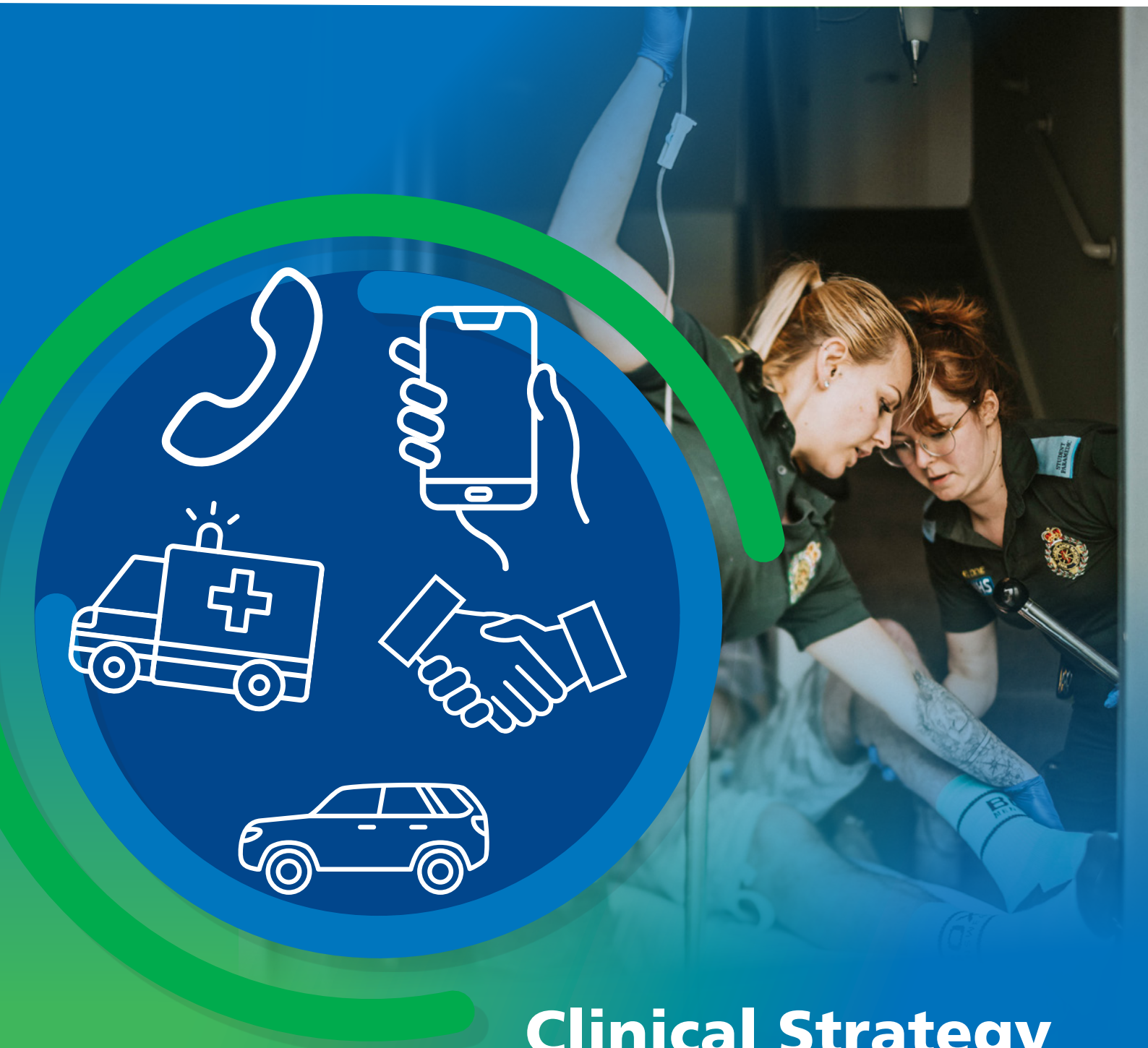
NHS
South Central Ambulance Service
NHS Foundation Trust



Clinical Strategy
2023 - 2028

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SCAS is a major first point of contact for patients in need of Urgent and Emergency care taking around two million calls a year, through our 999 and 111 Services.

Introduction

This clinical strategy seeks to set out by patient need/condition, the best practice pathway with which we are aligning with. It is a new way of thinking right across our services allowing us to deliver personalised care and support to patients and enabling us to integrate this care seamlessly with our NHS partners. This strategy is aligned with the NHS Forward Plan for Urgent and Emergency Care (IUEC) strategy as defined by NHS England and has taken into account the content of the Joint Forward Plans developed by the 4 Integrated Care Systems in our region.

Whilst the evidence base is stronger in some areas than others, we have tried to set out for each condition where we are now, what good looks like and how we are going to improve. The contents provide a working framework that will continue to evolve and be updated.

This strategy has been co-produced following feedback from our staff, NHS stakeholders, Council of Governors and NHS England. It aims to provide a blueprint for our clinical services and the role we aim to play over the next 5 years, setting out our priorities to guide our future decision making and the development of Operational Plans across our region.

Our aims are:

- → To deliver the right care, first time, by the right clinician in a clinically appropriate time frame
- → Achieve world-leading clinical outcomes for our patients
- → All ambulance clinicians/support staff and first responders are appropriately trained and equipped for their clinical roles

Our clinicians will be able to access advice and guidance when required from:

