Transforming urgent and emergency care services in England

Clinical models for ambulance services
# Clinical models for ambulance services

This document is designed to help Urgent and Emergency Care Networks to commission ambulance services that play an even greater role in the delivery of urgent and emergency care in a reformed and improved system.

## Target Audience

- CCG Clinical Leaders
- CCG Accountable Officers
- Care Trust CEs
- Foundation Trust CEs
- NHS England Regional Directors
- NHS England Directors of Commissioning Operations
- Directors of Finance
- Emergency Care Leads
- Directors of Children's Services
- NHS Trust CEs
- Commissioners of ambulance and integrated urgent care services / ambulance providers
- System Resilience Groups
- Urgent and Emergency Care Networks

## Additional Circulation List

- CSU Managing Directors
- Medical Directors
- Directors of Nursing
- Local Authority CEs
- Directors of Adult SSs
- NHS Trust Board Chairs
- Allied Health Professionals
- GPs
- Special HA CEs

## Cross Reference

- Revised planning guidance for 2015/16; Five Year Forward View

## Action Required

- Best practice

## Contact Details for further information

- england.urgentcarereview@nhs.net

## Document Status

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Transforming urgent and emergency care services in England

Clinical models for ambulance services (Guidance for commissioners regarding clinical models for ambulance services)

Version number: 12 FINAL

First published: November 2015

Updated: (only if this is applicable)

Prepared by: Urgent and Emergency Care Review programme team

The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Equality and Health Inequalities

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Local commissioners are reminded to pay due regard to the two duties above when this guidance is implemented locally.

Information Governance

Safe and efficient patient care requires effective, timely and appropriate transfer of key information that follows the patient through the healthcare system. This is particularly important in the urgent and emergency care system where, by definition, the patient is accessing care from outside of their routine care providers.
The informed consent of patients should normally be sought and obtained before accessing or sharing information about them. This informed consent needs to ensure that the patient understand who will access their data and for what purposes. If they are adults and lack the capacity to make these decisions, those decisions should be made in their best interests in accordance with the Mental Capacity Act 2005 and its Code of Practice.

If they are children aged under 16, those decisions should be made by someone with parental responsibility for them, unless they are Gillick competent and, after applying the Fraser Guidelines, it is best interests to respect their decision. If they are children aged 16 or 17, the principles set out in paragraph 12.13 of the Mental Capacity Act Code of Practice should be followed.

The wishes of children (and those with parental responsibility for them) can/should be overridden in their best interests to save them from significant harm; the wishes of adults with capacity cannot be overridden unless overriding their wishes may prevent serious crime. Significant abuse or neglect are/may be crimes.

All of the above is subject to what might happen in an emergency when people cannot make, or cannot properly be expected to make, decisions. When that is so, all decisions to do with their immediate care and welfare should be made in their best interests in accordance with chapter 5 of the Mental Capacity Act Code of Practice.
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1 Document summary

1.1 Transforming urgent and emergency care services in England

The NHS Five Year Forward View (5YFV) explains the need to redesign urgent and emergency care services in England for people of all ages with physical and mental health problems, and sets out the new models of care needed to do so. The urgent and emergency care review (the review) details how these models of care can be achieved through a fundamental shift in the way urgent and emergency care services are provided to all ages, improving out-of-hospital services so that we deliver more care closer to home and reduce unnecessary hospital attendances and admissions. We need a system that is safe, sustainable and that provides high quality care consistently. The vision of the review is simple:

- For adults and children with urgent care needs, we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients, carers and families.

- For those people with more serious or life-threatening emergency care needs, we should ensure they are treated at the scene and then in centres with the right expertise, processes and facilities to maximise the prospects of survival and a good recovery.

As part of the review, a number of products are being developed to help create the conditions for new ways of working to take root and when combined, deliver an improved system of urgent and emergency services. The review proposes that five key changes need to take place in order for this to be achieved. These are:

- Providing better support for people and their families to self-care or care for their dependants.

- Helping people who need urgent care to get the right advice in the right place, first time.

- Providing responsive, urgent physical and mental health services outside of hospital every day of the week, so people no longer choose to queue in hospital emergency departments.

- Ensuring that adults and children with more serious or life threatening emergency needs receive treatment in centres with the right facilities, processes and expertise in order to maximise their chances of survival and a good recovery.

