

PAPER FOR TRUST BOARD

AGENDA REFERENCE: 8.3

AUTHOR: John Scott

TITLE: Clinical Quality Report

KEY ISSUES:

- SUIs
- OOH provided by EEAST OOH (Norfolk)

WHAT IS REQUIRED OF THE BOARD

- To accept the Report
- To note the Appendix

IMPLICATIONS FOR THE TRUST:

1. Risk: Is there a significant risk? **Yes**
2. Operational Impact. **None**
3. Equality Impact required? **No** Has it been completed? **N/A**
4. Resources required? **No** Are they within existing budget? **No**
5. Legal Issues. Does this support compliance with legislation requirement? **Yes**

Trust Board Meeting
26th March 2008

Clinical Quality Report

Coroners Court

The Trust is seeking tenders from a firm of solicitors to support the Trust's needs and requirements focused around inquests and coroners courts but to include wider court appearance issues.

In the meanwhile it has been agreed that I will be a point of focus in the Trust for legal matters. It does require a concerted effort in operational management to obtain statement and reports early so that a set of contemporaneous records are created for every incident in a way similar to the very thorough investigations that happen after a vehicle accident.

Air Ambulance provision

There are continuing discussions in the two areas.

Within the Essex and Hertfordshire Air Ambulance Charity area of operation the consideration is to introduce doctors on to the helicopter that flies over Essex. There is a need to clarify the training and cost implications of this development. The Charity has indicated that they will in the near future have raised funds to support a helicopter over Hertfordshire. The debate about need continues with the proposal to consider the Charity developing a service provision model.

Within NSC and Bedford there are active discussions to develop a Critical Care and Retrieval Service bringing together the Air Ambulance Charity, Magpas and the Ambulance Trust.

SUI

Since the last Board meeting there has been five reported SUIs

- Inappropriate classification of call by GP leading to delayed response
- Issues around patient management and complexities of needs during the transfer between community and hospital
- Potentially inappropriate request (time) for transfer of patient to hospital against clinical condition of patient
- Inappropriate extrication by Fire Service leading patient harm
- Delay in hospital turn round for ambulances leading to delay and an appropriate response to a category A call

Patient Report Forms

Concern has been expressed previously about the level of completion of patient report forms with a lower level noted in those patients who are left at home.

The assessment of completion is undertaken every three months. It should have been undertaken in February for the March report. Unfortunately due to the operational pressures with staff undertaking operational duties we have not been able to complete the audits

HCC

There have been discussions with the HCC to consider the standards and assessment process for organisations that assist NHS Ambulance Trusts deliver clinical services. Much of this relates to the Health Care Standards as first set down in the Care Standards Act 2000 and the Trust needs to remain alert to this particularly when establishing contacts with private ambulance providers.

Driving

The Trust is joining other emergency services in considering the concept of speed capping for those undertaking emergency driving. Additional to this work the Trust is to propose standards for those non-trust employees who undertake emergency driving.

OOH

I bring to the attention of the Board the enclosed appendix on EAAST OOH (Norfolk) which describes the activities of the OOH system in Norfolk to give a clinical insight to the service provided

John Scott
Medical Director
March 2007

East of England Ambulance Service Out of Hours (Norfolk)

1. Background

When the GP Contract changed in 2004 and responsibility for OOH care was transferred from individual GPs to the PCT the old East Anglian Ambulance Service gained the contract to provide OOH services in Norfolk, Yarmouth and Waveney. The Trust managed the transition from 6 GP co-operatives and Healthcall covering Norfolk and Waveney to one unified OOH system. In 2007 the OOH contracts were put out to tender again. EEAST were successful in retaining the Norfolk PCT OOH contract for another 3 years (with possible extension of 2 years) but lost the Yarmouth & Waveney contract to Take Care Now (TCN).

The population covered by Norfolk PCT is 750,000.

2. National Quality Standards

OOH delivery is monitored on a monthly basis by adherence to OOH National Quality Standards (NQR). These are listed at Annex A.

3. PCT Annual Accreditation

The commissioning PCT undertakes an annual accreditation of OOH providers. Norfolk PCT undertook this process on 8th November 2007. This went well and a number of action points have been identified.

