SCAS FUTURE OPPORTUNITIES AND PRIORITIES TO FURTHER IMPROVE PATIENT CARE IN THE COMMUNITY
SCAS future opportunities and priorities to further improve patient care in the community.

SCAS is a major first point of contact for patients with a real or perceived need for Urgent and Emergency care taking around 2 million calls a year, through the 999 and 111 numbers.

This clinical strategy seeks to set out by patient need/condition the best practice pathway that we are aligning with. It is a new way of thinking right across our services allowing us to better tailor our care and support to patients and enabling us to integrate this care seamlessly with our Partners. This is in line with the Integrated Urgent and Emergency care (IUEC) plan as defined by NHS England.

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. It is particularly intended for a stakeholder audience to provide more depth of understanding between our high level aspirations to deliver the right care in the right time at the right place and the highly detailed clinical guidelines that our clinicians work to.

For ease we have classified 10 ‘conditions’ under Emergency Care and 6 ‘conditions’ under Urgent Care though we recognise that there will be overlaps between areas and the urgency of need.

There are many opportunities for the further development of over the phone assessment and management of 999 and NHS 111 callers. As an Ambulance service that also provides NHS 111 we recognise the benefits of being able to improve the communication, pathways and processes between the 999 and NHS 111 systems. There are new opportunities to improve the patient experience and ultimately provide right care, right place with one call. This will be enhanced by having a cohesive, joined up service that is integrated with a number of different providers. This will lead to improved care, rather than a fragmented approach which can be seen currently in some areas.
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The future clinical model for us could include increasing the clinical input and the development and provision of a clinical care coordination service that could be for specific groups of patients such as:

- Patients at the end of life
- Frail elderly
- Patients with mental health needs including place of safety
- Patients requiring urgent dental advice

Patients with complex needs where hospital admission is often not the most appropriate care, would benefit from coordination of care across agencies and sharing of crucial patient information to ensure appropriate and effective care.

A single point of access or gateway model could be developed as part of the new NHS 111 service, staffed by specialist clinicians and nurses, allowing a seamless single point of contact for patients and care accessed via a comprehensive Directory of Services.

We fully accept our responsibility to promote prevention and public health and in section 3 have set out our current and potential contribution in this area.

The clinical models we have set out in this document rely on the workforce for their successful achievement. We strongly believe in the need to break down the barriers further between professions and NHS and Social Care Organisations and provide greater support for staff and patients in complex clinical decision-making. We have developed two generic conceptual roles which we believe will help with this process in the Trusted Assessor, and the Trusted Advisor, and we have included our working definition of these as an appendix at the rear of this document.

We very much welcome engagement and feedback on our plans and recognise this is a working document.
SCAS future opportunities and priorities to further improve patient care in the community.

1 EMERGENCY CARE

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

The AACE clinical practice guidelines will continue to be underpinned by evidence collated and by Warwick University. The ACCE Clinical Guidelines Group will continue to be chaired by Dr Simon Brown (SCAS Northern Area Medical Director).

The National Ambulance Medical Directors Group will continue to provide strategic clinical direction for future clinical guideline development. SCAS will ensure that there are continued developments, including work with partner emergency services and others to develop joint strategies to further improve out of hospital emergency care outcomes for patients. SCAS aim will be to ensure that an ambulance clinician of paramedic level of training will undertake initial clinical assessment and management.

TOP 10 EMERGENCY CLINICAL CARE PRIORITIES AND STRATEGY 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 top 2 performers when benchmarked nationally. In 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.
- Further development of a National Defibrillator Locator App to extend coverage from South Central Area to the rest of England.
- Improved visibility of defibrillator locations to Ambulance Clinical Coordination Centres/EOCs.
- Carriage of defibrillators on all emergency service operational vehicles, including PTS, Police and Fire Service vehicles.
- Further roll out of Basic Life Support and defibrillator training to Commercial Organisations, Community Responder Schemes.
- Wider roll out of mechanical CPR devices to support the management of patients with unexpected cardiac arrest at scene and en route to hospital when clinically appropriate.
- Direct transport of resuscitated patients following unexpected cardiac arrest direct to heart attack centres with on site access to coronary angiography and pPCI 24/7 7 days a week.
- Participate in further high quality pre-hospital care research, for example multi-centre randomised control trials to establish to role of adrenaline in the management of pre-hospital cardiac arrest.