- Connecting and integrating all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.
NHS England is collaborating with patients and partners from across the system to develop a suite of guidance documents and tools to promote best practice and support commissioners and providers in achieving a fundamental shift towards new ways of working and models of care. These guidance documents have been developed as a suite entitled ‘Transforming Urgent and Emergency Care Services in England’ and are designed to be read together. The suite comprises the following components:

- **Role and establishment of Urgent and Emergency Care Networks** (UECNs), published June 2015.
- Clinical models for ambulance services (this document).
- Improving referral pathways between urgent and emergency services in England.
- **Safer, faster, better: good practice in delivering urgent and emergency care**, published August 2015. This good practice guide focuses on the safe and effective care of people with urgent and emergency health problems who may seek or need specialist hospital based services.
- Urgent and emergency care: financial modelling methodology.

### 1.2 Purpose

This document is designed to help UECNs to commission ambulance services that play an even greater role in the delivery of urgent and emergency care in a reformed and improved system.

The document will provide options and models for commissioning ambulance services, as well as help commissioners to understand the benefits that they can expect to see, and the complex relationships that may be required in doing this.

This document has been prepared by a group comprising clinicians (GPs, paramedics and other Urgent Care practitioners) and commissioners and providers of ambulance services. It has been prepared with the assistance of the Urgent and Emergency Care Review’s Delivery Group with input from wider stakeholders, including the Association of Ambulance Chief Executives (AACE).

### 1.3 Audience

The primary audience for this document are commissioners of ambulance and integrated urgent care services.

The secondary audience for this document are providers of ambulance services; it may help them to understand the standards that are required of them and provide options and models for the provision of services.
Because the primary audience of the document is those who commission ambulance and integrate urgent care services it contains some complex terms, but wherever possible plain English has been used.

1.4 Structure

The document begins with an introduction explaining the vision of what needs to be done to make the most of the potential of the ambulance service and its staff in the delivery of urgent and emergency care.

It goes on to describe the main ways in which this can be delivered: by dealing with more cases on the phone (hear and treat) and at the scene (see and treat) where it is safe and appropriate to do so.

The document outlines how the ambulance service can work with other parts of the health and social care system to make the best possible contribution to wider urgent and emergency care incidents.

Appended to this document are three case studies to share some examples of good practice to illustrate new approaches to the provision of emergency services and to promote the idea that the ambulance service is no longer simply a means of conveying patients to Accident and Emergency (A&E).

1.5 How it will be used

This document is part of the Urgent and Emergency Care Review suite of products described above to support the Review and will be released to commissioners by NHS England to provide advice against which they can design local services specifications.

It is hoped that this will provide a national framework on how ambulance services can play an enhanced role in the delivery of urgent and emergency care. It is envisaged that the principles set out in this document will be tailored to meet the needs of local communities across England.

Other products to support include a Directory of Services (DoS) – a tool to include all available services that can be referred to, and Commissioning Standards for Integrated Urgent Care (that includes the NHS 111 contact number), which has been published, as well as its supporting documents, to be published. These will include the Integrated Urgent Care Payment annex; Integrated Urgent Care Contract Alignment Plan; NHS England Integrated Urgent Care (NHS 111 Telephony) National Business Continuity Policy; Procurement Guidance and Integrated Urgent Care Model (Financial Model Tool).

Work to assess the financial and other implications has completed and is being tested is underway, and will be informed by comments we receive as part of the engagement process.
2 Introduction

2.1 Guidance for commissioners regarding clinical models for ambulance services

The first stage report of Professor Sir Bruce Keogh’s review of Urgent and Emergency Care (the “Review”) described the untapped potential of English ambulance services, and the need to expedite the transformation of these services from a transport to a treatment role. As a result of these changes the ambulance service will become a community-based provider of mobile urgent and emergency healthcare, fully integrated within UECNs.

This document sets out guidance for commissioners regarding the clinical models for future ambulance services, from initial telephone contact through urgent care to the most serious life-threatening emergencies.

Research has shown that only a small percentage of ambulance conveyances are the result of serious life-threatening illness and injury, requiring treatment at a specialist emergency centre. The remainder of cases have been classed for the purposes of this document as “urgent care”, and whilst care needs are urgent, they could be better managed in a care setting which is more appropriate to the patients’ needs. The first two sections of this document describe these two types of care (emergency and urgent) and potential methods of treatment.

Within the urgent care model this guidance proposes a number of pathways as an alternative to the current default conveyance to A&E. Commissioners should utilise UCCs, staffed by a multi-disciplinary team, and ensure that these accept patients conveyed to them by ambulance under agreed protocols and care pathways: other alternative care pathways are described later in the document.

This guidance also proposes two pathways as an alternative to conveyance of any kind, for selected patients contacting the 999 service: “hear and treat” and “see and treat”. The detail of these two treatment pathways and how commissioners might wish to deal with them are described in the final two sections of this document.

To achieve these models, radical changes will be required in the operational functions, culture and workforce of all ambulance services, and they will need to function as an integral component of a UECN and inter-disciplinary team, working flexibly with other providers across traditional service and professional boundaries.

