Ambulance Services
Working Collaboratively with Community Partners

John Black
Medical Director, South Central Ambulance Service FT
on behalf of the Association of Ambulance Chief Executives
October 2017
National picture 2016/17

- 10 English NHS Ambulance Services
- 999 calls increased by 21% since 13/14
- 11.2 million 999 calls
  - Includes 1.46 million transfers 111 > 999
- Led to 6.9 million face-to-face attendances
  - 52% conveyed to ED
  - 38% treated at home & discharged or referred
  - 10% telephone advice and/or referral
- 700,000 hours lost waiting to transfer care in ED
South Central Ambulance Service (SCAS)

Our services

- Patient Transport
- SCAS
- NHS111 Service
- Emergency 999

An integrated approach

- Enabling people to access right care, first time
- Saving lives and improving outcomes
- Supporting people in their own homes

Past

Future
Ambulance Services have visibility of the whole care system

Daily average per million population

- 270 999 calls
- 550 111 calls on weekdays /nights (more than double at weekends)
- 30 GP requests for urgent transport
- 370 bookings for non-emergency patient transport

Based on SCAS 2016-17

With data on demand trends, patient flow, pathways, processes and local variation

- 225 patients taken to hospital
- 105 people treated at scene
- 60 calls resolved with telephone advice
- 435 referred to primary care
- 55 referred to other services/agencies
- 60 advised to take themselves to ED
- 8 transported between care settings
- 320 journeys to and from outpatients
- 40 taken home after hospital discharge
The Emergency / Urgent Picture

10% Life threatening
- Advances in cardiac care, stroke, major trauma, cardiac arrest
- Alternative destinations - Trauma Centres, PPCIs, Stroke Units
- Acute service reconfigurations - maternity, paediatrics, surgery
- Clinical performance measures (AQIs)

90% Urgent care
- Mix of acute / chronic, LTCs / complex and multiple health issues
- Increasing care closer to home
- Alternative destinations - UCCs
- Ambulance clinicians working alongside community, primary care, social care, mental health in MDTs
- Advanced and specialist paramedic roles - expanded clinical decision making, advanced clinical assessment, diagnostic & treatment skills
- Public health promotion/prevention role

Plus, Resilience for major incidents & mass casualties - working with other emergency services and specialist response agencies
Five Year Forward View & UEC Review

- “Helping patients get the right care, at the right time, in the right place…” (FYFV)
- “Ambulance services empowered to make more decisions, treating patients and making referrals in a more flexible way…” (FYFV)
- “Ambulance Services should maintain clinical hubs in their EOCs to ensure appropriateness and timeliness of responses…staffed by range of clinicians” (SFB)
- “Ambulance Service & CCGs should develop mobile urgent treatment service capable of dealing with more people at scene and avoiding unnecessary journeys to hospital” (SFB)
- “Clinicians working in the 999 system - through ‘H&T’ or ‘S&T’ models - should have unrestricted referral rights to all other services in the UECN, including social care services, with free flow of information and feedback” (CMAS)
- “Effective urgent care services will be supported by the immediate availability of relevant patient information” (CMAS)
- “We cannot deliver the necessary change without investing in our current and future workforce” (FYFV)
Health and Social Care Transformation

As an example, SCAS has a role in 6 STPs

Emergency 999
NHS111
PTS
Sussex & East Surrey (excl IoW)
Bedfordshire, Luton and Milton Keynes
Thames Valley
Frimley (part)
Surrey Heartlands
Surrey & East Sussex
Hampshire (excl IoW)
Tendency to overlook Ambulance Services in STPs

NHS infrastructure

Scientific, therapeutic, technical staff and support

Support to doctors, nurses and midwives

Doctors hospital / community

Mobile clinicians / Paramedics
Coordination Centre / support staff

Nurses, midwives and health visitors

Indicative workforce based on FTE in England

Tiny but essential cogs in a very big machine
SCAS strategic themes

- Care coordination and integrated urgent care
- Mobile care and emergency responses
- Expanded patient transport and logistics
- SCAS as a partner in local care systems
NHS Ambulance Service 2020 & Beyond

www.aace.org.uk
See & Treat - Mobile Healthcare
High Impact Actions for Ambulance Services (issued by NHSE to SRGs in 2015)

1. Establishing an Urgent Care Clinical Hub - all Ambulance Trusts to develop with 24/7 access to range of specialist expertise
2. Improving access to community health and social care rapid response, including falls services
3. Increasing direct referral to all other components of UEC network
4. Enhanced working with community mental health teams
5. Enhanced working with primary care
6. Workforce development
7. Enhanced use of Information and Communication technologies
8. Increased use of alternative vehicles to convey patients
9. For patients who do need to be taken to hospital ambulance services should minimise handover delays!
Working with Community Services
Examples

Clinicians in EOC / Clinical Assessment Services
- Midwives
- Mental Health Nurses
- Pharmacists
- Palliative Care Nurses
- Dentists

Multidisciplinary Teams
- Falls Intervention - Paramedic & OT/Physio
- Mental Health Car - Paramedic & MH Nurse & Police Officers