4. Changes to the OOH Contract

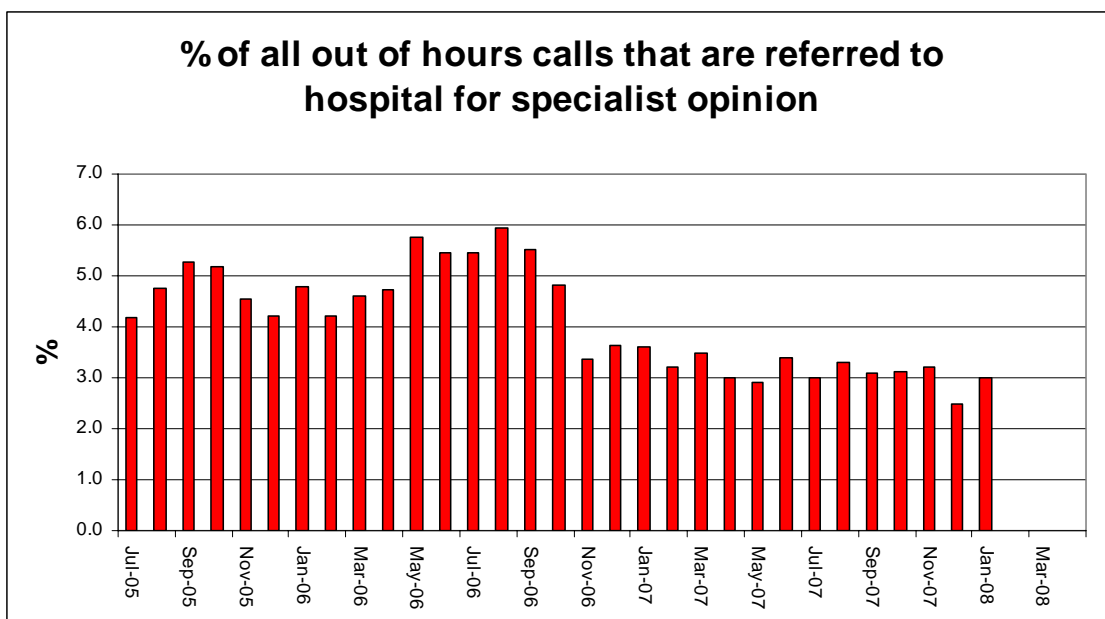
Norfolk PCT asked for considerable savings on the previous contract. This has been achieved by

1. **Centralising triage to Norwich HEOC** – we have a doctor and nurse just dedicated to triage with help from those clinicians not in a face to face consultation at the clinics. These are stressful shifts due to the numbers involved and trying to balance the outcome with available resources.
2. **Reducing bases** – midweek we only have Norwich, Kings Lynn, Thetford and North Walsham open. There is a 3 hour clinic at Diss to cover a separate contract for some North Suffolk practices. At weekends we open clinics at Dereham, Diss and Fakenham.
3. **Greater use of ECPs and NPs** – there has been problems filling these shifts as we do not yet have a large enough pool of ECPs and the rates of pay do not attract local nurse practitioners who are well paid in daytime practice and do not wish to work antisocial hours.

5. Admissions to Hospital

EEAST OOH Norfolk was tasked with helping the PCT achieve savings by reducing the number of emergency admissions. EEAST OOH Norfolk has been successful in keeping the percentage of all calls admitted at around the 3% mark. This has been as a result of a number of factors

