Avoidable Conveyance Steering Group Learning events

SDEC

14th July 2022
10:00-11:00

Safely Reducing Avoidable Ambulance Conveyance - Practical Examples

NHS E/I Ambulance Transformation team

NHS England and NHS Improvement

What are we covering today?

Time	Item	Speaker
10:00-10:05	**Welcome & Intro**	Jordan Wall
10:05-10:15	**National context – Ambulance services, current pressures and avoidable conveyance**	Mark Gough
10:15-10:25	**National Context – SDEC**	Sade Matakitoga and James Ray
10:25-10:45	**Sharing local solutions and good practice** a) NWAS SDEC priorities b) Oxford model	Caroline Hargreaves, Martin Rolls Jordan Bowden and Richard De Butts
10:45-10:55	**Q&A**	All
10:55-11:00	**Wrap-up, closing comments, next webinar**	Mark Gough/ Jordan Wall

Welcome & Intro

Mark Gough
Head of Ambulance Improvement -NHSEI

Sade Matakitoga
Senior Programme Manager, Hospitals

James Ray
Emergency Medicine Consultant, National Clinical advisors

Caroline Hargreaves Quality Improvement Manager-NWAS

Martin Rolls
Advanced paramedic-NWAS

Jordan Bowden
Consultant- Oxford

Jordan Wall
Ambulance Programme Manager NHSEI

Richard De Butts
Consultant- Oxford

National Context
Ambulance Services

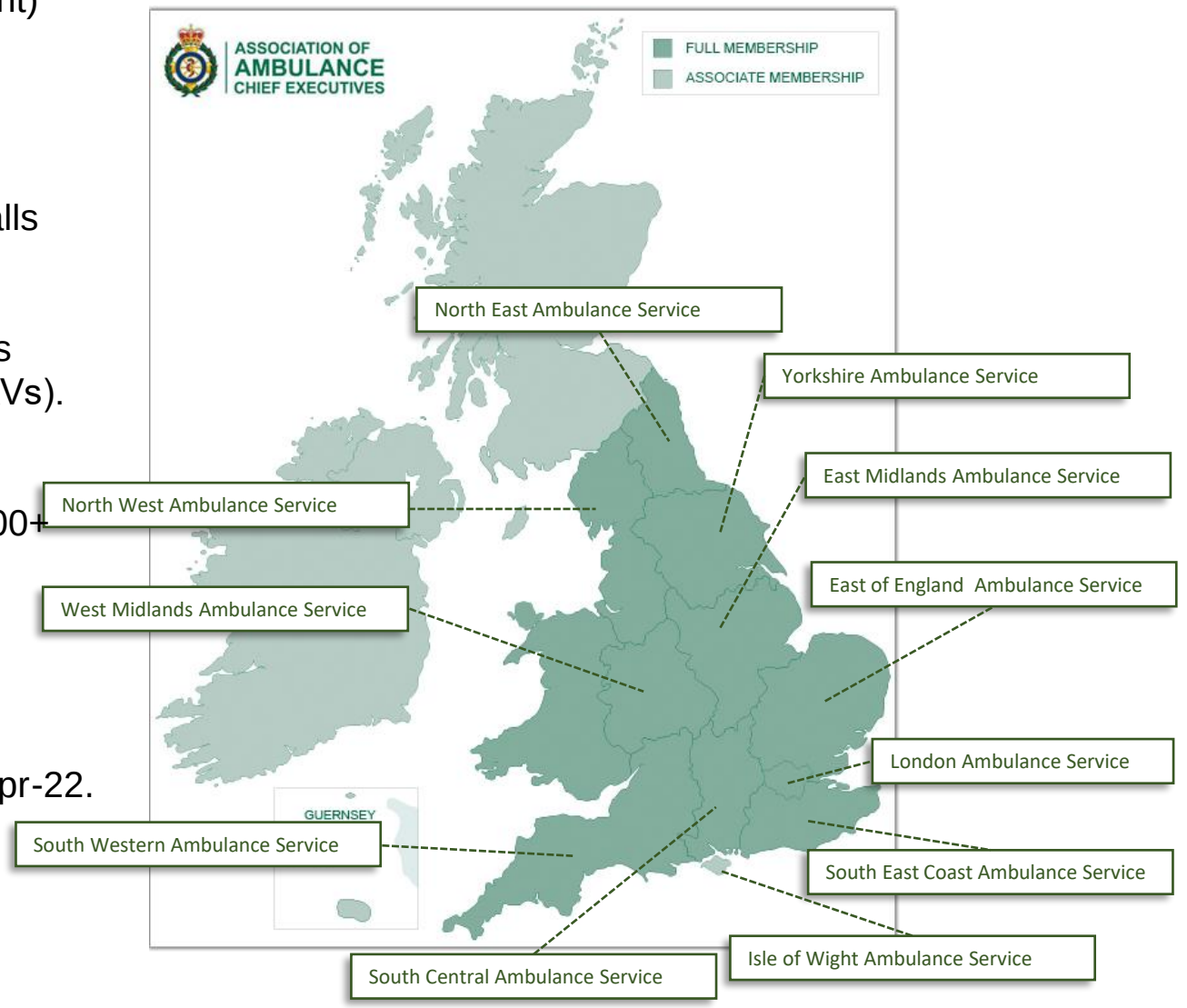
Mark Gough
Head of Ambulance Improvement

Reminder: please do pop any questions or comments in the Q&A box for the upcoming Q&A panel session. Or feel free to give a ‘thumbs up’ to questions from others you think we should prioritise

