

Welcome

This checklist is intended as an aid to all NHS ambulance trusts and their staff to ensure that all possible steps are being taken to improve and streamline the care of patients presenting to emergency care. This checklist will also assist emergency care networks in their work across the whole health economy.

Although this checklist focuses on actions by ambulance services, it is recognised that this is an issue for the whole system and that many important actions can be undertaken in other areas of emergency

healthcare that will impact beneficially on the work of ambulance services. Similarly, there is much that ambulance services can do to assist others in their health community achieve their goals.

In all improvement processes in emergency care, it is vital that the whole patient journey is considered from the viewpoint of the patient and that changes in single organisations do not negatively impact on other parts of the patient's journey.

This checklist details actions that

ambulance services could take to help improve access to emergency care and so help achieve response time performance measures and other emergency care access targets. Most are already being undertaken by some ambulance services. Although the targets are important, the ultimate aim is to improve patient experience and clinical outcomes. It is vital that this aim remains at the centre of all decision making.

This checklist will be regularly updated. Please send your comments to emergencycare@dh.gsi.gov.uk

Professor Sir George Alberti
National Clinical Director
for Emergency Access

Peter Bradley
National Ambulance Advisor

Dr Matthew Cooke
Emergency Medical Advisor

Click [here](#) to enter the checklist

Using this checklist

This checklist has been produced in PDF format. It is designed to be used on screen where you can click between the different sections and use the live links to access other relevant information and resources on the web.

The checklist is organised into 12 main sections displayed down the side of the page. Just click on a tab to go to the related suggestions and information.

Viewing tip: Go to 'view' at the top of your Acrobat Reader page and select 'full screen' or 'fit in window' from the drop-down menu to see the checklist more clearly.

Printing tip: PDFs are printer-friendly and can be easily printed out for off-line reference.

If you have any feedback about this checklist email us at emergencycare@dh.gsi.gov.uk

Click [here](#) to enter the checklist

Performance measures

Performance measures

First steps

General advice

Information management

Emergency control centre

On-scene management

Choice of destination

Hospital discharge systems

Training and education

Working across boundaries

Clinical quality

Useful resources

- Improved patient experience.
- Patients receiving their treatment in an appropriate location without unnecessary transfer between NHS organisations.
- 75 per cent of ambulance category A calls (immediately life threatening) have a response time of eight minutes or less.
- 95 per cent of category A calls receiving a response within 14 minutes (urban) or 19 minutes (rural).
- Where a doctor identifies a patient's needs urgent, ambulance services to take a patient to hospital within 15 minutes of the arrival time specified by the doctor in 95 per cent of cases.
- 95 per cent of category B calls receiving a response (if one is required) within the national 14 minutes (urban) or 19 (rural) minutes.
- Manage and monitor responses to category C calls as agreed locally.*
- Thrombolysis (clot busting drugs) should be delivered within 60 minutes of calling for professional help. Annual figures for April 2003 to March 2004 showed that 48 per cent were treated within 60 minutes of calling for professional help which is a 10 per cent improvement on the national baseline of 38 per cent and therefore meets the PPF target.
- A minimum of 98 per cent of patients spend less than four hours in A&E from arrival, admission, transfer or discharge by 31 December 2004.

* As from 1st October 2004, local NHS organisations have responsibility for managing and monitoring how local services respond to non-urgent 999 'Category C' calls.

CLOSE checklist

Back to START

First steps

There are some key steps that should take priority and are likely to result in achieving the response time measures. These are:

1. Fast activation is the most important action and the following factors should be addressed to achieve this:

- Call takers and dispatchers working adjacently
- Vehicle assigned on receipt of post code / location
- Rapid transfer of key information to crews
- Crews on standby in vehicles that are appropriately located according to previous call analysis
- Number of crews required is calculated using analysis of call history on an hourly basis

2. Ability to offer non-emergency calls an appropriate source of advice/care in a timely manner.

3. Agreeing “no send” policies with local partners.

Other ideas will help to further improve performance and improve the patient's experience in out-of-hospital emergency care.