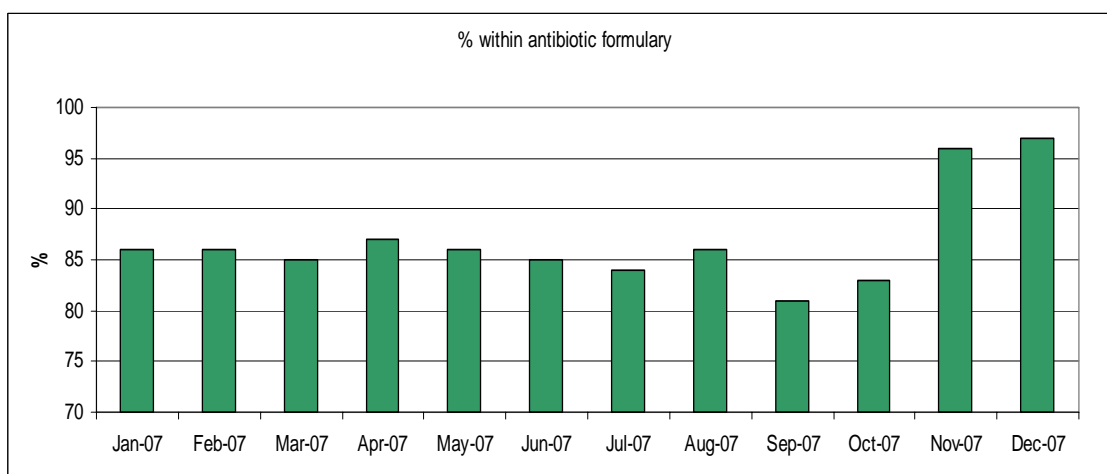
- Use of experienced clinicians
- Smaller group of OOH clinicians
- Use of other services
- Better technology



6. Prescribing

EEAST OOH Norfolk has three systems for monitoring prescribing

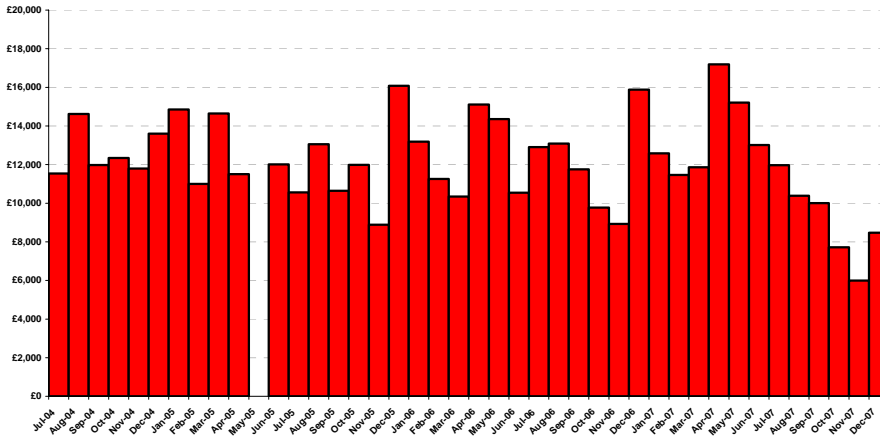
1. **PACT data** – this is a summary of all prescriptions issued to patients and taken to a community pharmacy to be dispensed. This records monthly costs, prescribing by pharmaceutical group and prescribing according to the OOH formulary.



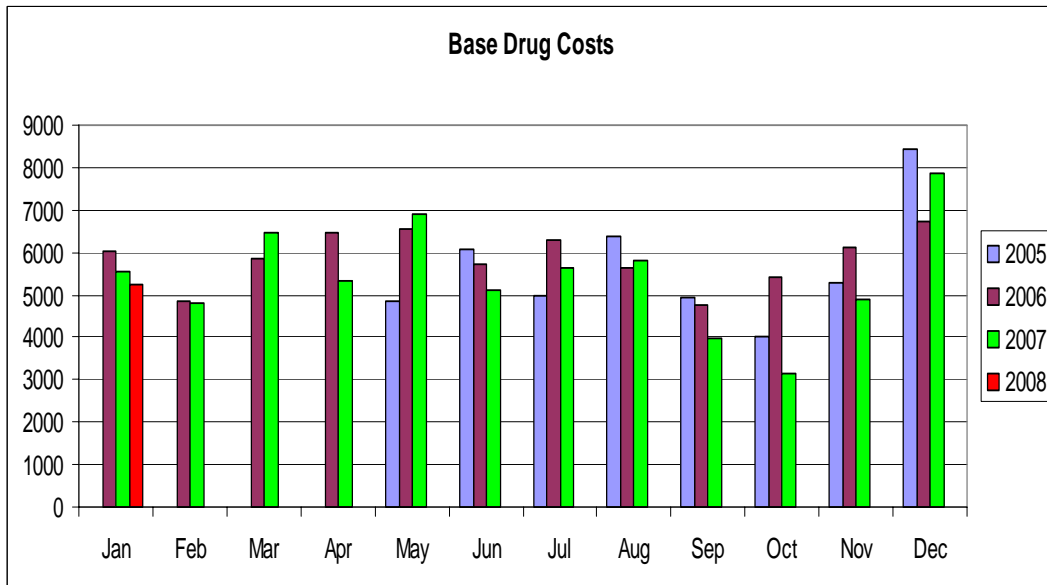
Antibiotic prescribing within formulary guidance is particularly important in the campaign to reduce the incidence of MRSA and C. difficile. Norfolk PCT issued new guidance on antibiotic prescribing in November 2007 and EEAST OOH Norfolk was quick to emphasize its intended compliance to all OOH clinicians. Normal GP compliance is about 85% so we are doing well. It will never be 100% as there are always clinical exceptions.