Direct Referral Pathways
- Alcohol Referral Service
- Diabetic Referral Scheme
- Falls Referral Service
Clinical Scenario:

- Elderly Care Home resident - respite care
- Friday early evening
- Non-injury fall on a background of general deterioration
- Multiple co-morbidities including Parkinson’s Disease/recurrent UTIs.
- uDNACPR with an ACP to include treatment with antibiotics
- Care home staff do not know patient well and have dialed 999
- Ambulance Service attends
Ambulance Clinical Assessment

- Airway Clear
- RR 20 Chest clear SaO2 96% on air
- Dry oral mucosa. Able to tolerate fluids orally
- BP 140/85 P110 ST Warm peripheries
- Alert no focal neuro deficit
- NEWS:3
- Temp 38.1 BM: 8.5mmols/L
- Minor pre-tibial laceration

- Urine analysis: cloudy /strongly smelling urine positive for nitrites and leucocytes

- No nursing staff support to care home. Nearest ED 20 miles away.

- What Next?
Clinical Scenario

- Access to Summary Care Records
- Referral to Senior Clinical Adviser

Actions:
- Referred to Hospital at Home Team
- Parental antibiotics
- Falls team referral
- Parkinson’s Specialist Nurse follow-up
Integrated Emergency and Urgent Care

- **Time Critical Patients**
- **Ambulance Clinician**
  - Patients for safe discharge without follow up
- **Trauma Patients**
- **Medical Patients**
  - GP unable to meet patient’s needs

- **‘Trusted’ Senior Clinical Adviser**
  - Admit to AAU, ward or ED
  - Admit to MIU, EMU or ward

- **Discharge Home with Support Including Hospital @ Home services**

- **Discharge Home with Support Including Hospital @ Home services**
Clinical Assessment Service (CAS) expertise*
Remote or Co-Located. Subject to professional review and clinical audit.
- GP 24/7 365
- Paramedic/Nurse Practitioners
- Mental Health
- Palliative Care
- Pharmacy
- Paediatrics
- Midwifery
- Dental

Integrated Urgent Care Service

Multidisciplinary CAS Clinicians*
Hear & Treat
Hear & Refer
Advice to HCPs

CDSS - TRIAGE

HCPs

Same day appt booked
GP in hours / extended access services

Community Services

Social Care

Urgent Care Centre

Emergency Dept

AMBULANCE 999

See & Treat

MDTs

Non-symptomatic calls completed
Admin/Navigators 24/7 365 Health Advisors

Care Home Staff

Health advice given and call completed

111

111 ONLINE

Based on NHS England IUC Service Specification 25 August 2017

BUT...
Are these structures, referral pathways, functions in place and working effectively?

Where are the gaps and how can they best be filled?
Clinical Hub

- This Hub will support enhanced Clinical review of vulnerable patient groups- Over 85, Under 5yrs, Frail Elderly and Palliative patients and Emergency Department / Green Ambulance (60 minute response time) calls.

- The GP lead will liaise directly with Acute and Specialist Practitioners as required to proactively manage more patients in Primary care.

- Clinical navigators will work directly with the local community and voluntary services, within the local Single Point of Access to support admission avoidance.
Barriers in progressing new models of care

**Hear & Treat**

- Multiple ‘clinical hubs’ and ‘single points of access’ in each region
- Competition for / inefficient use of resources
- Dislocation of 999 and 111
- Multiple 111 providers / changing contracts
- DoS - incomplete and unreliable
- Lack of ready access to patient records / care plans

**See & Treat**

- Development & retention of Advanced & Specialist Paramedic Practitioners
- Attraction for nurse practitioners and AHPs to AS
- Heavily dependent on reliable technology/connectivity in the field - access to records / info on other services
- Delays in call back from GPs / arranging follow up OOH more challenging
- Few direct referral pathways with community teams
- Lack of MH crisis team provision / Excessive time to respond (MH nurses in ambulance control rooms helps)
- Police can refer MH direct / paramedics often cannot!
- Alternative destinations e.g. UCC not consistent in scope/hours
- Professional perceptions / boundaries re taking referrals from paramedics
Transforming the Ambulance Service
What’s needed?

- Collaborative commissioning framework
- Developing & retaining the right skill mix & capacity across ambulance workforce, moving to multi-professional workforce
- Enhance & develop new models of care
- Less focus on targets - more on patient / system outcomes
- Changing NHS culture - building trust across professions and sharing responsibility for change
- New pathways within the community and smoother integration across providers
- Interoperable technology and timely data sharing

Improved patient safety, outcomes & experience and happier, healthier workforce and more sustainable systems & services
Our strategic journey

Our progress so far

✓ increased people’s chances of survival
✓ supported more people at home, assessing and treating them on the phone and at their home
✓ won new contracts for patient transport services as well as retaining our existing business
✓ recognised by Care Quality Commission as ‘good’
✓ introduced Specialist Paramedic roles for Critical Care and Urgent Care, both to improve patient outcomes and to offer career development
✓ performed well against a wide range of national benchmarks and standards
✓ worked with partners in four different regions, contributing to each of the Transformation & Sustainability Plans on behalf of our sector

Challenges in coming years

➢ growing demand and tightening finances
➢ ageing population, with rising numbers of frail people living independently at home
➢ increasing numbers of people living with one or more long term conditions
➢ too few Paramedics across country, with new roles in urgent care as well as emergency care
➢ opportunity to use technology to support care remotely, at scene, at home or whilst travelling
➢ new arrangements for health and care, with the emergence of Accountable Care Systems
In 2016-17, our Clinical Coordination Centres handled over 1,240,000 calls to NHS111, plus over 562,000 incidents arising from 999 calls.