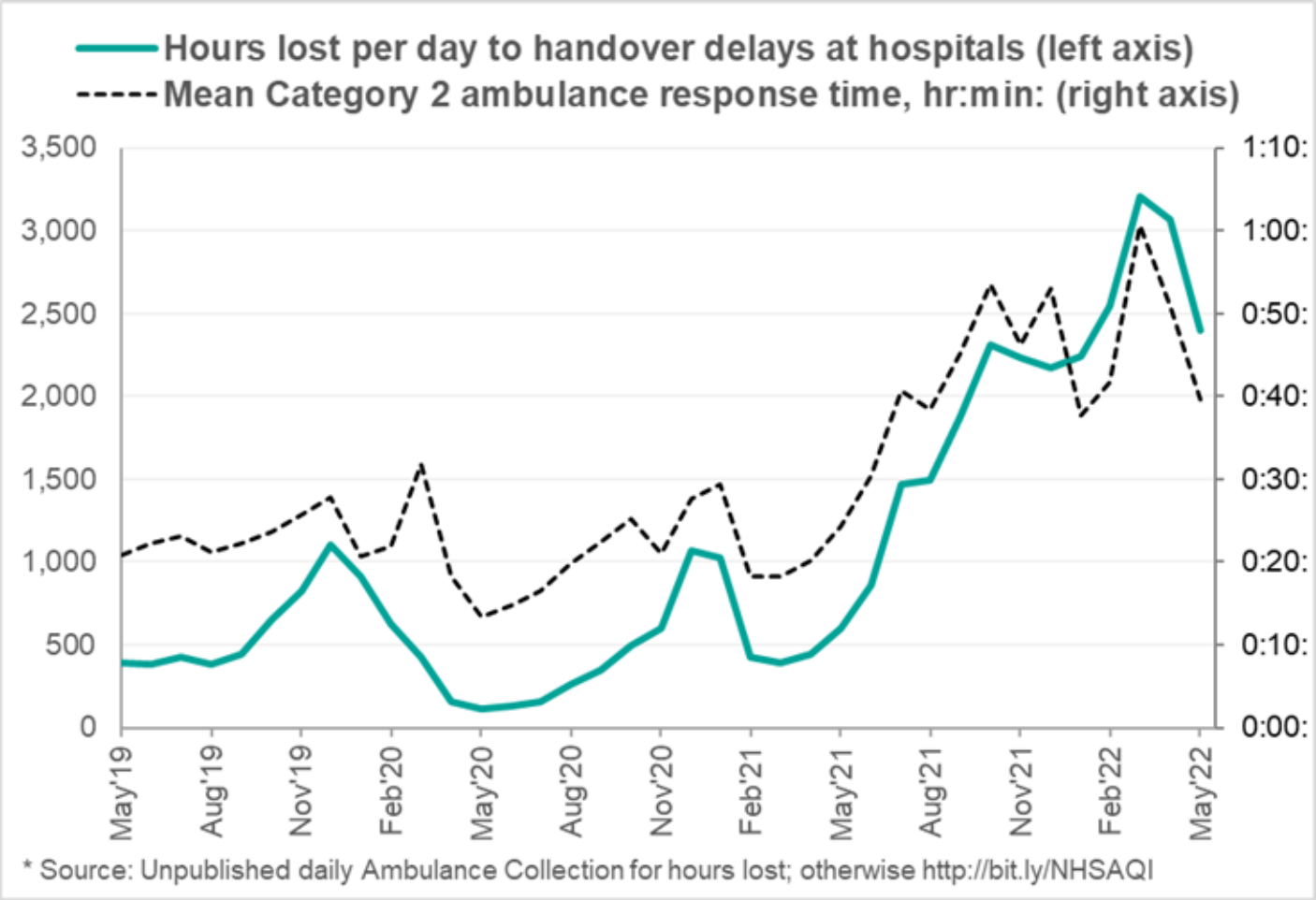
NHS England and NHS Improvement

Ambulance Service – Facts & Figures

- 11 Ambulance services operate across England (inc. Isle of Wight)
- National Annual spend equates to approx. £2.3bn
- Each year c12-14m calls are received into 23 Ambulance control rooms –through 22/23 this is expected to rise to c15m calls
- Currently there are +4000 double crewed ambulances(DCAs) operational across Ambulance trusts in England, and an additional ~900 rapid response vehicles (RRVs).
- Almost 49,000 WTE staff members were in post in Apr-22. With around 17,000 of these as registered paramedics, and 2,000+ WTE call handlers.
- Staff sickness is a challenge (10.2% rate of sickness nationally, up from 5.5% in April 18), with Anxiety/stress/depression/ other psychiatric illnesses accounting for the most days lost in Apr-22.