It is expected that through the UECNs these relationships and ‘ways of working’ will be forged and encouraged. The advantages of agreeing some common practices for the ambulance service across the UECN and Clinical Commissioning Groups (CCGs) / System Resilience Groups (SRGs) will also become apparent, as will appropriate bespoke elements in individual localities.

The Review team are aware of the implications of these changes on workforce, and future workforce planning is encompassed within the Review.
2.2 Modelling and Best Practice

As implementation of the Review progresses the review team will release guidance on financial modelling in relation to the some of the models of care suggested here, as well as best practice examples of emerging models throughout the country.

Commissioners must have robust plans to ensure that any changes to commissioned services fully realise the available financial savings at the local healthcare economy level and that these savings are realised at the same time as any new costs are brought on stream. When evaluating these potential savings commissioners should include all costs and savings across the whole healthcare economy that are borne by CCGs, NHS England, or any other organisation with delegated authority to commission healthcare locally.

3 Emergency care

Clinical models to support the rapid transportation of patients with life-threatening illness or injury, coupled with treatment in transit, are already well established. Commissioners will be aware that existing “bypass” arrangements for patients with major trauma, heart attack and similar conditions, which enable them to reach an Emergency Centre with specialist services in a timely way, are currently working successfully in many areas. Commissioners may wish to consider how these could be expanded over time to encompass a wider range of conditions where the concentration of specialist expertise has been shown to improve patient outcomes.

However this will account for less than 5% of patients accessing the UEC System, therefore a continuous emphasis on hear and treat, see and treat and urgent care, as described later in the document, are required.

Challenges for the ambulance service in delivering emergency care relate to the identification of patients who require immediate access to specialist services, ensuring effective treatment en-route whilst continuing to provide a timely and effective service to communities when one or more vehicles are engaged in transporting patients over long distances. Commissioners will need to pay particular consideration to this latter point when designing local services, and provides further justification for the need to ensure excellent local urgent care services in more remote and rural areas.

The current paramedic skill set is appropriate for the care of the overwhelming majority of this patient group, and therefore further workforce development should concentrate on urgent care as described in section four of this document, rather than emergency care. However where patients have additional emergency care needs, and possibly require transport over long distances, commissioners should be aware that staff with additional critical care skills may be required and the utilisation of specialist paramedics in critical care and of air ambulances may be considered and
provision should be available. In addition, commissioners should ensure that a dedicated service is in place for the secondary transfer and retrieval of all patients (adult and paediatric) who require transport from an EC to an EC with specialist services. This could involve the regional NHS ambulance service, or third sector or private providers.

3.1 Principles

At present the majority of patients who dial 999 are attended by an ambulance clinician. Many of these are then transported to an A&E Department despite the fact that this may not be the best place to meet the patient’s needs. The introduction of the 15/16 Commissioning for Quality and Innovation (CQUIN) for urgent and emergency care, focused on incentivising an “increase in the number of patients with urgent and emergency care needs who are managed close to home, rather than in a hospital (A&E or inpatient) setting”, including a reduction in the rate of 999 calls that result in transportation to an A&E Department, may help to address this.

Commissioners of urgent care services should be mindful that within the UECN, reconfigured delivery models for ambulance services will require a wider range of treatment options and destinations so that patients can be managed in collaboration with care co-ordinators (particularly general practice), according to agreed care plans and close to home wherever possible, in locations that provide effective and efficient care.

3.2 Alternative destinations

Commissioners should utilise UCCs, staffed by a multi-disciplinary team, and ensure that these accept patients conveyed to them by ambulance under agreed guidelines and care pathways. Contracts should reflect that the emphasis should be on appropriate assessment and acceptance (with its associated value to the system and patients) rather than a default current position of conveyance to A&E. Additionally, patients should be accepted when referred to general practices and out of hours services where a home visit is not practical or the patient is not at home.

Alternative destinations could include community hospitals (particularly in remote areas), facilities providing comprehensive geriatric assessment, third sector facilities and nursing homes able to provide respite care, dedicated paediatric assessment units, ambulatory care services, maternity units and hospice care. Commissioners will need to ensure that referral pathways include deferred referral with appropriate safety netting, as well as a requirement for the appropriate integration of electronic records and electronic referral of clinical information being present in contracts; in some cases this may be combined with the use of telemetry and telemedicine.

