



Llywodraeth Cymru
Welsh Government

GUIDANCE

Direct paramedic referral to same day emergency care: All-Wales policy

Supporting the Welsh ambulance service and health boards delivering same day emergency care.

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1. Purpose of this policy

The purpose of this policy is to support the Welsh Ambulance Services NHS Trust (WAST) and health boards in implementing direct referrals into same day emergency care (SDEC).

Direct referral reduces the 'double handling' of patients and ensures they reach the most appropriate clinical destination earlier in their journey through the system. The impact of reduction in double handling of patients should contribute to reducing the risk in the system for those patients experiencing long delays.

It is essential for the Welsh urgent and emergency care system that direct Paramedic* referral into SDEC/Ambulatory services is implemented, in line with 'Goal 3: Clinically safe alternatives to admission to hospital' under the '**Six goals for urgent and emergency care**'.

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This policy does not seek to increase activity into SDEC but to direct patients to the service without having to go through the emergency department (ED) system before the patient can be identified as suitable for SDEC services.

This document describes the overall principles to be adopted when implementing direct paramedic referral pathways into SDEC.

One of the key aims is to decrease ambulance conveyance to ED, through direct referral to SDEC where it is an appropriate pathway.

Direct paramedic referral avoids repeat clinical handoffs and exposure of patients to wider risks in the ED including nosocomial infection.

*'Paramedic' in this document refers to registered clinical professional employed by WAST on front line or clinical support desk and may include advanced paramedic practitioners, GPs and registered nurses as well as paramedics.

2. Background

What is SDEC?

SDEC, previously termed ambulatory care, allows specialists to care for appropriate patients on an ambulatory basis, removing delays for patients who require face-to-face assessment and further investigation and/or treatment, and who would otherwise be conveyed to an ED or admitted directly to hospital.

SDEC aims to minimise and remove delays in the emergency patient pathway, allowing services to care for patients on the same day of arrival without recourse to hospital admission.

- Hospitals should urgently expand or establish SDEC direct referral routes for primary care, paramedics on scene, or on the clinical support desk.
- Every health board should provide SDEC for a minimum of 12 hours per day, every day for both medical and surgical specialities (aim within 3 years).
- Every health board should offer a wide range of generalist and specialist

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clinicians providing SDEC to ensure that more patients receive the right care at the right time.

Access to SDEC services within health boards for appropriate patients is a key component in the urgent and emergency care system in Wales. Goal 3, of the 'Six goals for urgent and emergency care', highlights the requirement for clinically safe alternatives to admission to hospital. SDEC (ambulatory care) is a well-established, clinically proven service that has been shown to be popular with patients.

SDEC provides care and treatment for patients with conditions that are not immediately life-threatening but require a face-to-face clinical assessment, usually within hours rather than days, with the potential for further diagnostics within an ambulatory care setting. There are a number of methodologies that can identify a cohort of patients who should be managed in this way.

Funding has been made available to health boards in Wales to support them to develop SDEC services with an aim to provide SDEC for medical and surgical specialities as a minimum for 12 hours a day, 7 days a week within the next 3 years.

Health boards are in different places as regards this target at present and any overarching policy will need to be underpinned by local protocols until the 12 hours a day, 7 days a week target is achieved in every health board.

Paramedic direct referral is recognised as a develop care programme board is committed to increasing the number of patients who are referred directly to secondary care services such as SDEC as an alternative to ED or hospital admission, where this is the most appropriate service for the needs of the patient.

This means that patients will:

- Receive clear direction on what they need to do and where they need to go to resolve their immediate health issue.
- Receive an enhanced experience, being seen first time in the service that will meet their healthcare needs.

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- Be referred to secondary care by a suitably trained paramedic at scene or other clinical registrant (paramedic, nurse, GP) from the clinical support desk
- Avoid congregating in ED waiting rooms prior to a preliminary clinical assessment in secondary care, reducing contact with other patients and, thereby, risk of nosocomial infection.

Consequently, we need to ensure patients experience the benefits of direct referral or conveyance as an appropriate alternative to the ED.

3. Transfer of care to SDEC

Patients that are deemed clinically appropriate for SDEC by an appropriately trained, registered clinician on scene or within the clinical contact centre can be directly referred.

Every effort needs to be taken to ensure the patient is transferred to the most appropriate care setting and ED is only utilised when 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.

Each health board must introduce a process for accepting calls from paramedics to discuss and, where appropriate, accept referrals directly into the local SDEC services.

4. Expectations of ambulance providers

Criteria for direct access into SDEC is provided in collaboration with the accepting service, this will vary across health boards, and sites within health boards.

Where community and other non-hospital based pathways exist e.g. community frailty or community respiratory pathways, patients should not be referred to

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SDEC if they fulfil the criteria for these community pathways.

WAST Paramedics will be expected to refer patients who fulfil the agreed criteria for the following services as a minimum, but can instigate paramedic direct access into any ambulatory service which accepts paramedic referrals which in each health board will include a core minimum of:

- medical
- surgical
- frailty – in some areas frailty services are run on a community basis and should be accessed by the appropriate existing pathways; some SDEC units will however accept patient with a primary frailty related diagnosis.

