Healthwatch Hackney

**RIDEOUT WITH PARADOC**

**17th FEBRUARY 2020**

**HEALTHWATCH HACKNEY**

**Malcolm Alexander**

ParaDoc provides an assessment and treatment service for acutely unwell patients in City and Hackney, who might otherwise be admitted to ED and in some cases to a hospital bed. The focus of the service is on patients who are elderly and frail and those with complex needs, and includes patients who have suffered falls with harm.

The pm ParaDoc team comprises a GP and a Paramedic, who respond to a range of situations, and work closely with nursing and palliative care teams, physiotherapists and occupational therapist. The ParaDoc morning ‘Falls Service’ comprises a senior therapist (Occupational Therapist or Physiotherapist) with a Paramedic.

The Ride-Out was carried out in accordance with Healthwatch’s statutory powers.

The purpose of an Enter and View visit is to collect evidence of what works well and what could be improved to make people’s experiences of health and social care better. Healthwatch uses this evidence to make recommendations and inform changes both for individual services as well as system-wide.

I met Paramedic Janice Kelley and GP Dr Douglas Green at the Homerton Ambulance Station. They explained how ParaDoc operated and briefed me in detail on their roles. They are a highly impressive team who demonstrated outstanding clinical/medical practice in their interaction with patients, and their commitment to providing the very best urgent care.

I joined the team for a period of three hours (5-8pm), which included a visit to two patients. I was introduced to each patient and family as an observer from Hackney Healthwatch, and in both cases consent was given for me to observe work of the ParaDoc team.

**HISTORY OF PARADOC**

**The Pilot**

ParaDoc was initiated as a pilot project on April 1st, 2014, following discussions between the City and Hackney CCG Urgent Care Programme Board, and the LAS Ambulance Operations Manager (Nick Yard). The pilot was evaluated by the CCG in July 2015. It was funded originally through NHSE non-recurrent winter resilience funding - provided to cope with the anticipated heavy winter pressures on the urgent and emergency care system.

A primary objective of the pilot was to find ways for primary care services to work more effectively to support patients with chronic conditions at home, to reduce unnecessary attendances at hospital emergency departments (ED), and to reduce admissions to hospital following 999 calls to the LAS.

The development team included primary care leaders, the LAS, the CCG, acute clinicians and representatives from Homerton ED. An important catalyst for the pilot was recognition that Paramedics often felt unable to access appropriate local alternatives to ED, and therefore took patients to ED as a default risk-averse solution, even though it may not have been the most appropriate, safest and best treatment option for some patients.

The ParaDoc service is commissioned from the Homerton Hospital by the CCG, with a single car available for a noon to midnight shift, seven days a week. The service is based at the Homerton Ambulance Station (LAS). ParaDoc also provides a service for people who have suffered falls, which runs from 8am-noon each day of the week.

**TARGET GROUPS**

The main target groups include elderly people with a variety of complex conditions, sometimes on multiple medications, for whom an initial assessment suggests would benefit and be safer, receiving care at home instead of in ED or a hospital ward. Elderly patients seen by ParaDoc may have signs of dementia, UTI, chest infection and be at risk of falling. The the morning team visit patients who have had a recent fall, including those who may have suffered an injury.

Most patients have complex, late-stage chronic conditions. Other patients seen by ParaDoc, are adults of any age may have severe chronic conditions such as COPD, who are experiencing acute episodes of their illness, which can be assessed and stabilized by the ParaDoc team. The GP-Paramedic crew have the skills, experience and knowledge to enable such patients to remain at home, whilst ensuring that severe exacerbations of their illness can be treated quickly and safety.

Patients are referred to the ParaDoc team through many different routes, e.g. GPs and care workers concerned about a patient with complex needs, who is suffering from an acute episode of their illness. ParaDoc can phone the referring doctor or the patient’s carer to discuss the patient’s clinical problems before making a home visit.

**Q: Is treatment provided to children? If so what age range**? Children (<18) are excluded as it is felt there is less room to prevent an admission in this age group (i.e. if they need an admission that will happen anyway.