Patients in mental health crisis ideally should be conveyed to 24/7 mental health referral assessment units, including health-based Section 136 suite/place of safety. These may be stand-alone facilities, or co-located with other facilities. Ambulance teams will need access to live information about the current availability of local 136 suites and crisis houses, their contact details and information regarding the patients they can accommodate, such as children or patients with disabilities. The 2015/16 CQUIN for urgent and emergency care addresses this issue further.
At present in some parts of the country people in mental health crisis are being transported to a place of safety by a police vehicle which may be inappropriate for patients in acute distress. Commissioners should work with police and ambulance services and others to develop appropriate capacity for assessment and conveyancing in line with the Mental Health Crisis Care Concordat.

### 3.3 Response and transportation

Whilst specific response transportation ‘type’ will not be the responsibility of commissioners, they can encourage innovative uses of transport. For example, optimisation of fleet management within the new UECN may include an initial response by a skilled practitioner working alone from a car, followed by a double-crewed ambulance to convey the patient only after detailed physical and mental health assessment, and when no community-based alternative is possible. “Front-loading” with enhanced clinical skills in this way will provide the best chance to manage the patient in the community, and also ensures that the skills and equipment available in the transporting ambulance are appropriate to the patient’s needs.

Commissioners may find it helpful to consider the clinical needs and transportation requirements of the patient as two separate entities, each of which must be met by an integrated service. Modifications to the current time-based ambulance standards, and approaches to transport asset deployment, may be required to support this move towards a more clinically focussed model, and are also under consideration. In the meantime commissioners should include contractual incentives and/or contract monitoring information that reflect these new ways of working.

Commissioners should be aware that it will be essential to achieve the timely transportation of patients with urgent care needs who have been assessed by other healthcare practitioners (e.g. urgent hospital admission arranged by a GP, an Approved Mental Health Practitioner (AMHP) or for fixed diagnostics (e.g. computerised tomography (CT) scanning), whilst maintaining flexibility and resilience within the ambulance service. Transportation of patients with urgent care needs, following assessment by a GP or other Allied Health Professionals (AHP), does not always require the presence of a paramedic. Consideration should be given to alternative commissioning arrangements for this type of service to avoid inappropriate use of resources, including co-responder schemes where appropriate.

### 3.4 Informatics and Information Sharing: Access to relevant clinical data and the “Directory of Services” (DoS)

It should be noted that the integration of clinical records, the implementation of recently published Professional Guidance on the Structure and Content of Ambulance Records and subsequent automation of discharge and referral information will enable the measurement of system-wide outcomes.

Effective urgent care services will be supported by the immediate availability of relevant patient information. UECNs should ensure that the information available to all urgent care providers (locally commissioned NHS 111, GP Out of Hours, Urgent Care Centres etc.) is optimised (in terms of access to integrated clinical records) and
is also available to 999 services, including the summary care record and patient care plans. This access will be based on prior patient consent, confirmed where possible at the time of access, or in the patient’s best interests in an emergency situation where the patient lacks capacity to consent.

This will require the provider to be able to identify the NHS Number at the time of any contact and match it to the Spine, as well as ensuring that the NHS number is collected and recorded routinely during all patient contacts. This is being supported at a national level through work on going with system providers, to ensure that they are able to meet nationally-set standards for local commissioning.

Providers should also ensure that they share data with commissioners in order to assist with service and pathway planning. For example, the ambulance service has a wealth of valuable data regarding call patterns, such as calls from nursing homes, and other anonymised data information that can be used to inform service design and delivery.

Commissioners should ensure that providers of urgent physical and mental healthcare as well as primary care and community care are involved in integrated care planning relating to individuals and patient groups, and with patient consent they should have access to current copies of all relevant care plans, and be empowered and supported to enact these plans. This may be particularly pertinent where a patient known to specialist mental health services has ‘special patient notes’ in which there is patient consent to share a crisis plan with urgent care services or to share a suicide prevention ‘stay safe’ plan.

Anonymised aggregate information from ambulance services can also be used to support prevention and public health, for example by targeting drug and alcohol problems. Commissioners should empower providers to identify and report anonymised data on the locations from which 999 calls are received and be encouraged to opportunistically identify medical conditions such as hypertension, atrial fibrillation and diabetes. This will, in turn, reduce future healthcare demand. Commissioners will need to ensure that public health colleagues are involved/consulted in the commissioning and contracting process (through the urgent care network) to ensure that such issues are adequately addressed in contracts. For example, ambulance services can identify and refer patients, with their consent, to drug and alcohol services and could be trained to use tools such as Identification and Brief Advice (IBA) for a range of public health issues, including injury and alcohol.

In keeping with all other components of a UECN, ambulance services should have immediate access to a single Directory of Service (DoS) for their region. Nationally the DoS software is being compiled however it will be imperative that this is locally owned across Networks to ensure accuracy and timeliness of the information provided. Ideally commissioners should ensure that the DoS provides electronic information in real-time in order to support capacity management and a wide range of alternatives to ambulance attendance and conveyance to hospital.