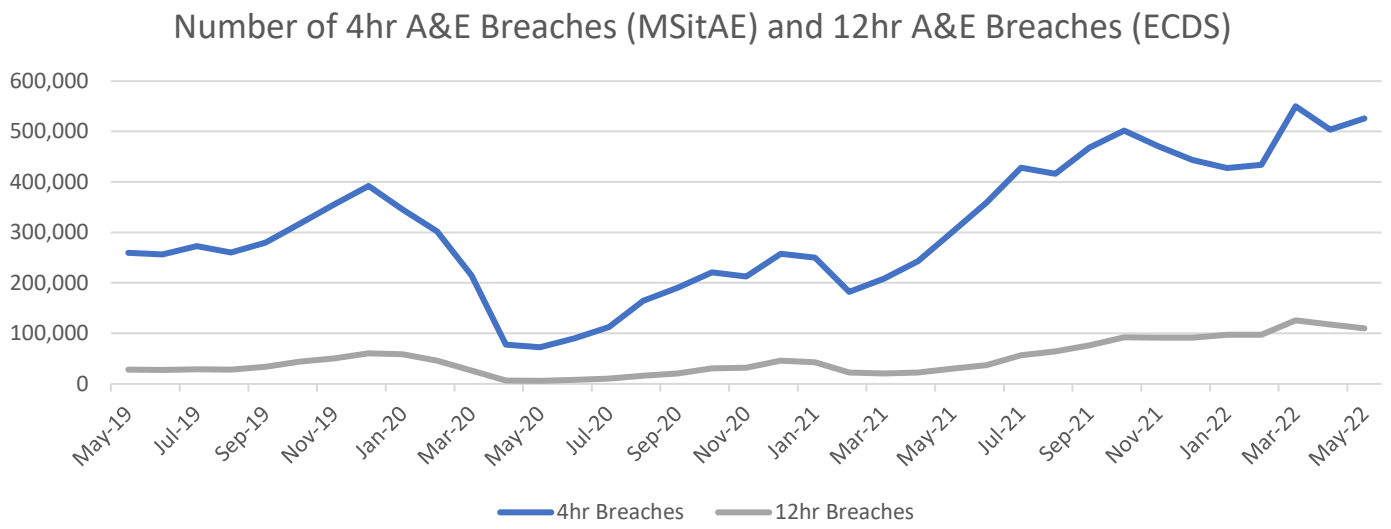


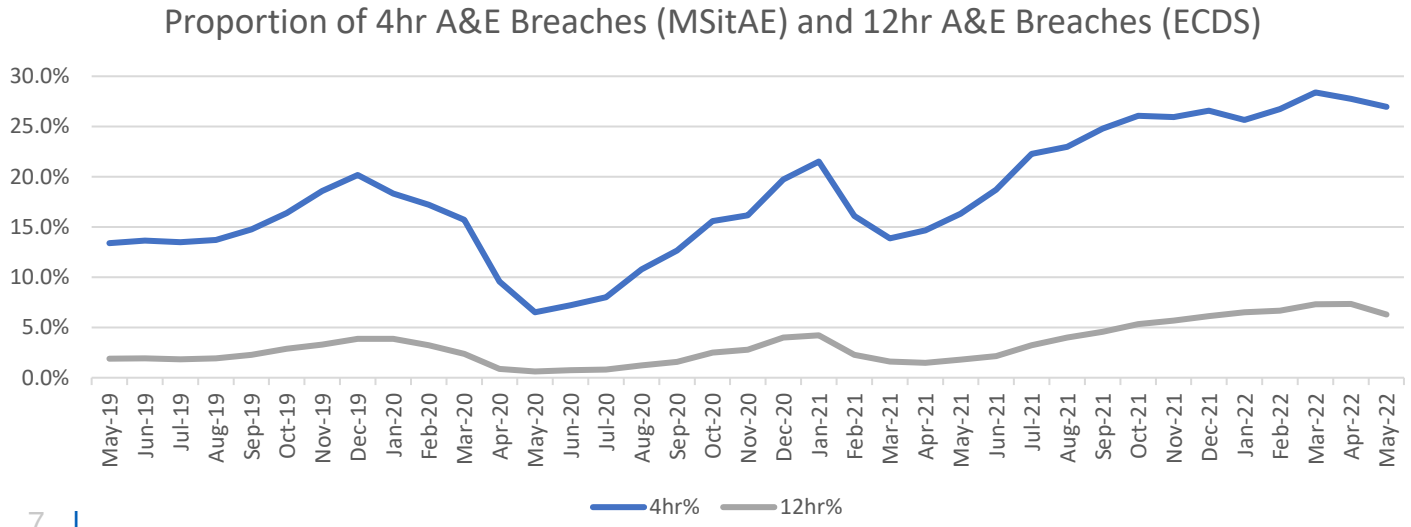
Current Ambulance Pressures



- Increasing response times for all four categories C1-C4, the average and 90th centile response times in March 2022 were the longest since the categories were introduced in 2017.
- There is a strong correlation between increased time lost to handover delays and Category 2 mean response time.
- For 80,000 total **hours lost to handover delays**, the C2 response time **increases to 52 minutes and 20 seconds**
- The evidence suggests that there is an **increased risk** to **patient harm** due to **increasing delays in handing over patients** from ambulances to the hospital

Current ED Pressures





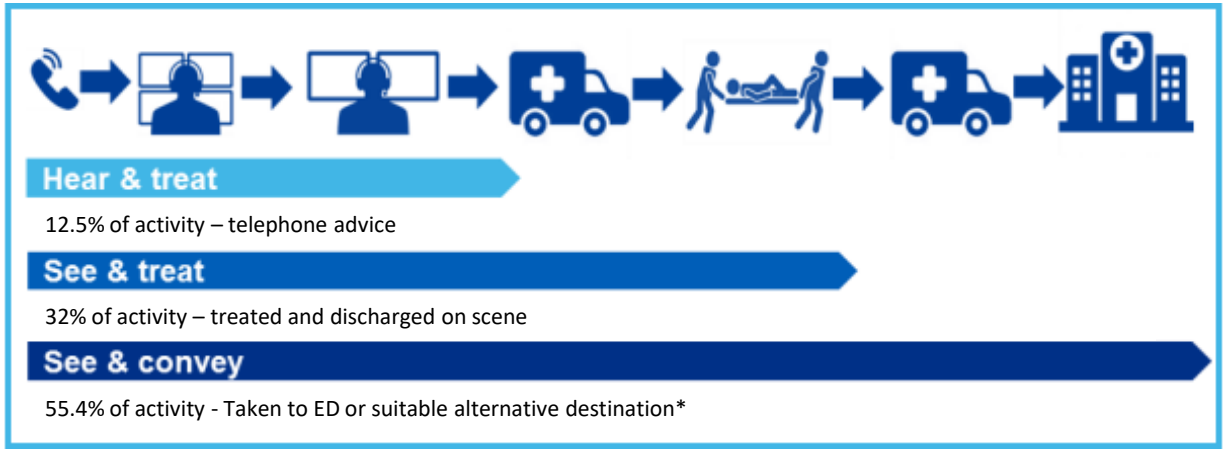
- Correlation between increased hospital handover times and number of patients waiting longer than 4 hours.
- Longer waits for patients in ED's with a higher number of patients waiting more than 4 hours, in May 22, there was an increase by 103% from May 19
- Increasing rates of 12 hour breaches with a significant increase in May 22 by 296% from May 19.

