The crisis in NHS Ambulance Services in the UK: Let's deal with the 'elephants in the room'!!

Context and background

The contribution of NHS Ambulance Services toward the government's urgent and emergency care strategy is duly reflected in various recent official reports[1-4] including academic publications [5-6]. NHS ambulance services drew universal praise for their swift and professional response during the recent tragic events of the Grenfell Tower fire and the terrorist attacks in Manchester and London but concerns have also been raised about resources, funding levels and the sustainability of the increased activity. The ongoing NHS winter crisis has further put a massive strain on ambulance resources with huge bottlenecks in the transfer of patients in the hospital Accident and Emergency (A&E) wards[7]. Some of these arguments have been well rehearsed but the scale of these challenges is exacerbated due to ongoing winter pressures. Several media reports [8-9] covered delays on the part of ambulance crews arriving at the scene, including death of patients waiting for an ambulance, which has prompted emotional debates and the cries of "52 weeks of the year crisis" in Parliament[10-11]. In order to prepare for an Ambulance Service for the future which can respond to such crises, it is important to tackle the '*elephant(s) in the room',* so in this article I wish to highlight three problems which need to be addressed urgently. These are, (i) growing demand and funding pressures, (ii) developing a modern work force and (iii) providing strong and innovative leadership. I will begin by analysing the scale of the problem and then I will offer some suggestions on how to deal with them.

Issues

The first issue I wish to highlight is the sustainability of an underfunded and overstretched service. Several recent reports[1-3] have yet again highlighted the impact of the annual rise of demand for NHS Ambulance Services and the fact that the increased funding for urgent and emergency activity has not matched this rising demand. Between 2009-10 and 2015-16, the number of ambulance calls and NHS 111 transfers increased from 7.9 million to 10.7 million showing an average year-on-year increase of 5.2%[1, p. 5]. The problem is further compounded by a mismatch between demand and resources available. Statistics show that between 2011-12 and 2015-16, income for NHS ambulance trusts' urgent and emergency care activity increased by 16% from £1.53 billion to £1.78 billion but ambulance activity over this period (NHS ambulance calls and NHS 111 transfers) rose by 30% [1, p. 7]. Doing 'more with less' is proving impossible and should be strongly contested at the highest levels.

NHS Ambulance trusts have made great progress in delivering new models of care including the '*hear and treat*' and '*see and treat*' options. A range of different specialist paramedic roles such as the paramedic practitioners, emergency care practitioners and consultant paramedics are now in place which are helping to reduce the conveyance of patients to ED's, thus reducing the costs associated with ambulance journeys and increased discharge at scene[12]. It is also widely being acknowledged that the response time targets are not useful indicators of quality or a useful benchmark for comparing services, since they reflect only the transport element of the service and not the care provided, thus 'treating the clock, not the patient' [13-15]. But attempts to work out a national framework for a broader, outcome-led performance regime introduced in 2011[16] haven't found much success. Recent evidence however suggests that while ambulance demand is showing

an average annual increase of 5-6 % only ten percent of the callers dialling 999 have a life-threatening emergency.[1, 13] In our recent paper, [17] we have again highlighted the dominance of the response time targets as one of the key factors for cultural perpetuation of old mind sets in the Ambulance Service. The recently launched *Ambulance Response Programme (ARP)* [13] is a welcome step to help to do away with the practice of "stopping" the 8 minute clock on arrival of the first vehicle but not on the arrival of the vehicle that the patient actually needs. However, in my view, it is designed largely to give additional time to ambulance staff to allow them to make a decision while the trust performance is still being measured against the national Red 1 and Red 2 targets and there is a danger that "too much reliance on meeting response times" will continue to be placed by the commissioners, regulators and providers.[1, p.8]

