WEBINAR:
What do Ambulance Trusts get out of using NHS Advice & Guidance – Q&A

22nd September 2020

Speaker panel:

- **Dr Brendan Lloyd,** Medical Director, WAST
- **Paula Jeffrey,** Regional Clinical Lead, WAST
- **Dr John Black**, Medical Director, SCAS
- **Jonathan Patrick,** CEO, Consultant Connect

To watch the webinar recording, click here.

Question 1: Do you have any tips for how you keep the workforce motivated when you're rolling out new tech?

Answer:
(Paula Jeffrey):
We have a very technology enabled workforce, and then we have perhaps less so technology enabled proportion of the workforce, probably include myself in the latter. So at the moment we have the new iPads, so we are very proactive in terms of the pre-loaded apps on that, and so staff are familiar with using apps and the technology enabled with that. One of the issues that we've had is making sure that our IT systems align to support new initiatives and that's always a challenge and we're working really hard to make sure that we try and resolve some of the local issues we have with technology. The other issue is of course as always it's signal, so staff may well get frustrated if you're trying to use a technology, telephone enabled platform in rural West Wales. It's not always easy and that is frustrating, and but there's not a lot we can do about that in terms of the infrastructure around mobile technology but we're working hard to resolve that and make this a workable platform as we can across WAST.

Question 2: Is there a fear that the 111 First approach may increase the burden on the ambulance crews by people just ringing for an ambulance rather than just dialling 111, has there been any evidence of that happening in Portsmouth?

Answer:
(Dr John Black):
Not that we've seen, we did do a soft launch to warn the local population that this was a process that was put in place, but in effect we haven't taken anything away from them. We are monitoring activity, we are able to identify all of our patients that

contact either the 1s or the 9s service, so we do what we call ‘spine match’ those patients, we establish their NHS number and we can monitor. Indeed if a patient phones the 111 service and they need a timely 999 response then literally the call is passed from one part of the room to the other and there’s an immediate despatch process. That again is one of the many positives of the 111 service being hosted by the ambulance service is that for those calls that potentially end up in the wrong part of the system, the ambulance service completely owns that responsibility and we can despatch ambulances appropriately. But what we haven’t been is data to suggest that there’s inappropriate use of the 9 service locally as a consequence of the 111 First approach. And if patients do self-present we clearly have appropriate pathways in place so those patients can be appropriately directed straight into the resus room or the emergency department - if that’s clinically appropriate, or we can refer them to another clinical area for further clinical assessment, and potentially direct streaming to other inpatient teams at the hospital if that’s clinically appropriate.

Question 3: I am a >12 year paramedic, the fear we face is the lack of support if a patient deteriorates following a non-conveyance, the saying goes "nobody has ever got into trouble for taking someone to hospital", what can be done to convince us that the support is in place?

Answer:
(Paula Jeffrey):
This was a culture we have definitely experienced previously in our Trust (and still do in some areas). We have worked hard to ensure our Team leaders undertake PADRs with all operational staff, which includes looking at compliance to Clinical Indicators, Condition Code completion and individual conveyance rates and alternatives for our patients (such as our own referral pathways). We encourage safety netting of patients left at home, two sets of obs and good hx and documentation, and we will support our staff if that patient deteriorates in the community if all is in place and it is a well-founded decision at that time. We have developed a 24/7 Clinical on call system for senior clinicians (8a and above) to take clinical calls from operational staff to support their decision making and “no decision in isolation”, as well as seeking advice from GP or GPOOH or Medical Teams in hospital. It is harder to support when documentation is poor, observations are grossly abnormal and both acts or omissions may have contributed to that patient’s deterioration, so in this case we do a clinical review and sit around the table with a clinical lead and explore the incident, learning and reflection. It is not punitive, and we work hard to support our staff to make the right decisions for our patients. Hope this helps.

Question 4: Does this also work for Mental Health Patients calling the ambulance service?

Answer:
(Dr Brendan Lloyd):
Our use of Consultant Connect does not change the way in which patients with

mental health issues contact the ambulance service. The benefits lie with simplifying the way in which the paramedic would contact the local mental health crisis team or obtain advice from mental health teams.