Safely Reducing Ambulance Conveyance

- Patients should only taken to hospital if that's the right place for them; An avoidable conveyance happens when a patient, whose health and social care needs could be effectively and safely met in a community setting, within or close to their own home, is conveyed to hospital unnecessarily.
- The NHS's Long Term Plan places ambulance services at the heart of the UEC system and commits to implementing Lord Carter's recommendations, putting in place timely responses so people can be treated by skilled paramedics at home, or in the most appropriate setting outside hospital whenever it is safe to do so.
- Ambulance services have adapted to work in different ways; and ambulance clinicians now treat more people in their own homes (See & Treat), give more advice over the phone (Hear & Treat) and take more people to alternative points of care then Emergency Departments than in previous years (see below).
- But there is always more that can be done

Year	Hear & Treat	See & Treat	Transport to non-ED	Transport to ED
2017-18 (Oct-Mar)	**5.8%**	**29.3%**	**5.8%**	**59.1%**
2018-19	6.1%	29.4%	5.4%	59.1%
2019-20	7.0%	30.5%	5.4%	57.1%
2020-21	8.2%	34.3%	5.4%	52.1%
2021-22	11.3%	31.7%	5.1%	52.0%
2022-23 (April)	**12.5%**	**32.0%**	**4.8%**	**50.6%**

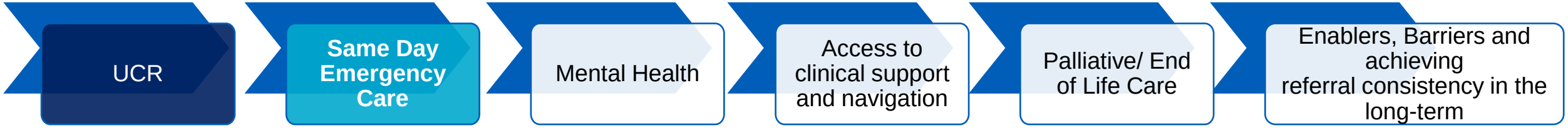
**AmbSYS data April 2022 -* Statistics » Ambulance Quality Indicators Data 2022-23 (england.nhs.uk)



** Includes both transport to ED and Non-ED*

The webinar series

AIM: To use the following six webinars to **s**howcase and set out practical examples of initiatives that are working well to enable ambulance services to access alternative pathways and reduce the number of people arriving at ED, over the next few months.



Avoidable Conveyance Enablers:

- **Directory of Services and CAS**
- **Building the right pathways**
- **Referral Efficiency**
- **Engagement, Collaboration and Integration**
- **Consistency, reducing variation**
- **Single Point of Contact**
- **Measuring Success, audit and feedback**

Lord Carter recommendations

- **The provision of high-quality clinical care and good resource management go hand-in-hand**.
- **The need for genuine local and national collaboration and coordination.**
- A single reporting framework should be adopted across all trusts, which pulls together clinical quality and resource performance data and compares it to the ‘best in class’.
- Delayed transfers of care have a significant impact on achieving efficiency savings.

National Context
SDEC

Sade Matakitoga
Senior Programme Manager, Hospitals
James Ray
Emergency Medicine Consultant, National Clinical advisors (Hospitals)

Reminder: please do pop any questions or comments in the Q&A box for the upcoming Q&A panel session. Or feel free to give a 'thumbs up' to questions from others you think we should prioritise

