Priority: Reducing pressure on emergency hospital services

Betsi Cadwaladr University Health Board and Welsh Ambulance Service NHS Trust

What were you aiming to achieve/what was the problem you were trying to solve/what was your goal?

The NHS 5 year forward view explains very clearly why patients should be seen by the right person at the right place at the right time. Services within the NHS are stretched and we need to ensure our patients get the best treatment suitable to their need in the most efficient way removing any unnecessary steps in the patient journey. In England the development of the clinical assessment service (CAS) within integrated urgent care adds a clinical overview to patients directed to local services through the 111 system. 111 is a fantastic service with regards demand management and signposting of patients however we are well aware that any non clinical pathways based system can at times offer pathways not always suitable for some cohorts of patients, hence the need for clinical oversight. 111 has not yet landed in North Wales however there is a plan and a timeline for its implementation. Within the Betsi Cadwaladr University Health Board our aim was to ensure we had the correct assessment, signposting and locally delivered treatment options to ensure that patients weren't directed unnecessarily to emergency, secondary or primary care when the need could have been met elsewhere.

What was the solution/what interventions took place?

Demand in the ambulance service is high all year round but more so over the winter period. Working collaboratively with the ambulance service, BCUHB implemented a clinical assessment service, SICAT (single integrated clinical assessment and triage) working from the North Wales Ambulance Clinical Contact Centre reviewing 999 calls that were waiting on the "stack". These were calls where at the time of the assessment there was no available resource to send and therefore there was no delay in patient care. GPs were recruited to the clinical role. General practitioners have huge amounts of experience and knowledge in clinical decision making and risk assessment skills that are vital for this role. The GP together with the Advanced Paramedic Practitioner from WAST would review suitable calls from the "stack", gain further clinical history from the patient/patient's representative or carer and where safe and possible offer an

alternative route than conveyance to the emergency department via emergency ambulance. The APP enters the SICAT call sign onto the relevant job to indicate that the SICAT desk are reviewing the call and will close the call adding a summary of the case and outcomes to the record.

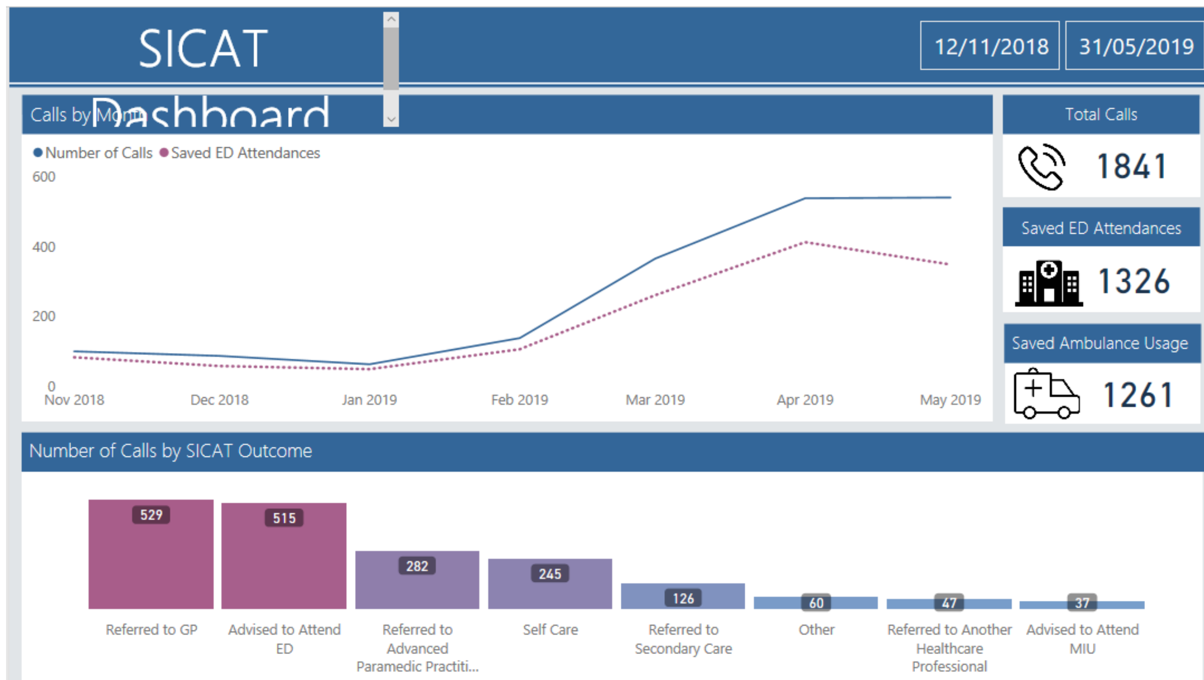
This service not only allowed patients to access healthcare best suited to their need but also allowed a review of services within community, primary and secondary care. This gap analysis has allowed BCUHB to focus on further services are required to ensure patients are given the best care closer to home. There has also been a review of pathways into secondary care ensuring patients are seen sooner by a relevant speciality rather than attend ED.

SICAT now provides a safe, governed and effective platform for signposting patients to the right person at the right place at the right time. Plans are now ongoing to develop this service and bring together all clinical assessment and triage across North Wales, develop better access for patients into this service and identify any further gaps in treatment.

Case Study

A 999 call was received for a 94 year old lady stuck on the toilet unable to move. The clinician in SICAT was able to speak to the patient and the daughter to gather more clinical information. The lady was more confused than normal with a reduction in her mobility. The duty Advanced Paramedic Practitioner was dispatched to conduct a face to face clinical review. The APP and GP were then able to have a clinical discussion about the best treatment pathway for this patient. A urinary tract infection was diagnosed and the APP was able to offer antibiotics through use of his PGD's. One of the main concerns was the patient's mobility, in particular getting on and off the toilet as the seat was too low. The SICAT desk were able to contact the Occupational Therapy department at the hospital and they were able to install a higher toilet seat. As her observations were otherwise unremarkable she remained at home on antibiotics with her daughter and a copy of the event sent to her GP for follow up. The patient remained at home and did not require admission to ED via an emergency ambulance.

Describe the measured results/ What was the impact on your aim or goal?



Our aim was to develop a safe way of signposting patients where appropriate away from the emergency department. As of the 31st May the service had dealt with 1841 calls, 1326 of these were directed away from ED and to more appropriate pathway of care.

All calls in the first 2 weeks of this service were followed up to ensure that the service had not caused any delay in patient care. There were no cases where this was identified. The service now routinely follows up a random 10% of cases to ensure there has been no admission to ED within 72 hours of the original call to SICAT. All calls are recorded, cases are subject to audit and fed back to the relevant clinician.

What were the learning points? What worked well/less well and why? What else did you observe? Were there any unintended consequences

This is a collaborative project between BCUHB and WAST. This has been a really positive project from the beginning and the support from staff from both organisations has been tremendous. There has been a real sense that we are starting to make a difference and people working with the project can see the impact this has had on many patient particularly frail, vulnerable and palliative patients.

There have been challenges along the way, most noticeably those associated with culture and change. We have worked really hard to engage with all staff, provide regular information and updates, include patient stories and offered visits to the service to try and allay the concerns raised.

The number of patients currently coming into the service are still relatively small, although increasing daily. We have to be aware of the unintended consequence of overloading and already full to capacity primary care service. We are therefore in discussions currently about developing urgent treatment centres alongside our minor injury units that will allow us to signpost patients with minor illness needs to a place where they can be assessed and treated by an allied healthcare professional.