**Q: Can patients requiring intravenous antibiotics, who are cared for at home be treated by ParaDoc to remove the necessity for them to spend hours in the A&E department?** ParaDoc does not provide an IVI service. This is covered by Homerton Ambulatory Medicine Unit (HAMU) which ParaDoc can refer to.

**WHY GP AND PARAMEDIC**

The GPs professional role allows them to assess a patient’s health care needs fully, make immediate treatment decisions and rapidly access services needed to care for the patient at home – if that is the best option. They can also refer to the Homerton Integrated Independence Team (IIT), specialist teams for respiratory conditions and heart failure, and out-of-hours nurses, who can deal with dressings and catheter problems. [www.homerton.nhs.uk/integrated-independence-team/](about:blank)

A Paramedic is a specialist [healthcare professional](about:blank) who responds to emergency calls for medical help outside of a hospital. The scope of practice for Paramedics includes autonomous decision-making around the emergency care needs of patients.

Paramedics often report problems about getting access to support from primary care services, when they provide treatment for patients who they think could be better cared for and treated outside of hospital. They sometimes convey to hospital in the knowledge that it might be better not to.

After the ParaDoc team has seen a patient, the clinical report is agreed between the GP and Paramedic, but the GP takes primacy of care and will write the medical notes for the core ParaDoc service (whereas the Falls service is Paramedic-led).

**Q) Where are medical records stored? By the GP and LAS?** Notes are stored on the OOH Adastra system and are sent to the patients’ own GP. The LAS does not keep copies of the patient’s record, but Paramedics can access them from the GP ‘summary care record’ if they are on an emergency call.

Paramedics and GPs working as a ParaDoc team develop new skills and knowledge through this enhanced way of working, and greater insight into each other’s professional skills and clinical knowledge. This includes critical links with community health and social care services. GPs and Paramedics form trusting and positive professional relationships, as a result of working with patients who have a wide variety of clinical presentations.

**SELECTING PATIENTS FOR THE PARADOC SERVICE**

Although the service runs as a doctor-paramedic team the LAS is no longer directly involved. In the previous ParaDoc model the GP and Paramedic team used the LAS system to view clinical details and locations of patients who were awaiting Category

3 or 4 ambulance responses and chose the most appropriate patients to visit to provide the ParaDoc service.

Direct allocations by the LAS Emergency Operations Centre (EOC) happen rarely because the LAS IT system is not sufficiently refined to request ParaDoc attendance to a particular patient in City and Hackney. The LAS and Paradoc did consider whether it would be possible for an LAS system to be developed to embed the

ParaDoc profile within the automatic dispatch system, to increase the number of appropriate referrals, but in practice this was not possible.

When the service was first set up the majority of calls came from ambulance crews or a first-response team, who had visited a patient and assessed them as being appropriate for a ParaDoc response. Although this was theoretically a good system, it sometimes resulted in two or more ambulance responses to a single patient and high levels of staff involvement.

A critical aspect of the ParaDoc service is its focus on complexity, i.e. meeting the needs of patients who may have multiple medical conditions, which the team are best placed to respond to. The development of the ParaDoc service now means that they still take calls from the LAS clinical hub and EOC, but the numbers of patients from that source are very low.

Since the LAS pulled out of the contract, new referral streams have been built, which enable the following organisations to refer to ParaDoc directly instead of calling 999.