Continuing to improve the clinical care for patients with life threatening conditions remains a core priority for the ambulance service.
The presence of Police and Fire Liaison Desks within our CCC, with real time visibility of other emergency service resources, linked to wider defibrillator carriage, could further improve access to prompt defibrillation and CPR, as well as improving the management of patients coming into the contact with these partner emergency services through shared clinical governance.

1.2 Patients suffering from Heart Attack
SCAS are committed to ensuring that all patients suffering from a heart attack are treated are assessed adopting all the elements of the evidence based care bundles. Currently SCAS deliver this to a high standard with the exception of being able to evidence that the pain relief element set out in the care bundles is administered and recorded effectively.

Continue to ensure that all patients with a heart attack (STEMI and non STEMI) are identified and treated appropriately in the pre-hospital phase and have timely access to appropriate and agreed care pathways i.e. 24/7 access to expert cardiology assessment, early coronary angiography when required, and primary percutaneous coronary intervention.

What we are going to do to further improve:

- Support and training in cardiac pain assessment and management
- ‘Face to Face’ training for all operational staff
- Clinical case reviews
- PCI feedback through MiNAP data.
- Improve PCI unit location awareness.
- Swift conveyance to nearest 24/7 pPCI centre.

1.3 Patients with Heart Disease
SCAS clinicians currently do not have direct access to 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 decision support and urgent cardiac clinics/CCU where available and appropriate for patients with known heart disease presenting with symptoms suggestive of acute coronary syndrome, arrhythmias including atrial fibrillation, transient loss of conscious with abnormal ECGs, and using ECG telemetry and troponin assays as required 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 any direct access rights for those patients that present to us and have a known history of Chronic Lung Disease and that are being managed by a specialist centre or clinician either in primary or secondary care.

SCAS in the future by working with other hospital and community providers 24/7 will ensure that the patient is clinically assessed, triaged and referred to the right care first time without the need to be conveyed to an emergency department unless clinically appropriate to do so.
SCAS future opportunities and priorities to further improve patient care in the community.

**What we are going to do to further improve:**

- Develop pathways for direct access to Specialist Community and Respiratory teams supporting the care of patients with Chronic Lung Disease, for example COPD

**1.5 Patients with Hyper- or Hypoglycaemia**

Known diabetic patients who on occasions require clinical interventions as a result of a hyper- or hypoglycaemia episode are frequently conveyed to an emergency department for further assessment. SCAS clinicians currently do not have any direct access rights for those patients that present to us and have a known history of diabetes and that are being managed by a specialist centre or clinician either in primary or secondary care.

**What we are going to do to further improve:**

- Develop pathways for direct referrals to primary care/community specialist diabetes teams for decision support for patients presenting to the ambulance service with poorly controlled diabetes that does not need immediate management in the Emergency Department supported by near patient diagnostics (e.g. ketone assay) when required.

**1.6 Major Trauma Patients**

SCAS has over more recent years developed injury care pathways for patients following major trauma through our collaborative work within the Thames Valley and Wessex Trauma Networks. Patients are clinically assessed, treated and transferred directly to two of our areas dedicated major trauma centres in Oxford and Southampton.

There has been great successes in improving the mortality and morbidity of this cohort of patients through enhanced skills, knowledge and resource that are routinely now deployed to these incidents.

**What we are going to do to further improve:**

- Extending further the access to prehospital emergency medicine/critical care support for patients needing on scene pre-hospital intensive care, or for emergency secondary inter-hospital transfer from Trauma Units to Major Trauma Centres 24/7
- 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.

**1.7 Vascular Emergencies**

Ensure patients with vascular emergencies (including ruptured abdominal aortic aneurysms) are assessed, treated and quickly transported directly to the nearest specialist vascular unit to manage their care.

As with other life threatening emergencies, speed is of the essence to ensure good clinical outcomes for patients. SCAS will continue to work collaboratively with the vascular networks to ensure that specialist arterial centres are appropriately located to address the needs of the South Central population.

**What we are going to do to further improve:**

- Working with our vascular network partners as further re-configurations of surgical services take place
SCAS future opportunities and priorities to further improve patient care in the community.

1.8 Stroke Patients

SCAS already deliver a first class service for patients who present with a Stroke using evidence based assessment and treatment with the Stroke care bundle. Paramedics can already facilitate emergency transfer to a hyper acute stroke unit (HASU) that improves clinical outcomes.

