South East Coast Ambulance Service NHS
NHS Foundation Trust

Specialist & Advanced Paramedic (Urgent & Emergency Care) Deployment Procedure

Contents

2 Procedure 3

2.1 Urgent Care Hub 3

2.2 Operational PP 4

3 Definitions 6

4 Responsibilities 7

5 Audit and Review (evaluating effectiveness) 7

6 References 8

1 Scope

1.1 South East Coast Ambulance Service NHS Trust (the Trust) has developed a grade of staff to offer treatment closer to home for patients with urgent and emergency care needs. These staff are termed Specialist & Advanced Paramedics (Urgent & Emergency Care) and throughout this document they will be referred to as Paramedic Practitioners (PPs).

1.2 This document provides colleagues with a clear procedure to be followed when considering the deployment of a PP or Student PP (SPP).

1.3 PPs meet the level 7 descriptors of the skills for health framework and at the level of *specialist* on the College of Paramedics career framework.

1.4 PPs aim to deliver the right care in right place, first time in line with the national audit office. They may do this by:

1.4.1 Assessing and treating on scene using a range of advanced assessment approaches, including a wide range of medicines, advanced wound care and risk management strategies.

1.4.2 They may also assess and refer to an appropriate community service, GP or direct to specialty within secondary care as an alternative to Emergency Departments (ED).

1.4.3 Supporting clinicians by acting as senior clinical decision maker, either remotely or on scene. Involving a senior clinical decision maker has been shown to improve patient outcomes.

1.5 PPs can also undertake urgent or routine assessments of patients in other settings, where service level agreements exist or are being developed. This may include patient's homes in partnership with GPs and community teams, Minor Injury Units (MIU) or ED. This helps people to better manage their own health and avoid an unnecessary ambulance conveyance to hospital.

1.6 PPs should be considered for medical or trauma support, including on scene clinical support, triage and multi-casualty incidents.

1.7 PPs operate in teams located within Operating Units (OU) across the Trust. PPs will operate 'out of plan' within a local Urgent Care Hub model. For further explanation of 'out of plan' see 2.1 & 2.2.

1.8 PPs will have up to 80% of their hours providing clinical care as part of the Urgent Care Hub Model. 20% will be divided between skills assurance time and providing clinical support within an OU. This equates to 130 hours for Skills Assurance Time and the remaining 260 hours for OU support per annum.

1.8.1 Indicative activities include:

- Supporting the OU leadership team with clinical support for staff
- Providing CPD sessions for staff
- Providing clinical supervision within the OU
- Contributing to clinical audit and quality improvement projects
- Local frequent caller management support
- Clinical stakeholder meetings
- Managing high call care settings
- Providing clinical opinion on adverse incidents

2 Procedure

2.1 Urgent Care Hub

2.1.1 Urgent Care Hub (The Hub) will be based within local OUs. The hours of operation will be agreed at an OU level depending on the demand within each OU. The primary function of The Hub is to provide an operational PP and remote clinical support, enabling safe, timely and quality collaborative decision-making.

2.1.2 The Hub may proactively contact clinicians on scene after 30 minutes to offer specialist support and guidance. This will be for decision support and clinicians on scene are expected to provide a clinical update.

2.1.3 The Hub will have excellent knowledge of all local clinical referral pathways and enable signposting as required.

2.1.4 The Hub PP is not available to the Emergency Operations Centre (EOC) for standard deployment.

2.1.5 The Hub will have access to Computer Aided Dispatch (CAD) where they will receive the call back requests via the Emergency Crew Advice Line (ECAL) system. Where this is not available CAD Online can be utilised with the support of a neighbouring Hub or alternatively EOC, in line with the clinical call back procedure.

2.1.6 Following discussion with clinicians on scene and where appropriate, The Hub will be able to generate a PP referral incident on the CAD.

2.1.7 The Hub will be able to access patient care plans to assist with collaborative decision making and management of patients. This may include the Trust Intelligence based information system (IBIS) system, frequent caller lists, electronic patient clinical record (ePCR) or clinician pages on the ‘Teams SharePoint App.

2.1.8 The Hub will maintain good communication with the operational PP and dispatch team to support with appropriate deployments. The Hub will be able to arrange Grade 4 backup requests for the Operational PPs and Clinicians on scene.

2.1.9 Neighbouring PP Hubs will assist if the local hub is unavailable. Scheduling and operational PPs will work in partnership to prioritise hub cover to ensure 24/7 provision. However, 24 hour access to a PP should be prioritised.

2.1.10 Although 24/7 provision should be prioritised, qualified PPs should be aware of skill fade and reduce clinical exposure and ensure adequate time in a rota to maintain competence.