In future, we will …

- increase the number of clinicians available to assess your needs
- enable a broader range of specialists to help, by connecting remotely as well as on the telephone
- improve the inter-operability of our systems
- ensure staff can view relevant information, to tailor our response to your needs and circumstances
- book appointments in appropriate services, so you do not have to make more calls or repeat yourself
- give you online access to NHS111 Services

We will enable you to get the care you need
SCAS as a partner in local care systems

*We will work with each local care system to*

- support more people at home or online
- consider whether to undertake a proactive support role for frail people living alone
- expand our Paramedic workforce to meet local needs and plans *including potential for secondments into primary, community and urgent care settings*
- develop our technical infrastructure, digital capability and connectivity
- share our capability with our partners *perhaps vehicle management, telephony or digital developments, or bidding experience*
- offer a ‘helicopter view’ across care systems *sharing analysis of demand trends, patient flow, service gaps, processes and local variations*

*We will work with you to meet local needs*
Ambulance Response Programme Principles

What does the patient need?
- The right vehicle
- The right skill
- The right place for care (Home, A&E, stroke centre ....)
- The right time

What does SCAS need?
- Less on scene time for RRVs
- Less diverts
- Less multi-vehicle deployments on CAT 2,3&4
Our staff are critical in delivering these goals

Enabling people to identify and access the care they need
Any questions or suggestions?

john.black@scas.nhs.uk
## What are the new categories

<table>
<thead>
<tr>
<th>CATEGORY 1 - LIFE-THREATENING</th>
<th>Time critical life-threatening event needing immediate intervention and/or resuscitation e.g. cardiac or respiratory arrest; airway obstruction; ineffective breathing; unconscious with abnormal or noisy breathing; hanging.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CATEGORY 2 - EMERGENCY</td>
<td>Potentially serious conditions (ABCD problem) that may require rapid assessment, urgent on-scene intervention and/or urgent transport.</td>
</tr>
<tr>
<td>CATEGORY 3 – URGENT</td>
<td>Urgent problem (not immediately life-threatening) that needs treatment to relieve suffering (e.g. pain control) and transport or assessment and management at scene with referral where needed within a clinically appropriate timeframe.</td>
</tr>
<tr>
<td>CATEGORY 4 – NON-URGENT</td>
<td>Problems that are not urgent but need assessment (face to face or telephone) and possibly transport within a clinically appropriate timeframe.</td>
</tr>
<tr>
<td>TYPE S – SPECIALIST RESPONSE (HART)</td>
<td>Incidents requiring specialist response i.e. hazardous materials; specialist rescue; mass casualty</td>
</tr>
<tr>
<td>Categories</td>
<td>National Standard</td>
</tr>
<tr>
<td>------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Category 1</td>
<td>7 minutes mean response time 15 minutes 90th centile response time</td>
</tr>
<tr>
<td>Category 2</td>
<td>18 minutes mean response time 40 minutes 90th centile response time</td>
</tr>
<tr>
<td>Category 3</td>
<td>120 minutes 90th centile response time</td>
</tr>
<tr>
<td>Category 4</td>
<td>180 minutes 90th centile response time</td>
</tr>
</tbody>
</table>
### EXISTING RESPONSE STANDARDS

<table>
<thead>
<tr>
<th>TYPE</th>
<th>% Calls / Demand</th>
<th>National Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red 1</td>
<td>3%</td>
<td>75% within 8 mins 95% within 19 mins</td>
</tr>
<tr>
<td>Red 2</td>
<td>47%</td>
<td>75% within 8 mins 95% within 19 mins</td>
</tr>
<tr>
<td>Green</td>
<td>50%</td>
<td>No National Standard – Locally agreed Green 30 mins or Green 60 mins</td>
</tr>
</tbody>
</table>

### NEW RESPONSE STANDARDS

<table>
<thead>
<tr>
<th>TYPE</th>
<th>% Calls / Demand</th>
<th>National Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cat 1</td>
<td>8%</td>
<td>Standard mean ≤7 mins ≤15 mins 90th centile response</td>
</tr>
<tr>
<td>Cat 2</td>
<td>48%</td>
<td>Standard mean ≤18 mins ≤40 mins 90th centile response time</td>
</tr>
<tr>
<td>Cat 3</td>
<td>34%</td>
<td>≤120 mins 90th centile response time</td>
</tr>
<tr>
<td>Cat 4</td>
<td>10%</td>
<td>≤180 mins 90th centile response time</td>
</tr>
</tbody>
</table>

% of activity may vary slightly and is dependent on which call triage assessment tool in use by each Trust (NHS Pathways or AMPDS)