The second issue which I want to highlight is a lack of progress in developing a modern, flexible work force. The NHS Five Year Forward View (2014) makes a key commitment to support a diverse, modern and healthy workforce but there are huge challenges on this front. Shortages and retention of paramedic staff[1-3] accompanied by high sickness absence rates[18] dominate the workforce agenda. Lord Carter's NHS Efficiency Review[19] reported serious concerns over the variations in the sickness rates within the NHS and argued that a 1% reduction could save around £300 million towards annual staff cost. Improving staff productivity and reduction of turnover follows from this analysis. Peter Bradley's highly influential report, *Taking Healthcare to the Patient* (2005) argued for a clearly defined career progression and the scope for ambulance professionals to become clinical leaders. It has taken almost 12 years for this to happen with the recent Health Care Professions Council (HCPC)'s consultation process in late 2017 gathering evidence towards a graduate level entry qualification. The ARP is also underpinned by expansion of the clinical autonomy of paramedics to deal with the ever-increasing demand without the need to take the patients to the hospital with the focus increasingly on getting the patient to the 'right' hospital rather than to the 'nearest' hospital. Building an evidence-based approach to decision-making and harnessing the research capacity of staff should be a key policy and management priority.

Media reports are on the rise highlighting cases of harassment and bullying in the NHS Ambulance Service while pointing to the pressures of meeting performance targets[20-21]. Some of the recent Care Quality Commission (CQC) inspection reports have also highlighted similar concerns of low staff morale due to 'workload pressures' [22-23]. NHS Ambulance staff have also reported the highest ever levels of discrimination within the NHS in a study carried out recently by the King's Fund[24]. The data measured discrimination reported in the NHS Staff Surveys in 2014 from managers and staff, between colleagues, patients and members of the public on grounds of age, gender, religion, sexual orientation, disability, & ethnicity. Worryingly, the discrimination reported by NHS ambulance staff was the highest on eight dimensions, including the gender imbalance amongst NHS staff other than ethnicity.

There is also growing evidence that NHS ambulance staff are prone to risk factors, such as acute and chronic stress, that can lead to the development of cardiovascular diseases and post-traumatic disorders (PTSD) and other associated illnesses[25-26]. Research conducted by *Mind,* the mental health charity, as part of its blue light programme, shows that members of the emergency services are even more at risk of experiencing a mental health problem than the general population, but are less likely to seek support[27]. This was captured best in a recently aired TV documentary covering the day of a paramedic when it was reported that "being a paramedic can feel like eat, sleep, work, repeat" [28].

The third issue I would like to highlight is creating an environment to solve problems innovatively and through strong and collaborative leadership. For instance, the issue of ambulance hours lost due to turn around at A&E departments is a long on-going one which is having serious implications on patient safety and availability of the resources. The 30 minute cycle (handover and readiness for next call) is proving difficult to resolve. The NAO report[1, p. 21] reported that in 2015-16, only 58% of hospital transfers met the 15-minute expectation, as against 80% in 2010-11, and only 65% of ambulance crews were then ready for another call within 15 minutes, with wide variation across NHS ambulance trusts. On the recommendation of the Committee of Public Account (2011)[29] that commissioners should take a consistent approach to penalising hospitals that do not adhere to the guidance of 15-minute transfers, the fining regime introduced in the 2015-16 contracts between providers and commissioners was suspended for most trusts from January 2016. Furthermore the recommendation from Committee of Public Account (2011) that a quality indicator should be developed for hospital performance in meeting the transfer-time target has not yet materialised [4,p. 7]. Similarly, the attempts by NHS Ambulance Services to be incorporated into the local Sustainability and Transformation Plans[30] remains unclear.

It is acknowledged that such delays are symptomatic of the problems of the wider health system and also contingent on plans made elsewhere in the local health economy. Local initiatives by NHS ambulance trusts have helped to ease the situation. It is however in the interest of NHS Ambulance Services to push for a penalty/fining regime and the development of a hospital performance indicator to highlight such delays. This will require dialogue and negotiations with ministers, politicians and with other health partners to achieve a consistent service offer across all regions. There are no easy solutions for these problems but NHS Ambulance Services need strong, collaborative leadership and a clear road map to deal with the current crisis. I offer some suggestions next on dealing with these issues.