Performance measures

First steps

General advice

Information management

Emergency control centre

On-scene management

Choice of destination

Hospital discharge systems

Training and education

Working across boundaries

Clinical quality

Useful resources

CLOSE
checklist

Back to
START

General advice

Performance measures

First steps

General advice

Information management

Emergency control centre

On-scene management

Choice of destination

Hospital discharge systems

Training and education

Working across boundaries

Clinical quality

Useful resources

CLOSE
checklist

Back to
START

- Ensure that a geographical emergency care network is in place, involving all relevant parties and emergency care leads as well as joint working with cardiac networks.
- Appoint a non-executive lead with particular responsibility for patient experience and emergency access.
- Develop a culture that has improved patient outcome and experience as its key objective.
- Involve patients in all aspects of trust work, including planning and performance management. Develop a culture that has user participation as a core value.
- Ensure that staff understand the drivers for change regarding performance standards, are aware of the daily performance of the trust and the local health community and have an opportunity to contribute to the provision of continually improving services.
- Identify high acuity and high volume patient groups and focus specific attention on these groups initially.
- Identify factors associated with decreased performance and initially focus change in that area, for instance by time of day, day of week, geographical location, patient group.
- Develop systems that transmit information ahead of the patient and help to reduce duplication, for example transmission of ECGs to A&E.
- Consider the local health economy as a whole system. Explore safe, effective, alternative ways of managing different patients' needs and understand how changing the delivery of one element of the service impacts on another - for example, locally agreed hospital discharge arrangements and their impact on bed management and A&E waits.
- Develop a culture that looks at ways of improving performance in the local economy rather than within the individual organisations. One example is looking at improvements in 'call to needle' times. Change should address the whole patient experience and not focus solely on achieving performance measures.
- Ambulance trusts may wish to designate a coronary heart disease champion at executive level.

Information management

Performance measures

First steps

General advice

Information management

Emergency control centre

On-scene management

Choice of destination

Hospital discharge systems

Training and education

Working across boundaries

Clinical quality

Useful resources

CLOSE
checklist

Back to
START

1. The key step is matching supply and demand on an hourly basis by good use of information.

2. Establish systems to analyse and predict demand and resulting capacity requirements throughout the trust on a dynamic basis. Ensure that this information underpins a robust operational plan, which informs appropriate workforce utilisation, identifies appropriate standby positions, is monitored regularly and discussed at operational, executive and board meetings.

3. The trust should have systems in place to measure, monitor and manage the following key information on an hourly, daily and weekly basis as appropriate:

- Activation time
- Mobilisation time

- Response time
- On scene time
- Turn around time for each acute trust
- Quality assurance of emergency call prioritisation systems to ensure validity in categorisation
- Down time by vehicle and crew
- Percentage utilisation – to include single ambulance responders and crews
- Demand analysis and resource allocation analysis
- Sickness / absence information

4. This information should be shared within the emergency care network and ambulance services should be aware of their partners' monitoring data.

5. Put in place appropriate forecasting and planning for managing capacity and demand,

incorporating trend analysis. Utilise this to determine optimal matching of resources and workload by day of week and hour of day.

6. The trust should work with other healthcare organisations to identify trends in activity across the whole emergency system, for example cardiac networks, in order to improve local intelligence and focus resources. Trusts should recognise that a service provided within the overall resources of the network can improve the response of partner organisations, as well as the trust, and make more effective use of the total resource.

7. The trust should be working towards establishing trust-wide and multi-organisational systems to identify clinical outcomes that are relevant to the patient.

Emergency control centre

Performance measures

First steps

General advice

Information management

Emergency control centre

On-scene management

Choice of destination

Hospital discharge systems

Training and education

Working across boundaries

Clinical quality

Useful resources

CLOSE checklist

Back to START

1. Ensure rapid 999 call answering and call prioritisation:

- call answering times monitored regularly
- quality assurance of call taking in place

2. Ensure fast activation by:

- Call takers and dispatchers working adjacently
- Pre-assign vehicles on receipt of post code
- Rapid transfer of key information to crews
- Crews on standby in vehicles that are appropriately located according to previous call analysis

3. Use of alternative resources if rapid response time cannot be guaranteed, which may include use of:

- Other operational staff, including training staff and managers

■ Other health service clinicians in the community

- Voluntary first responders

4. Have systems in place to divert the calls that are unlikely to need an ambulance response to an appropriate agency for advice or care, NHS Direct for example.