NHS England and NHS Improvement

Same Day Emergency Care

National strategy launched in May 2021, focusing on 7 elements

Staffing

Access

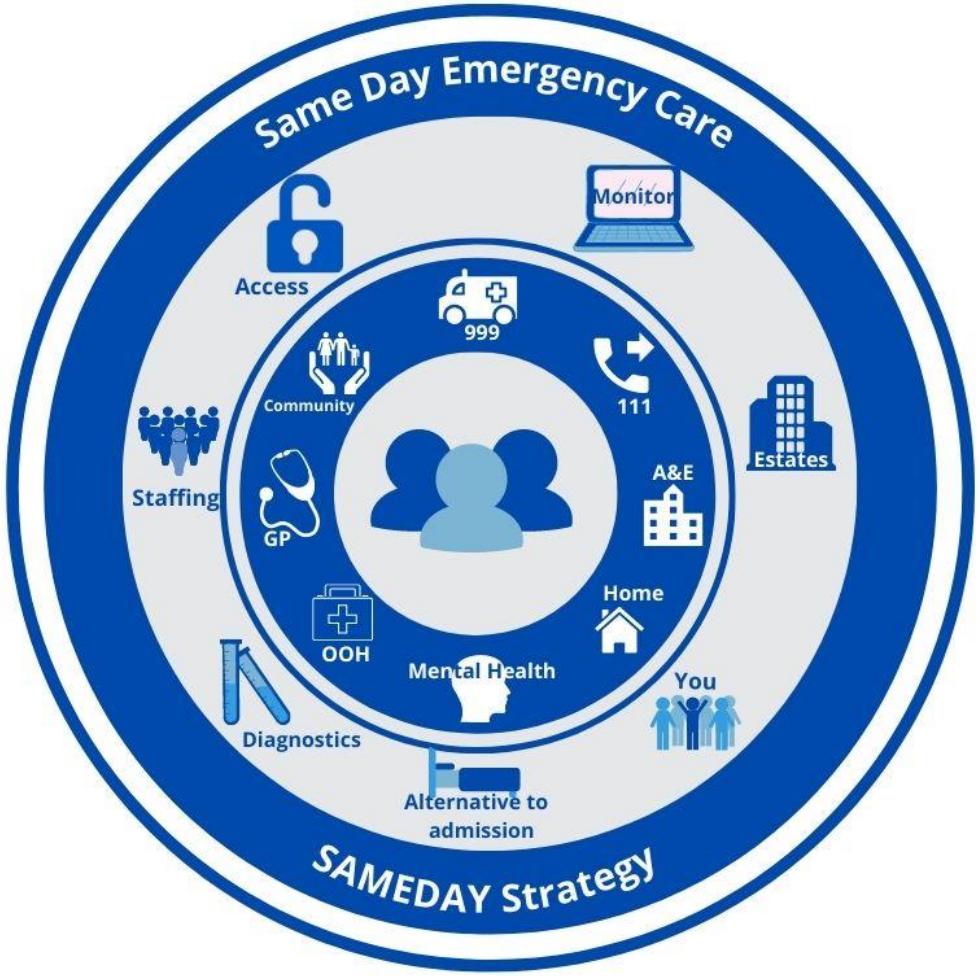
Monitoring

Estates

Diagnostics

Alternative to admission

You



Priority overview - Access

Why will we do this?

Aim: **Access to SDEC is integrated system-wide**.

Initiative: **Make SDEC available across all parts of the healthcare system** including 111, 999, primary care, community care and mental health so that patients are navigated to the right service, first time. This will be **achieved by developing a system-wide access model that maximises routes into SDEC/AFS for a minimum of 12 hours per day**.

What will the impact be?

Impact: Virtual and physical resources improve access and patient flow.

Restoration
Medical, surgical and AFS services are delivered in line with national standards

→

Transformation
Patients are directly referred across 111/999/Primary/ Community/Mental Health

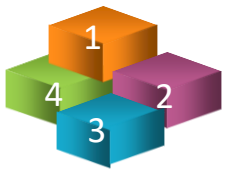
→

Integration
Historical service boundaries are addressed to reduce duplication and fragmentation

How will we do this?

Actions: We have identified **four priority actions** that will enable us to make a **series of commitments to our providers.**

1. Develop direct access criteria/ principles /service design
2. Develop high volume pathways to reduce variability
3. ICS level Directory of Service will support increased referrals
4. Digitally enabled direct referral and booking platforms



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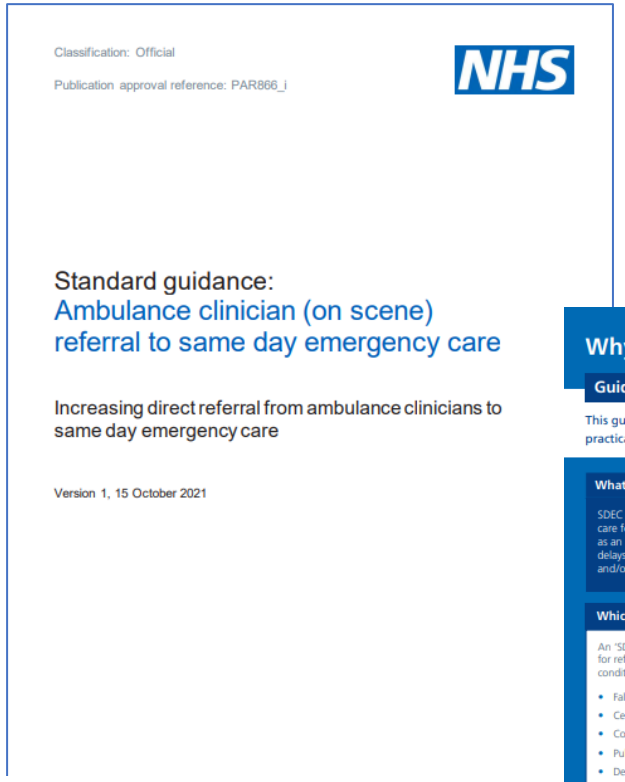
Commitment to our providers

1. Increased number of patients seen on the same day
2. Patients are seen in the right place first time
3. Clinician to Clinician referrals enabled system-wide

Ambulance & SDEC

- Guidance launched in October 2021
- Comms materials shared in March 2022 (Editable version available)
- Case studies available
- Inclusion and exclusion criteria and available to use
- Task & Finish group with all providers started in June 2022

**All materials are available on the futures collaboration platform*



Classification: Official

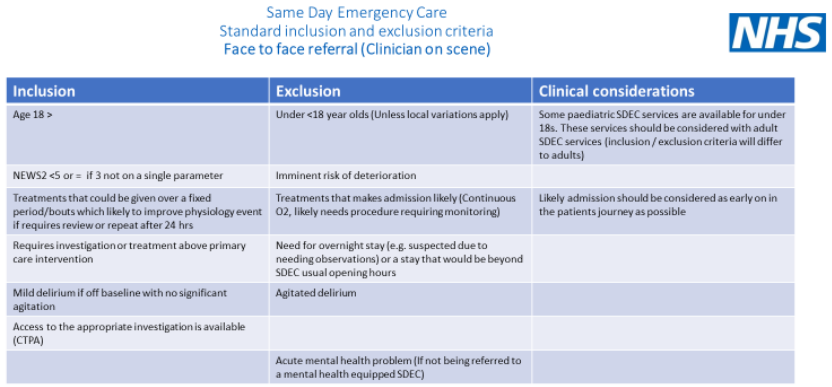
Publication approval reference: PAR866_i

NHS

Standard guidance:
Ambulance clinician (on scene) referral to same day emergency care