Finally, Clinicians working in the 999 system – through ‘hear and treat’ or ‘see and treat’ models - should have unrestricted referral rights to all other services in the UECN, including social care services, with free flow of information and feedback,
ideally through an electronic referral system. This flow of information will be based on prior patient consent, confirmed where possible at the time, or in the patient’s best interests in an emergency situation where the patient lacks capacity to consent. Local authority colleagues’ involvement in the UECN will be critical to ensuring this seamless pathway. Referrals and transport into emergency departments should be facilitated with electronic transfer of patient information, consistent with the emerging Emergency Care Data Standards and patient consent as described above.

4 Hear and treat

4.1 999 and NHS 111 Call Handling

“Hear and treat” describes the scenario when 999 calls are successfully completed ("closed") without despatching an ambulance vehicle response. This may include advice, self-care or a referral to other urgent care services. Hear and treat services have been developed over recent years, largely led by ambulance trusts in response to increasing 999 call demand.

Evaluation of the success of hear and treat should include anonymised measurement of subsequent contacts with the entire integrated urgent care system, to ensure that the call has been fully resolved, and not simply deferred. The electronic sharing of information and universal use of the NHS Number will help with this, and the requirement should be built into contracts where possible, specifying the requirement for seamless transition and mutually beneficial relationships between services with different providers.

To achieve effective and safe call closure, commissioners should ensure that 999 services are much more closely integrated with the urgent care system, and, until mental health crisis lines are fully aligned with integrated urgent care services, with these services also. This will include direct access to a single DOS the national contribution to which is currently in development: at present NHS 111 guarantees the ability to despatch an ambulance without re-triage, but flow in the opposite direction (referral from 999 to NHS 111) is much more limited.

Closer working between existing NHS 111 providers (and emerging Integrated Urgent Care providers), mental health crisis lines and 999 will be supported by the increasingly widespread use of Clinical Decision Support Systems (CDSS), to provide a consistent process of assessment and determining dispositions. This has a number of potential benefits:

- Seamless re-direction of the patient to the most appropriate service, regardless of the initial number called. This provides a consistent response and allows a more efficient use of resources;

- More effective feedback and enhanced learning between the services, building mutual trust and reducing the number of unnecessary ambulance responses;

- Sharing of resources (for example call handling and clinical advice) to more effectively manage peaks in demand, whilst improving consistency and efficiency.
In many cases commissioners may find that co-location of Integrated Urgent Care (including NHS 111 contact centres) and 999 services may enhance the benefits described above. Additional integration may yield further benefits and commissioners may wish to consider which configurations will work best in their areas, possibly across wider urgent care networks.

4.2 The Integrated Urgent Care Multi-Speciality Clinical Advice Service

The core vision is for a more closely Integrated Urgent Care. Central to this will be the creation of an "urgent care clinical hub" offering patients access to a wide range of clinicians, both experienced generalists and specialists. It will also offer advice to health professional in the community so that no decision needs to be taken in isolation.

The diagram below illustrates what this functionally integrated urgent care service might look like:
To support effective hear and treat, as well as ambulance staff at scene, it is recommended that commissioners include the urgent care clinical hub described above in specifications. To improve working relationships, dialogue and feedback the clinicians that make up this hub may be physically located in the same place and provide a 24/7 presence. For clinical specialties and expertise which is consulted less frequently it may be more appropriate to make arrangements to contact an individual who is off site through the creation of a “virtual urgent care clinical hub”. (The integrated care model is described in more detail in Commissioning Standards - Integrated Urgent Care (for NHS 111 services).

Commissioners will want to consider maximising the utility of the ‘clinical hub’ e.g. it could be shared with an NHS 111 provider, and also provide support to other components of the ambulance service (for example clinicians at scene) and the wider UECN (for example nursing and residential homes and other emergency services such as the police, for use in street triage). We encourage the joint commissioning and establishment of hubs and at an appropriate scale – avoiding overlap and duplication. Over time additional methods of communication and support (for example video-conferencing) should be explored to further increase the effectiveness of this clinical input.

The exact mix of clinicians in the urgent care clinical hub, and their seniority, should be specified in contracts/service arrangements and dictated by a careful assessment of local needs and the UEC network design. The composition of the workforce and associated competencies for NHS111 contact centres and clinical advice services are subject to consideration by the National Workforce Development Programme (a joint NHS England and Health Education England programme), which is expected to report in 2018.

However, it is expected that the types of clinicians currently available will include:

- Specialist or advanced paramedic with primary care and telephone triage competences;
- Nurses with primary, community, paediatric and/or urgent care experience;
- Mental health professionals;
- Prescribing pharmacists;
- Dental professionals; and
- Senior doctor with appropriate primary care competences.