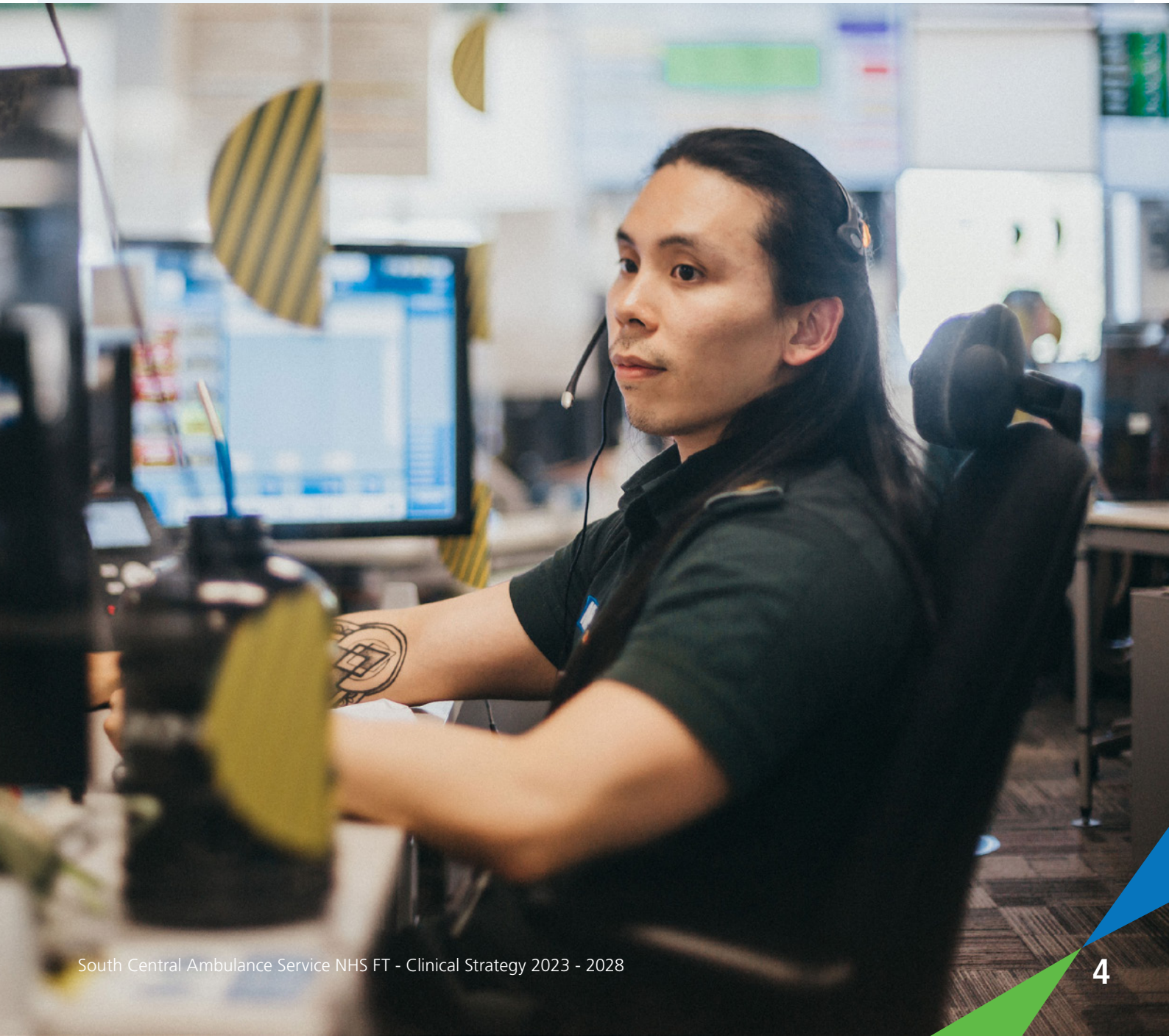
- → Primary Care/Out of Hours GP Services
- → Community and Mental Health Trusts
- → Secondary Care Acute Specialties

- Local Authority Care Support Services
- Voluntary Sector

SCAS recognises the importance of public health strategies to address inequalities in health outcomes in our South Central population and our role in helping to identify patients at risk of developing complications for undiagnosed medical conditions (for example atrial fibrillation, hypertension and diabetes).

SCAS will support the use of our clinical data to help inform and improve population health management – in section 3 we have set out our current and potential future contribution in this area.

SCAS very much welcomes engagement and feedback on our clinical strategy that is constantly evolving and adapting to the ever- changing NHS environment in which we operate.



Clinical Coordination Centres (999 & 111) and 'Care Navigation':

SCAS Clinical Coordination (Contact) Centres (CCC) are a critical component in the delivery of emergency and urgent care in our region. Moving forwards, we will explore and further develop the use of audio and video streaming technologies to further improve the remote assessment of patients using our 999 and 111 services, including potentially the use of Artificial Intelligence (AI) as is being developed and adopted in other European Countries.

As an Ambulance Service that uses NHS Pathways for both our 111 and 999 Services, we recognise the benefits of being able to seamlessly transfer emergency calls between our 111 and 999 services when there is a need to do so on clinical grounds.

There are further opportunities to improve the patient experience and ultimately provide right care, right place with just one call – 2 numbers: one service offer. This will be enhanced by having a fully integrated telephony platform that can connect to other healthcare provider clinical information systems; for example, with Community and Mental Health and Social Care Providers.

SCAS as a **'Care Navigator'** will also be important so that we can escalate the care patients appropriately in an emergency and transfer the patient to the right clinical team for onward care as illustrated below:

Our clinicians working in our CCCs and frontline need to be able to easily connect to the Directory of Services so that they can refer onto the right local service for patients. This will lead to better coordinated care, rather than a fragmented approach which can sometimes be seen in some parts of our region during out of hours periods.

Our future clinical service offer will include an increasing range of clinical expertise, both within, or remotely connected to, our Clinical Coordination Centres based in Milton Keynes, Bicester and Otterbourne.

This will include integrated clinical teams supporting both our 999 and 111 Services providing a broader range of expertise including:

- Advanced/Specialist Emergency Care Practitioners and Paramedics
- General Medical Practitioners and Hospital Consultants from a range of acute specialties connected through NHS 111 and community referral hubs
- Mental Health Specialist Nurses
- Midwives
- Prescribing Pharmacists
- Dental Nurse Practitioners
- Palliative Care Practitioners

Our ambition is that no patient will need travel to see a clinician for emergency and urgent care unless determined following remote assessment that this is necessary.

Access to Health Records and Directory of Services:

Clinicians working in our Clinical Coordination Centres (CCC) and frontline will have access to integrated care records and advanced treatment care plans to help inform personalised onward care and support navigation to community based, mental health, and secondary care services as required.

Our frontline and contact centre clinicians will be empowered as care navigators to seek advice and guidance and to directly refer patients to an increasing range of hospital and community-based services, in including Same Day Emergency Care (SDEC) Units, including Ambulatory Care, Frailty and Mental Health Crisis Services when required.

They will also have access to Urgent Care Community Response Teams with a 2-hour response time as these new services come on stream throughout the South-Central Region who will be able to take over the care of patients in need of acute care in the community.

Care Pathway Development:

SCAS is a strong advocate for the principles of co- design and co-production for the development of local services in partnership with patients, NHS and Social Care providers.

SCAS needs to provide greater support for frontline staff managing complex patients in the community.

We have previously described two generic conceptual roles which we believe will help with this process in the **'Trusted Assessor'** and the **'Trusted Advisor'** models of care, and we have included our working definition of these as an appendix at the rear of this document.

The SCAS Clinical Pathway Team will continue to transform the way our clinicians are able access appropriate services for our patients. We have seen a significant rise in availability, accessibility and usage of care pathways, enabling more patients to be managed in the right place, either in the community or directly by specialist teams in hospitals.

We are supporting all operational patient facing and clinical staff to make simple, safe and efficient decisions about appropriate care pathways to enable them to give the best possible care to their patients. We will aim to improve the number, access and visibility of urgent care pathways for our staff and patients and embed the usage of urgent care pathways into every day clinical practice.

SCAS future opportunities and priorities to further improve emergency and urgent care in the community.

We have identified key patient groups to prioritise the teams work streams to ensure the greatest number of patients that will benefit, including:

- Urgent low acuity medically unwell patients
- Older patients who are frail, have chronic medical conditions or who are at risk of falls
- People with Chronic and Acute Respiratory Conditions, including COPD and Asthma
- Patients requiring urgent surgical assessment
- People with Mental Health needs
- Children who require review by an Urgent Care Service, GP or in Hospital by a Paediatric Assessment Team

As patient and integrated care system priorities evolve, there is the opportunity to be flexible to the demand for services required in each region. The Clinical Pathway Team will continue to establish, develop, streamline and integrate other referral pathways directly into a wide range of services, as new opportunities arise.

SCAS Connect Application

SCAS Connect is our care pathway digital platform, providing frontline clinicians with increased visibility and accessibility to all our Clinical Care Pathways. This ensures appropriate pathways are available to operational staff, when engaged in the management of patients that do not require emergency conveyance or treatment in an acute setting.

