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MANCHESTER EVENING NEWS

Lost hours

There were 12,699 of lost hours in August – equivalent to the whole of Lancashire and Cumbria having no ambulances for nearly six days

Ambulances stuck outside hospitals waiting to hand over patients reflect wider pressures in the urgent and emergency care sector, according to one ambulance trust finance director. Steve Brown reports

Hospital handover delays are the single biggest problem facing ambulance services. They have a direct impact on patients, delaying assessment or treatment. But they also have a knock-on effect on ambulance services' ability to respond to further emergency calls.

Carolyn Wood, finance director at the North West Ambulance Service (NWAS), one of 10 ambulance trusts in England, says: 'Delayed hospital handovers started increasing at the back end of summer last year and they have been on a steady upward trajectory since then.'

The big worry is how this could worsen over winter. Trusts measure handover performance against a target of 15 minutes, with a further 15 minutes for crews to be back on the road. In the North West, the average overall turnaround time was 43 minutes and 33 seconds in August, mostly tied up in patient handover. The total time taken above the 30-minute handover target was 12,699 hours in August, equivalent to the whole of Lancashire and Cumbria having no ambulances for nearly six days.

As well as the number of patients waiting outside A&E trending upwards for the past year, there have been more extreme waits across the UK, with reports of crews spending whole shifts waiting to hand over a patient.

Ms Wood says NWAS has certainly seen an increase in longer waits. More than 7,000 attendances had a turnaround time of over one hour, with 679 taking more than three hours.

'It's really frustrating for the patients. It's frustrating for the crews. It's frustrating for the A&Es,' she says. 'People didn't train to go and stand in a corridor waiting to hand over a patient; they trained to be out on the road. And that's why staff are getting really frustrated.'

The causes are well understood. Demand for A&E services remains high. Flow in hospitals is impaired by patients blocking beds, while they wait for social care support to be organised in the community to allow them to be discharged. That means A&Es can't get patients admitted, leaving emergency departments overcrowded and staff unable to take on new admissions.

There are also staffing pressures across the whole NHS, with Covid-19-related absences compounding the problems with record levels of vacancies. 'What we're seeing are the symptoms of a very overstretched urgent and emergency care system right across the whole system,' Ms Wood says.

Problems start in primary care with demand up and GP numbers down, piling pressure on 111 services, and then on 999 services. Meanwhile, social care faces its own capacity

challenges. Ambulance handovers are just where the pressure is bulging out. There is no obvious single solution; it will take action on multiple fronts. The reintroduced £500m adult social care discharge fund will help get medically fit patients out of hospital and back into the community faster. Plans to extend bed capacity – for example, through increased use of virtual wards – will also help.

Ambulance services are also playing their part. 'As a service, we are trying to reduce the number of people we are taking to A&E,' says Ms Wood. 'Over the past few years, that has gradually decreased. We are now transferring on average about 1,300 fewer patients per week across our different hospitals and sites compared with 2019.' This is done by increasing the amount of hear-and-treat and see-and-treat responses, alongside the more traditional see-and-convey activity.

Alternative options

Accessing an alternative crisis service in the community can really help take the pressure off A&E. But it relies on those services being available and, crucially, ambulance services knowing about them and able to access them.

Ms Wood says it is about doing what is best for the patient and working as systems. 'A see-and-treat response can take longer than a traditional conveyance directly to A&E,' she says. So it still ties up staff and vehicle resources. But it may provide the best option from both a patient and system perspective.

The handover delays have an impact on broader ambulance response times. Ambulance trusts are measured against four main response targets for different types of call. For a category 1 call – defined as life-threatening – an ambulance is supposed to arrive on scene in an average of seven minutes. And 90% of those calls should be responded to within 15 minutes. The comparable standards for category 2 calls (emergency) are an average response of 18 minutes and 90% of responses within 40 minutes.

"We are now transferring about 1,300 fewer patients per week across our different sites compared with 2019"
Carolyn Wood, NWAS

But ambulance services across the country are struggling to hit these targets. None of the targets were met for England as a whole in September. The mean response time for a category 1 call was two minutes and 19 seconds above the seven-minute target. And the target for 90% of calls to be responded to within 15 minutes was also missed, with a 90th centile time of 16 minutes 38 seconds.

Compared with the national average, the North West did relatively well, but still missed all the targets apart from the 90% target for category 1 calls. Its mean response time for a category 1 call was eight minutes 43 seconds.

Analysis from the Health Foundation makes a direct link between handover delays and response times. Even small increases in handover time can have a major impact on the number of calls a trust can respond to per hour. It said tackling ambulance performance would need an increase in hospital capacity and out-of-hospital care, as well as more ambulance staff. All of this will require further investment in the NHS and social care and a comprehensive, funded workforce plan.

There is also a financial consequence to the delayed handovers but, unlike the acute sector, service pressure can't always be easily spotted in the financial position. The trust does incur higher costs through increased overtime payments. And it can access third-party crewed ambulance supply (from organisations such as St John Ambulance) to increase the number of ambulances on the streets, although their responses are limited to lower acuity calls.

'However there's only so much [staff and third-party supply] can do in terms of filling that gap,' says Ms Wood. 'So we get to the point where we are saturated in what we can physically do. We don't necessarily see the impact in the finances, but we do see it in a performance deterioration. We see it in complaints increasing. We see it in hospital handovers.'

Ambulance trusts face their own unique financial pressures. This year's pay deal in England provides a flat £1,400 for all agenda for change (AFC) staff, which translates into increases of 9.3% for the lowest paid down to just 1.5% for those on the highest bands.

Acute trusts face an estimated 5% increase in their pay bill, a combination of the AFC increases and the 4.5% doctors' pay rise. But ambulance trusts tend to have far more staff on lower AFC bands and so face a higher percentage increase in pay costs overall.