Increasing direct referral from ambulance clinicians to same day emergency care

Version 1, 15 October 2021



Same Day Emergency Care
Standard inclusion and exclusion criteria
Face to face referral (Clinician on scene)

NHS

Inclusion	Exclusion	Clinical considerations
Age 18 >	Under <18 year olds (Unless local variations apply)	Some paediatric SDEC services are available for under 18s. These services should be considered with adult SDEC services (inclusion / exclusion criteria will differ to adults)
NEWS2 <5 or = if 3 not on a single parameter	Imminent risk of deterioration	
Treatments that could be given over a fixed period/bouts which likely to improve physiology event if requires review or repeat after 24 hrs	Treatments that makes admission likely (Continuous O2, likely needs procedure requiring monitoring)	Likely admission should be considered as early on in the patients journey as possible
Requires investigation or treatment above primary care intervention	Need for overnight stay (e.g. suspected due to needing observations) or a stay that would be beyond SDEC usual opening hours	
Mild delirium if off baseline with no significant agitation	Agitated delirium	
Access to the appropriate investigation is available (CTPA)		
	Acute mental health problem (If not being referred to a mental health equipped SDEC)	

2 | Same Day Emergency Care

Why think Same Day Emergency Care?

NHS

Guide for ambulance clinicians

This guide is designed to provide ambulance clinicians with the practical advice and information they need to refer into SDEC services.

What is Same Day Emergency Care (SDEC)?

SDEC allows specialists, where possible, to care for patients within the same day of arrival as an alternative to hospital admission, removing delays for patients requiring further investigation and/or treatment.

What are the benefits of directly referring into SDEC?

- **Clinical touchpoints are appropriately reduced** through the patient's journey and experience.
- **Helps to safely reduce avoidable conveyance to emergency departments (EDs)** which means patients are directed to the right place, first time.
- **Helps reduce ambulance handover times** as it frees up capacity in the ED.
- **Improves patient flow** as patients avoid delays in ED waiting rooms and further triage.
- **Patients have a better experience** – they spend hours, rather than days, in hospital.

Which patients are suitable for SDEC?

An 'SDEC by default' approach should be considered for referrals. SDEC services treat many common conditions including (not an exhaustive list):

- Falls (without injury)
- Cellulitis
- Community acquired pneumonia
- Pulmonary embolism
- Deep vein thrombosis
- Chest pain
- Shortness of breath (COPD, heart failure, asthma)
- Early pregnancy bleeding
- Palpitations
- Atrial fibrillation
- Acute headaches

Referrals should only be made when the patient's condition requires treatment above and beyond primary care.

What can I do?

- Always **think SDEC first** when considering sending a patient to an ED.
- Make sure you have **access to an appropriate digital referral tool (e.g. MiDoS, Service Finder or Pathfinder)** to find the most up to date information on local SDEC services.
- **The referral tool you have access to will provide you with a direct dial number for your local SDEC service.** You can use this for advice regarding individual patients and their suitability for SDEC.
- **A discussion with the clinician or senior decision maker** within the SDEC unit will deem if a referral is appropriate.

Where can I find out more?

- **National guidance is available** to support ambulance providers and systems in designing and implementing direct referrals into SDEC. The guidance also includes a **Situation, Background, Assessment, Recommendations (SBAR) template** to support decision making pre-conveyance.
- The **SDEC Collaboration Platform** is a dedicated space for members to access guidance and tools to support whole system transformation.

You can register to join the workspace here:

[Ambulance - SDEC Collaboration Platform - FutureNHS Collaboration Platform]

The important bit…

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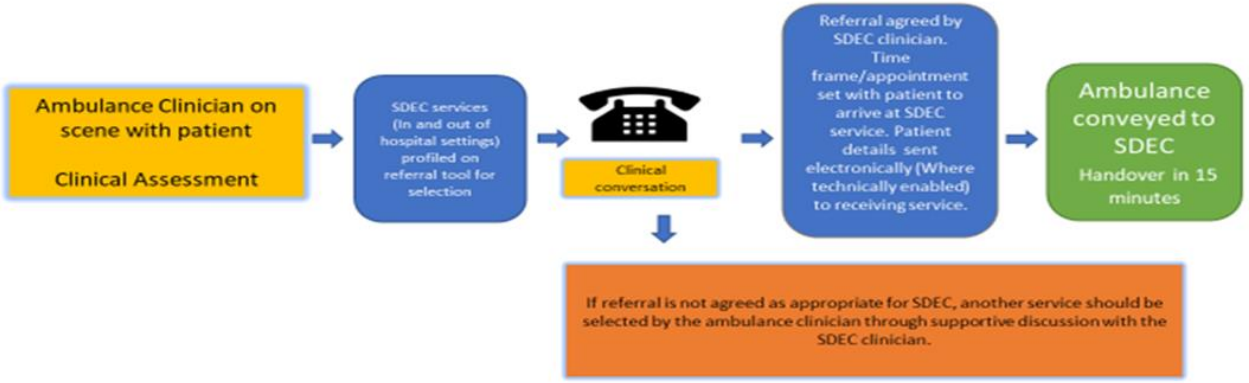
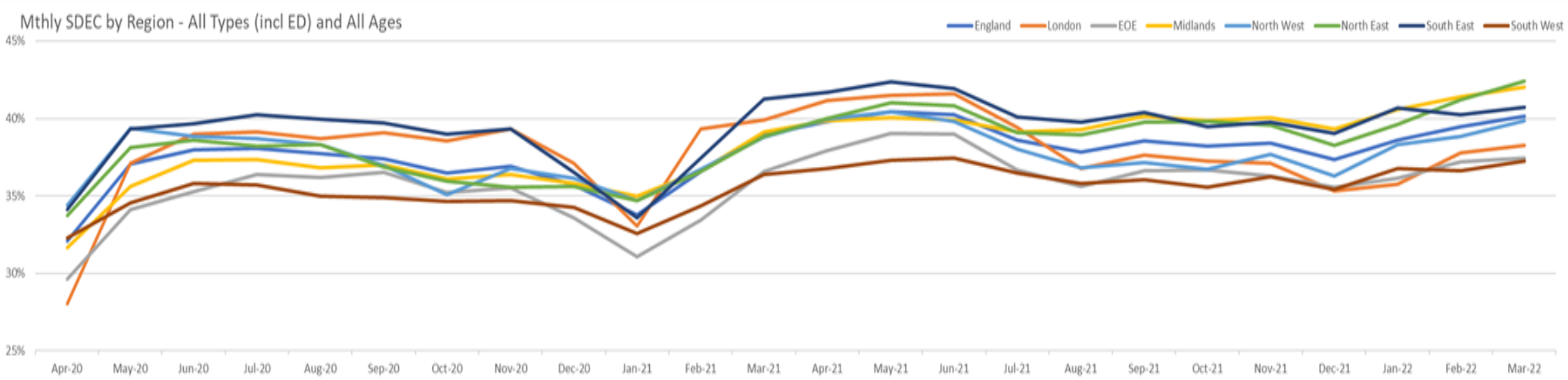
The clinical discussion