This live platform, which is available on our ePR system, smart phones and desktop computers, provides our patient-facing staff and CCC clinicians with the referral information for all Urgent Care Pathways across our network, within all our local care systems.

SCAS Connect, which is powered by MiDoS, is available for all Health Care Professionals from all health care settings in the SCAS region. We will continue actively engage with several key partners including system designers, system administrators, and both internal/external stakeholders (ICBs, CCGs, neighbouring Ambulance Trusts) to ensure SCAS Connect continues to develop and enhance, meeting the needs of operational staff and the wider NHS, now and in the future.

1. EMERGENCY CARE

Continuing to improve the clinical care for patients with immediately life- threatening emergency conditions remains a core priority for the ambulance service.

The Ambulance Service Clinical Practice guidelines will continue to be underpinned by evidence under the direction of the National Ambulance Medical Directors (NASMeD) and behalf of the Association of Ambulance Chief Executives (AACE). SCAS will continue to work closely with the national Joint Royal Colleges Advisory Liaison Committee (JRCALC) in the development of clinical practice guidelines for our frontline clinicians. Our clinicians will be able to access updated clinical practice guidelines as soon as they are published and downloaded automatically on the JRCALC App which all of clinicians have access to.

SCAS' aim will be to ensure that an ambulance clinician of at least paramedic level of training oversee all patients in need of emergency and urgent care. All newly qualified paramedics, associate ambulance practitioners and Emergency Medical Technicians will be able to access advice and guidance from experienced clinicians prior to discharging any patient in the community.

All SCAS frontline clinicians were offered a personal issue iPad in 2022 to improve their connectivity to SCAS intranet and the SCAS Clinical Hub that contains the clinical/operational resources they need to support their continuing professional development and clinical decision making.

EMERGENCY CLINICAL CARE PRIORITIES FOR THE FUTURE

1.1 Out of hospital cardiac arrest survival

Ensuring that patients who suffer from a cardiac arrest get the right treatment quickly in the pre- hospital setting is vital for their survival and longer term clinical and quality of life outcomes.

SCAS are consistently in the upper quartile performers when benchmarked against other ambulance services nationally. Over the next 5 years our ambition would be to improve this performance when compared against the best in the world.

What we are going to do in partnership to further improve cardiac arrest outcomes:

- Increased provision of Public Access Defibrillators in schools, sports clubs, transport hubs, shopping centres, industrial complexes and larger businesses, GP/Dental practices/Urgent Care Centres, village halls, public houses
- SCAS will ensure our CCC staff have access to British Heart Foundation National Defibrillator Locator App (The Circuit) to ensure that the location of the nearest registered AED can be shared with 999/111 callers in an emergency
- Further roll out of Basic Life Support and defibrillator training to commercial organisations, schools and community based First Responder Schemes
- Continue to develop first responder schemes including with other emergency services (Police, Fire and Rescue, and Military) to attend patients in cardiac arrest when required
- Introduce the GoodSam First Responder application to mobilse staff and registered volunteers to attend patients who have suffered an out of hospital cardiac arrest
- Transport of resuscitated patients following out of hospital cardiac arrest direct to specialist cardiac centres (Heart Attack Centers) with on-site coronary angiography and primary percutaneous coronary intervention (pPCI) 24 hours a day including to centers offering extracorporeal membrane oxygenation (ECMO)
- Participate in further high-quality clinical research on out-of-hospital cardiac arrest therapies – for example, the nationally funded PARAMEDIC 3 Trial

1.2 Patients suffering from Heart Attack

SCAS are committed to ensuring that all patients suffering from a heart attack are treated in line with all the elements of the evidence-based care bundles. Currently SCAS deliver this to a high standard (NHSE publishes SCAS cardiac arrest performance nationally) with the exception

of being able to evidence pain relief effectiveness (i.e., pre- and post-analgesia administration pain scoring) in our electronic clinical records.

- ➔ SCAS will continue to ensure that all patients with a heart attack (STEMI and non-STEMI) are identified and treated appropriately.
- ➔ SCAS will use appropriate cardiac care pathways to ensure our patients are transferred to hospitals with access to interventional cardiology 24/7.

What we are going to do to further improve:

- ➔ Support and training in cardiac pain assessment and management
- ➔ Closely monitor Ambulance Clinical Quality Performance Indicator compliance against national standards
- ➔ Simplify entering pain scoring on our electronic patient record systems
- ➔ Swift conveyance to nearest 24/7 pPCi centre when required

1.3 Patients with Heart Disease

SCAS does not currently have direct access to all specialist clinical teams for decision support for those patients that are being actively managed actively by hospital specialists.

What we are going to do to further improve:

- ➔ Further develop clinical pathways to access early senior cardiology advice and urgent cardiac clinics where available and appropriate for patients with known heart disease presenting with symptoms suggestive of acute coronary syndrome, arrythmias including fast atrial fibrillation, transient loss of conscious with abnormal ECGs, and using ECG telemetry and troponin assays to improve appropriate access to urgent ambulatory care pathways
- ➔ Direct access to community-based heart failure specialist nurses for patients not requiring immediate emergency admission to hospital

1.4 Chronic Lung Disease Patients

SCAS clinicians currently do not have widespread access to community or hospital based respiratory services for advice and guidance for patients with long term respiratory conditions.

SCAS will continue to work closely with other hospital and community SDEC units and Urgent Community Response Teams 24/7 to ensure that all patients are clinically assessed and referred on to the appropriate clinical team without the need to be conveyed to an emergency department unless clinically appropriate to do so.

What we are going to do to further improve:

- ➔ Develop new referral pathways for direct access to specialist SDEC Community and respiratory response teams supporting the care of patients with Chronic Lung Disease, for example COPD
- ➔ Improve access to Virtual Wards for remote clinical monitoring of patients that do not require immediate admission to hospital

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1.5 Patients with poorly controlled diabetes

Patients with poorly controlled diabetes who present to the ambulance service as a result of low or high blood glucose levels are frequently conveyed to an emergency department for further assessment. This is not always necessary. SCAS clinicians currently do not have consistently available referral pathways for diabetic patients other than to Emergency Departments or to their patient's GP.

What we are going to do to further improve:

- ➔ Develop more advice and direct referral pathways to community or hospital specialist diabetes teams for patients who have poorly controlled diabetes.
- ➔ Introduce blood ketone measurement to help with the identification of diabetic ketoacidosis and the onward care of patients with high blood glucose levels that do not require same day care at hospital

1.6 Major Trauma Patients, PHEM and CCPs, ACCTS

SCAS has developed specific injury care pathways for patients following major trauma through our collaborative work within the Thames Valley and Wessex Trauma Networks, and with our 2 Regional Air Ambulance Partners (TVAA and HIOWAA). Patients with major trauma are clinically assessed, treated and transferred directly to our major trauma centres in Oxford and Southampton when required.

There are now more unexpected survivors of major trauma throughout England, and clinical outcomes for patients are continuing to improve as progress is made enhancing the quality and timeliness of care at every stage of their treatment pathways.

