Annex D: List of recommendations

Ambulance services should improve the speed and quality of their call handling, provide significantly more clinical advice to callers, and work in a more integrated way with partner organisations to ensure consistent telephone services for patients who need urgent care

1. Ambulance services need to improve the speed with which 999 calls are answered and the quality of call handling.

2. Ambulance services need to deliver significantly more clinical telephone advice, with higher levels of clinical expertise.

3. Ambulance services need to work more closely with urgent care providers to ensure consistent standards of call taking and response.

4. There should be a standard competency framework and core training syllabus for callhandling staff.

5. Work needs to continue at pace to build an evidence base so that call categorisation can reflect as safely as possible patients' needs.

6. There should be significantly improved clinical supervision, support, audit and quality assurance in ambulance control rooms to provide clinical direction and advice.

7. There should be further research to compare approaches to call handling and also to establish the level of medical support necessary to maximise the effectiveness of the advice.

8. Contestability and integration of urgent care provision should be improved by making the provision of clinical assessment by NHS Direct an optional service for PCTs to commission.

Ambulance services should provide and coordinate an increasing range of mobile healthcare for patients who need urgent care

9. There should be improved focus on the large numbers of patients calling 999 who require urgent primary or community care services.

10. Ambulance clinicians should work locally to undertake appropriate home visits on behalf of GPs, both in and out of hours, and help with GP same day appointments.

11. Ambulance clinicians should also rotate through urgent care centres to help develop practice and manage demand costeffectively.

12. To facilitate coordination of urgent care provision, response hubs – which may be virtual or physical – must be able to deliver assessment, information, resource dispatch and referrals (including bookable appointments) in real time.

13. Information on referral options, including primary, secondary and community services needs to be available to staff delivering clinical telephone advice in order to advise patients on care appropriate to their need.

14. A patient record summary should be available to ambulance service staff to assist them with providing targeted, appropriate, quality clinical care. As a minimum, the summary should contain information on:

    - the patient's GP, district nurse or other regular provider of care;
    - whether the patient is on the child protection or vulnerable adults register;

- key medical conditions and critical treatment information (e.g. being treated at hospital while awaiting heart surgery);
- any medication and allergies;
- details of how to access the patient's care plan (if there is one);
- the last five contacts with NHS services and the treatment pathway recommended, to aid decisions about that patient's care;
- whether the patient is violent or abusive to NHS staff;
- whether the patient is a regular user of 999 or other urgent care services.

Ambulance services should provide an increasing range of other services, e.g. in primary care, diagnostics and health promotion

15. Ambulance clinicians should increasingly undertake routine assessments of patients in their homes in partnership with the primary care team.

16. Ambulance clinicians can play an increasing role in undertaking diagnostic procedures in patients' homes, particularly for patients whose condition or transport situation makes it more difficult to access community diagnostic centres or hospitals.

17. PTS operating hours should be better structured around patient need e.g. being available to take patients home after day care or surgery so that avoidable overnight or weekend admissions are prevented. The implications for planned and emergency transport provision should be considered as part of local service planning in order to optimise impact.

18. Ambulance clinicians can play a role delivering health promotion and education for self-care. They can also train community responders, teach CPR to local communities and also support health screening programmes.

Ambulance services should continue to improve the speed and quality of service provided to patients with emergency care needs

19. Ambulance services need to improve their treatment of major trauma, through partnership working with critical care networks and transport to the most appropriate provider.

20. Pain should be better assessed and pain relief more widely used, particularly with children.

21. Ambulance services need to further improve their provision of cardiac care. There should be continued improvements in cardiac arrest survival and the treatment of acute coronary syndrome including direct admission to cardiac catheter laboratories and continued rollout of prehospital thrombolysis to treat cases of ST segment elevation myocardial infarction (where eligible) according to locally agreed care pathways.

