The NHS oil tanker: heading towards a new horizon for urgent and emergency care

Paramedics have a key role to play in reducing current pressures on NHS services and providing patients with better care within a more sustainable NHS system. **Hilary Pillin** looks at some of the current transformations in urgent and emergency care delivery and illustrates how these new initiatives highlight a slowly changing culture in the NHS.

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Pressure on NHS services is nothing new, and we all know it is unlikely to ever end. Demand on NHS ambulance 999 services alone has increased by around 25% over the past 5 years and it is widely recognised that the whole system is unsustainable in its current form. It is time for the NHS oil tanker to turn and head towards a new horizon.

NHS ambulance Trusts, and paramedics in particular, have a key role to play in NHS England's *Five Year Forward View* announced by Dr Simon Stevens at the end of last year (NHS England et al, 2014), and the transformation of urgent and emergency care (UEC) services instigated by the Keogh Review in 2013 (NHS England, 2013). Both share a common aim: to alleviate current pressures and provide patients with even better care within a more sustainable NHS system.

Since their inception, NHS ambulance Trusts and their staff have notoriously shown themselves to be good adapters, being willing to turn their hand and their services to meet whatever requirements are placed upon them in order to better help as many patients as possible.

We all know that when things really do kick off in a big way, as an emergency response our ambulance services are second to none, highly professional and nothing is held back. That willingness to extend and enhance day-to-day services, was often enabled through sheer goodwill and dedicated effort in the past, without the necessary investment and commitment from 'the system' or those doing the asking, who became used to the ambulance service just 'getting on and doing the necessary'.

As a consequence, for a long time now, the ambulance service right across the UK has been stretched to the limits of its capacity, and it is only in recent years that commissioning bodies have begun to recognise that ambulance provision is a serious and essential cog in the big healthcare wheel—and that it needs oiling with appropriate levels of funding as much as any other part of the system if the wheels are going to keep on turning.

Within the *End of Phase 1 Report* of the Keogh Review, the introduction states:

> ***'The reality is that the pressure our A&E departments and ambulance services are experiencing is absolutely not a sign of failing services, but that these services have become victims of their own success. The unsustainable demands being placed upon them have been fuelled by their own responsiveness but also the difficulty patients experience in navigating and securing help for their urgent care needs elsewhere' (NHS England, 2013: 12–13).***

NHS England's *Five Year Forward View* (NHS England et al, 2014) reflects that recognition, building on the acknowledgements within the Keogh Review that ambulance services should be developed, so that:

> ***Ambulances can become and are seen as a community-based mobile urgent treatment service, rather than solely a means of transportation' (NHS England, 2013: 19).***

In fact, ambulance services have been providing considerably more than 'a means of transportation' for many, many years, particularly with the introduction of paramedics in the 1980s. But the greater meaning in that stated aim is about the shift in emphasis away from the life-saving, emergency response element of the

role, towards reflecting the much larger proportion of the workload that presents to an ambulance service: that dealing with urgent health care provision. Examples of this include: the frail and elderly; fallers; broken bones; those with chronic conditions, such as diabetes; those with multiple complex health needs; those with mental health conditions; those nearing end of life; those with dental problems, urinary tract infections, burns, convulsions, fevers, antenatal concerns, effects of excess alcohol/drugs—the list is seemingly endless.

This is not to say that emergency response is no longer a priority—saving lives will always be the priority and remains a statutory responsibility for NHS ambulance Trusts. The capability and capacity to do this must be maintained for life-threatening calls, major incidents and mass casualty response; but while our ambulance Trusts have the most challenging response time standards in the world (8 minute response to 75% of calls to life-threatening conditions), fewer than 10% of calls actually involve life-threatening conditions.

The current response regime means a fast response is being despatched to 40% of patients, most of whom do not actually require that speed of response, which is very resource intensive and temporarily diverts resources away from those who may need them more. For most patients there is little correlation between the speed of response and their clinical outcome. In the future, time-based targets preferably need to be limited to those patients with genuine life-threatening conditions, enabling the service to commit more appropriate resources to the majority of calls received.