Capital is another challenge. The Carter review of productivity in ambulance services in 2018 highlighted that five years was the optimum length of time to keep an ambulance on the road, with annual maintenance costs rising significantly after this point. But for

NWAS in numbers

Workforce: 6,700 staff, roughly split into 4,500 for the 999 service, 800 for PTS and 600 for 111, with 800 in corporate and other functions

Areas covered: 5,400 square miles across three main areas – Cheshire and Merseyside; Cumbria and Lancashire; and Greater Manchester. This covers big inner cities such as Liverpool and Manchester; smaller cities such as Preston and Lancaster; and real rural areas such as the Lake District that have major vehicle access challenges

Number of sites: 100+

Budget (2021/22): £460m, broken into income of £360m (patient emergency services); £44m (patient transport services); and £32m (111). Other income amounts to just over £22m

Activity (2021/22)
999: more than 1.8 million calls and 1.1 million incidents
See-and-convey: 679,000, of which 598,000 to A&E
See-and-treat: 343,000
Hear-and-treat: 107,000
PTS: 1.2 million conveyances
111: 2.7 million-plus calls offered

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most ambulance trusts, available capital will not stretch to delivering this refresh rate.

In the North West, a seven-year vehicle life is the target. With more than 500 ambulances in its fleet, the trust needs to replace about 70 ambulances a year. A dedicated national capital pot to help reduce the age of the ambulance fleet and increase numbers was announced in the planning guidance, but this provides just £20m a year across 10 trusts for the next three years. And at £125,000 for a converted van ambulance, the trust's share of this only covers 15 to 20 ambulances.

This year, the trust's capital allocation stretches to about £20m and half of this will go on fleet replacement, with the remainder covering backlog maintenance and developments across its 100 or so sites.

Another Carter recommendation was to reduce the number of sites used by ambulance trusts, building bigger stations where appropriate and consolidating the number of control centres. This would improve efficiency and effectiveness, particularly in urban areas. But this kind of development – and productivity improvement – remains off the agenda in the current environment of scarce capital funding.

Income issues

Ambulance trusts' income is largely fixed. Back in the days of payment by results, there had been moves to link payment to a currency based on hear-and-treat, see-and-treat and see-and-convey. But this was overtaken by wider events and the move away from the activity-based payment by results approach for acute providers. Patient transport services may have been on a cost and volume basis pre-Covid, but all contracts moved to a block basis as part of the temporary financial regime introduced for the pandemic. In the North West, there has been no return to cost and volume as yet.

However, there are discussions under way within the sector about how the variable element in the new aligned payment and incentive system could be used to reflect increased activity or incentivise performance in key areas, but this will not be concluded for the next planning round.

'One idea is you could have a fixed element for core activity and then a flexible element that starts to pick up the increased activity or reflect where handover delays increase beyond the planned level,' says Ms Wood.

Much like the wider NHS, many ambulance trusts think they will hit their financial targets this year. But next year looks much more challenging. They carry a lot of non-recurrent savings into the new year and inflation continues to soar. And the cost-of-living crisis will continue to keep demand for pay increases above the level assumed in current allocations. Industrial action remains a real threat.

But the real consequences of this continued extreme pressure on ambulance services is likely to be most evident in performance, response times and patient experience, and not in the financial reports.

PTS, 111 and staffing pressures

Patient emergency services (PES) are only one aspect – albeit the biggest – of ambulance services. Many ambulance trusts also run patient transport services (PTS) and 111 services. In the North West, of the trust's £460m income, about £360m relates to PES. But it earns a further £44m for PTS and £32m for 111 activities, with a small amount of other income on top.

PTS should be a lot more predictable than emergency services but it has its own pressures. It supports individuals to attend either regular appointments such as dialysis or cancer care, where they have a medical need that prevents them from using their own transport. During the pandemic, PTS fell below the baseline level included within the contract – almost 25% less in the last contract year. However, delivery involved more resources and higher cost.

In part this reflected infection control measures, which effectively required people to be transported individually rather than in groups. While Covid rules have been relaxed, activity continues to be below the baseline, although it is gradually increasing. However, NWAS continues to experience high levels of patients who meet the criteria for single occupancy transport and is exploring the possible reasons behind this cost driver.

In contrast, calls to the trust-run 111 service were 40% above pre-Covid levels last year, partly a result of the NHS-wide 111 first programme to reduce pressure on A&E departments. The call demand is not covered by the funding included in the contract, yet the trust also faces significant staffing pressures.

All ambulance trusts report challenges with recruitment and retention in all parts of their service. There is a shortage of paramedics with the potential for the increased recruitment of paramedics by primary care networks to exacerbate the situation. And, after an increase in recruitment during the first part of the pandemic for its 111 and PTS services, recruitment is again more challenging.

Junior call handlers in the 111 service or drivers for PTS services could earn similar money in hospitality or retail.

The trust has taken a number of steps, improving fair access to annual leave, trying to improve the rostering of people in teams, and introducing a retention premium as a short-term measure. But Ms Wood says the trust is also keen for the ambulance service to be seen as providing careers not just jobs.

'A lot of people who start within PTS on a vehicle, quite often go through the training to become a technician, then paramedic,' says NWAS finance director Carolyn Wood. 'And there are examples of people who start in 999 call-handling moving into a dispatching role -- allocating a vehicle to a job and moving the resources around. And, again, from there they might actually go on the road as a technician or paramedic.'

So a role in 111 is not just a short-term call centre job detached from the rest of the business, but entry into a much broader organisation. A single triage system across the 999 and 111 services helps improve flexibility and movement across the trust. 'We want the trust to be seen as offering a career, not just a job,' she says. 'It should be seen as an organisation for life.'