22. There should be improved specialist transfer arrangements for emergency inter-hospital transfers including local agreements between ambulance and acute trusts on the equipment to be used.

23. Rapid admission to stroke units should be agreed locally as protocols for stroke care evolve.

24. There should be continuing improvement in governance and support for community responder schemes and the use of doctors to respond to Category A calls.

25. There should be greater emphasis on developing local agreements for rapid referral of patients where there is evidence of improved outcomes the earlier the treatment takes place, e.g. for stroke or heart attack.

Improve leadership, both clinical and managerial, so that organisation structure, culture and style matches new models of care

26. Commissioning, purchasing and provision of integrated emergency and urgent care needs to be progressed in partnership through local emergency/urgent care networks.

27. There should be a lead PCT for each ambulance service who is responsible for commissioning ambulance services for all the PCTs in that area.

28. The Department should fund a programme of management and leadership development for ambulance staff, having first commissioned research to understand development need.

29. The Department should also resource and support the development of regional forums for operational directors and for service modernisation/strategy leads to share good practice and innovation.

30. The Department should provide similar support for clinical directors to come together at a national level.

31. Ambulance managers need to continue to focus on their own development as professional healthcare managers, understand the impact that their services can have on patient outcomes and work with their colleagues to enhance quality of care. Leadership needs to focus more fully on crossorganisational team work, building relationships and coaching and supporting staff to improve patient care.

32. Ambulance services need to play a full and active part in emergency care networks, including chairing networks where appropriate. Networks should identify ways of freeing up more time and resource to look at strategic issues such as planning, commissioning, funding and wholesystem performance indicators. Constituent organisations should ensure that networks have dedicated support, to facilitate local action.

Improve the consistency and quality of care provision

33. There should be a single data repository and data set for ambulance services through Connecting for Health.

34. Measures of patient outcome and experience should be used to promote evidence based practice and assess how far ambulance services and local health economies are delivering high quality care.

35. Development of clinical quality measures needs to be embedded into the full spectrum of ambulance service provision and directly linked to NSFs, NICE and JRCALC guidance. It is equally important that clinical quality development is embedded in the work of networks.

36. The recommendations will benefit from a single data repository and dataset through Connecting for Health.

37. The Department of Health should commission a programme of work to build the evidence base for prehospital and out of hospital care.

38. The Department of Health should develop wholesystem indicators to incentivise commissioners and providers to work together to improve patient flow and quality of care. Development of clinical performance indicators should be undertaken in phases.

39. A system for accrediting independent ambulance providers should be introduced.

Improve efficiency and effectiveness

40. There should be a reduction in the number of services broadly in line with SHA boundaries. Precise decisions on the configuration and number of services should be made after consultation with NHS and the public to ensure that configuration reflects local operational requirements.

41. The Department of Health should explore the scope for further efficiencies through national procurement and outsourcing of appropriate support services by reviewing common capital procurements particularly for fleet, but also potentially for other aspects.

42. The Department of Health should ensure that support is made available (or commissioned) to support trusts in achieving optimum call activation, mobilisation, resource production and distribution, recognising this will vary with rural and urban models.

43. The Department should support servicess to understand and analyse their demand. Commissioners need to recognise the impact of increases in activity as well as striving for increased efficiency.

44. SHAs and ambulance services should examine how clinical resource can be fully utilised in other ways – for example in call handling, working in GP practices or in Walk-in Centres, or taking diagnostic services to the patient.

45. SHAs should work with PCTs to ensure that ambulance service resources are included in capacity planning for primary care and for urgent care.

46. Networks should work with SHAs to ensure coordinated and cross system workforce planning for urgent and emergency care.

Support performance improvement

47. For measuring 999 Category A and Category B response times, the clock should start when the call is connected to the ambulance control room. This will more closely match the patient's experience and can be consistently understood and applied by services. This change should be introduced from April 2007 to allow sufficient time for the necessary technical and operational changes and to avoid a mid-year change to national performance definitions. Good practice suggests that the phone should be answered within 5 seconds at least 95% of the time.