Additional competency areas that may require provision include: midwifery, paediatrics, hospital specialists, occupational therapy, third sector organisations, alcohol and drug services, palliative care (end of life care) nurses, social care, housing and other depending on local need. Wherever possible individuals working in the clinical hub should be based in that community, and be familiar with local services and practice or have connections to local single entry point.
4.3 Managing expectations

The current ambulance service model, which is widely understood by the general public, is one of rapid attendance and early conveyance to a hospital. Hear and treat, and to a lesser extent see and treat, challenge this expectation, and may be less well understood. It is therefore essential to ensure that the public are aware of emerging clinical models, and their benefits, whilst still being assured of a skilled and timely response for more serious illness and injury.

Commissioners will want to be aware of and responsive to reactions within their areas, although the national support centre will also develop and disseminate a lay summary of what patients can expect from the future Ambulance Service, introducing the various clinical models of care.

5 See and treat

5.1 Principles

The 'see and treat' model is one which provides focused clinical assessment at the patient’s location, followed by appropriate immediate treatment, discharge and / or referral. Often a patient may be referred to other services that are more appropriate to the patient’s needs, or which can provide further support to the individual at home or in a community setting, in close liaison with the patient’s general practitioner.

To be effective, see and treat models require the commissioning of two distinct components:

- Skilled assessment, diagnosis and treatment at scene: This will be achieved by educated and equipped practitioners; usually a paramedic with specialist or advanced skills but potentially also other healthcare professionals. Commissioners should ensure that these practitioners are supported by real-time access to pre-existing clinical information, including the SCR, access to GP records and other repositories of patient and wider clinical information and near patient testing where appropriate. This access will be based on prior patient consent, confirmed where possible at the time of access, or in the patient’s best interests in an emergency situation where the patient lacks capacity to consent. These practitioners will also be supported by peers and specialists accessible through the urgent care clinical hub.

- A range of treatment and referral options (ideally including independent prescribing) that are consistently available and accessible in a time frame that is consistent with the patient’s needs and expectations.

In rural areas, where journey times to hospital are long, effective see and treat is particularly important, and highly valued by patients. Commissioners will want to consider that additional investment in rural areas may prove particularly cost effective, with paramedics based at UCCs in remote communities, and working as an integral part of the local urgent care system (e.g. with general practitioners both in and out of hours, community nursing teams and social care).
5.2 Core clinical pathways

There are a number of core clinical pathways that do not require traditional A&E attendance or hospital admission. With the right relationships and skill mixes in place, commissioners may successfully and quickly commission against these pathways through some initial see and treat urgent care models. Many of these are high volume conditions that have the potential for substantial impact on the urgent care system. Examples are given below, and commissioners may identify other pathways and develop them locally according to need:

- Mental health problems, with direct referral to mental health services and places of safety;
- Deterioration in an identified long-term condition, with direct access to patient specific care plans and teams;
- Falls in the elderly, with direct referral to falls teams, social care and community based services;
- Minor illness and injury in adults, with management at home, or referral to primary care or a UCC with appropriate interim care instructions and safety netting;
- Minor illness and injury in children, with arrangements as above;
- End of life care, including access to end of life care drugs, palliative services and support for dying at home or other chosen location; and
- Ambulatory care, for patients requiring a short term intervention or testing that would previously been undertaken in an A&E Department.

5.3 Integration with other services

Commissioners should be aware of the potential for the ambulance service to become an integral component of an overall urgent care system that provides “wrap-around” integrated care in community-based settings. Successful commissioning of this type of approach will require awareness of the flexibility and overlap in the skills and functions of staff, crossing traditional organisational and professional boundaries. Commissioners will need to work with colleagues across the system to ensure that contractual models encourage this type of working and there are no perverse incentives within payment mechanisms. Some examples that will require particular consideration to relationships and cross-boundary working arrangements are:

- The model will specifically require informatics and information integration across the system, with a focus on clinical information, based on good quality consent and sharing models. Commissioners will want to consider how best to procure informatics and how best this fits within contracting of services. Advice will be available from regional and national teams to support this.
• See and treat models gain particular benefit from the support of general practitioners and other primary care professionals, and it is recommended that commissioning arrangements ensure that general practitioners support the ambulance service in this role 24/7. This support could be achieved through a dedicated commissioned service or existing contractual arrangements.