Great effort has been put into reducing drug expenditure. One of the commonest calls on a weekend is for patients who have run out of medication. This is now dealt with by a referral to a community pharmacy for an emergency supply of medication rather than issuing a prescription. In the event that a prescription is required a maximum amount of seven days is prescribed and only for essential medication. There is no system for recouping this drug cost from the GP practice prescribing budget.

EEAST OOH (Norfolk) Monthly Total Expenditure



2. **JPH monthly report** – the OOH service obtains its drug supply for the clinics and vehicles from the James Paget Hospital pharmacy department. Each month the pharmacy department sends EEAST OOH Norfolk a list and costing for all drugs ordered.



Increased costs are seen around Easter and Xmas when because of the Bank Holidays greater stocks are held. The availability of community pharmacies has improved around Norwich but in the rest of the county is quite poor.

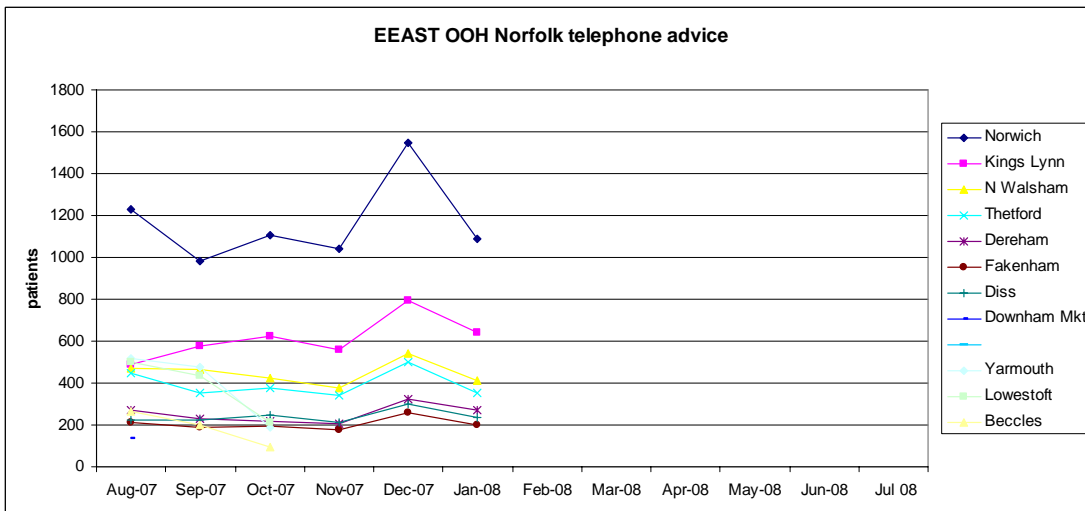
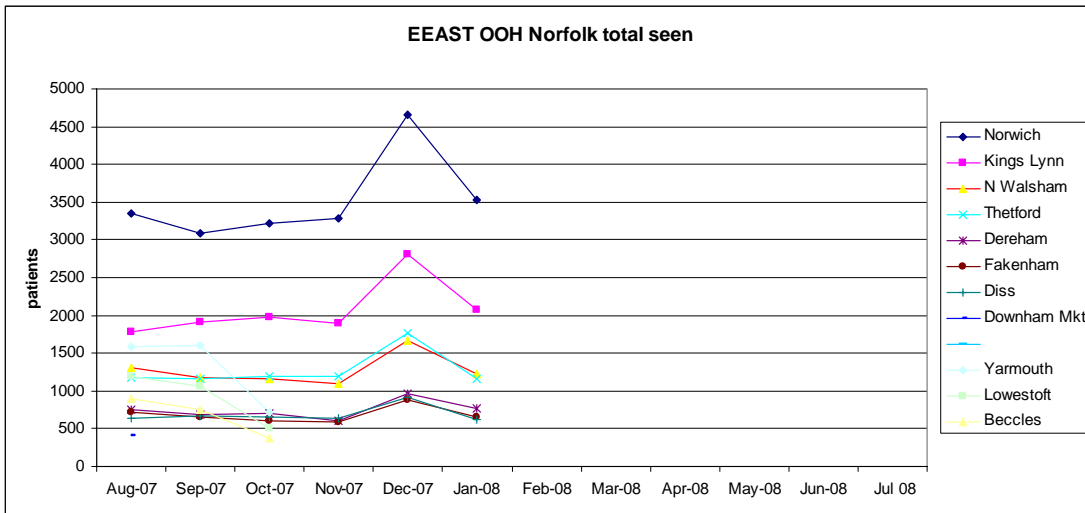
3. **Prescribing analysis** – each month the Asst Medical Director does a search on the Adastra clinical system to identify prescriptions issued per clinician and whether these were within or outside the OOH formulary. This forms part of the feedback to a random selection of clinicians but also allows identification of high prescribers who warrant a more detailed look at prescribing habits. A list of all prescribed items per clinician can be identified through a standard search of the system.