Aside from this, NHS England have recently announced a clinical review of ambulance response times, and pilots to run in the London Ambulance Service NHS Tust and the South Western Ambulance Service NHS Foundation Trust from February 2015 will evaluate the benefits of allowing up to an additional 120 seconds on clock start times. This is in order to better assess the nature of the call and required response for all 999 calls except the Red1 category (calls indicating life-threatening conditions), for which the clock start time remains as the time the call is received by ambulance control (EOC). If these pilots show that outcomes improve for all categories of patients, with more evenly distributed and proportionate clinical risk, the change will be implemented across the country and would be welcomed by ambulance Trusts and their staff.

Extending the skill set of paramedics would increase the number of patients with urgent care conditions and minor injuries who could be assessed, treated and discharged on scene

Specialist paramedic practioners working from within GP practices can undertake Red1 and urgent home visits

The urgent care workload is broad in content, requiring a range of capabilities and responses, and if ambulance services are going to make the necessary impact within the UEC Review they need significant investment in resources (especially workforce), closer collaboration with other providers of health and social care, and appropriate commissioning models and payment mechanisms.

As the Keogh Review *End of Phase 1 Report* states:

> ***'Ambulance services are highly valued for the speed of their service and the skills of paramedics, but these skills are incompletely used when, in some cases, an ambulance simply drives a patient to hospital. By supporting and developing paramedics, and providing direct access to the expertise of general practitioners and specialists, around half of all 999 calls which require an ambulance to be dispatched could be managed at the scene, avoiding an unnecessary trip to hospital' (NHS England, 2013: 19).***

This is not news to ambulance Trusts who have been horizon scanning and adapting over the past decade, endeavouring to anticipate demand patterns and address locally identified pressure points, and developing better ways of working with other NHS and social care providers. This has resulted in pockets of excellent integrated care provision and various pilots of new ways of responding to those needing urgent care being tested out.

Some of this has had to be done within existing resources and funding, while other initiatives are being proactively commissioned by CCGs, but all are inevitably being introduced with an already stretched workforce working under intense pressure to meet demand and targets, and this can sadly stifle effective innovation.

Much effort, therefore, is going into evaluating these initiatives to provide the necessary evidence for commissioners as to how beneficial they are for

Table 1. Examples of current urgent and emergency care initiatives in place or being piloted by ambulance Trusts

Intitiative	How initiative is carried out
Clinical hubs	Not yet widespread or fully developed in most cases. Based in ambulance EOC staffed (variously) with specialist paramedics, nurses, midwives, GPs, mental health nurses, end-of-life specialists—providing 'Hear and Treat' care to patients and/or clinical advice to paramedics and technicians on scene and can undertake secondary triage on lower acuity 999 calls, or NHS 111 calls (seamlessly where the latter services are also provided by the Trust). They can quickly and effectively identify response requirements and organise onward referral to other health and social care services if needed
Telephone triage and advice systems	Non-scripted systems run by nurses and paramedics to stream patients into the most suitable healthcare pathway and safe referral without need for ambulance attendance
Pathfinder systems	Handheld decision support algorithm facilitating assessment and referral of patients by specialist paramedics on scene
GP referral systems	Allowing paramedics on scene direct access to GPs to discuss alternative care pathways or book GP appointments to avoid hospital attendance/admission
Specialist and advanced paramedic practitioners	Provide assessment, treatment and discharge on scene for a range of urgent care conditions and minor injuries, or organise onward referral, thus avoiding unnecessary hospital attendance and admission; or, working from within GP practices to undertake Red1 and urgent home visits
In Case of Emergency (ICE) buses/Mobile treatment Centres	Providing medical care to public at peak times in city centres, thus avoiding unnecessary hospital attendance and admission
GP in a response car	Providing care alongside paramedics or as back-up to paramedics or support at emergency departments when ambulances are waiting handover
Acute geriatric intervention/falls response services	Paramedic responding with an occupational therapist to elderly fallers providing safe, appropriate admission avoidance solutions and practical interventions to reduce risks of future falls
Mental health triage schemes	Multi-disciplinary team made up of police officer, mental health nurse and a paramedic responding together, carrying out street triage for patients referred through 999 and police control where there are suspected mental health issues involved, reducing Section 136 admissions and providing an emergency pathway to places of safety other than an emergency department
Alternative care pathways	For conditions such as alcohol misuse, long-term conditions, end-of-life care, mental health, hypoglycaemia, etc.
Systems enabling immediate access for paramedics on scene or in EOC to patient care plans (e.g. IBIS, CMC)	Facilitates appropriate advice and care, e.g. for end-of-life choices, and avoids unnecessary conveyance