SCAS is committed to improve its performance for conveying FAST +ve Stroke patients with symptom onset less than 4 hours to Hyper Acute Stroke Unit (HASU) in less than 60 minutes.

What we are going to do to further improve:

- Early identification of stroke in the Clinical Coordination Centre
- Immediate appropriate dispatch with ability to convey quickly (right skill set / right transport)
- Further development of the clinical care pathways for patients presenting with symptoms of acute stroke, including direct access to thrombectomy capable stroke centres for patients suffering a dense stroke associated with a major vessel occlusion
- Explore direct access to stroke specialist trusted adviser decision support using video- telemetry to further improve the early identification of time critical stroke syndromes
- Appropriate direct admission of patients to Hyperacute Stroke Units.
- Direct transport of appropriate acute stroke patients to ED CT scanning facilities for stroke team assessment may further improve call- to-needle and door-to-needle response times with further improvement in stroke outcomes.
- Working collaboratively with commissioners, STPs and the stroke networks ensure that all Stoke Units are are appropriately located throughout South Central and adjacent neighbouring regions.

1.9 Patients with Sepsis

Sepsis is a time-critical condition that can lead to organ damage, multi-organ failure, septic shock and eventually death. It is caused by the body's immune response to severe infection. Sepsis is one of the leading causes of death in the developed world, rivalling myocardial infarction (heart attack) in its annual toll and resulting in substantial costs to the health economy.

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. Ambulance clinicians use a systematic handover tool to convey details of septic symptoms and signs to the receiving hospital which will trigger the activation of Surviving Sepsis Clinical Care Bundle upon arrival at the Emergency Department. This care pathway has been demonstrated to significantly improve patient survival.

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.

What we are going to do to further improve:

- Create a sepsis campaign approach that aligns to the calendar of trust wide campaign events
- Deliver face to face training for frontline staff
- Introduce evidence based pre-hospital sepsis clinical assessment tools and treatment algorithms in adults and children to further improve clinical outcomes
SCAS future opportunities and priorities to further improve patient care in the community.

- Consider acquiring additional IV antibiotics for ambulance clinician use in immediately life threatening sepsis
- Access to broader range of antibiotics for less severe infections suitable for management in the community

1.10 Extended Role Competency, Confidence and Resource

Over the years SCAS has invested in the development of a number of key clinical roles. Examples of these include Clinical Support Desk Clinicians, Emergency Care Practitioners, Emergency Care Assistants and availability of a Midwife within the Clinical Coordination Centre.

Going forward further development and review of the roles of advanced, specialist and critical care paramedics, ambulance nurses, doctors, and prescribing pharmacists and how their advanced clinical skills could be utilised to benefit patients with urgent or life threatening conditions.

What we are going to do to further improve:

- Consider the use of a standard pre-hospital early warning score (such as the National Early Warning Score) once validated for use in both adults and children
- Pilot the use of biomarkers such as troponin, D-dimer, lactate and ketones assays to support complex decision making when required
- This will include access to pre-hospital ultrasound for enhanced diagnostics/ interventional procedures for critically ill patients
- Ensure that ambulance services continue to improve their emergency preparedness and resilience, working effectively with the Hazardous Area Response Teams
- Further develop MERIT teams for deployment to a casualty clearing station at a major incident

EMERGENCY CARE
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.

Patients with complex needs, where hospital admission is often not the most appropriate care, would benefit from enhanced assessment, clinicians with enhanced skills and joined up / coordination of care at home or closer to home.

Going forward SCAS future clinical models could include increasing the clinical input and the development and provision of a clinical care coordination service that could further improve the outcomes for a number of patient groups e.g. patients at the end of life, frail elderly, patient with mental health needs, dental patients and pregnancy related care.

This aligns to the aims and plans recently published by NHS England’s - Urgent and Emergency Care Delivery Plan, April 2017 – which describes increasing hear and advise rates and capacity by using alternative referral pathways, and supporting community-based services, that will be in place to ensure that all ambulance services have a safe and viable alternative to taking patients to ED (such as Urgent Care Centres).

TOP 6 URGENT CLINICAL CARE PRIORITIES AND STRATEGY FOR THE FUTURE

2.1 Patients Mental Health Needs

Calls to mental health patients are common presentations to 999/111 and at times of crisis and can result in frequent calls from some patients and often involve influences of alcohol and drugs. These calls are complex and may take a significant amount of time to manage well. Some patients may require face-to-face assessment, and direct access to mental health records may be particularly important in order to determine the appropriate care pathway for these patients. Patients who self-harm will still require assessment in the Emergency Department.