5. Ensure seamless handover during shift changes to enable constant call handling and dispatch of emergency calls.

6. Establish cross-border arrangements with neighbouring trusts to provide a timely and appropriate resource for emergency patients with seamless transfer of information (preferably electronically).

7. Ensure robust communications exist between operational managers and control staff in order to proactively respond to and manage delays in patient flows. For example on-scene management at multiple casualty incidents, complex incidents, delays in A&E departments, required downtime for vehicles or staff.

8. Consider the development of local agreements to provide safe, alternative crew resourcing for the transfer of ventilated patients, particularly in trusts with high levels of inter-hospital transfers and/or retrievals.

Positive practice pages



Emergency control centre

Positive practice example

1

First responders strike gold

A team which uses the skills of paramedics to improve emergency care for patients in rural Shropshire took top billing at the NHS Health and Social Care Awards. The Shropshire Ambulance First Emergency Responders (SAFER) scheme, a community responder initiative, was first introduced in 2001 to improve emergency ambulance care to patients in outlying rural communities.

SAFER comprises emergency medical responders (full time paramedics) and community first responders. Community first responders are local residents who

volunteer their time to respond to incidents within their local community. Eight emergency medical responders based in market towns throughout Shropshire and South Staffordshire manage the community first responders. Members of the SAFER scheme have treated more than 10,000 patients since the scheme was first introduced, delivering rapid medical treatment to patients. Judges described SAFER as "truly a solution to the challenge of delivering emergency care rapidly in a dispersed rural environment, with strong community involvement."

Link-up

For further information contact **Barry McKinnon, Clinical Network Service Manager at West Midlands Ambulance Service NHS Trust** barry.mckinnon@wmas.nhs.uk

Performance measures

First steps

General advice

Information management

Emergency control centre

On-scene management

Choice of destination

Hospital discharge systems

Training and education

Working across boundaries

Clinical quality

Useful resources

CLOSE checklist

Back to START

← Emergency control centre

Performance measures

First steps

General advice

Information management

Emergency control centre

On-scene management

Choice of destination

Hospital discharge systems

Training and education

Working across boundaries

Clinical quality

Useful resources

CLOSE
checklist

Back to
START

On-scene management

- Develop locally agreed, safe, audited procedures to enable patients to receive alternative pathways of care as appropriate. For example assessment with subsequent referrals to minor injuries units, walk-in centres, GP services.

■ Develop systems so that appropriate patients can be treated and discharged at scene, for example by increased training of ambulance staff, or using other professional groups as part of the initial response.

■ Use an appropriate range of professionals and competencies to enable care to be delivered in the most effective way.

■ Develop and implement admission avoidance policies in conjunction with primary care partners, concentrating on high-volume groups.
- Develop community-based preventive support teams with PCTs and intermediate care, particularly for the elderly.
- Develop clinical supervision and clinical support systems for staff.

Positive practice pages



On-scene management

Positive practice examples



New ways of managing non life threatening 999 calls

Working with PCTs, Social Services and NHS Direct, Bedfordshire and Hertfordshire Ambulance Service NHS Trust is establishing new ways of managing non-life threatening 999 calls. By establishing a single point of contact, newly trained emergency care practitioners can arrange care that is more appropriate for patients who do not need to go to an A&E department.

Link-up

For further information contact **Dean Ayres** at **Bedfordshire and Hertfordshire Ambulance and Paramedic Service**
dayres@bhamb.nhs.uk

Performance measures

First steps

General advice

Information management

Emergency control centre

On-scene management

Choice of destination

Hospital discharge systems

Training and education

Working across boundaries

Clinical quality

Useful resources

CLOSE checklist

Back to START

◀ On-scene management

Positive practice pages ▶