Ambulance clinician – SDEC referral flow



Note: Patients may make their own way to the SDEC service if clinically appropriate and agreed by all parties.

Demand & capacity



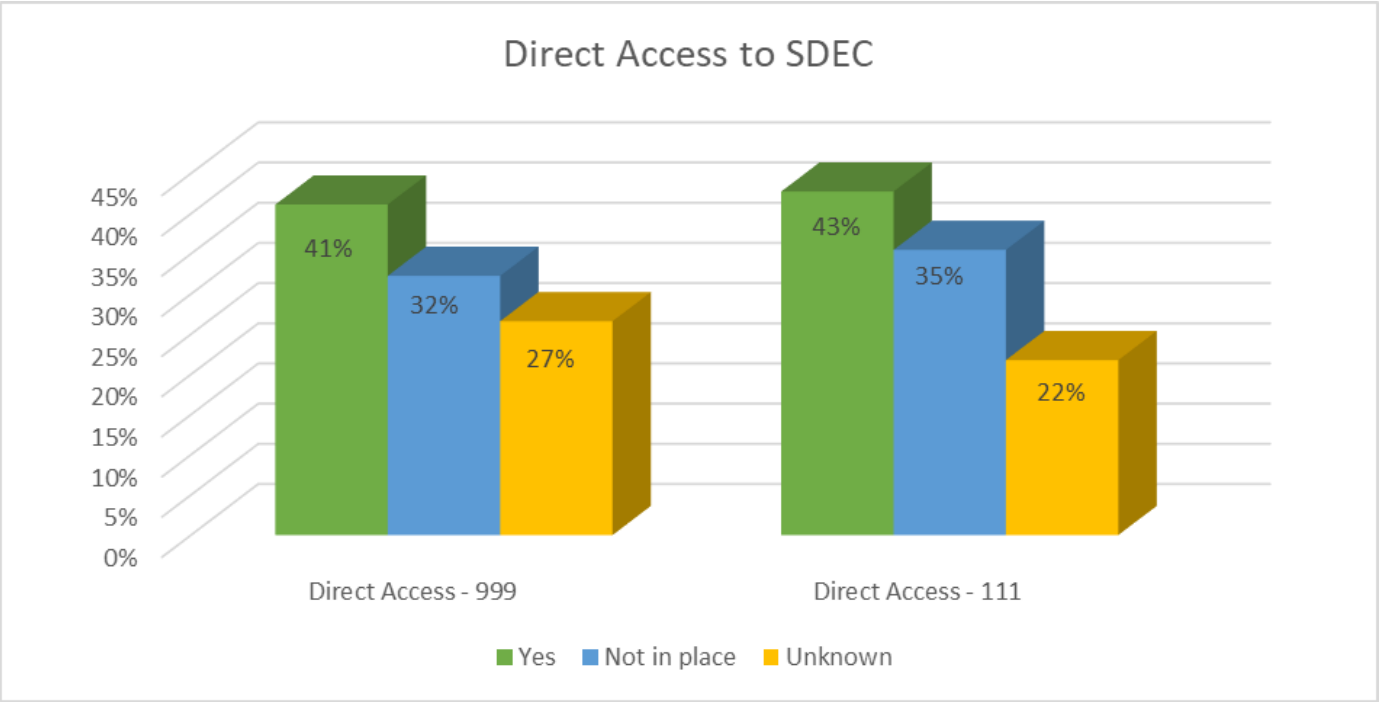
SDEC activity has been trending upwards since Dec 2021

SDEC provision is still recovering with services impacted by bedding and covid

Number shared with sites that have started to refer into SDEC are low, approx. 30 per month into medium sized hospitals

Current position

- Current no single data set to collect SDEC referrals into SDEC
- The ambulance data set (ADS) will capture this when fully implemented by providers
- Currently ambulance referral including 111 amounts to 3% all of SDEC activity
- DOS now profiles over 300 SDEC services across England



- <50% of the organisations stated that they had direct access routes available for NHS 111 & 999 services to SDEC.
- Majority of organisations who did not have direct access routes in place, referenced they had plans to do so in the coming months and were actively working with providers to implement.

