National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Follow-up inquiry into the performance of Ambulance Services in Wales / Ymchwiliad dilynol i berfformiad Gwasanaethau Ambiwlans Cymru
Evidence from Royal College of Nursing – PAS(F)02 / Tystiolaeth gan Coleg Nyrsio Brenhinol – PAS(F)02

Coleg Nyrsio Brenhinol
Cymru
Royal College of Nursing
Wales

Follow-up inquiry into the performance of ambulance services in Wales.

Submission from the Royal College of Nursing, Wales
Presented to the National Assembly for Wales Health & Social Care Committee

ABOUT THE ROYAL COLLEGE OF NURSING (RCN)

The RCN is the world's largest professional union of nurses, representing over 400,000 nurses, midwives, health visitors, nursing students and healthcare support workers, with over 25,000 members in Wales. The majority of RCN members work in the NHS with around a quarter working in the independent sector. The RCN works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care, and public policy as it affects health and nursing.

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

INTRODUCTION

The RCN recognises the immense pressure in providing holistic healthcare is to be able to provide for unscheduled care. This requires all those involved in health delivery, including preventative health and social care services, to recognise and plan for the challenges presented by unscheduled demands on the service provided.

One of the largest contributors to this provision is the Welsh Ambulance Service Trust (WAST). It is an historic and continual challenge to ensure that other partners care, including those strategically planning and operationally running A&E, the care home sector, acute hospital provision, primary care and community nursing care recognise how the services they run impact on WAST operations. In the last decade of primarily acute service reorganisation there has been a failure to include the ambulance emergency services in planning. In addition demographic and changes to the complex nature of care required have also had their impact e.g. all care services are now generally responding to a much older and frailer patients with usually complex co-morbidities such as dementia, diabetes etc.

This has resulted in the service always having to 'run' to catch up, and in many circumstances they have not been able to do so.

EIGHT CHALLENGES TO WAST

1. Performance Indicators

The revised Clinical Response Model went live on the 1st October 2015. As part of this all Ops staff are utilising Digipen technology which will allow a much more timely analysis of PCR's to be able to report on agreed quality outcome targets and providing feedback to staff on their performance thus improving/maintaining quality standards. To date the Red standard remains in excess of 65%, and work will soon commence to look at the quality indicators/patient outcomes going forward.

The Clinical Modernisation Board Programme is closely monitoring the effects of the effect of the changes in the model and EASC (Chair of EASC is Siobhan McClelland and Commissioner is Stephen Harry) are monitoring additionally.

It is the view of the Royal College of Nursing that the patient should receive the most appropriate clinical response to deliver the best outcome. The new system may help remove inefficiency and perverse consequences from the system and may help deliver better patient outcomes. It is important the new system continue to have the assessment and judgment of a registered clinical professional at its heart. We look forward to a robust evaluation.

Transparent and accessible performance indicators for any public funded service are extremely important. They show the outcomes achieved, can drive up performance and are necessary for future planning. The new system should not mean that this transparency is lost.

2. Accountability and Engagement

WAST requires greater engagement with Health Boards to ensure that they are involved in discussions at the earliest opportunity where health board actions are likely to have an impact on its service. There are early indications of greater engagement and more importantly an appetite to do things differently. We believe the work of EASC is playing positively into this dynamic. However when considering service change (particularly at short notice) a transferral of funding that is inclusive of the impact on ability to provide the service WAST should be considered.

There is also excellent work ongoing in developing clinical pathway such as those for Neck of Femur, Mental Health, and End of Life Care whilst clinical pathways for stroke and Myocardial Infarction are relatively well established. A clinical pathway is the care pathway the patient may already be on, and if this is known, the patient is directed to that area instead of Accident & Emergency.

A major benefit of this is the ability of paramedics to refer patients to other sources of help than A&E. Paramedic Pathfinder is being introduced across Wales. This is an excellent initiative but, of course, it relies on the existence of agreed clinical pathways to refer patients into.

The skill set of paramedics is also an issue and even today, paramedics are leaving education having been trained in the traditional way to deal with the top 10% of demand which is the high end trauma or cardiac arrest etc. Instead responding to chronic disease management should be the emphasis.

Advanced Paramedic Practitioners (APP's) are an important part of the team response however numbers of these are low within the Trust with just 6 APP's. There is a requirement for workforce planning to recognise this skill set and to ensure that these skills are more widely available within the service.

3. Leadership, organisational change and staffing

Whilst progress has been made in reviewing rota's this process did not deliver the financial savings which were forecast. The Revised Clinical Response Model (RCM) may suggest further rota reviews are needed in order to align both resources (vehicles) and staff resource (skill mix) given the revised approach. With the evolvement of the 111 service, there will be a need to ensure the employment of additional nurses as early clinical input in 999 calls is critical to appropriate outcomes. Indeed, given the reliance on professional nursing advice it is vital that the Nurse Director remains a member of the Executive Board to ensure professional accountability for that clinical input and appropriate strategic advice.

4. Non-emergency patient transport

The RCN supports the recommendation of separating non-emergency patient transport from emergency ambulance provision**.** However there appears to be no appetite from the health Boards to take on the provision of non-emergency transport. We are also aware that WAST is currently working up a business case to retain the

Non-Emergency Patient Transport Services (NEPTS) albeit however, with this service disaggregated from EMS Ops and with robust and separate line management and leadership. It would be helpful to all in the NHS to have a clear policy statement from Welsh Government on their intentions for this service.