What we are going to do to further improve:

- ➔ Extending further the access to pre-hospital emergency medicine (PHEM) teams and specialist critical care paramedics (CCPs) for patients needing on-scene critical care interventions to save lives, or for emergency secondary inter-hospital transfer from Trauma Units to Major Trauma Centres 24 hours a day. We will

also establish, in partnership with NHSE and Adult Critical Care Networks/ Acute Trusts, dedicated Adult Critical Care Transfer Services for secondary inter-hospital transfer and out-of- area repatriations and share best practice across SE England developed during the pandemic

- ➔ We will continue to introduce collaboratively new clinical trauma resuscitation pathways/techniques (e.g., introducing improved pre- hospital haemostatic therapies) when there is good evidence to support this

- ➔ We will continue to participate in high quality clinical research to further improve the outcomes of our injured patients – for example, the Tranexamic Acid CRASH 4 trial for elderly patients with head injury

1.7 Vascular Emergencies

SCAS now has direct referral pathways to major arterial centres for patients presenting with vascular emergencies (for example ruptured aortic aneurysm, clinically suspected aortic dissection, or acutely ischaemic limbs). We will continue to ensure that patients are assessed, treated and quickly transported directly to the nearest specialist vascular unit to manage their care.

We also ensure that such patients are rapidly transferred to arterial centres for patients who self-present to emergency departments with a vascular emergency.

As with other life-threatening emergencies, speed is of the essence to ensure good clinical outcomes for these patients.

What we are going to do to further improve:

- ➔ We will continue to ensure that our frontline staff are trained to recognise vascular emergencies and that they know when to directly transfer patients to regional arterial centers

1.8 Stroke Patients

SCAS already provides high quality care to patients with acute stroke and transient ischaemic attack (TIA) and has direct admission access to Acute Stroke Units (ASU) throughout the region when required.

SCAS has worked closely with the Oxford and Wessex Academic Health Science Networks (AHSN) and Stroke Network Clinical Governance Leads to agree transfer protocols from Acute Stroke Units (ASU) to Comprehensive Stroke Centres (CSC) for patients requiring emergency Mechanical Stroke Thrombectomy and has shared best practice ambulance guidance it has produced nationally.

What we are going to do to further improve:

- Use NHS Pathways to help identify potential acute stroke patients more quickly in our Clinical Coordination Centers

- Dispatch an ambulance to arrive at the patient within 18 minutes as aligned with national ambulance response programme standards

- Further develop the clinical care pathways for patients presenting with symptoms of acute stroke, including direct access to CSC stroke for patients suffering a major stroke associated with a large artery occlusion (LAO) when ambulance clinical triage tools for stroke have been validated for this purpose

- Establish direct access to consultant stroke physicians using patient video-streaming applications to further improve the early identification of time critical stroke syndromes and to prevent unnecessary admissions to Acute Stroke Units by helping to identify stroke mimics

- Direct transport of appropriate acute stroke patients to ED CT scanners for stroke team assessment in order to shorten thrombolysis treatment times and further improve neurological outcomes

- Work collaboratively with commissioners, ICBs and the stroke networks to ensure that all ASUs are optimally located throughout South Central and neighboring regions in order to optimize call to door times across our region and to help reduce demand for ED to ASU secondary transfers

1.9 Patients with Sepsis

Early recognition of life-threatening sepsis is essential to enable the Ambulance Service to initiate life-saving therapy and issue a pre- arrival alert to the hospital's emergency department so that patients can be promptly treated after arrival at hospital.

Early recognition and prompt treatment saves lives and also greatly improves the outcomes for patients. Going forward all SCAS staff will have the skills, knowledge and tools to recognise and treat sepsis patients appropriately and with speed.

SCAS has already introduced National Early Warning Score 2 (NEWS 2) and Paediatric Priority Observations Scores (POPS) to help with the recognition of evolving sepsis and has embedded this within our ambulance patient monitoring and clinical record systems.

What we are going to do to further improve:

- Introduce evidence-based pre - hospital sepsis clinical assessment tools and treatment algorithms in adults, maternity patients and children to further improve clinical outcomes as they are developed.

- ➔ Review available antibiotic therapies in line with national guidance
- ➔ Ensure specialist paramedic practitioners have access to appropriate antibiotics for the management of less severe infections that can be managed safely in the community

1.10 Extended Roles and Commissioning

Over the years SCAS has invested in the development of a number of key clinical roles. Examples of these include Clinical Support Desk Clinicians, Specialist Practitioners, pharmacists, dental nurses, midwives and Mental Health Nurse Practitioners within our Clinical Coordination Centres.

Going forward SCAS will review of the roles of advanced, specialist and critical care paramedics, ambulance nurses, doctors and prescribing pharmacists and how advanced clinical skills could be further utilised to improve the care and clinical outcomes of patients using our services.

What we are going to do to further improve:

- ➔ Secure additional resources to enable specialist paramedics to perform bedside blood testing of biomarkers such as troponin, D-dimer, lactate and venous blood gases to support complex clinical decision making when the need for hospital admission to hospital may not be clear cut from clinical assessment alone. This will build on the successful pilot of care home resident testing in Oxfordshire in partnership with Oxford University Hospitals' Ambulatory Medical Unit
- ➔ This will include access to pre-hospital ultrasound for enhanced diagnostics/ interventional procedures for critically ill patients by community (PHEM) emergency physicians

1.11 Major Incident Response

SCAS Emergency Planning, Resilience and Response Team.

What we are going to do to further improve:

- ➔ SCAS will rollout training for a new system for Mass Casualty Triage for first responders and healthcare professionals in 2023-24
- ➔ Continue to train our SORT/HART Teams to respond to marauding terrorist Incidents
- ➔ Continue to provide regular command training for incident officers and live casualty and tabletop exercises to maintain SCAS response capability for such incidents

1.12 Paediatric Emergencies

SCAS Clinicians have access to comprehensive JRCALC clinical practice guidelines for paediatric emergencies that includes identification of adults and children in need of safe-guarding referrals.

Moving forwards, we will prioritise additional Level 3 safeguarding assessment and reporting competencies at during face-to- face statutory and mandatory training for both adults and children.

SCAS will also offer annual refresher resuscitation update training to all frontline clinicians that will include newborn and young children up to the age of 12 years.

We will undertake more collaborative research with other academic institutions to help with the pre-hospital validation of the Paediatric Early Warning Scores in unwell children.

We will also develop additional urgent care pathways for admission advice and decision support from primary and secondary care, both in and out of hours.

We will also explore building more clinician capacity with paediatric expertise for both our 111 and 999 Clinical Coordination Centres.

1.13 Maternity Care

The JRCALC clinical practice guidelines for maternity emergencies were extensively updated in 2021-22.

SCAS hosts a teams of midwives based in our Otterbourne and Bicester Clinical Coordination Centres in partnership with Frimley Healthcare and North Hampshire Hospitals that help coordinate emergency and urgent maternity care in the community and offers advice and guidance to frontline ambulance paramedics.

Our clinicians also have access to all Obstetric Units (and Maternity Assessment Units) throughout the region with contact details within SCAS Connect Application.

Advice on newborn resuscitation is available from the Southampton Oxford (Neonatal) Transport Service (SORT) when required 24/7 and all of neonatal pathways were last reviewed and updated in 2021.