* Direct referrals from care homes/supported living/nursing homes.
* Home carers / Homecare agencies
* IIT (Hackney Integrated Independence team)
* GPs
* Telecare
* District nurses/community teams/OTs/physios/Matrons/social workers etc
* Family carers for very vulnerable/unwell/palliative adults
* Hatzola (Orthodox Jewish ambulance service)
* St Joseph’s Hospice
* Out of Hours providers 111/ Hot hubs

A total of 412 patients were referred to ParaDoc between 1st April and 30th June 2014. 304 referrals were made by ambulance clinicians on scene and 101 patients were calls identified by the LAS Clinical Hub - CHUB (specialised paramedic team) in the EOC. 44 referrals were not accepted. The average number of referrals made per shift was4.6 and the average number of patients seen was 4.3. A breakdown by each month for 2014 and 2019 follows:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **2014**  **Month** | Total Referrals | Referrals from CHUB (LAS) | Referrals from LAS crews on scene | Referrals Declined\* | Number of patients seen |
| April | **142** | **26** | **116** | **15** | **127** |
| May | **146** | **37** | **102** | **23** | **123** |
| June | **124** | **38** | **86** | **6** | **125** |
| **Total** | **412** | **101** | **304** | **44** | **375** |

There have been multiple changes to the ParaDoc system since 2014. The table below is updated, and examples also shown for some of the key sources of referral.

**More Recent data**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **2019**  **Month** | Total Referrals | Referrals from CHUB | Referrals from LAS all sources | Referrals Declined\* | Number of patients seen |
| April | **172** |  | **56** | **11** |  |
| May | **144** |  | **49** | **6** |  |
| June | **151** |  | **51** | **2** |  |
| **Total** | **467** | **9** | **156** | **19** |  |

**For the same period (April-June 2019):**

152 Referrals direct from Care Homes

53 from GPs

35 from IIT

19 from Home carers

12 from Telecare

**MEETING PATIENTS’ NEEDS**

In 2014, an average of around 140 patients were seen each month by Paradoc and 90% of these were not transported to the ED but treated at home. The average monthly figure for 2019 was 155. There is wide recognition of the medical benefits of not being hospitalized for a range of patients – if the same treatment can be delivered out of hospital, but under conditions that are safer in terms of the patient’s care, wellbeing and prevention of infection.

Other developments in Hackney include improvements to the referral process following calls from patients using the Telecare system. The aim is to create a radical new system that responds at an appropriate level to these calls and avoids unnecessarily taking Telecare users to ED. Users of the Telecare system tend to be people who have a severe disability or who are elderly and frail.

This service can also connect directly with IAT (Information and Access Team), which is a ‘front door’ service for the assessment of people’s needs for adult social care. www.hackneylocaloffer.co.uk/kb5/hackney/localoffer/service.page?id=MgQ-mBO5fC8

The ParaDoc falls service does not have a GP in the team; it is run by a Paramedic and OT or physiotherapist from IIT. They have access to the DOS (Directory of Services), which includes a wide range of local health and social care services to which they can refer if necessary.

The LAS emergency/urgent care system would benefit from the non-conveyance of a significant proportion of patients seen by ParaDoc, by freeing up ambulances for the transport of other patients to ED who have greater clinical needs. This approach would seem to be consistent with the LAS’s long term strategy, but in practice does not fit in with the LAS’s operational model.

**COMPARISON WITH OTHER COHORTS**

ParaDoc attends 4-5 patients per 12-hour shift, with an aspiration to increase this to 6 or 7 patients. The average number of patients seen by LAS ambulance crew and first response cars is approximately 6-7 patients per 12-hour shift. I was told that avoiding one unplanned admission to hospital per shift, covers the cost of running one ParaDoc shift.

A study of cohorts similar in age and clinical presentation to patients seen by ParaDoc, suggests that about 40% of these patients would be admitted to the hospital after being treated in the ED - sometimes with prolonged hospital stays, whilst further medical investigations are carried out and care packages put in place to support discharge**.**

**Q) Is data available showing how many patients initially seen by ParaDoc, are taken to the ED by ambulance in the days or weeks following the Paradoc visit, and how many of those patients are admitted to a ward?**

Answer: An audit was carried out by ParaDoc in which the service counted as a failure, patients going to A&E within 7 days of the visit by ParaDoc. Results showed that only 4% attended A&E within 7 days of a Paradoc visit.