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

Going forward SCAS will work with our partners in mental health trusts to ensure timely and appropriate transport for mental health patients in crisis, to a destination that is suitable and sensitive for their needs. This is to ensure that patients in mental health crisis are not conveyed inappropriately to emergency departments and police premises and that their needs are met and outcomes enhanced.

1 NICE (2013) Clinical Guideline 161 Falls: Assessment and prevention of falls in older people, Manchester
SCAS future opportunities and priorities to further improve patient care in the community.

-going forward patients will benefit by increased knowledge and awareness of dementia to assist in the identification of patients who require dementia-appropriate community services, and initiation of appropriate liaison / links with these services. This could result in fewer unnecessary admissions for patients with dementia to hospitals following collaborative work between the ambulance service and health and social care providers.

What we are going to do to further improve:

- Consider the development of a more sophisticated pre-hospital mental health risk assessment tool that is suitable for ambulance clinicians and their working environment.
- Further education for ambulance clinicians in mental capacity assessment and how to apply appropriate aspects of the mental health legislation.
- Consider access to approved mental health practitioner training programmes for paramedics.
- Consider the development of a specialist mental health paramedic role as the current education for paramedics in mental health is very limited and variable.
- Develop processes that enable sharing of clinical information between ambulance and mental health services to enable more effective integrated, safe and joined up care for mental health patients.
- Consider the commissioning of access to mental health specialists within 999/ NHS 111 Clinical Coordination Centres. This service could then provide timely, specialist advice and support to clinicians, manage frequent callers and improve systems for managing mental health patients more appropriately. These Mental Health Specialists could either be co-located with ambulance CCCs or connected virtually to existing Mental Health Clinical Hubs.
- Improve the care and recognition of patients with dementia, including those under the age of 65 with younger onset dementia.
- Consider further education of ambulance clinicians for people with learning disabilities.
- 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.
- Explore access with Mental Health Trusts 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 and we have an ageing population placing increasing demands on all health and social care services. The frail elderly are high intensity users of the ambulance service, and represent a large proportion of acute admissions to hospital.

NICE (2013) state that the over 65’s have the highest risk of falling, with 30% of people older than 65 and 50% of people over 80 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. 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.

- Further development of 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 following a fall to ensure robustness, effectiveness, consistency, timeliness of follow up, and falls prevention strategies. The pathway must ensure that the patient receives a multifactorial falls risk assessment where appropriate and put in place falls prevention strategies.

- Consider how ambulance services could be commissioned to provide a bespoke and specific response to frail elderly and falls patients. Particularly in urban areas with high demand of calls to falls and the frail elderly, this enhanced service could provide the initial over the phone assessment, appropriate response, falls assessment and further management, discharge or referral.

- Further integration of SCAS with existing community multi-professional assessment teams is likely to be beneficial to patients in terms of outcomes and experience.

- Further consideration should be given to how SCAS could be commissioned to assist in the development and delivery of advanced health technologies. Opportunities and efficiencies could be realised in areas such as tele-health and tele-care, building on the existing call handling, infrastructure, resilience and control functions within ambulance services. Access to video streaming technology to support clinical decision making is likely to be helpful and important.

- Further consideration to an Online NHS 111 triage service that enables patients to enter their symptoms and receive tailored advice or a call back from a healthcare professional. This envisages that an online facility will provide links to the healthcare economy through delivering clinically safe and accurate symptom assessment to the same standard as a traditional inbound voice call with an NHS 111 call handler.

### 2.3 Long Term Conditions

In England, more than 15 million people have at least one long term condition. This figure is set to increase over the next 10 years, particularly those people with 3 or more conditions. Examples of long-term conditions include hypertension, depression, dementia, epilepsy, COPD, heart failure and arthritis².

Patients with long-term conditions should have a personalised care plan and along with carers and relatives be supported in how to manage their own condition. However, many such patients will deteriorate and feel it necessary to access emergency or urgent care. These plans need to be accessible to SCAS and all community based services.

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

Unlike many other ambulance services, SCAS can now rapidly identify the NHS number for all patients in whom the patient’s identity is known, which enables for the first time for patients to be tracked across the healthcare system, for their utilisation of both health and social care to be monitored. This will enable much better access to health and social care records going forward.