• Mental health problems require careful consideration to ensure that an appropriate range of services are accessible in a timely way. The Mental Health Crisis Care Concordat, which has received wide cross-agency support, sets out important guidance for commissioners of health services in relation to the facilities that should be provided. It is essential that ‘see-and-treat’ models are commissioned in accordance with this; providing timely and easily-accessed support from dedicated mental health professionals and services that can be rapidly mobilised to support patients at home or in the community at all times of the day and night. This will reduce demand on other parts of the healthcare system and the police. It is important too to ensure these services are commissioned in close liaison with the other services involved in supporting people in mental health crisis, including local police services, Associated Mental Health Practitioners (AMHPs) as well as with mental health inpatient and community services and places of safety.

• Another essential support service is social care. Many patients present to the ambulance service with either primary or underlying social, housing or psychosocial needs. This will represent a large volume of ‘see and treat’ work, and has the potential to avoid many ambulance journeys and hospital admissions. Commissioners should ensure therefore that built into provider models are consistent and timely links into social care and associated third sector organisations at all times of the day and night. This may be achieved through commissioning a single entry point arrangement. Particularly it is recommended that a dedicated multi-professional falls service be developed and commissioned in line with see and treat to assess, manage and implement future preventative strategies in persons who have fallen or are at risk of falls. Joint education and training initiatives will improve understanding and cooperation between agencies.

• Finally, full integration is required with community health services to ensure effective access to nursing and other community-based healthcare services. This is essential to the management of exacerbations of long-term conditions and end of life care.

5.4 Workforce

Commissioners will need to recognise that significant developments in paramedic workforce planning and practice will be required to maximise the potential of see and treat capabilities. Recent moves to consistent degree based education for all paramedics by 2019 (subject to financial resources), and the proposed introduction of paramedic independent prescribing, are important steps in the right direction.

Commissioning arrangements for the future ambulance workforce will need to recognise a wider range of experience and skills, coupled with clear mechanisms for effective governance from the service in which they work, and support from a wider
community of other clinicians. This includes a clear development framework through supervision and appraisal, and also the mentorship and preceptorship of newly qualified staff. No ambulance clinician should be required to make a decision in isolation, and they should work as part of an interdisciplinary team.

The future clinical development of ambulance staff should place an emphasis on urgent care, with placements in primary care and mental health, and specific consideration of the frail and elderly, falls, dementia, and end of life care, self-harm, mental health crises and febrile illness in children. Consideration should also be given to the use of simulation-based training wherever possible. In some areas enhanced access to diagnostics, or the introduction of specific “point of care” tests, may further facilitate assessment and treatment at scene to avoid unnecessary conveyance. NHS England is working with Health Education England on these issues but they will also need to be taken into consideration in local contracting arrangements. In some cases it might be appropriate to consider joint training with other services involved in supporting people in mental health crisis, for example local police forces.

6 Conclusions

Commissioners should be mindful of the following points when considering the reconfiguration and contracting of ambulance, and all urgent care, services:

- The future system of integrated urgent and emergency care requires a radically different ambulance service which places a clear emphasis on treatment at scene and in community settings, with transport to alternative care settings where required to access established pathways of care.

- Transport to hospital A&E Departments should no longer be the default option, but reserved for those patients who have needs best suited to the skills of an Emergency Centre.

- The ambulance service must be fully integrated within one or more UECN, with a single triage system, consistent response, DoS and universal referral rights, and commissioned with this in mind.

- Electronic care records, appropriate integration of records and the standardisation of systems, care plans and telemetry should be further developed to ensure wide availability.

- Successful hear and treat requires closer integration with Integrated Urgent Care (including NHS 111 call centres), timely access to relevant patient information and care plans, and the support of a multidisciplinary clinical hub and advice service.

- Ascertainment of NHS number and access to the SCR and other patient information repositories should be achieved across 999 and the Integrated Urgent Care system, accepting that for a small percentage of patients’ identification will not be possible.
• Successful see and treat requires more paramedics to have enhanced assessment and diagnosis skills, competences and support to be able to treat patients at or as close to the incident as possible without the need for conveyance to hospital. Some examples of this could include independent prescribing, robust clinical supervision models and multi-professional collaboration. This would also be supported by access to senior clinical advice through the clinical hub and advice service to ensure safe decision making.

• New clinical models for ambulance services require flexible, inter-disciplinary working across traditional organisational and professional boundaries, with guaranteed and timely access to primary care, mental health provision, social care and specialist clinical advice 24/7.

• Where the ambulance service cannot provide treatment at scene a wider range of destinations, appropriate to the patient’s needs, should be available.

• Education for ambulance clinicians should be continued and enhanced with mentorship programmes across the country.

• Development of the ambulance workforce, coupled with sustained changes to working practices, will be essential to long-term success
7 Appendices

The case studies below give further examples of good practice and have been selected from Good practice in ambulance commissioning from the National Ambulance Commissioners Network, NHS Clinical Commissioners.

