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Standard guidance:
Ambulance clinician (on scene) referral to same day emergency care

Increasing direct referral from ambulance clinicians to same day emergency care

Version 1, 15 October 2021

Contents

1. Purpose of this document

The purpose of this document is to support ambulance providers in designing and implementing direct referrals into same day emergency care (SDEC).

This document has been created by NHS England and NHS Improvement through consultation with key stakeholders and describes the overall principles to be adopted when implementing direct referral pathways to SDEC. It should be recognised that developing work with services that provide both remote and face-to-face 'first point of contact' for patients (such as NHS 111, 999 and ambulance clinicians and primary care) to increase secondary care referrals, is to adopt a system-wide approach to patients having the most direct appropriate pathways.

A key aim of direct referral is to decrease ambulance conveyance to emergency departments through direct referral to SDEC as an appropriate pathway. This should be supported to avoid patients attending emergency departments only to be transferred to SDEC.

2. Background

SDEC should be provided for a minimum of 12 hours a day, seven days a week. Acute frailty provision should be available 70 hours a week. Access to SDEC should be available during these hours across all parts of the healthcare system.

Increasing the number of patients who are referred directly to secondary care s such as SDEC 'hot clinics' or 'hot hubs.' SDEC should also be considered both in and out of hospital settings, and therefore community SDEC services should be profiled in the same way as in hospital services are.

The aim of increasing secondary care referrals directly from services such as NHS 111, 999 and ambulance clinicians (on scene) and primary care is to ensure patients have the most direct route to the most appropriate service for their needs.

This means that patients will:

- Receive clear direction on what they need to do and where they need to go to resolve their health issue.

- Receive an improved experience while being protected from nosocomial infection.
- Be referred to secondary care by an **on-scene ambulance clinician**. Clinical referral to SDEC to receive care and treatment for a condition that is not immediately life-threatening and requires a face-to-face clinical assessment, with the potential for further diagnostics within a hospital setting.
- Avoid delays.

Ideally, patients will be referred to clinical specialists providing high quality, swift access to expert care and diagnostics. In this document, the design of this will focus initially on establishing the referral to SDEC/hot clinics via on-scene ambulance clinician.

3. What is same day emergency care?

Same day emergency care (SDEC) allows specialists, where possible to care for patients within the same day of arrival as an alternative to hospital admission, removing delays for patients requiring further investigation and/or treatment.

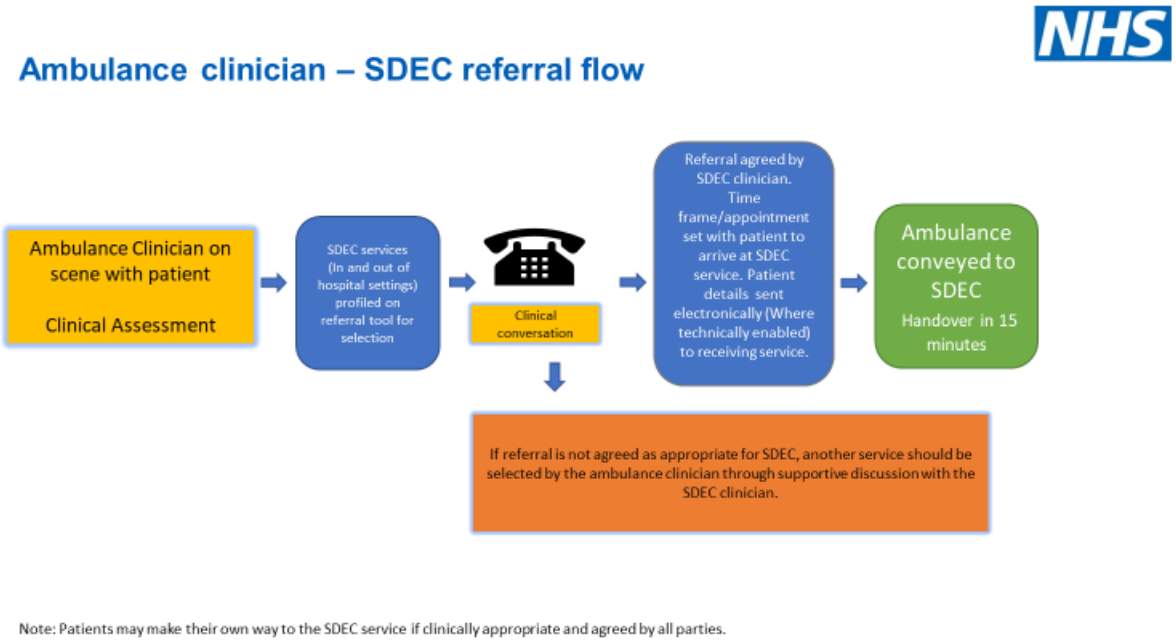
4. Adopting new ways of working

Patients that are deemed clinically appropriate for SDEC by the responsible clinician on scene can be directly referred following a clinical conversation. Every effort needs to be taken to ensure the patient is transferred to the appropriate care setting and emergency departments are only utilised when clinically appropriate.