Where health boards provide other SDEC services that will accept paramedic referrals, WAST will be expected to use them when appropriate e.g. Gynaecology or Trauma and Orthopaedics.

4.1 Standards of referral

Standards of referral

The ambulance clinician should be of a paramedic skill set or above and be competent in making the referral to an SDEC speciality clinician.

The SDEC clinician at the health board is responsible for accepting the referral from the Paramedic in a timely manner via direct dial in (DDI) telephone access.

Patients with an agreed referral to SDEC via the ambulance clinician and SDEC clinician should be handed over to the receiving service within 15 minutes of arrival.

The patient (or their guardian) 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 secondary care if the ambulance service is not conveying the

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Standards of referral

patient to SDEC and a later appointment with private transport is deemed appropriate and agreed.

The SDEC clinician may accept the patient for an admission pathway where they feel the patient is unsuitable for an ambulatory pathway rather than the paramedic convey the patient to the ED.

The ambulance clinician must redirect the patient appropriately, should the SDEC clinician not deem the referral appropriate for SDEC (or accepted on behalf of another service as above) based on the outcome of telephone call between the two clinicians.

The health board is responsible for the timely management of the patient once they arrive.

The Welsh Ambulance Service has the responsibility for ensuring that the correct assessment and advice is provided to the patient (and/or carer) if symptoms worsen in the case of non-conveyance to SDEC by ambulance.

All clinicians should be aware that SDEC services vary in speciality but should include Medical and Surgical referrals where the patient cannot be managed on site or referred into an established community pathway or back to the GP and would otherwise be conveyed to the ED.

When considering whether the patient is appropriate for SDEC the following criteria should be considered:

- Consider SDEC/Ambulatory care referral for any patient thought to need further hospital based investigation and treatment but who is thought to be well enough that they could be sent home the same day after that assessment, investigation and treatment.
 - NEWS: scoring a news score of 4 or below should be an alert that the patient should be considered for SDEC (some patients with chronic shortness of breath or atrial fibrillation may always run a high NEWS score so a score of >4 is not an automatic exclusion in these cases).
 - Patients aged over 18 should be accepted in all SDEC/Ambulatory care units and
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Standards of referral

many will have the facilities to manage 16 and 17 year olds as well.

- Medical speciality symptom list/working diagnosis (see illustrative list of high volume conditions).
- Surgical/urological speciality working diagnosis.

Exclusion criteria

- Patients presenting with a time critical condition, requiring immediate treatment upon arrival at hospital; this would include any patients where the paramedic would instigate an ASHICE/ATMIST pre-alert.
- Age under 16 when referring to adult services.
- Trauma / medical patients requiring immediate transfer to a more appropriate specialist unit according to their plan of care.

Clinicians on scene or at the clinical support desk must use the direct dial number provided by the receiving health board/unit for the SDEC service to speak directly to the SDEC clinician or agreed senior decision maker. Some units will use third party services, such as Consultant Connect, to facilitate the direct referral pathway, others may use a more generic flow centre model. If the referral is made by a clinician on the clinical support desk there must be facilities for either a 3-way conversation with the onsite non-registrant or the patient. If this is not technically possible the clinician may want to phone the patient/on-site non-registered clinician for further clarification before accepting/rejecting the referral.

Referrals should be made directly and the conversation had with the SDEC clinician or senior decision maker within the unit. A decision about whether the referral is agreed should be made during the initial phone call, there is a presumption that patients fulfilling the criteria for SDEC referral will be accepted.

The ambulance provider is responsible for agreeing appropriate, timely conveyance to SDEC and is required to set expectations with the patient around arrival time at the service into which they have been referred.

Clinical judgement should be used if a later appointment/arrival to SDEC with a patient using their own/alternative transport is clinically appropriate. This should be agreed with the patient whilst on scene with arrival times confirmed.

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Standards of referral

Transfer of the patient clinical record (PCR) should be completed via electronic transfer on the WAST portal by the clinical desk or on-site paramedic.

The receiving hospital must provide a receiving area for ambulance arrivals. Where possible this should not be ED.

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

Common conditions/symptoms and higher volume pathways can be found in section 4.2 and should be referred to when activating SDEC referrals.

The list is not exhaustive and any patient who is considered appropriate within the criteria above should be considered for referral rather than transfer to ED. The list of clinical conditions/symptom complex should be seen as a minimum standard.

4.2 High volume pathways

The table highlights pathways that should always be considered for paramedic referral as a minimum.

Paramedics may, however, consider referral to SDEC clinicians of any patient who they consider could be managed on an ambulatory basis and return home the same day.

These conditions should be considered in the context that the patient would otherwise be conveyed to ED, i.e. excluding those who can be managed on-site or by alternative GP/community pathways, but also excluding those patients who require immediate resuscitation or who would normally trigger an ASHICE/ ATMIST pre-alert.