5. Patient Handover

This is still an area of high challenge for the NHS. Major delays are still happening such as that of the weekend of 03/04 October 2015 when the patient flow in Betsi Cadwaldr ground entirely to a halt. Help was required from both Chester & Shrewsbury at this time. A review of a like for like period in October 2014 shows a similar pattern which demonstrates that the challenges to providing the service are not diminishing. October 2014 had a 6,860 handovers with a total lost hours of 1,082.85. The corresponding period in 2015 shows 6,595 handovers with a total lost hours of 1,174.08. The number of handovers is down but with an increase of lost hours. It is also important to note the 'lost hours' measurement does not fully capture the costs of prolonged job cycles or the effect of the emergency vehicle leaving its footprint.

A scoping exercise is currently being conducted within WAST to look at "Card 35" work calls to see how WAST can improve the patient experience. Card 35 refers to a specific protocol in the Medical Priority Despatch System. Card 35 is used by health care professionals to determine the response time for a call coded as Green 3 – usually a parameter of between 1 to 4 hours. An emerging recommendation may well be to commission a dedicated desk to manage all Card 35 work.

Too often 'leaders' in the health service resort to calling for WAST to solve the handover problem without regard to issues of patient safety at stake. Nor is the matter simply one of recalcitrant A&E staff. A patient must be safe. If there are not enough nursing staff available in A&E then the paramedic is required to wait with the patient. If there is no bed or trolley available the ambulance trolley is still needed. Utilising corridors or unsuitable treatment rooms to place patients would mean that vital lifesaving equipment may not in reach and again the patient would be potentially safer in the ambulance.

However if the patient is assessed in the ambulance by a nurse (an environment and equipment they may not be familiar with) is that nurse on WAST property and therefore operating out with any governance procedure of the Health Board?

This is an area that requires a major review and it is the view of the Royal College of Nursing in Wales that a central issue is a lack of sufficient capacity (in terms of both the physical environment and also the number of medical and nursing staff employed) in A&E facilities in Wales. Clearly there are other significant issues which impact on this problem. Some of these we have already alluded to in this paper and some of which, such as the need for nursing care beds to reduce delayed discharges the Committee will be aware of from previous Inquires. However RCN Wales is calling for a national review of A&E planning and provision.

6. Models of deployment

The 'return to footprint' Cwm Taf Pilot has now rolled into Aneurin Bevan Health Board. Results so far appear to be very favourable showing work has become aligned to the skillset of the responding crew i.e. areas do not 'lose' trained paramedics to simple conveyances to hospital.

7. Frequent callers

To successfully resolve this issue will require the engagement of social care services, community nursing teams, GP surgeries, and specialist multi-disciplinary dedicated teams (e.g. falls or end of life)

WAST are currently exploring using registered nurses as an option to facilitate falls assessments. We believe this is a very positive model.

WAST does utilise registered nurses to triage low acuity green 3 calls presenting in Emergency Medical Services (EMS) and transferred via technology to NHS Direct Wales. Of all the calls taken by these nurses approximately 50% are triaged *away* from EMS. Of the 50% of calls that continue to EMS approximately 50% receive a scheduled response from EMS or PCS/Taxi.

For example in the 4 week period 07/09 to 04/10, 2364 calls transferred to NHSDW, 1140 were directed away from EMS, 1224 returned to EMS of which 585 required an emergency response and 639 required scheduled transport (this can be with UCS, NEPTS or even Taxi). In addition WAST also run a clinical hub where both nurses & paramedics triage calls utilising the Manchester Telephony Triage System which again finds alternative pathways or alters the required timeline for response on clinical need.

If there were more care options (or clinical pathways) for the nurses to refer callers to this would resolve more calls without recourse to either A&E admission or ambulance transport. For example in Aneurin Bevan Health Board at present no telephone based assessment to refer a caller into a care pathway is permitted, instead referral can only be made following a face to face assessment by a paramedic. Another example would be an immobile patient simply requiring an antibiotic or pain relief prescription. If the community nursing team does not include a prescriber or if the GP cannot make a home visit then an ambulance will have to be dispatched to admit the patient.

8. Anticipating demand for services

WAST submitted an IMTP to WG for approval that outlines future developments. The RCN would like to draw the Committee's attention to two factors which, if achieved, we believe will deliver improvements in service.

The first is ensure that the NHS Direct Wales approach of using registered nurses to advise and triage calls is applied to the new 111 service. Experience has clearly shown (and the statistical evidence of many years demonstrates this) that results in far lower rates of referral to A&E/999 calls than that from out-of-hours GP services.

The second point is related to this. Previously NHS Direct Wales triaged calls for the GP out of hour's services for Gwent, Swansea, Gwynedd & Anglesey. There were clear and consistent KPI's applied and a performance management framework to ensure appropriateness of referral for the patient. Indeed at one point a national out of hours service was envisaged. Now however Wales appears to have fragmented its out of hours services once more. It is not clear on the comparable cost of this or its impact on WAST referrals but previous evidence would suggest that non-clinically run out of services tend to result in a higher level of emergency referrals.