2.1.11 Student PPs (SPP) will only be able to provide hub cover when they have successfully passed Clinical Reasoning in Physical Assessment (CRIPA), minor illness and minor injury modules. This is to ensure that SPPs have adequate time to develop and embed their skills and knowledge.

2.1.12 Once an SPP has completed CRIPA, minor illness and minor injury, they are eligible to provide cover in the hub. During year 2 of study, time in the hub should be supported by a qualified PP.

2.2 Operational PP

2.2.1 The operational PP can be a student PP or fully qualified PP.

2.2.2 Will self-activate with support from The Hub, targeting appropriate incidents of any category, even if a resource is already on scene with a view to avoid conveyance to Hospital and enhance timely intervention.

2.2.3 Will be tasked to PP referrals within their OU.

2.2.4 Will attend C1 responses or when paramedic back up is required on other categories of calls.

2.2.5 On scene times should be kept to a minimum, if a conveyance to hospital is required, this should be requested as soon as possible and consideration should be given to utilising a NET vehicle within a timeframe of 1-4 hours where available.

2.3 EOC PP

2.3.1 This procedure will not affect the current way of working for PPs within EOC.

2.4 Call allocation strategy for Operational PPs

Category	Types of Calls	Mobile PP allocation
Category 1 (Life-threatening event)	• Cardiac Arrests • Choking • Unconscious • Continuous Fitting • Not alert after a fall or trauma • Allergic Reaction with DIB	• **Auto Dispatch** • **Paramedic Backup** • **Self Tasking**
Category 2 (Emergency, potentially serious incident)	• Stroke patients • Fainting, Not Alert • Chest Pains • RTCs • Major Burns • Sepsis	• **Self Tasking** • **Paramedic Backup**
Category 3 (Urgent Problem)	• Falls • Fainting Now Alert • Diabetic Problems • Isolated Limb Fractures • Abdominal Pain	• **Self Tasking** • **Paramedic Backup**
Category 4 (Less Urgent Problem)	• Diarrhoea • Vomiting • Non traumatic back pain • End of Life Care	• **Self Tasking** • **Paramedic Backup**
Conveyances to hospital	**The mobile PP should not routinely convey patients to hospital.** NET vehicles should be utilised with the consideration for a grade 4 backup within a 1-4 hour timeframe.	

3 Definitions

3.1 Urgent Care Hub Model. A team of Specialist Paramedics (Urgent & Emergency Care) situated within an OU providing clinical supervision and clinical support to operational clinicians.

3.2 Urgent Care Hub (UCH). A PP or SPP providing remote clinical supervision from an OU.

3.3 Paramedic Practitioner (PP). A qualified Specialist or Advanced Paramedic in Urgent and Emergency Care.

3.4 Student Paramedic Practitioner (SPP). A paramedic who is undertaking a recognised specialist or advanced urgent care development educational pathway.

3.5 Operational PP. A PP or SPP who can self-task to incidents.

3.6 Computer Aided Dispatch (CAD). A system used by the Emergency Operations Centre (EOC) to assist with dispatch decisions.

3.7 Emergency crew advice line (ECAL) – a system for allocating and recording clinical call backs.

3.8 Non-Emergency Transport (NET). A resource for simple urgent transport to a healthcare facility.

3.9 Operational Toolkit. An operational document setting out the implementation of the Urgent Care Hub Model in an OU.

4 Responsibilities

4.1 The **Chief Executive** is responsible for patient safety.

4.2 The **Executive Medical Director** is responsible for clinical practice in the Trust.

4.3 The **Consultant Paramedic (Urgent and Emergency Care)** is responsible for the management of this procedure.

4.4 The **Operations Management Team** are responsible for the implementation of this procedure.

4.5 The **Operations Management Team** are responsible for audit and monitoring this procedure.

4.6 **All Staff** are responsible for adherence to this procedure.

5 Audit and Review (evaluating effectiveness)

5.1 The procedural document will be reviewed at least every three years; or earlier if required due to change in local/national guidance and/or policy; or as a result of an incident that requires a change in practice.

5.2 Ongoing audit against set KPIs as per the Operational Toolkit.

5.3 All policies have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new policy is approved and disseminated.

5.4 Effectiveness will be reviewed using the tools set out in the Trust’s Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

5.5 This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the policy is not working effectively.

5.6 All changes made to this policy will go through the governance route for development and approval as set out in the Policy on Policies.

6 References

6.1 National Audit Office Transforming NHS Ambulance Services (2011 & 2017)

6.2 NG94. Emergency and Acute Medical Care in Over 16s, Service Delivery and Organisation.

6.3 QS174. Emergency and Acute Medical Care in Over 16s