Answer:
(Dr John Black):
We do have a team dedicated team of Mental Health nurses based in our Clinical Coordination Centres who are employed by the Community and Mental Health Trusts to take calls from our ambulance clinicians following a face to face clinical assessments, 999 and 111 callers. We have this 24/7 in one of our centres and will be 24/7 in our second centre in the near future. The Mental Health nurses have access to the Mental Health records and care plans when required and can directly refer patients to acute Mental Health crisis centres/ assessment hubs / support services as appropriate.

Question 6: What percentage of the calls to the ambulance service utilise the advice service, presumably some simply convey, which may explain the 15%?

Answer:
(Dr John Black):
I need to ask colleagues for data on shared decision making. For patients requiring a Cat 1 response and a significant proportion of patients receiving a Cat 2 response will have clear cut medical emergencies requiring emergency protocolised care and onward transport to an appropriate secondary care destination (usually the nearest Emergency Department but increasingly to directly to an acute admissions/assessment/specialist unit as per local care pathways).

For patients approaching the end of life / advanced care planning where a further escalation in care may not be clinically appropriate, our ambulance clinicians would ordinarily speak directly to the clinical team responsible for the onward care of the patient (in-hours this would be usually be the patient's GP or another clinical team as documented in their care plan) to determine an appropriate care pathway/follow-up for the patient in the community where possible.

All of our 999 Cat 3 and Cat 4 calls are filtered (validated) by a clinician prior to emergency ambulance dispatch to ensure that an emergency ambulance response is required - these calls can be re-directed to other services as required.

Question 7: What would each of you like the participants in this webinar to leave with, what thoughts would you like to send them off as your parting shot?

Answer:
(Dr Brendan Lloyd):
I think from our perspective that there's always a tendency to have pressure to use things that are shiny and new, particularly in the digital and communications area, and what we really need to focus on is what is it adding to patient safety, and patient outcomes. And I think that from our perspective we can see the role for Consultant Connect as we integrate it, as part of that clinical support structure, so it doesn't

replace the structure that you're putting in place, but it is going to be an essential part of it, and it will be supported within Welsh ambulance by our full clinical structure working across the system. Enabling us to make those connections, getting the patients seen as Paula said, the first time by the right clinician, and then I think, you know, we're carefully monitoring those outcomes but there's also a slightly softer outcome on how some of those conversations then improve relationships going forward, within each of the localities. So very much part of the clinical support structure, supporting our clinicians, as you said Jonathan at the start, sometimes making quite scary decisions for them and this will add value. And I think that as we bring on more technology including the use of images and videos possibly, that is going really support our clinicians on the frontline, enabling them to make the best decision the first time.

Answer:
(Dr John Black):
My message would be firstly to thank all of our colleagues for all the work that they have done to enable us to have opened up so many pathways which are really, really benefiting our patients, so we haven't really talked about our urgent care workstreams. But technology is a key enabler, and I think any technology that makes the task of frontline clinicians easier, that at the end of the day will be what drives improvements in practice, it will open up and transform pathway development, the momentum that we've had during the COVID emergency has been fantastic. I've been able to get pathways put in place that would otherwise have taken many months and years to be put in place, we've been able to transform the mental health landscape for many of our patients by embedding specialist mental health nurses within our clinical coordination centre who can directly access their information systems and direct patients appropriately either following a face-to-face assessment by the ambulance service, or following telephone 111 or 999 calls and plugging those patients directly into specialist services, or patient support services if that's clinically appropriate. So my ask would be continue to work closely at any opportunity to build systems of care so that we can work as effectively as partners. I think there are huge opportunities for further integrating single points of access for many community based services, harnessing the expertise of the ambulance service to support that, because we're the only service that currently tracks our patients who are working with our staff in the community and that is a key enabler for running an efficient and responsive service.

Answer:
(Paula Jeffrey):
This is about supporting our clinicians, our patient facing clinicians to do the best thing for their patients using technology enabled care so that there's no wrong door for whichever point of the healthcare continuum the patients' access.