When making a referral to SDEC, the referring clinician should routinely consider any relevant safeguarding issues as per business as usual and by following local policy.

An SBAR (situation, background, assessment, recommendation) is included in appendix 1 to support decision making.

Figure 1: Referral flowchart



Note: Patients may make their own way to the SDEC service if clinically appropriate and agreed by all parties.

5. Expectations of ambulance providers

Criteria for direct access into each of the SDEC specialties below is provided in collaboration with the accepting SDEC services, this may be variable across sites:

- Medical
- Surgical
- Acute frailty
- Obstetrics and gynaecological (including early pregnancy)
- Paediatric
- Mental health
- Any further speciality provided via SDEC within a hospital or community setting.

5.1 Standards of referral

To ensure effective development of referral pathways, the standards of referral below should be implemented to provide consistency and ease of referral into SDEC. Inclusion and exclusion criteria should be led at integrated care system (ICS) level to minimise variation. See Appendix 2.

5.2 High volume pathways

The table below highlights 11 high-volume pathways that should be considered for ambulance clinician referral as a minimum. (These conditions or symptoms should be taken in context of requiring hospital or community SDEC over and above primary care.)

The list has been developed through clinical review, in line with data that highlights SDEC opportunity to provide a system wide benefit where hospital admittance is avoided. This list should be considered as a minimum standard for direct referral but is not an exhaustive list.

Table 1: Common conditions/symptom groups

Common conditions/symptom groups
Falls without injury
Cellulitis
Community Acquired Pneumonia
Pulmonary Embolism
Deep Vein Thrombosis
Chest Pain
Shortness of breath (COPD, Heart failure, Asthma)
Early pregnancy bleeding
Palpitations
Atrial Fibrillation
Acute headache

5.3 Patient experience of care

It is important that patients are kept informed and updated about the decisions related to their care. They should be informed they are being transferred to an SDEC service and they should be aware what an SDEC service is and what they can expect to happen on arrival.

6. Expectations of acute care and community providers

6.1 SDEC capacity

Acute trusts and community settings must plan how to facilitate the referral of patients from the ambulance service. In most cases this will require the SDEC service to have a senior clinical decision maker who is immediately accessible to referring clinicians through a direct number and avoid the use of bed bureau or elongated switchboards to access the service.

It is likely the numbers of referrals per week will be low and may increase over time. An increase of referrals over time would depend on the success and benefits realised from implementing the process, for both the ambulance and SDEC provider. The referral demand is within the current emergency department activity, and is usually streamed to SDEC. This pathway provides a better way to direct patients and support a reduction in unnecessary clinical touchpoints and possible delays within the pathway.

It is expected that referral tools are populated with correct opening times and availability times for referral. For instance, some services may open until 20.00 but the last referral is accepted at 19.00; in this case the profiling needs to be clear. This will provide a practical benefit to ambulance clinicians and avoid refusals (which could be detrimental to future referrals).

Secondary care must evaluate the availability of their existing workforce and plan any communication, expectation setting and additional training to support direct referral from the ambulance service. Engagement from the receiving clinicians is key to the referral being effective, any conversations held between the clinicians should advocate best practice and be supportive in nature.

6.2 Call answering

- An agreement will need to be developed between commissioners and providers to outline expectations on call answering standards to avoid delays in referral.

- A direct dial number for SDEC should be accessible by the ambulance clinicians and not a switchboard/bed bureau number. Lengthy processes to refer may not add benefit, and could drive unnecessary conveyance to emergency departments.

- Working towards best practice, commissioners and providers should agree a call answering agreement to ensure that clinical resource is managed effectively both from an acute provider and ambulance provider perspective.

- Should the call not be answered within a specified timeframe the next appropriate service should be chosen to safely refer the patient to secondary care.

6.3 SDEC demand

The demand generated by local ambulance providers as well as historic emergency department activity datasets will allow the design of a consistent, safe, and high-quality patient experience for accessing SDEC and will require a technical solution to manage the flow of patients. Important prerequisites include:

- There should be enough resource available to adequately staff the direct dial numbers during the opening hours profiled on the referral system

- Ensure IT systems allow ambulance providers to share patient information where appropriate to enable safe transfer of patient information ahead of the consultation in SDEC.