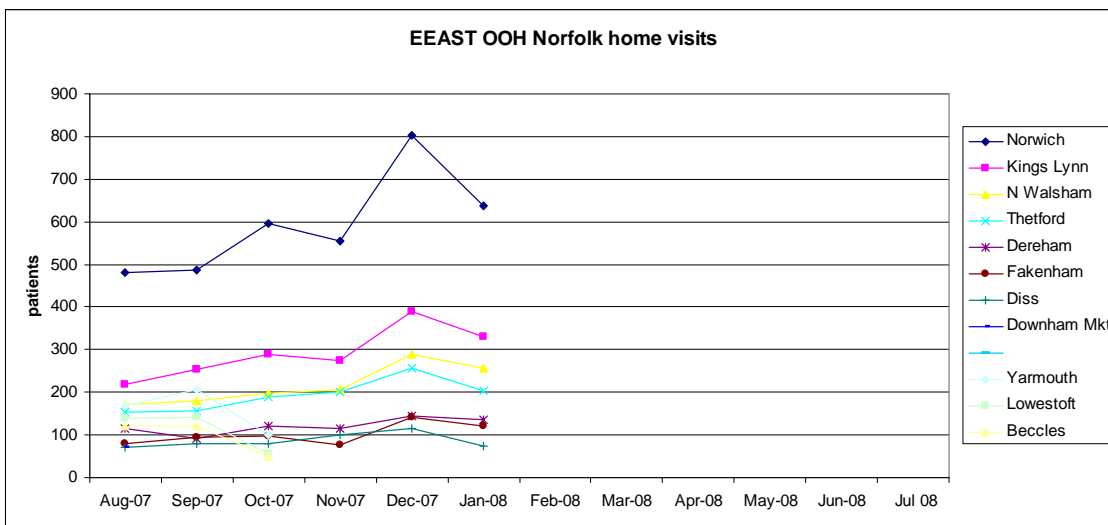
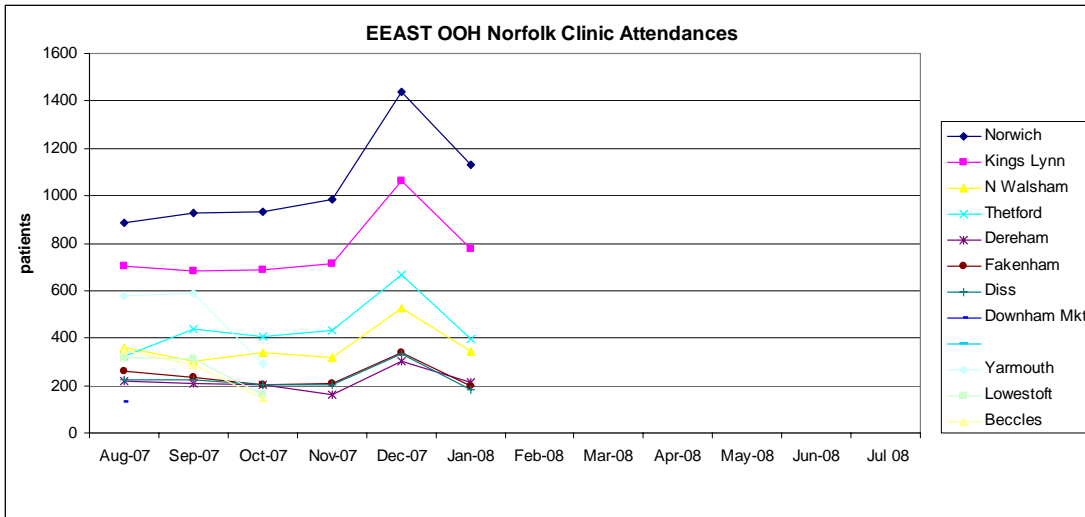
7. Workload