**What we are going to do to further improve:**

- Ambulance services need to be able to access special patient notes and Enhanced Summary Care Records, including access to information about specific patient care plans/end of life care plans, in order to deliver appropriate care. However access to information can be difficult due to the variation in the multitude of NHS and Social Care IT systems in current use. Further investment in the technologies and integration of IT systems to facilitate this, including access to the NHS number and to GP clinical information systems, will help improve and streamline care.

- Further development of referral pathways so that paramedics attending a patient with a long term condition can refer the patient, 24/7, to an appropriately skilled healthcare professional, based in either primary or secondary care, to access prompt follow up for the patient, and if appropriate, to access timely social care in order for the patient to remain safely at home. Alternatively the paramedic could be provided with the appropriate training and skills, at an advanced or specialist paramedic level to be able to assess, treat, refer and discharge the patient safely.

- Paramedics can play a role in recognising patients with undiagnosed long term conditions and need to be able to refer patients for more specialised support via their GPs (to prevent unnecessary duplication of activity). Examples of such conditions include heart failure, chronic atrial fibrillation, hypertension and diabetes.

- Development of paramedic prescribing (e.g. broad spectrum antibiotics) would enable timely and appropriate treatment to acute exacerbations of long-term conditions enabling the patient to remain at home.

- Further education of paramedics in medicines management and a greater understanding of pharmacology and interactions with complex and/or co-morbidity patients would aid decision-making and care planning.

- Development of a robust, funded, national database of patients that present to ambulance services with hypoglycaemia, will aid further research and development of prevention strategies and contribute to reducing this common diabetic complication. Direct access to both hospital and/or community based diabetic teams, following contact with the ambulance service, is likely to be an important enabler for further improving the long term management of patients with diabetes and, reduce morbidity and mortality.

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 sudden crisis or deterioration, worsening symptoms and anxious carers and family members call 999. Paramedics are frequently at the scene at or shortly after the point
SCAS future opportunities and priorities to further improve patient care in the community.

of death, and have to 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 at this point.

What we are going to do to further improve:

- Ensure that there is generic documentation around do not resuscitate orders/ACPs and when and when not to resuscitate policies.
- Ensure ambulance systems are linked to patient specific end of life care plans and RESPECT plans so that paramedics have timely access to these care plans before they arrive with the patient.
- Ambulance service involvement with the development of end of life registers, potentially ambulance services can host these registers.
- Direct access to specialist palliative advice/services 24/7 for ambulance clinicians.
- Ambulance service involvement with the development of end of life registers, potentially ambulance services can host these registers.
- Commissioning of bespoke transport and booking processes to ensure rapid discharge or transfer for patients who are at the end of life.
- Investment in regular education and training in end of life for ambulance clinicians.
- Develop procedures around how paramedics can administer appropriate end of life medications to support patients who have contacted the ambulance service.
- Commissioning of integrated information systems, education programs and appropriate arrangements for urgent 24/7 care provision.

2.5 Extended Role Competency, Confidence and Resource

The workforce of ambulance services should be commissioned to further develop its urgent care capabilities, 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 emergency care needs.

Going forward further integration of ambulance 999/111 and Community Health Single Points of Access and social care hubs, co-located or connected virtually, could become key enablers for robust, high quality and cost effective regional coordination centres of urgent as well as social care.

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 should be further developed and educated to expand the urgent care workforce in a Trusted Assessor role. e.g. potential use of emergency nurses, dental nurses, pharmacists, matrons, midwives, mental health nurses. This should be in line with the Allied Health Professional Career Framework.
- Use of co-location of systems in community settings and acute trusts with clear referral guidelines supported by senior clinical judgement would mean fewer front end-pathways, but higher use of the correct services for the acuity and condition of the

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patient. Enable ambulance clinicians to have comprehensive access to special patient notes and enhanced summary care records with one system across whole health communities so ambulance services see the same message about a patient’s special situation as NHS 111, out of hours, Emergency Department etc. This would enable access to individual care plans, end of life plans, records of DNACPR forms, mental health plans and violent patient warnings.

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.

2.6 Prescribing for paramedics

Independent prescribing for paramedics should be considered as a priority. 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.

Going forward prescribing by paramedic will enable early intervention to improve patient outcomes, reduce potentially avoidable hospital admissions.