**END OF LIFE CARE**

ParaDoc GPs may adjust medication for people who are at the end of life, thus avoiding unnecessary and traumatic admissions to hospital. Recently ParaDoc started carrying End of Life palliative and controlled drugs and now can act as a rapid access palliative care team. ParaDoc embedded itself in the C&H End of Life care pathways as part of their response to the Covid 19 pandemic.

**CONTINUITY OF CARE**

If ParaDoc sees patients during surgery hours they can call the patient’s GP to discuss the patient’s history and findings. When a patient has been seen by ParaDoc out of surgery hours, ParaDoc may, if appropriate, call the patient’s GP the following morning, to ensure continuity of care. All ParaDoc clinical notes are put onto the Adastra system and go to the patient’s usual GP the next day. ParaDoc always has access to patients’ notes through the NHS spine and the GP EMIS system.

**CARE HOMES**

In addition to providing clinical care in patients’ homes, the ParaDoc team visit care homes and other institutions in Hackney, where vulnerable patients are receiving care and would benefit from home-care rather than inpatient care. The ParaDoc team aim to connect with community care services and a range of other health and social care professionals. Care-home visits in Hackney enable ParaDoc to meet staff and keep up their profile. Consequently, they have very good rapport with staff, who have come to trust them to provide the most appropriate care to residents (instead of calling the 999 service).

**OUTREACH WORK**

The ParaDoc team actively link with 15 providers of health and social care across City and Hackney, including care and residential homes, the Home Care Providers Forum, social care services, palliative care teams and community matrons.

**Q) What other services does ParaDoc connect with?**

**Homerton consultant teams** – ParaDoc takes referrals from geriatricians to see frequently admitted patients, to prevent future admissions, by meeting these patients in their homes and discussing future care options with their carers. This leaves ParaDoc as a referral option for carers and clinicians.

**East London Foundation Trust**

ParaDoc have a pathway to see ELFT inpatients with physical health problems (on mental health wards) rather than them being taken over to the Emergency Department at the Homerton.

**GP OUT OF HOURS SERVICE –**

**CHUHSE** (City & Hackney Urgent Healthcare Social Enterprise)

The contract with CHUHSE for the provision of Out of Hours (OOH) services came to an end in March 2019. CHUHSE had provided an excellent service for City and Hackney patients over 6 years. From 1 April 2019 the provision of the GP OOH service was taken over by the Homerton Hospital and the provision of GP OOH home visits by the Tower Hamlets GP Care Group. The service has now been taken over by LCW (**London** Central and West Unscheduled Care Collaborative (**LCW** UCC) who can refer to ParaDoc. There is only one doctor working for the OOH home visit service per shift, who can be contacted through 111 IUC.

Alternatively, patients can get urgent medical help by visiting the OOH service at Homerton Hospital (PUCC – Primary Urgent Care Centre). About 20% of patients who attend Homerton ED are diverted to PUCC, but some of the available slots are currently not being filled.

ParaDoc can accept appropriate patient referrals from 111 if it is felt that a ParaDoc visit would help prevent an admission to A&E or a hospital bed.

**VISITING PATIENTS**

**Patient One –**

A 94-year-old woman who was unable to leave her bed. She had a fully equipped room with lifting equipment installed. The patient was not very alert and is paralysed on her left side following removal of a tumour 40 years ago. Initial consideration was given to a diagnosis of stroke, but clinical findings did not support that diagnosis.

The team examined the patient and reported that she had a slow pulse, slightly laboured breathing (wheezing), difficulty expectorating and that her face appears slightly swollen, she was also dribbling. Her condition had worsened over past two days. BP was normal. It was noted that she tends to urinate slowly.

Diagnosis was urinary tract infection and/or chest infection. Nitrofurantoin was chosen for treatment after consideration and discussion with the family, as a broader spectrum antibiotic was more likely to cause diarrhoea, which would have made caring for the patient more difficult. She had been on antibiotics two weeks

previously for four days. The patient indicated that she felt something was pinching her. No evidence of sepsis was found.