The OOH period covers 112.5 hours (66.9%) out of a total of 168 hours in the week and so it is not surprising that it is quite heavily used by patients with problems that occur when their own GP surgery is closed.

Calls either come directly to the OOH call handlers based in HEOC Norwich or by automatic telephone diverts from GP practices. The calls are given a priority grading by the call handler. Obvious life threatening emergencies (e.g. chest pain or acute breathing difficulties) are diverted to the 999 desk in HEOC for an ambulance response. The calls are then triaged by a clinician who has one of three possible dispositions:

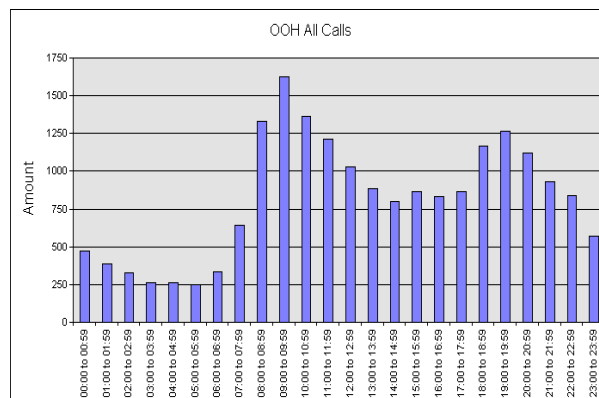
- Clinical advice
- Appointment at an OOH clinic
- Home visit