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Common conditions

Shortness of breath which might include patients with working diagnoses of conditions including:

- COPD
 - Heart failure
 - Asthma
 - PE
 - Community acquired pneumonia
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Cellulitis (Where hospital is required over and above primary care)

Deep vein thrombosis (DVT)

Diabetes

Chest pain (no acute ECG changes)

Atrial fibrillation that needs hospital assessment

Abdominal pain

- Non-specific abdominal pain in the absence of any signs of sepsis
 - Suspected early uncomplicated appendicitis (right Iliac Fossa pain)
 - Suspected early uncomplicated diverticulitis (left Iliac Fossa pain)
 - Suspected biliary colic/mild cholecystitis (Right upper quadrant pain)
-

Post-operative wound problems – which cannot be managed by community district nurses

Painful but reducible hernia – which cannot be managed in the community/by GP

Abcess – without evidence of systemic sepsis

- Perianal, trunk, pilonidal or groin to general surgery
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Common conditions

- Limb abcess to Orthopaedic surgery
-

5. Expectations of acute care providers

5.1 SDEC capacity

The health boards must consider how to facilitate the direct referral of patients from WAST. In line with standards set out in the 'Six goals for urgent and emergency care', all health boards should be working towards having 12 hours a day, 7 days a week SDEC/ambulatory care services for medical and surgical patients.

Health boards need to consider if this can be achieved with the current roles and care models or if new roles or care models need to be introduced.

Secondary care must evaluate the availability of their existing workforce and plan recruitment and any additional training to support direct referral from WAST.

The aim of this policy is not that more patients will go through SDEC units, but that patients will be managed in an SDEC unit from arrival at the hospital rather than go through an ED service only to be referred on later in their journey into SDEC.

5.2 Call answering

- A process will need to be developed between WAST and health boards to outline expectations on call answering standards to avoid delays in referral.
- A direct dial number for SDEC clinical decision makers should be accessible by the ambulance clinicians.

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

5.3 SDEC demand

Any demand generated by WAST will allow the design of a consistent, safe and high-quality patient experience for accessing SDEC and may require a technical solution to manage the flow of patients.

- Health board clinicians must accept appropriate direct referrals into SDEC during operating hours from a clinician within WAST. In order to do so, WAST will need to list a dedicated number for each available SDEC service to enable referral and handover to take place.
- There should be enough resource available to adequately staff the direct dial numbers in each health board.
- 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.

5.4 SDEC service provision

Acute Trusts must ensure the needs of the whole population are considered, including clinically vulnerable groups, and that any proposed changes to implement ambulance referral enhance the patient experience.

Acute 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 variable across health boards and units but over a 3 years period is being mandated to reach a minimum of 12 hours per day, 7 days a week) and any specific access criteria included in the provider's referral information.

SDEC clinicians must be available for referral via ambulance clinicians during standard

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Acute provider referral standards

SDEC opening hours. This means that patients can be seen and treated during and up to the time before the SDEC service closes e.g. 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 WAST to refer patients to SDEC and following clinical conversation with the SDEC clinician, they may decide to refer into other services e.g. Hot Clinics or admission pathways. The onward referral is then the responsibility of the SDEC clinician.

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 hospital setting.

Attendance at hospital must permit the patients to be spaced to enable social distancing in SDEC where appropriate.

Attendance at hospital will usually be face-to-face.

Where virtual options for consultation are considered, this would need to be communicated clearly to the patient. This would be a key consideration for clinically vulnerable patients.

The referral message to SDEC post clinical conversation must include the patient's name, date of birth and symptom/suspected diagnosis and agreed appointment time.

The patient's NHS number should be used as the unique identifier to ensure records can be matched. Where the patient is a temporary resident and does not have an NHS number registered in Wales, full name and date of birth will have to suffice.

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 health board should record the SDEC attendance on the hospital patient administration system and, where the technology exists, the referral source selected

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Acute provider referral standards

should be 'ambulance'.

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. WAST must record all referrals manually until the business continuity is no longer required.

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

Health boards must consider alternative arrangements for dealing with patients who are shielding in line with the Infection, Prevention and Control policy (IPC).

Health boards must have arrangements in place to regularly review the WAST paramedic referrals. Where there are any concerns or a higher than expected conversion from referral to SDEC to admission, currently 10-15%, a lessons learnt process must be followed, in partnership with WAST.

Health boards should have manual processes available to record patient attendance in the event of technical failure (or due to business continuity).

6. Expectations of commissioners

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 health boards take a whole system view to invest in areas that

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will have greatest impact in terms of cost–benefit and patient outcomes.

6.1 Data protection impact assessment

Commissioners and providers will need to review existing Information Sharing Agreements to ensure that any new data flows meet the governance requirements for increasing service provision.

6.2 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 WAS and health boards.

The purpose of this is to establish whether referrals are accurately being identified by ambulance clinicians; are being accepted by secondary care in sufficient volume; and to ensure the system is continually learning from the process, to improve service provision for patients.

An all-Wales process should be developed to evaluate and bring providers together to continually develop and evolve service provision, 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
- health boards have an active role in supporting change
- in the medium term, key performance indicators (KPIs) will be developed through learning and development

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