What we will do to further improve:

- ➔ Provider regular refresher training in emergency maternity care for all frontline/

CCC clinicians

- SCAS will continue to work closely with Local Maternity and Neonatal Systems (LMNS) and to share transfer time information from free standing midwifery lead units (MLU) as required to help mothers make an informed decision on place of birth

- Consider appointing a professional lead for maternity care to support education, training and audit of ambulance delivered maternity care

- Further extend midwifery presence 24/7 in our CCCs to handle and coordinate SCAS response to maternity emergencies arising in the community

1.14 Community First Responders

SCAS will continue to expand our Community First Responder (CFRs) schemes to help save lives, especially in our more rural communities.

- SCAS will explore expanding the pool of trained volunteers in the community mobilising them to attend victims of out of hospital cardiac arrest through applications such as GoodSam

- SCAS will also continue to work with the British Heart Foundation to improve access to and visibility of all Public Access Defibrillators for not only our 999 Clinical Coordination Centres but also for members of the public throughout England

- We will also review and explore broadening the types of emergency incidents that CFRs attend including both non-injury and injured fallers

1.15 Safeguarding of adults and children

Our clinicians will be able to seamlessly escalate and refer and report any adult or child to Local Authorities Safe-Guarding (SG) Services 24 hours a day when required and will support multi-agency investigations when required.

- We will continue to strengthen our safeguarding referral and monitoring processes by building capacity and broadening the range of expertise within our safeguarding teams.

- We will also uplift the SG training of all SCAS staff through the use of e-learning and face- to-face training that will include the assessment of patients with autism and learning disabilities (Oliver McGowan Training), with additional training on the Mental Capacity Act 2019.

2. URGENT CARE

Ambulance services need to work in partnership with other community health care and social care providers to help deliver a consistent 24/7 urgent care service. SCAS aims to become and be seen as an integral community based mobile urgent treatment service provider rather than solely a means of transportation to community-based health care facilities.

Complex patients in need of urgent care may require assessment by clinicians who have received additional training to undertake this role which will help achieve the ambitions of the NHS Long Term Plan 2021 to deliver as much care in the community as close to home as possible.

Going forward SCAS will further develop clinical models of care including care navigation for patients at the end of life, frail elderly, patient with mental health needs, dental patients and pregnancy related care. We will aim to deploy our specialist paramedics who have received additional urgent care training to attend patients with more complex presentations in order to deliver the right care first time.

The NHS Long Term Plan describes increasing hear and advise/referral rates by using appropriate care pathways, directly accessing community-based services that will be in place to ensure that ambulance services have a safe and appropriate alternative to transporting patients to hospital for further care when this is not required medically nor in the patient's best interest.

URGENT CLINICAL CARE PRIORITIES FOR THE FUTURE

2.1 Patients in Mental Health Crisis

Calls from mental health patients are common presentations to 999 & 111 Services at times of crisis. These calls are often complex and may take a significant amount of time to manage optimally. Most cases can be assessed entirely remotely which is facilitated by access to mental health care records. A smaller proportion may require further face-to-face assessment by the ambulance service or a Mental Health Professional to determine the optimal care pathway for the patient.

Patients who self-harm may still require further assessment in the Emergency Department.

Patients in crisis can pose difficult challenges for the ambulance services and for clinicians, especially for complex patient assessment, safety, agreeing appropriate care plans and trying to avoid inappropriate attendance at emergency departments.

To further improve;

- SCAS Mental Health Team Clinical Leads are looking to co-produce with patients and service users to inform how we can improve the service being offered to those in our care to better meet their needs
- Moving forward SCAS will continue to host and develop the Mental Health Crisis Triage Services staffed by Mental Health Nurse Practitioners from Southern and Oxford Health for calls originating from both 111/999 callers in line with NHSE national guidance
- SCAS will extend mental health crisis team provision to further develop mental health rapid response vehicle triage and dedicated Section 136 MH Transport to help ensure these patients access the care they need in the right clinical setting and are transported when required in vehicles that are fit for purpose
- SCAS will also further develop simulation- based training for SCAS clinicians in the management of patients with mental health presentations
- A CPD package is being developed and designed to increase the awareness of staff of stress and anxiety in patients and colleagues
- SCAS future opportunities and priorities to further improve emergency and urgent care in the community
- SCAS will deliver the nationally mandated Oliver McGowan training, further enhancing the Trust's staff abilities to engage effectively with autistic people and people with learning difficulties
- SCAS will further develop processes that enable sharing of clinical information between ambulance and mental health service clinicians to enable more effective integrated, safe and joined up care for mental health patients in crisis

We will evaluate the effectiveness of current Section 136 processes and procedures, in conjunction with the police and mental health service partners to identify improvements and efficiencies in service delivery.

We will expand access to voluntary and on-line networks designed to support patients struggling with solitude.

2.2 Frail Elderly and Falls

Falls are one of the most common primary presenting complaints to ambulance services. The number of people aged 65 (and over) is projected to rise by over 40 percent in the next 17 years to more than sixteen million, which will place increasing demands on all health and social care services. The frail elderly are high intensity users of the ambulance services and represent a large proportion of acute admissions to hospital.

NICE (2019) state that the over sixty-five's have the highest risk of falling, with 30% of people older than 65 and 50% of people over eighty falling at least once a year. Given that ambulance services are commonly the first point of contact following the falls episode, opportunities for improvement in care are significant.

What we are going to do to further improve:

- Review the competencies, education and skills needed for ambulance clinicians to assess and manage frail older people and patients living with dementia

- Ensure emphasis on clinical decision making, psychosocial context, attitudinal aspects of care, communication barriers and techniques, assessment of mental capacity, as well as training in ethics and Mental Capacity Act, with reference to advance decisions and advance care planning, and working with the wider multi- professional health care team

- Further development of urgent care pathways and direct ambulance access to community care, community elderly care physicians and geratology specialist nurses, access to frailty/step up/step down/intermediate care units, virtual wards and hospital at home services rather than conveyance to the emergency department

- Review of pathways for patients who have fallen to ensure effectiveness, consistency, timeliness of follow up, and falls prevention strategies

- Continue to work with care/nursing homes to ensure that they only call for an ambulance when a patient requires hospital treatment, or when care is not already available from urgent community response services

- Review the competencies, education and skills needed for ambulance clinicians to assess and manage frail older people. We will consider delivering a more specialist programme which would both consolidate the knowledge, skills and attitudes needed to deliver best practice as well as highlight the importance of this specialty in an ageing population

- Ensure emphasis on clinical decision making, psychosocial context, attitudinal aspects of care, communication barriers and techniques, assessment of capacity, as well as training in ethics and law, with reference to advance decisions and advance care planning and working with the wider health care team

2.3 Long Term Conditions & Digital Requirements

In England, more than fifteen million people have at least one long term condition. This figure is set to increase over the next 10 years, particularly those people with three or

more conditions.

Examples of long-term conditions include hypertension, depression, dementia, epilepsy, COPD, heart failure and arthritis[2].

[2] Department of Health (2013) Improving quality of care for patients with long term conditions, London

Patients with long-term conditions should have personalised care plans and with guidance for carers and relatives be supported in how to manage their own condition.