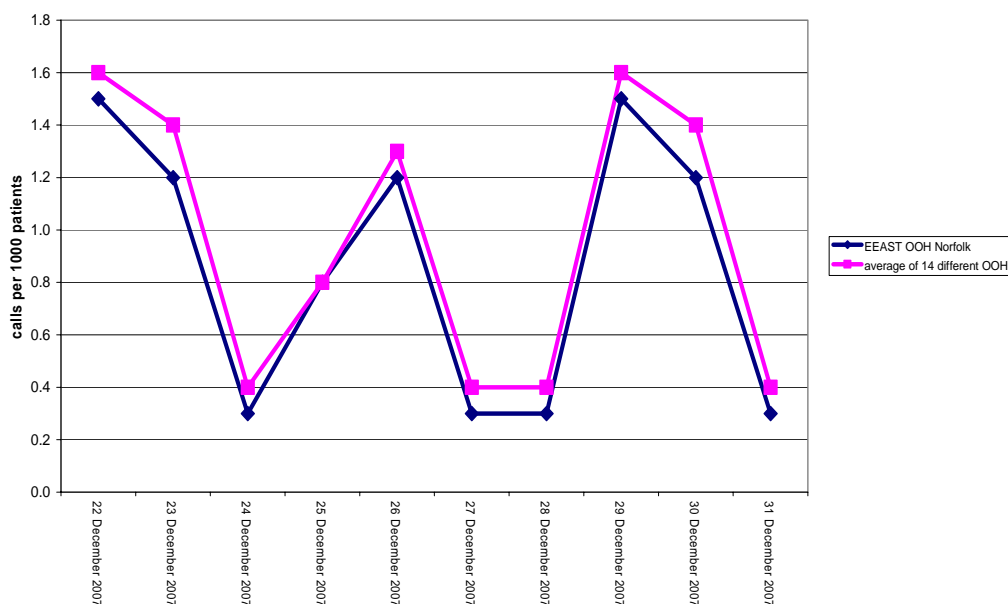


Home visits should be reserved for those that are bedridden or who moving them will make their clinical condition worse. It is apparent that with the ageing population in which we live the majority of calls are to the very elderly who have multi-factorial disease.

The following graph demonstrates the calls taken by hour in December 2007. This well illustrates the peak of calls taken on Saturday and Sunday mornings and the other peak in the early evening. This pattern is replicated by A&E departments, NHS Walk In Centres and NHS Direct and represents human nature rather than timing of illness.



OOH Call rates Xmas 2007



How do we compare nationally? It is difficult to gauge as statistics are not openly shared because of competition for tenders. However, at Xmas 2007 we gained statistics from a group of other OOH providers around the country who had experienced similar difficulties with overwhelming call volume on the Saturday on either side of the Xmas break. This allowed a comparison to be made in terms of calls per 1000 population. Our disadvantage is that these calls are spread over a larger geographical area than other providers.

8. Workforce

The number of clinicians working for EEAST OOH Norfolk has reduced from over 300 to about 120 in the last 4 years. We are still lucky to have many dedicated local clinicians working for us which has meant that our reliance on GP agencies has dropped. These agencies tend to be used to fill difficult to fill weekend shifts as well as last minute vacancies. EEAST OOH Norfolk only uses two agencies – Cimarron UK Ltd in Colchester and MTS in Cambridge. The agency GPs have to undertake the same induction session as local GPs. The same agency GPs come to work for us on a regular basis so have built up their local knowledge. However, they take up a greater amount of time in clinical governance audit so their easy availability has to be balanced against the higher inherent quality from local clinicians.

9. Future challenges

1. Install mobile electronic clinical system (Aremote) onto toughbooks in all vehicles using the same technology that allows frontline ambulances to use ePRF. This will cut down on administrative time and allow more efficient use of the vehicles who currently take calls by mobile phone.
2. Attract more nurse practitioners to work OOHs. Agenda for Change has restricted what we are allowed to pay.
3. To retain and enthuse our ECP workforce in OOH work. They need close mentoring to retain the skills to deal with acute medical problems without resorting to admitting patients unnecessarily.
4. To deliver the OOH service expected by the public within a much reduced budget.
5. competition from private providers – this has proved very destabilising for our ECPs who have realised that loss of contracts can mean redundancy or transfer under TUPE to another provider. This has meant that the role is even less attractive to potential ECPs.
6. Integration with secondary care – we have links with the A&E Department at The Queen Elizabeth Hospital, Kings Lynn to take any primary care patients that access their system inappropriately. The aim is to move the Norwich clinic from the community hospital to somewhere near to the A&E Dept at the Norfolk & Norwich University Hospital has been delayed because of issues with the PFI owners.

7. To install IT links in the GP practice in Thetford that we use for the OOH clinic there. We used the cottage hospital in Thetford until the PCT closed it and we could not afford the high rent demanded by the PFI Healthy Living Centre hence finding alternative accommodation. The demands on the EEAST IT department have meant that this installation keeps getting delayed. This delay compromises the OOH system as we are unable to use the Adastra electronic clinical recording or to utilise the clinicians there on central triage.

The model within Norfolk, where the OOH is integrated within the ambulance service, has many advantages not only that the service has control of the whole system but also to the patient. There have been numerous instances when integration has meant a fast, co-ordinated response in a case of acute medical need. The presence of a doctor within HEOC has been perceived positively by all who work there and allowed outcomes only open to that skill group.