Need to see problems as shared across providers or health/social care economy rather than belonging to one organisation – would enable joint or shared solutions
- How can we mitigate the loss of skill, expertise and established relationships which are likely to occur over next three years
- Rigid front end
- 4 steps –sequential not follow on
- Times and outcomes, PPCI – outcomes
- Targets times and outcomes
- Equity of deployment model choosing clinical outcomes
- Patient outcome feedback was clinical decision suitable.

Notes taken by Paul Clarke – Table 5

- Educate the public
- Bewildering array of choices (better local information to crews)
- SPA – with pathways – natural development for ambulance service?
- What is the patient view – what do they want?
- Education of public. Don't know of other pathways – can't call GP so call us. Bewildering array of choices – growth of SPA with pathways.
- Want appropriate calls – not any calls.
- Local issue – knowledge of locality.
- Patient records on line to us – more data/more quickly.
- Sigh of relief on arrival.
- Telephone too remote.
- Sharing of data and information between Social Services and the ambulance service.
- Need a two way flow.
- Incomplete information systems.
- Demonstrate to SC that we can add value and reduce costs.

- Not communicating up and down the supply chain.
- Portsmouth experience.
- Social Services to work closely with us.
- Local Authorities – various scrutiny committees defend their budgets – very arrogant.
- Ambulance service to represent councils – council to lead on public health.
- Feedback to ambulance service from Social Services e.g. children
- Fizz with directors of safety/vulnerable.
- SC don't perhaps see the value in sharing information with ambulance service.
- SC culture of insularity.
- SC and NHS number not used.
- Why are we generating so many calls?
- Education of public, delivery of the public health agenda through advice

Notes taken by Benita Playfoot - Table 6

- Hampshire Community Provider – Patient Care Plans required
- Southampton – example of EMI patient
- Better senior clinicians at point of contact
- OOH issues (out of hours)
- 20%/80% split re urgent care model
- Face to face assessment of patient
- Aging population requirements – long term conditions
- COPD Hospital at home model

Themes

1. Clinical assessment – pathways
2. Coverage of service
3. Integration with other services
4. Decision making process
5. Integration of care. Triage (using acute trust triage facilities)
6. Variability of PCT processes
7. OOH and GP's

Comments from the group

- Contract and communication
- Patient care pathway – Personalised care plans
- Clinical Dashboards
- Understanding what the actual problem is – fundamentals sit to primary care/GP's as an adjunct
- 'Why what happens, happens?' Clarity, consistency, and coherence

Notes taken by John Divall – Table 7

Feedback question 1

- Address the low fruit first
- Extend GP Triage
- Are there local plans signed up by partners?
- Working closer with lead government to develop pathways of care
- HOSC's are scrutiny and we need to improve our engagement with Social Services

Feedback question 2

- Clinically Outcome focused?
- We need to be able to share informed move widely across the health system, which means we need to be better embedded, and engaged. We need to be able to gather outcome data and to share ambulance information regarding commissioning.
- IT Systems Capability
- Ambulance needs to be more pro-active working with other agencies.
- Single point of access
- Need to contribute to improving health rather than treating illness
- Clinical outcomes focus, fast admission
- Single point of access
- IT issues

Notes taken by John Black – Table 8

You will note discussion was broad ranging.

- 'Balanced' Status Plan for urban and rural areas
- Clinically appropriate despatch
- Need for better cross boarder ambulance despatch
- Strong support for SPA
- Anxiety re implications of relaxed ambulance and ED (emergency departments) performance standards
- Acceptance that ambulance delays at EDs is a useful whole systems performance indicator (as is 'ED' 4hr emergency access standard)
- Concern re implications of reduction of ED emergency access (95%) and potential suspension
- Clinically appropriate despatch of DMAs
- Automatic back up of all CFRs – who should routinely update EOC on clinical status of their patient via CSD – not currently undertaken
- Concern that CSD cannot upgrade calls
- Should SCAS provide an increasing range of services
- Should SCAS commission primary care OOH
- PCTs/SHAs do not have clear/shared vision of service delivery model for urgent care

- Challenges for ambulance services negotiating with multiple commissioners
- Locality engagement important
- Importance of access to outcome data – challenges for ambulance services to obtain this directly from acutes
- Direct access to adequate alternative urgent care pathways essential to avoid unnecessary ED attendances
- Importance integrated LA commissioned social care with health
- Assurance re; status plans Balanced. Urban/Rural
- Dispatch criteria
- CSD- important re call grading
- Response times target to be relaxed

The following are anonymous comments given during the day:

POST-IT NOTE COMMENTS

"We need to commission research to understand the explosion of demand for ALL kinds of emergency care, rather than speculate on the causes"

"Clinicians taking more ownership for care and following the patient through their pathway (feedback on clinical outcomes) to help them"

"Social care links need to be improved – commissioners can assist/ support in this"

"The one thing which was never really discussed was the deployment model"

"Care needs to be evidence based and of quality however don't set objectives too high – realistic key priorities"

"Information is key in ensuring outcomes are achieved – don't look to change current systems but use them more wisely – add value"

"Can't move away from time while national target or SCAS will not exist"

"Merit data by commissioner/GP. Liaison with L.A.S. 2012. Divert policies"

"Work on opening dialogue with other bodies in Local Government, Third sector to share information and get feedback and models of good practice"