The patient reported back pain and is on pain killers, but paracetamol is not working well. Other painkillers are being avoided because of the risk of constipation.

Dr Green carried out a non-intrusive physical examination. Paramedic Janice Kelley carried out tests for BP, pulse and other clinical examinations.

During my observation several members of the family were present. They reported that a professional carer attends four times daily to assist the patient. The patient has a highly supportive and very caring family – present during the visit were the patient’s son, daughter-in-law and grandchildren. Their role in supporting the patient to remain at home and avoid hospitalisation was fundamental. They said that if the patient went to hospital it could cause considerable distress.

Dr Green raised the issue of a referral to St Joseph’s Hospice if necessary, in order to enhance the patient’s end-of-life homecare and pain control. There was a very sensitive discussion between the clinical team and family about a DNAR notice, the use of CmC and avoidance of hospitalisation, if the patient suffered a cardiac arrest. The family agreed to discuss the setting up of a DNAR notice with the GP. The patient’s grandson was anxious that all grandchildren were involved in a DNAR decision.

**Conclusion** –There was no evidence of a stroke, and the team suspected a possible chest infection and UTI, but the pragmatic view was to treat the symptoms of UTI and to avoid an excess of medication that might lead to unpleasant side effects.

The patient was on many medications. Dr Green felt that a medication review was needed and that it was wise to reduce the impact of unnecessary medications. Dr Green asked if the family had any questions –

Q: “For how many days should we use antibiotics”.

A: “7 days, but 4 days if symptoms go”.

Dr Green spoke to patient’s GP after meeting the patient to provide a briefing on the outcome of the ParaDoc visit.

I was deeply moved by the families display of love for the patient and for each other.

**Patient Two -**

Prior discussion with ParaDoc team.

A phone call was received from a social worker regarding a 91-year-old man with mobility problems. 111 had sent an ambulance earlier in day, but had left without taking the patient to hospital. The patient’s daughter re-contacted 111 and a second ambulance was being sent. The patient is normally quite mobile and the intention of all parties was to keep patient at home if possible. However, while ParaDoc was with the patient an ambulance was on its way.

Initially, it seemed to me that there were communication problems between LAS EOC, 111 and ParaDoc, i.e. a second ambulance should have only been sent if the ParaDoc team had assessed the patient as requiring acute hospital care. Dr Green spoke to the patient’s daughter whilst on the way to the patient’s home and found she was at home with the patient. He explained to her that both ParaDoc and the ambulance might arrive at the same time.

On arrival at the patient’s home, he appeared very cheerful, talking a great deal and appearing rather disinhibited in his communications. The patient’s daughter was not aware of his recent fall, except that he had apparently fallen “down” into the toilet and got stuck. His left leg was painful at thigh level, no sharp pain, but he described his leg as feeling weak and experienced pain on trying to stand. He couldn’t lift himself onto his walking frame without help, and he could not weight bear. Dr Green suspected a fracture to the L thigh bone. There was also bruising to the left elbow.

The patient’s daughter is very supportive, sees him twice a week and had noticed deterioration since the weekend. He is normally very active. She identified that he had not been eating regularly over the previous few days and that he can’t go out. Carers come in once daily.

The ParaDoc team were trying to avoid hospital care, but as Dr Green’s physical examination suggested a possible fracture and as the patient could not move one foot in front of other, it was unsafe for him to remain at home. There was also a loss of awareness associated with dementia.

It was decided to immediately refer the patient to hospital by ambulance for an x-ray of his thigh to see if there was a fracture. There was a risk of a fall and serious harm if a referral to hospital was not made.

The patient was keen to go to UCH (his 5-star rating) and was told that as it was equidistant to Bart’s that it should be no problem for the LAS to take him to UCH. Confirmation was received that an ambulance was on its way and Dr Green prepared a handover note for the Paramedics. We saw as ambulance nearby as we were leaving the site.