7.1 Case study 1

Birmingham and Solihull Mental Health Triage Scheme: Helping those in mental health crisis

In a mental health crisis, it is fair to say that a busy, pressurised environment is not the most conducive to appropriate care and recovery. Yet each year, many people in serious mental distress are taken to A&E Departments when alternative mental health crisis care services would often be more appropriate. In other instances, people may be detained by the police under the Mental Health Act and a place of safety must be found where an assessment can take place. The result is sub-standard care for patients and, sometimes unnecessary and inappropriate use of police and A&E resources.

In Birmingham, there was recognition that a new approach was needed. “There is an increasing need to provide a different type of support and intervention to reduce the number of people experiencing mental health crisis being transported to A&E,” explains Gail Fortes Mayer, regional commissioner for urgent and emergency ambulance services.

Cue the January 2014 introduction of the Mental Health Triage scheme. Under the initiative, a team of mental health nurses, paramedics and police officers – who travel in an unmarked ambulance service vehicle – respond to those in crisis. It means that patients receive immediate, appropriate attention in the community. “The Crisis Care Concordat (a national agreement between those involved in the care of people in mental health crisis) stated that people should have urgent and emergency access to crisis care, and the right quality of treatment and care when in crisis. That’s exactly what the Mental Health Triage team enables,” says Ms Fortes Mayer. It also supports another aspect of the concordat: long-term recovery following a crisis. “Third sector organisations are very supportive of the scheme. They give the team pathways into their services, enabling us to support people not only with their mental health issues, but with other social-type issues that may be contributory factors to their distress.”

Data analysis suggests the scheme is having a notable impact. From January to December 2014, the team prevented 647 emergency department attendances – “the paramedic can address any physical health problems, with the mental health nurse signposting to mental health services,” explains Ms Fortes Mayer. Meanwhile police detentions under the Mental Health Act have been reduced by just over half, to approximately 330.

Contact: Gail Fortes Mayer, Lead for Ambulance Commissioning, NHS Sandwell and West Birmingham CCG, West Midlands
7.2 Case study 2

South West: Right care, right place, right time

For the past five years, the Right Care, Right Place, Right Time initiative has aimed to reduce the number of people taken to A&E in the South West. Through a funded agreement with commissioners, it has been possible for South West Ambulance Service NHS Foundation Trust to make a number of changes in support of the aim. More paramedics have been trained in advanced clinical decision-making skills. GPs have joined the clinical hubs where 999 calls are answered, offering their expertise on whether a patient needs to be taken to hospital. More recently, the idea of GPs travelling with paramedic crews has been piloted.

The result has been a decrease in the number of patients taken to A&E. More and more people are taken to other more appropriate hospital settings instead or indeed offered support closer to home in the community.

Now commissioners are working with the trust to develop highly local Right Care action plans. This involves assessing what emergency care populations might need – for instance, a falls team would be especially appropriate for an area with high numbers of older people – and addressing any gaps in services. Again, the aim is to increase the number of people who can be cared for without being taken to A&E.

Contact: Richard Crocker, Ambulance Service Contract Performance Manager, South West and Central

7.3 Case study 3

Innovations in the delivery of care for older people: Hardwick and North Derbyshire CCG Falls Partnership Service

Each year, around 30 per cent of people older than 65 experience a fall. For people aged 80 or above, the rate rises to 50 per cent. Many will be taken to hospital, often by ambulance. Staff at Hardwick CCG for instance, report that falls are the most common cause of emergency hospital admission in the area they serve. Commissioners decided to explore what they could do to bring that rate down. The result is the Hardwick and North Derbyshire CCG Falls Partnership Service, which brings together an integrated team of a consultant geriatrician, a paramedic and an occupational therapist.

When 999 is called in the event of a fall, there is the option for this team to respond rather than an ambulance. Together, these professionals can provide immediate on-scene assessment and treatment, provide any aids the patient may need, and refer to social services as necessary, delivering care closer to the patient’s home.

“The integrated team approach was deemed vital to bring a comprehensive package of assessment and care direct to the patient in the community, and that can be accessed via 111, 999 or via healthcare professionals such as GPs,” explains Dr Steve Lloyd, chair of Hardwick CCG.
Within its first 15 weeks of operation, the service had seen 152 patients. It was possible to avoid hospital admission in 55 per cent of cases. That represents a cost saving of £239,000 and, as Dr Lloyd points out, “a much better outcome for patients to remain safe and independent at home, with community and social service support”.

He says the hardest part of setting up the service was overcoming initial scepticism. “But once the benefits had been seen, it was rapidly rolled out to include a neighbouring CCG. The benefits not just to patients, but to the system as a whole, were quickly apparent.”

Contact: Dr Steve Lloyd, Chair, NHS Hardwick CCG, East Midlands