SCAS 999 and 111 Services can now rapidly identify the NHS number for all patients in whom the patient's identity is known. This enables SCAS to be able to quickly access Integrated Care Records, Advanced Care Plans and Directives, including information on treatment escalation and care navigation, including contact details for the lead clinician with overall responsibility for the patient's on- going care. This is essential so that appropriate emergency care is delivered to the patient. Paramedic access to this information can be difficult due to the variation in the multitude of NHS and Social Care IT systems in current use.

What we are going to do to further improve:

- → Further investment in digital integration technologies for access to external NHS and Local Authority Care patient records
- → Further development of urgent care referral pathways
- → Consider specialist/advanced practice roles for paramedics
- → Development of paramedic and nurse prescribing

2.4 Care for Patients at the End of Life

Ambulance services may be involved at any stage of a patient's care towards the end of life. Planned journeys include transferring patients who are approaching the end of life, for example from acute setting to preferred place of death.

Unplanned involvement is common when a patient has a crisis or deterioration, worsening symptoms and anxious carers and family members call 999. Paramedics are frequently at the scene at or shortly before or after the point of death and must make decisions on whether resuscitation is required or if it would be futile, often based on limited knowledge of the patient or their end-of-life plan[3].

[3] National end of life care programme (2012) The route to success in end of life care: achieving quality for ambulance services

What we are going to do to further improve:

- → Ensure SCAS has access to patient specific end of life care plans before

patient contact

- Direct access to specialist palliative advice/services 24/7 for ambulance clinicians
- Training updates in end-of-life care for ambulance clinicians
- Develop procedures around how paramedics can administer appropriate end of life medications to support patients who have contacted the ambulance service

2.5 Extended Role Competency

The workforce of ambulance services could be commissioned to further develop its urgent care capabilities through rotational appointments, particularly in relation to expanding the assessment clinical decision- making skills and diagnostic skills of ambulance clinicians for non- immediately life- threatening illness.

Traditionally ambulance clinicians have been trained in emergency care only which enables them to be very proficient in identifying patients with serious life-threatening conditions, however it is clear that the majority of patients contacting the 999/111 service have urgent care, as opposed to time sensitive emergency care needs.

As the range of urgent care activity expands it will be important that there is further investment in SCAS clinical support services such as pharmacy to support this rising clinical demand.

What we are going to do to further improve:

- Existing health care professionals in different parts of the system with appropriate core education and skills could be further developed and educated to expand the urgent care workforce capacity in a Trusted Assessor role by SCAS - e.g., potential use of emergency nurses, dental nurses, pharmacists, matrons, midwives, mental health nurses. This is aligned with the Allied Health Professional Career Framework
- Ambulance clinicians should also be able to access emergency and urgent social care, this could be facilitated through the NHS 111 service and an expanded Directory of Services to include adult social care and voluntary services

2.6 Prescribing for Paramedics

SCAS already have a robust process to administer medication to patients using Patient Group Directions but independent prescribing for paramedics should be considered as a priority for future advanced paramedic roles.

Non - medical prescribing by paramedics will lead to new ways of working to improve clinical outcomes for the patients and enable more patients to be managed in the community.

This extended practice role will enable a greater focus on re-ablement, including return to work and help older people to live longer in their own home.

What we are going to do to further improve:

- ➔ Provide decision support to paramedics administering 'just in case medication' for patients on end-of-life care pathways
- ➔ Support the supply of pre-labelled drugs that would otherwise necessitate hospital admission for patients without access to independent means of transport to collect prescriptions or attend a pharmacy

2.7 Ambulant patients with injuries and illness

A number of models across ambulance services have been developed that have extended the clinical assessment, diagnostic and treatment skills of paramedics and nurses. This has enabled them to be able to manage lower acuity injuries (e.g., use of wound care and wound closure techniques) and non-life- threatening illness (e.g., urinary tract infections) in order to avoid attendance at emergency departments and hospital admissions.

- ➔ Going forward SCAS aim to further increase the numbers of specialist practitioners of a nurse or paramedic background with appropriate urgent care training, enhanced by the ability to assess, treat, prescribe and refer for a range of minor conditions when required

SCAS future opportunities and priorities to further improve emergency and urgent care in the community.

3. PUBLIC HEALTH AND PREVENTION

SCAS can make significant contributions to the wider public health agenda to address health inequalities. Ambulance clinicians are routinely in situations and in patient's homes where they can identify health care prevention issues such as lack of heating, social care needs, mental health needs and the recognition of vulnerable adults. This type of concern for welfare and safeguarding information needs to be shared with other health and social care partners and more referral pathways developed at a local level.

What we are going to do to further improve:

- Identification of undiagnosed diseases. For example, whilst assessing a patient, conditions such as chronic atrial fibrillation, hypertension and high blood glucose readings can be identified and shared with the patient and healthcare partners
- Where the patient does not require immediate conveyance to hospital, robust pathways for further management should be developed via onward referral pathways to primary care
- Ambulance Service Business Intelligence teams could be commissioned to provide and analyse data on ambulance attendances, identify geographical location hotspots (e.g., nightclubs) linked to population and demographics e.g., alcohol related 999 calls, preventable accidents, violence to support targeted multiagency intervention
- Ambulance clinicians can play a proactive role and contribute to the education of domiciliary care staff and staff in nursing and residential care settings in relation to health promotion, when to call for primary care support, falls prevention, who to call, and when to use 999/NHS 111
- Further explore the role of ambulance services in community support programmes around public health initiatives to address inequalities in health
- Consider seconding a Public Health Registrar to SCAS to explore integrating our patient utilisation of NHS services and clinical data on preventable harm into existing Public Health datasets to help inform future Public Health Strategy and Integrated Care Board Joint Forward Plans to address health inequalities in our region

Ambulance clinicians can potentially play a more proactive role using their trusted status to influence patient behaviour in relation to smoking cessation, asthma management, management of high intensity service users/frequent callers and other condition specific care plans. Additional examples where ambulance services could play in public health both for their staff and patients include:

- Public health campaigns, diet, fitness, obesity, smoking cessation and blood pressure checks.
- Cycle to work and exercise programmes
- Falls prevention
- Mental health and well-being
- Social care needs-recognition and referral

4. NON EMERGENCY PATIENT TRANSPORT SERVICES (NEPTS)

Whilst the majority of this paper has focused on Urgent and Emergency Care, SCAS also undertake just under 1 million non-emergency patient transport journeys every year (22/23 figures). Many of the patients that the non- emergency patient transport service (NEPTS) interact with have complex and long term health needs, requiring frequent outpatient appointments across a whole range of services whether that be for renal dialysis multiple days a week or on-going checkups once a year. NEPTS also plays an important role in repatriating patients back to their homes or other care settings after Acutes have discharged them from their care.

There are a number of core elements that staff working within NEPTS, either within one of our contact centres or directly patient facing, that are critical to ensuring that every patient gets the right care, first time, every time. These include:

- Ensuring the resources deployed meets the mobility needs of the patients
- Ensuring the best possible experience for patients when travelling to and from their appointments, including getting them to where they need to be in a timely and safe manner
- Have training in safe manual handling
- Have an awareness of relevant clinical policies and processes, particularly in supporting patients whose conditions worsen whilst being transported
- Identification of any safeguarding issues. Many NEPTS patients are frequent users of our service due to the nature of their conditions and often the same crews transport them. This gives an increased opportunity to observe and identify when an individual may be moving into crisis or need additional support that might otherwise not be detected

Since 2022, work has been undertaken by SCAS to develop a financially sustainable aspirational vision and strategy for the future development of NEPTS.