This extended practice will enable a greater focus on reablement, 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 additional training for paramedics to prescribe for minor illness and injury
- Provide decision support to paramedics dispensing ‘just in case medication’ for patients on end of life care pathways
- Support limited dispensing of drugs that would otherwise necessitate hospital admission (e.g. 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. This has enabled paramedics to be able to manage lower acuity injuries (e.g. use of wound toilet 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 paramedic’s with appropriate training, enhanced by the ability to prescribe, can assess, treat and refer a range of minor conditions. This can be aided by being able to administer a wider range of medications for example to help prevent spasm and manage pain in a patient presenting with musculo-skeletal lower back pain or to administer antibiotics for infections.

What we are going to do to further improve:

- Recruit and train additional Specialist Practitioners with the required level of skill
- Extend the current basic paramedic skill set to include wound management and closure
- Early recognition of urinary tract and chest infection and treatment out of hospital
- Ambulance clinicians able to access emergency and urgent social care, this could be facilitated through the commissioning of the enhanced NHS 111 service and an expanded Directory of Services.
3 PUBLIC HEALTH AND PREVENTION

SCAS can make significant contributions to the wider public health agenda. 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 safe-guarding 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 atrial fibrillation and high blood sugar 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.

- A patient presenting with conditions such as hypertension are, for example, at risk of a transient ischaemic attack and stroke. Paramedics are often in a clinical situation where they can observe and recognise transient motor/speech dysfunction, cognitive and behavioural changes which could signal a stroke risk. SCAS needs to work with stroke networks to further strengthen TIA referral pathways who have fully recovered at time of ambulance assessment. Access to emergency TIA clinics should be within 24 hours of referral.

- Alcohol related admissions and 999 calls for alcohol and substance misuse problems warrant development of referral pathways, brief interventions and preventative strategies including highlighting locations of violent incidents.

- Ambulance services should be commissioned to provide and analyse data on call outs, identify location hotspots (e.g. nightclubs) linked to population and demographics e.g. alcohol related 999 calls, preventable accidents, violence.

- 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.
Ambulance clinicians can potentially play a more proactive role in public health issues such as smoking cessation, asthma management, management of high 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, blood pressure checks, stress
- Cycle to work and exercise programmes
- Falls prevention
- Mental health
- Social care needs-recognition, referral

**CONCLUSION**

To support this SCAS Clinical strategy, significant engagement needs to take place with our commissioners and all NHS Provider Organisations, so that we collectively further improve the care of patients in the community.

All Ambulance services, including SCAS, need to continue to be a significant part of and contribute to the urgent and emergency care review being led by Sir Bruce Keogh and NHSE.

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.
- A future, robust, education framework for paramedics, extending the scope of their skills and capabilities to improve patient care. Work is underway nationally through HEE in further define this.
- Further clinical audit and research opportunities in pre-hospital care.
- Recognition and implementation of effective quality improvement methodologies throughout all organisations, and evidence based transformation. Use of a ‘positive deviance’ approach to spread excellent best practice, recognising trusts that demonstrate exceptional performance in a particular area of care.
- Further development of clinical leadership and professionalism of the paramedic profession
- Improved information technology systems to enable patient information to be recorded electronically and relevant patient information to be shared between organisations
SCAS future opportunities and priorities to further improve patient care in the community.

APPENDIX

Trusted Clinical Assessors and Advisors in Emergency and Urgent Care

Definitions:

A. **Trusted Assessor:** A clinician undertaking assessments in the community.

A. **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 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.

7. **Trusted Assessors** will be able to request further assessment by other health/social care professionals working in primary care, community health trusts and secondary care when required, following a telephone or face to face assessment.

8. **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.

9. **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.

10. **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.
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.

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
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>AACE</td>
<td>Association of Ambulance Chief Executives</td>
</tr>
<tr>
<td>PADs</td>
<td>Public Access Defibrillator</td>
</tr>
<tr>
<td>AED</td>
<td>Automated External Defibrillator</td>
</tr>
<tr>
<td>EOCs</td>
<td>Emergency Operations Centres</td>
</tr>
<tr>
<td>ROSC</td>
<td>Return of Spontaneous Circulation</td>
</tr>
<tr>
<td>pPCI</td>
<td>Primary Percutaneous Coronary Intervention</td>
</tr>
<tr>
<td>CCC</td>
<td>Clinical Coordination Centres</td>
</tr>
<tr>
<td>MINAP</td>
<td>Myocardial Ischaemia National Audit Project</td>
</tr>
<tr>
<td>MERIT</td>
<td>Medical Emergency Response Incident Team</td>
</tr>
</tbody>
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