6.4 SDEC service provision

Acute trusts or community SDEC providers must ensure the needs of the whole population are considered, including clinically vulnerable groups, and that any proposed changes to implement ambulance referral enhances the patient experience. Referral standards are outlined in Appendix 3.

7. Expectations of commissioners

To successfully implement this programme's necessary changes, provider organisations will need to follow national and local guidance. Responsibility for ensuring guidance is implemented lies with system leaders in ICSs and clinical commissioning groups (CCGs). This may require variation to contracts but also local discussion about implementation.

A key enabler will be providers having the necessary IT infrastructure in place. Consideration must be given to interoperability of systems to facilitate appropriate data interchange.

It is essential that CCGs/ICSs take a whole system view to invest in areas that will have the greatest impact in terms of cost-benefit and patient outcomes.

7.1 Referral system requirements

The Directory of Services (DOS) is nationally promoted as a tool of choice with widespread use and ability to profile services availability. This also supports a standardised approach across providers and systems.

The referral tool utilised should have the ability to profile all the information required by the referring ambulance clinician. This is inclusive of the inclusion and exclusion criteria, location for ambulance arrival and direct contact number to enable the clinical conversation.

It is important that the profiling is clear around opening hours for referrals into the service regardless of the closing time.

7.2 Data protection impact assessment

Commissioners and providers will need to review existing information sharing agreements (ISAs) to ensure that any new data flows meet the governance requirements for increasing service provision for both SDEC units and ambulance services.

7.3 Monitoring and evaluation

There is a national expectation that local monitoring and evaluation is implemented from service go live to ensure that rapid feedback on the implementation is available to both ambulance and acute are and community providers.

The purpose of this is to establish

- Whether referrals are accurately being identified by ambulance clinicians,
- Whether referrals are being accepted by secondary care in sufficient volume (eg conversion rate is high)
- To ensure the system is continually learning from the process to improve service provision for patients.

Commissioners (and NHS England and NHS Improvement regional teams) should develop an evaluation process and bring providers together to continually develop and evolve service provisions ensuring that further enhancements meet assurance and governance standards by all parties. It is important that:

- The system evolves through learning
- Information is collected consistently to measure success
- NHS England and NHS Improvement regional teams have an active role in supporting change
- Longer term key performance indicators (KPIs) can be developed through learning and development.

Appendix 1: SBAR template

It is recommended that ambulance services train all their ambulance clinicians in SBAR methodology to support decision making pre-conveyance. This will support earlier detection of patients who are suitable to be referred directly to the right services and not conveyed to the emergency department.

S (situation)	I am (name) on scene calling about: (Patient X) I would like to consider this patient for SDEC Chief complaint is: I am calling from patient home/care home
B (Background)	Patient has/has not sought medical advice/treatment in last seven days Long term conditions are: Known care plans/ Resuscitation status Medication is known/unknown Covid positive/negative/unknown
A (assessment)	NEWS-2 score GCS, Resp Rate, HR, Sats, BP, Blood Glucose I think the problem is (xx) Or I am not sure what the problem is, I think the patient requires further diagnostics And I have given (eg oxygen/fluids/analgesia)
R (recommendations)	I think the patient requires secondary care and would be suitable for SDEC (same day emergency care) I would like to convey the patient to the SDEC service and not ED (emergency department) Or I feel the patient is clinically safe and happy to make their own way to the SDEC service by (specific time to be agreed) Is there anything I need to do in the meantime?

Appendix 2: Standards of referral

Standards of referral
The ambulance clinician should refer to an SDEC speciality clinician prior to conveyance.
The SDEC clinician is responsible for accepting the referral from ambulance clinicians in a timely manner via direct dial in (DDI) telephone access (until there is sufficient system maturity to agree a direct booking/referral process).
Patients with an agreed referral to SDEC should be handed over to the receiving service within 15 minutes of arrival as per national standard.
The patient (or their carer) is responsible for choosing whether to follow the recommendations of the ambulance service.
SDEC clinicians must advise the ambulance clinicians of the timeframe in which the patient should attend if this is not an immediate conveyance. Clinical judgement should be used if a later appointment/arrival to SDEC is appropriate, where a patient is able to access their own/alternative transport. This should be agreed with the patient while on scene with arrival times confirmed.
The ambulance clinician must redirect/convey the patient to the most appropriate care setting, should the SDEC clinician not accept the referral following clinical discussion.
The acute trust or community setting is responsible for the timely management of the patient once they present.
The ambulance provider has the responsibility for the correct assessment of the patient and of safety netting should the patient's symptoms worsen. They are also responsible for the appropriate onward referral/advice in the case of non-conveyance to SDEC by ambulance.
The commissioner must ensure that the system utilised by the ambulance provider has all the relevant up to date referral information to SDEC to be profiled effectively. The Directory of Services (DOS) should be used to standardise profiling.
Clinicians on scene must have access to an appropriate digital referral tool to access the most up to date information on local SDEC services.