48. The performance requirements for Category B response times – and Category A transport times – should be based on a single measure of 19 minutes for all services – with effect from April 2006.

49. By April 2009, national performance requirements for Category B response times should be replaced by clinical and outcome indicators against which performance should be managed locally. This is an indicative timescale.

50. There should no longer be a requirement to report the number of Category B calls within 8 minutes.

51. Local networks should be able to put in place standards that are consistent with wider approaches to urgent care provision for nonurgent (Category C) patients.

52. The performance requirements for responding to patients whose GP calls 999 on their behalf (known as 'GP urgents') should be the same as for other 999 calls – with effect from April 2007. From April 2006, as an interim measure, the clock should stop for this group of patients when an ambulance clinician arrives at the scene.

53. All ambulance services should prioritise calls in the same way. Prioritisation should be reviewed annually.

54. All ambulance services should use a single 999 call prioritisation system and use the most up to date version available. Consideration should be given to prioritisation

systems being standard across urgent care providing this can be done safely.

55. There should be further work to ensure that the financial incentives introduced by Payment by Results help as far as possible to support the improvements recommended by this review and to appropriately incentivise the development of integrated urgent care provision. An early task will be to develop reference costs for patient transport services and to refine the classification of reference costs for emergency and urgent care services.

56. The Department should develop a national implementation support framework, with tailored support for those services with particular implementation challenges.

Develop the workforce

57. Ambulance clinical training needs to be designed around the case mix they deal with. Course content should therefore be reviewed.

58. The Department should support SHAs in ensuring the NHS has the right staff with the right skills to meet patient needs, as well as helping to identify and remove barriers to robust workforce planning in urgent care.

59. The Department, working with key stakeholders, should develop guidelines on patient pathways to promote consistency between urgent care providers.

60. The training of ambulance clinicians and call handlers should have greater commonality with that of other health professionals and their career pathways should be integrated with the wider NHS, so that people undertaking similar tasks and gaining similar competencies have the opportunity to train and develop together.

61. To aid integration, there should be a move to higher education delivered models of training and education for ambulance clinicians. Initial registration should be at diploma or foundation degree level.

62. There should be improved opportunities for career progression, with scope for ambulance professionals to become clinical leaders. While ambulance trusts will always need clinical direction from a variety of specialties, they should develop the potential of their own staff to influence clinical developments and improve and assure quality of care.

63. The Department, in conjunction with SHAs, should review funding arrangements where necessary to facilitate consistent access to funding. Funding of ambulance clinician education and training should be consistent with the arrangements for other non-medical clinical professions.

64. Ambulance services, PCTs, acute trusts, foundation trusts and SHAs will need to work together to review funding arrangements and priorities for the training of the overall urgent care workforce.

65. The Ambulance Service Association, the British Paramedic Association, NHS Employers, NHS Careers and NHS Jobs work together to market ambulance clinician roles as a profession with excellent opportunities for development and progression across the NHS.

66. Ambulance services should take increased steps to support the recruitment of black and minority ethnic staff.

67. When recruiting and designing new roles, ambulance services should also focus on the competencies, underpinning education, attitudes and behaviours required to deal with patient need and consider the increased use of and diversification into intermediate grades (between PTS and emergency ambulance grades) as well as more advanced and specialist clinical grades.

68. The recruitment and development of ECPs should continue at pace, encouraging recruitment from a variety of professional backgrounds, including within the NHS.

69. ECPs should be regulated as a profession in their own right with the Health Professions Council and prescribing responsibilities should be actively explored. This should include the development of a national curriculum for ECP training, with education programmes nationally accredited by the HPC and delivered by HPC approved higher education institutions, alongside HPC arrangements for CPD and clinical mentoring.

70. The Department should work with SHAs and ambulance services to develop a five year workforce development plan.