This is an evolving document that will be used to identify key deliverables and action plans, as part of the wider Organisational Strategy refresh. Within it there are a number of principles that support a continuation of patient care from non-urgent through to UEC, looking to build on synergies between the services.

Standard Operational Procedures already exist to enable the deployment of PTS crews to transport clinically appropriate cohort of patients, on behalf of 999, for example. This aligns with the national position and re-enforced by Commissioners increasingly looking to extend the type of patients that are managed via NEPTS such as, but not limited to, mental health and interfacility transfers.

There is also an expectation of greater interaction with community and social care provision, particularly within patient signposting and system engagement.

5. CONCLUSION

To support this SCAS Clinical strategy, significant engagement needs to take place at every level as the NHS is reconfigured to support integrated emergency and urgent care, through collaboration, service redesign and partnership working so that we can collectively improve access to, and improve the quality of care of, all patients in need of emergency and urgent care and non-emergency patient transport.

All Ambulance services, including SCAS, will need to continue to play a central role in the design of new pathways of care.

Additionally, and underpinning this strategy, the following wider issues need to be explored to further improve patient care within all healthcare settings:

- To continue to provide timely, appropriate and consistent clinical responses to patients with potentially life- threatening conditions, working with our partners in emergency and urgent care and ensuring resilience in the event of major incidents
- An updated education framework for paramedics including multi-professional training opportunities, extending the scope of practice of paramedics and nurses
- Participation in high quality clinical audit and research in pre-hospital care to inform future developments in emergency and urgent care clinical practice
- Implementation of effective quality improvement methodologies (for example QSIR - Quality, Service Improvement and Design) combined with evidence based transformation
- Further development of clinical leadership and professionalisation of the paramedic profession
- Improved information technology systems to enable patient records to be seamlessly accessed and shared across NHS and care organisations when required to support the delivery of personalised care plans and the monitoring of clinical outcomes

6. APPENDIX 1

Trusted Clinical Assessors and Advisors in Emergency and Urgent Care Definitions:

- **Trusted Assessor:** A clinician undertaking assessments in the community
- **Trusted Advisor:** A professionally accredited and experienced primary or secondary care clinician with responsibility for and access to specific health and social care pathways, who will offer expert advice on further clinical management after a telephone/telemedicine referral from a trusted assessor based in the community

Principles:

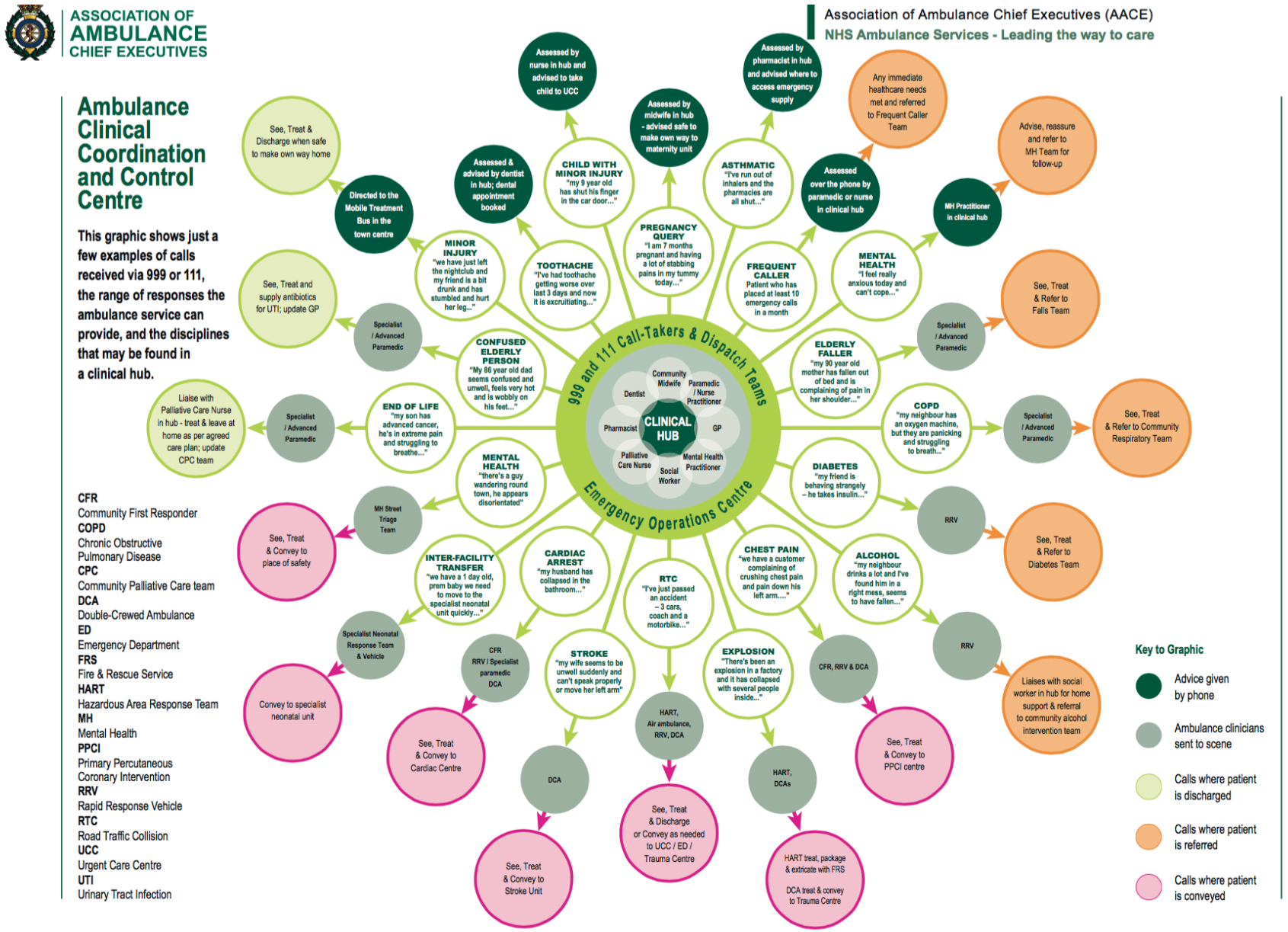
1. Clinical assessments, undertaken either over the telephone or in person, will be underpinned by current best practice evidenced based clinical practice guidelines
2. A Trusted Assessor will develop a care plan based on a personalised assessment of clinical need
3. These assessments will be undertaken in a clinically appropriate time frame 24/7
4. A Trusted Assessor will have direct access to decision support from a Trusted Advisor when required and will have authority to transfer patients to any appropriate healthcare setting when required. This would ordinarily be the patient's GP/Out-of-Hours Service unless the patient's problem was already being actively managed in an alternative care setting (i.e., secondary/tertiary hospitals/community and mental health/dental health/social care services)
5. Trusted Assessors will be able to directly access locally agreed alternative urgent care pathways and Emergency Care Networks 24/7 when clinically appropriate to do so
6. Trusted Assessors will have direct access to Local Summary Healthcare Records/ National Summary Care
7. Records so that they will no longer have to make important decisions without access to clinically relevant information to ensure that patients receive the right care first time
8. Trusted Assessors will be able to request further assessment by other health/ social care professionals working in primary care, community & mental health trusts and secondary care when required, following a telephone or face to face assessment