**REFLECTIONS ON THE PARADOC RIDEOUT**

The collaboration between GP and Paramedic appears to be a highly successful clinical model that enables access to high quality urgent care. This approach enables patients to receive appropriate services that meet their needs at home instead of being taken to a hospital ED. The excellent collaboration between the 2 clinical colleagues, I believe significantly enhances the effectiveness of the service and its contribution to effective continuing care.

The ParaDoc team were open to my questions and to my observing them during their visits to patients.

The Homerton Hospital has repeatedly demonstrated that it has the lowest number of ambulance handover breaches in London[[1]](#footnote-1). It would be interesting to see a comparison between the ParaDoc model and services in other London boroughs in relation to the number of patients diverted away from ED, by either local borough/CCG commissioned services, or the LAS, e.g. the LAS mental health and urgent care teams.

The financial savings accrued as a result of the diversion of patients away from ED are very significant, but my interaction with the ParaDoc team gave me confidence that their decision-making was based entirely on clinical need and not on cost savings.

**COST SAVINGS RESULTING FROM THE PARADOC SERVICE**

As an example of the costings generated by ParaDoc, for the period (April/May/June 2019) total system savings were:

£175,942 (April)

£204,307 (May)

£196, 780 (June).

This is based on 97 + 86 + 94 avoided Hospital Attendances or Admissions, and 73 + 66 + 61 ambulance callouts avoided. Figures are adjusted for patient age etc and average costings taken from HUH data.

**OUTCOME DATA**

An audit was carried out by ParaDoc in which the service counted as a failure, patients going to A&E within 7 days of the visit by ParaDoc. Results showed that only 4 % attended A&E within 7 days.

It would be useful to see data on what happens to patients in the weeks following their ParaDoc visit, so that we can be assured that ParaDoc provides safe ongoing

care at home. Delaying transfers to ED and admission to hospital is also important as a means of providing space to generate care plans, that enable appropriate care and services to be provided in the patient’s home. This approach can significantly reduce the trauma associated with emergency transfers to ED, which are especially inappropriate during the pandemic period.

However, the data above demonstrates that very few patients are admitted to hospital within seven days of been seen by ParaDoc. Commissioners have costed system-wide savings based on ED avoidances and hospital admission avoidances

and reduced ambulance callouts, and it is therefore surprising that this model is not more widely used to ensure continuity of urgent care in patients’ homes.

**EXTENDING THE PARADOC MODEL OF CARE**

It is interesting to note that the ParaDoc model has not been adopted by other London boroughs, and it would be useful to know whether other boroughs have considered the ParaDoc model and if so, why they have rejected it. The dual

professional model has been adopted by the LAS, e.g. a nurse/paramedic model used in mental health and urgent care.

Healthwatch has not been able to speak independently to patients who have used the ParaDoc service, but for most patients, being able to remain at home instead of spending hours in ED, and then being admitted to hospital is likely to be welcome. However, feeling safe to remain at home instead of going to the ED, requires local access to a GP practice team that is proactive in supporting the patient after the ParaDoc assessment. A clinical plan may also be needed following the ParaDoc assessment and evidence of implementation– which could be particularly difficult during the current pandemic crisis.

**EFFECTIVE COLLABORATION**

Additional resilience is also built into the system by access to a range of onward referrals, e.g. to IIT, St Joseph’s Hospice, district nurses and other services to support the decision to manage the patient at home.

A critical factor in the success of ParaDoc, is the effectiveness of the working relationship between GPs, ParaDoc and other clinical community services in City and Hackney, e.g. community nurses, falls and respiratory teams and the Hackney IIT service.

In our experience of the LAS, despite having had a DOS (Directory of Services) for many years, the number of patients referred to local services, apart from GPs, is very low and the link between Paramedics and GPs not usually robust.

It would be interesting to learn how the CCG commissioners determined the required level of capacity for the ParaDoc service, in relation to the number of patients who are currently taken to Homerton ED by the LAS but could have received a ParaDoc response instead.