**SDEC benchmarking data Oct 2021*

THE FUTURE IS BRIGHT

THE FUTURE IS

Access

NHS
North West
Ambulance Service
NHS Trust

SDEC in Greater Manchester

Martin Rolls, Advanced Paramedic

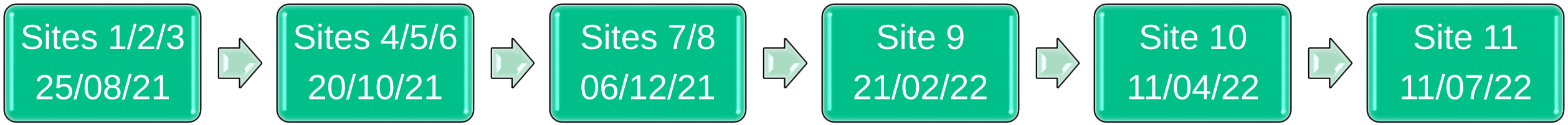
Hello!

- Implementation
- Approach
- Benefits
- Challenges
- Next steps
- Questions?

Implementation

- Initial conversations began July 2021 with one trust (3 sites)
- Developed one exclusion list to use across the 3 sites
- Developed single SOP
- Go live 25/08/21
- Further sites in GM went live throughout the year.

Implementation



Approach

- Paramedic conducts face-to-face assessment and examination
- Manchester Triage System used as part of decision-making
- If ED outcome, and not on exclusion list, contact SDEC
- Have clinician-to-clinician conversation with SDEC re: patient suitability
- Convey to SDEC or ED?
- Can patient make their own way?

Approach

- Age < 16
- Specialist pathways e.g. CVA, major trauma, PPCI
- Incidents that generate a pre-alert
- NEWS2 ≥ 5
- Acute ECG changes
- Infection transmission risk e.g. COVID, D+V
- Intoxicated
- Acutely confused/lacks capacity
- Mental health presentation with ED MTS outcome
- Patient unable to sit or transfer
- All trauma

Approach

Site	Go Live Date	Successful Referrals
1	25/08/21	50
2	25/08/21	47
3	25/08/21	14
4	20/10/21	243
5	20/10/21	321
6	20/10/21	318
7	06/12/21	82
8	06/12/21	75
9	21/02/22	51
10	11/04/22	21

Benefits

- One exclusion list for all sites – familiarity for paramedics
- Greater utilisation of Service Finder
- No queueing – patient flow is smoother, and less likely to block
- Better patient and crew experience

Challenges

- Differing risk appetite per site regarding exclusion criteria
- Paramedic buy-in, and confidence in process
- Site internal issues – comms, operational, staffing
- Data – successful vs unsuccessful referrals
- Feedback limited
- Inconsistent offer – hours of referral differ at some sites

Next Steps?

- All clinicians to refer
- Meaningful data
- Surgical SDEC?
- Paediatric SDEC?

Sharing good practice
Oxford Model

Dr Richard De Butts – Acute Medicine consultant – Lead for Ambulatory care at Oxford University Hospital NHS Trust

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NHS England and NHS Improvement

Acute Ambulatory Unit

- Set up in 2016
- Now sees 50-70 patients daily, <10% admitted – over 50% of medical take
- Phone held by Consultant/Ambulatory Fellow 8am to 9pm – Junior doctor overnight
  - Take calls from primary care, SCAS, ED, 111 and other specialties
- SCAS call this phone direct if they feel their patient would benefit from seeing medicine directly
  - Try to be broad in our definition of ‘benefit from medical input’
  - Some conditions eg – acute back pain, trauma, renal colic etc have separate pathways
  - Many SCAS referrals seen direct in ambulatory care and go home later that day

Avoidable conveyance

- AAU Phone holder should:
  - Consider alternative pathways in the community:
    - Single point of access -> urgent community response (SPA/UCR)
    - Acute hospital at home (AHA)
    - Emergency Medical Units (EMU)
    - Primary care
    - Advice only

- Needs to consider best interests of patient
- Able to balance risks appropriately/risk sharing
  - weigh the risk of unnecessary attendance against best place to manage current problem
- Respect for everyone’s skills and experience
- Allow for patient priorities
- Good communication with other teams
- Time of day of phone call can affect management options

Case study 1

- Frail elderly patient with significant co morbidities, live alone and has care.
- Calls SCAS as SOB with cough -
- Found to be hypoxic (91% on RA), febrile (38) and tachycardic (hr 109) but BP 126/74
- SCAS -?pneumonia
- Patient does not want to come to hospital and has capacity

- SCAS calls AAU – we discuss with patient and hospital at home team

- Hospital at home see her in community and treat for CAP with IV antibiotics, iv fluids (and o2 concentrator if needed), daltaparin etc.

Case study 2

- Elderly patient with no carers fallen out of chair and could not get back up. SCAS called
- SCAS assessed – no injuries, been on floor for 4-5 hours but able to roll over. All obs normal
- Calls AAU -> Agree as no obvious injury, low probability of rhabdo -> no need for secondary care review – advice call single point of access
- SPA send urgent community response to see patient in her house later that day and she has care put in in community

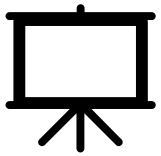
Case study 3

- 25yr old normally fit and well, no risk factors for IHD
- Eating meat when it got stuck – then vomited it up.
- Calls SCAS as has ongoing burning chest pain since vomiting. All obs normal and normal ECG with SCAS.
- SCAS call AAU consultant – given reasonable cause of pain is identified, patient can stay at home and given safety net advice.

Q&A panel with speakers

Next up…

Next webinar **Thursday 24th August 15:00-16:00, Mental Health. Registration to be circulated with webinar slides.**



Slide deck and recording – Will be made available and circulated after the event

AACE repository - [Safely Reducing Avoidable Conveyance Programmes - aace.org.uk]

FutureNHS Collaboration Platform

NHS Futures- [Safely Reducing Avoidable Conveyance]