9. Trusted Assessors will undertake healthcare assessments in a range of health care settings, including at home or at work, or in residential accommodation, or other health care facilities (including community/acute hospitals and Day or Urgent Care Centres), when clinically appropriate to do so

10. Trusted Assessors will also be able to access and escalate social care support for patients in the community, via increasing integrated Health and Social Care Clinical Coordination Centres

11. Trusted Assessors will be equipped with modern clinical monitoring systems when required, clinical equipment and emergency drugs, and to undertake a range of bedside diagnostics (urine and blood) if necessary, to determine the most appropriate location/setting for further care

6. APPENDIX 2


ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES
Association of Ambulance Chief Executives (AACE)
NHS Ambulance Services - Leading the way to care
Ambulance Clinical Coordination and Control Centre
This graphic shows just a few examples of calls received via 999 or 111, the range of responses the ambulance service can provide, and the disciplines that may be found in a clinical hub.
999 and 111 Call-Takers & Dispatch Teams
Emergency Operations Centre
CLINICAL HUB
Community Midwife
Paramedic / Nurse Practitioner
GP
Mental Health Practitioner
Social Worker
Palliative Care Nurse
Pharmacist
Dentist
CHILD WITH MINOR INJURY "my 9 year old has shut his finger in the car door..."
Assessed by nurse in hub and advised to take child to UCC
See, Treat & Discharge when safe to make own way home
Assessed by midwife in hub - advised safe to make own way to maternity unit
PREGNANCY QUERY "I am 7 months pregnant and having a lot of stabbing pains in my tummy today..."
Assessed & advised by dentist in hub; dental appointment booked
TOOTHACHE "I've had toothache getting worse over last 3 days and now it is excruitiating..."
Directed to the Mobile Treatment Bus in the town centre
MINOR INJURY "we have just left the nightclub and my friend is a bit drunk and has stumbled and hurt her leg..."
See, Treat and supply antibiotics for UTI; update GP
Specialist / Advanced Paramedic
CONFUSED ELDERLY PERSON "My 86 year old dad seems confused and unwell, feels very hot and is wobbly on his feet..."
Liaise with Palliative Care Nurse in hub - treat & leave at home as per agreed care plan; update CPC team
Specialist / Advanced Paramedic
END OF LIFE "my son has advanced cancer, he's in extreme pain and struggling to breathe..."
MENTAL HEALTH "there's a guy wandering round town, he appears disorientated"
MH Street Triage Team
See, Treat & Convey to place of safety
INTER-FACILITY TRANSFER "we have a 1 day old, prem baby we need to move to the specialist neonatal unit quickly..."
Specialist Neonatal Response Team & Vehicle
Convey to specialist neonatal unit
CARDIAC ARREST "my husband has collapsed in the bathroom..."
CFR RRV / Specialist paramedic DCA
See, Treat & Convey to Cardiac Centre
STROKE "my wife seems to be unwell suddenly and can't speak properly or move her left arm"
DCA
See, Treat & Convey to Stroke Unit
RTC "I've just passed an accident – 3 cars, coach and a motorbike..."
HART, Air ambulance, RRV, DCA
See, Treat & Discharge or Convey as needed to UCC / ED / Trauma Centre
CHEST PAIN "we have a customer complaining of crushing chest pain and pain down his left arm...."
EXPLOSION "There's been an explosion in a factory and it has collapsed with several people inside..."
HART, DCAs
HART treat, package & extricate with FRS
DCA treat & convey to Trauma Centre
ALCOHOL "my neighbour drinks a lot and I've found him in a right mess, seems to have fallen..."
CFR, RRV & DCA
See, Treat & Convey to PPCI centre
RRV
Liaises with social worker in hub for home support & referral to community alcohol intervention team
DIABETES "my friend is behaving strangely – he takes insulin..."
RRV
See, Treat & Refer to Diabetes Team
COPD "my neighbour has an oxygen machine, but they are panicking and struggling to breath..."
Specialist / Advanced Paramedic
See, Treat & Refer to Community Respiratory Team
ELDERLY FALLER "my 90 year old mother has fallen out of bed and is complaining of pain in her shoulder..."
Specialist / Advanced Paramedic
See, Treat & Refer to Falls Team
FREQUENT CALLER Patient who has placed at least 10 emergency calls in a month
MENTAL HEALTH "I feel really anxious today and can't cope..."
MH Practitioner in clinical hub
Advise, reassure and refer to MH Team for follow-up
ASTHMATIC "I've run out of inhalers and the pharmacies are all shut..."
Assessed over the phone by paramedic or nurse in clinical hub
Assessed by pharmacist in hub and advised where to access emergency supply
Any immediate healthcare needs met and referred to Frequent Caller Team
CFR Community First Responder
COPD Chronic Obstructive Pulmonary Disease
CPC Community Palliative Care team
DCA Double-Crewed Ambulance
ED Emergency Department
FRS Fire & Rescue Service
HART Hazardous Area Response Team
MH Mental Health
PPCI Primary Percutaneous Coronary Intervention
RRV Rapid Response Vehicle
RTC Road Traffic Collision
UCC Urgent Care Centre
UTI Urinary Tract Infection
Key to Graphic
Advice given by phone
Ambulance clinicians sent to scene
Calls where patient is discharged
Calls where patient is referred
Calls where patient is conveyed

7. GLOSSARY

AACE	Association of Ambulance Chief Executives
PADs	Public Access Defibrillator
AED	Automated External Defibrillator
EOCs	Emergency Operations Centres
ROSC	Return of Spontaneous Circulation
PPCI	Primary Percutaneous Coronary Intervention
CCC	Clinical Coordination Centres
MINAP	Myocardial Ischaemia National Audit Project
MERIT	Medical Emergency Response Incident Team
SDEC	Same day emergency care
ASU	Acute Stroke Unit
CSC	Comprehensive Stroke Centre
NEPTS	Non-Emergency Patient Transport Services
SCAS	South Central Ambulance Service
COPD	Chronic Obstructive Pulmonary Disease
NICE	The National Institute for Health and Care Excellence
CPD	Continuing Professional Development
CFRs	Community First Responders
AED	Automated External Defibrillator
TIA	Transient Ischaemic Attack
ASU	Acute Stroke Units
NEWS2	National Early Warning Score 2
POPS	Paediatric Priority Observations Scores
LAO	Large Artery Occlusion
ECMO	Extracorporeal Membrane Oxygenation
ECG	Electrocardiogram
NASMeD	The National Ambulance Service Medical Directors
JRCALC	Joint Royal Colleges Ambulance Liaison Committee
LMNS	Local Maternity and Neonatal Systems
SDEC	Same Day Emergency Care

SCAS future opportunities and priorities to further improve emergency and urgent care in the community.

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