An important aspect of the GP-Paramedic collaboration is the opportunity for both professionals to expand their clinical knowledge, improve resilience and develop new kinds of collaborative clinical relationships. ParaDoc is clearly a powerful model for hospital admission avoidance and the increasing flexibility of Paramedics to work in a range of clinical settings will provide access to additional staff if required.

**CONNECTIVITY**

A possible weakness of the ParaDoc system appeared to me to be how the EOC, Paramedics on the front-line, and other healthcare professionals make referrals to ParaDoc. It did seem as if these components were not always well connected to ensure that appropriate referrals got to the ParaDoc team, e.g. in the case of the second ParaDoc visit that I observed, an ambulance had already been sent to the patient before ParaDoc had even started their assessment. They could have arrived at the same time creating an overwhelming and confusing situation for the patient.

However, it was explained that this unusual situation occurred because the patient’s carer had called 111 on a number of occasions and it was 111 that requested that an ambulance be provided on two occasions on the same day. Usually, referrals come directly from other sources.

**DISCUSSIONS WITH THE PARADOC TEAM**

I raised a number of issues with the Team in a discussion following visits to patients.

**Q1) Who commissions the ParaDoc service?**

A1) The City and Hackney CCG commissions Homerton University Hospital to provide the service.

**Q2) What management and administrative support is provided to the ParaDoc service?**

A2) There is some managerial or administrative support available to the Paradoc clinicians who run the service.

**Q3) How many ParaDoc vehicles are there and how are they serviced and maintained.**

A3) There is one car that covers two services: ParaDoc falls service 8am - midday; ParaDoc core/GP-led service 12-12. No technical support is provided for maintenance of the ParaDoc car.

**Q4) Is collaboration with the CCG effective and are they supportive? Has there been a cost-benefit analysis of ParaDoc?**

A4) The CCG is very supportive. The CCG links are: Anna Hanbury and Clara Rutter from the Unplanned Care Workstream. The CCG contract is with the Homerton Hospital.

**Q5) Is ParaDoc funding secure?**

A5) The funding is recurrent, but it is not known for how long this funding will continue. ParaDoc significantly reduces cost by diverting patients away from ED and hospital admission, but it could be vulnerable to CCG/HUH cuts.

**Q6) How do providers of health and social care know about the ParaDoc service?**

A6) There is significant input by the ParaDoc team into a wide range of local service to prevent patients being inappropriately taken to hospital. Information about ParaDoc and their confidential telephone number is given to providers of care, so that they can call ParaDoc instead of LAS. The number is not publicly available.

**Q7) Does ParaDoc run the falls service for City and Hackney?**

A7) Yes, we run the falls service every morning 8am to 12noon.

**Q8) Is treatment provided to children? If so what age range**?

A8) Children (<18) are excluded as it is felt there is less room to prevent an admission in this age group (i.e. if they need an admission that will happen anyway).

**Q9) Can patients requiring intravenous antibiotics, who are cared for at home be treated by ParaDoc to remove the necessity for them to spend hours in the A&E department?**

A9) ParaDoc does not provide an IVI service. This is covered by Homerton Ambulatory Medicine Unit (HAMU) which ParaDoc can refer to.

**Q10) Where are medical records stored? By the GP and LAS?**

A10) Notes are stored on the OOH Adastra system and are sent to patients’ own GPs. The LAS does not keep copies of the patient’s record, but Paramedics can access them from GP ‘summary care records’ if they are on an emergency call.

**Q11) Is data available showing how many patients initially seen by ParaDoc, are taken to the ED by ambulance in the days or weeks following the ParaDoc visit, and how many of those patients are admitted to a ward? Does ParaDoc delay admission, rather than prevent admission to hospital?**

A11): An audit was carried out by ParaDoc in which the service counted as a failure, patients going to A&E within 7 days of the visit by ParaDoc. Results showed that only 4 % attended A&E within 7 days.

**Q12) What other services does ParaDoc connect with?**

**A12) Homerton consultant teams** – they take referrals from geriatricians to see frequently admitted patients, to try to prevent future admissions, by meeting these patients in their homes and discussing future care options with their carers. ParaDoc is therefore a referral option for staff caring for patients and for ambulance crew.