patients—in terms of outcomes, safety and experience, as well as demonstrating the impact on local health pressures and systems overall, in anticipation of securing appropriate funding to support the ongoing development and sustainable implementation of those models of care that can be shown to be making a positive difference on all counts.

In 2014, the Association of Ambulance Chief Executives (AACE) established a National Ambulance Urgent and Emergency Care Group (NAUECG) involving urgent care leads from all ambulance Trusts in the UK and linking in with the National Ambulance Medical Directors Group (NASMed). Details of new response models and initiatives have been collated and the aims, challenges and benefits are being evaluated and shared so that effective models, demonstrating improvements in care and outcomes for patients, can be discussed in very meaningful ways with CCGs and hopefully replicated where appropriate across the country (see *Table 1* for examples).

Many initiatives are involving specialist and advanced paramedics with extended skill sets, able to provide 'Hear and Treat' and 'See and Treat' care, as described in the UEC review. What we have learnt, however, is that with these roles having been introduced at various times and to various extents and purposes across Trusts, we now have a somewhat inconsistent profile of paramedic education, development and nomenclature in place across the country, which does not serve to assist the process of attracting the significant investment needed to increase the number of these roles and the scope of clinical provision they are capable of.

The AACE is working closely with Health Education England and the College of Paramedics to address these inconsistencies and identify actual requirements around workforce numbers, paramedic curricula and a recognised career framework as a matter of urgency, to ensure that ambulance Trusts will be able to deliver efficiently and effectively within the UEC transformation.

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Emergency operation centres staffed with specialist paramedics offers 'Hear and Treat' services to patients

We know that some paramedics are choosing to leave their ambulance Trust—and some the NHS altogether—due to the consequences of the unprecedented demand pressures and frustrations of chasing targets, often feeling disillusioned about what they are being asked to do and what they feel they are ultimately able to achieve for their patients. Shortages of paramedics inevitably exacerbates the pressures on those who remain, but if these stalwarts can hold on they will see that the NHS oil tanker really is turning—slowly but surely—and the role for paramedics is becoming broader and their career path clearer.

They are very much needed (and there is no question we need more) and valued both by their Trust and by their patients, and this recognition needs now to extend in real and meaningful terms to NHS England in providing the necessary endorsement and direction, and commissioners in providing the essential engagement and investment.

The transformations that are taking place in UEC delivery would appear for once to not be an attempt at wholesale, top-down organisational change, or futile name-changing of functions that stay the same but want to start everything over again, but are representing tangible changes on the ground in how we deliver services and a slowly changing culture that, rather than pitting NHS colleagues against each other in the battle for commissioner attention, is breaking down those barriers, enabling professionals to communicate on a par and work together in ways that they know are so much better for patients, because they are the ones designing and delivering these new models of care.

Commissioning mechanisms still need to be worked on and commissioners need to be able to focus on outcomes rather than targets. While there is still a long way to go on all counts, there seems to be a very real desire among managers and those on the frontline alike to reach these new horizons and to do so quickly, before it is too late and the oil tanker begins to irretrievably sink.

References

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