Reform to 'transform'

Firstly, ambulance response targets are useful but do not give a complete picture of the range of interventions provided by staff. Managing such levels of demand and quality of patient care is clearly unstainable and it is no secret that NHS ambulance trusts across the country are struggling to cope with demand and meet their performance targets. Current models of service delivery and management also do not reflect considerable changes to the working and nature of demand in the NHS Ambulance Service. I have written extensively about the perversity of the target regime and its detrimental effect on the health and safety of ambulance crews and on staff morale. NHS Ambulance Services need to be more flexible in exploring a more balanced approach to performance measurement to satisfy all its stakeholders. The ARP is a step in the right direction but is focused around *'slowing the clock'* rather than measuring performance differently. It presents an opportunity to engage in meaningful conversations with a range of partners to assess best practice examples to jointly come up with solutions and options. For example, the suggestion to consider routine use of 'drunk tanks' to ease pressure on A&Es would also benefit the Ambulance Service. Developing meaningful partnerships with HEIs to influence the policy context in preparing a modern Ambulance Service should be supported and welcomed[31]. Doing more to educate the public about available options while managing expectations and changing behaviours is equally necessary.

On the second point about workforce issues, it is quite ironic that the worst NHS crisis in its history has prompted the government to put out its draft NHS Workforce Strategy[32] for the first time in 25 years. One of the worrying statistics for NHS Ambulance Services is that almost 17,000 nurses, midwives and allied health professionals (AHPs) went on to the professional registers between 2015 and 2017, but only 7,000 of them joined the NHS with a suggestion that the primary reason staff are leaving the NHS is the 'growing pressure' they are experiencing in the workplace[33]. Having a clear road map for equipping paramedic staff with the necessary skills is crucial for the future and success of NHS Ambulance Services. This has proved difficult due to the complexity of the work undertaken, organisational challenges, disconnected ministerial oversight coupled with shifting political landscape and changing priorities. Having a clear understanding of the funding situation and staffing requirement for the next 10 years will thus be crucial. AACE will have a key role in pushing through the service requirements for the NHS Workforce strategy. Dealing with issues of staff heath, sickness and mental wellbeing is critical and should be one of the key priorities for the service as part of its workforce strategy.

On the third issue, the huge variations in meeting response time targets are still not being clearly understood with only 1 NHS ambulance trust meeting the Red 1 and 2 targets nationally in 2015-16[1.p.9]. The NHS Five Year Forward View signposts organisations to consider new and innovative solutions to address quality and financial challenges but the impact of different organisational models depends critically on the skills of the leaders involved and their ability to bring about the 'changes in culture and behaviour on which sustainable improvements in performance depend'[34,p.4] . Across England local flexible solutions are being piloted and are showing positive results, but such a 'horses for courses' approach may not always resonate with the politicians aiming to bring salvation to a troubled NHS[33]. As the Dalton Review[35, p.8] suggests, leaders of successful organisations should become 'system architects' encouraged to use their entrepreneurial spirit to develop innovative organisational models and to codify and spread their success to other localities. Local NHS, government leaders, clinicians and wider partners will have to work together to develop services to suit local population. The '*bottom up, top down, middle out'* approach being implemented as part of the Greater Manchester Strategy[36] offers an interesting perspective into the future footprints of NHS Ambulance Services.

To conclude, this is an important moment for NHS Ambulance Services to embark on a bold vision for their future in a very challenging environment, not least what Brexit might additionally bring. Arguably some of the challenges I have discussed here require cooperation from other NHS partners, but the need for an open and honest debate about the shared purpose for diverse individuals doing different work and inspiring them to deliver benefits for patients, their families and the community, has never been greater. A strong but collaborative approach to leadership will be needed to navigate the ship during these turbulent times. But as I have argued in this article, the current crisis also presents opportunities to innovate by trying new innovative organisational forms and developing meaningful partnerships to bring about real reforms and transformational change across NHS Ambulance Services.

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