When determining whether the patient is appropriate for SDEC the below should be considered:

- NEWS-2 scoring
- Age (Over 16 except for paediatric)
- Medical/ frailty speciality working diagnosis
- Surgical/urological speciality working diagnosis
- Clinical frailty scale (CFS) scoring, eg Rockwood.

Exclusion criteria

- Patients presenting with a time critical condition, requiring immediate treatment upon arrival at hospital
- Patients requiring resus
- Age under 16 when referring to adult services
- Trauma patients requiring immediate transfer to the most appropriate unit according to their plan of care.

Ambulance clinicians on scene must use the direct dial number (DDI) profiled on the referral tool for the SDEC service and speak directly to the SDEC clinician or senior decision maker.

Referrals should be made directly; the conversation should be held with the SDEC clinician or decision maker within the unit.

A decision about whether the referral is agreed should be made during the initial phone call.

The ambulance provider is responsible for timely conveyance to SDEC (in a hospital or community setting) and is required to set expectations with the patient around arrival and the service they have been referred to.

Transfer of patient details should be completed electronically

The receiving hospital or community setting must provide a receiving area (seating/trolley) for ambulance arrivals. This should not be the emergency department.

Electronic patient records to be shared with SDEC within 15 minutes of handover or in live time, where systems allow.

Common conditions/symptoms and higher volume pathways can be found in section 5.1 and should be referred to when activating SDEC referrals.

The list is not exhaustive but should be considered as a minimum standard.

Ambulance_Handover_to_Secondary_Care_Standard_Revision_Final_Report_v1.0.pdf (theprsb.org)

Ambulance Handover to Emergency Care Standard V1.0 - PRSB (theprsb.org)

Appendix 3: Acute or community provider referral standards

Acute or community provider referral standards
Appropriate patients must be referred/directed by ambulance clinicians to SDEC only during operating hours of the SDEC service (which is currently mandated for a minimum of 12 hours per day) and any specific access criteria should be included in the providers referral information.
SDEC clinicians must be available to receive referrals during standard SDEC opening hours. This means that patients can be seen and treated during and up to the time the SDEC service closes; eg where a patient is able to attend for a blood test or diagnostic prior to subsequent treatment the next day.
There is technical capability for ambulance providers to refer patients to SDEC and other departments/hot clinics and transfer details.
Telephone access must be available for ambulance clinicians to refer a patient and attendance times should allow the patient enough time to travel to their appointment if they are not conveyed by ambulance to the SDEC service.
Attendance at a hospital/community setting must permit the patient to be spaced from others to comply with current social distancing guidance.
Attendance at hospital must be face-to-face.
The referral message to SDEC post clinical conversation must include the patient's name, date of birth, and symptom/suspected diagnosis.
The patient's NHS number should be used as the unique identifier to ensure records can be matched (eg interim and final dispositions can be reconciled).
Patients should not be booked beyond the timescale in which they are intended to receive care, unless this is advised by the SDEC clinician.
The provider should record the SDEC attendance on the hospital patient administration system and where the technology exists, the referral source selected should be Ambulance. Emergency care dataset (ECDS) is the preferred dataset.

Patients who do not attend (DNA) will be notified via existing reconciliation of appointment bookings by the secondary care provider in line with local safeguarding policy and procedure.

This is only relevant when an ambulance does not convey but arranges an appointment later through clinical discussion and patient agreement

In the event of a technical failure business continuity will need to be implemented.

The ambulance provider must record all referrals manually until the business continuity plan is no longer required.

Should a business continuity process' need to be implemented, providers should track the referrals that were unable to be transferred in order that patient information can be restored retrospectively following return to business as usual.

Acute trusts/community provision must consider alternative arrangements for dealing with patients who are shielding in line with the infection, prevention and control (IPC) policy (eg a separate entrance/area in SDEC, direct referral to other departments).

Acute trusts/community provision must have arrangements in place to regularly review the referrals ambulance providers send, so that conversion from ambulance to SDEC remains appropriate; where this is not the case providers must take action to resolve this.