**East London Foundation Trust -** ParaDoc have a pathway to see ELFT inpatients with physical health problems (on mental health wards) rather than them being taken over to the Emergency Department at the Homerton.

**Q13) Apart from care homes, what other organizations does Paradoc visit to explain the role of ParaDoc and how to access this service?**

A13)

* Direct referrals from care homes/supported living/nursing homes.
* Home carers / Homecare agencies
* IIT
* GPs
* Telecare
* District nurses/community teams/OTs/physios/Matrons/social workers etc
* Family carers for very vulnerable/unwell/palliative adults
* Hatzola
* St Joseph’s Hospice
* Out of Hours providers 111/ Hot hubs

**Q14) How many patients are seen on each ParaDoc shift and each month?**

A14) Between 130 and 200 referrals/month

**Q15) What percentage of patients are transported to hospital?**

A15) Approximately 10%

**Q15) What are the predicted savings of preventing each hospital ED transfer?**

A15) As an example of the data and costings generated by ParaDoc, for the period (April/May/June 2019) total system savings were:

£175,942 (April)

£204,307 (May)

£196, 780 (June).

This is based on 97 + 86 + 94 avoided Hospital Attendances or Admissions, and 73 + 66 + 61 ambulance callouts avoided.

Figures are adjusted for age of patients etc and average costings taken from HUH data.

**Q16) What are the factors that result in these savings?**

A16) There is a combination of savings generated by avoiding:

a) ambulance call-out

b) ED attendance

c) Admission.

Data for all of these factors is available. There is also data for admissions further broken into age categories. An independent report compared our guestimates and found them to be conservative.

**Q17) How is the Paramedic role defined in ParaDoc?**

A17) The Paramedic is acting as a Paramedic so that we have the correct skills should we encounter an acute event/emergency (as we are asking people to call us instead of 999). Other than those situations, the GP takes the clinical lead and acts as a GP.

**Q18) How do you prevent multiple attendances to a single patient, e.g. ambulance/car/ParaDoc?**

A18) That should not happen as calls come directly to ParaDoc. It may happen at times if the patient’s severity is not clear or if another source has called 999 or 111.

**APPENDIX**

**DATA on TRANSFERS from LONDON’S 111 SERVICES to the LAS/ED**

The data below illustrates that LAS led 111 services transfer fewer patients to ambulances and ED than other London 111 services, but the experience of the ParaDoc service is that very few referrals are made by 111 to Paradoc.

**Transfers from 111 Ambulance ED**

North Central London LCW 13.8 % 11.4%

Inner North West London LCW 13.7% 13.3%

Outer North West London Care Uk 13.4% 10.7%

Hillingdon Care UK 13.6% 11.0%

South West London Vocare 11.9% 9.5%

North East London LAS 10.0% 8.9%

South East London LAS 8.8% 9.3%

[https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/nhs-111-minimum-data-set-2019-20/](about:blank)

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**REFERENCE DOCUMENTS**

1. Service Development Proposal – July 2014
2. Service Provision Summary – Aug 2014
3. Paradoc Dashboard – Oct 2014
4. Paradoc Data – Nov 2014
5. Paradoc Open University Report – August 2015
6. Paradoc Rideout Report – February 2020
7. NHSE data on the 111 service

[https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/nhs-111-minimum-data-set-2019-20/](about:blank)

**RECOMMENDATIONS**

**DO NOT ATTEMPT RESUSCITATON DNAR**

Written advice on DNARs should be made available for families in leaflet form, in a variety of languages, so that after a visit to the patient’s home, where a DNAR notice was under consideration, that information could be left with the family for their full consideration.

**MEDICAL NOTES**

A copy of the medical note prepared by ParaDoc should be left with the patient/family.

**OUTCOMES OF PARADOC REFERRALS**

It would be useful to see data on outcomes of ParaDoc care and treatment, in relation to what happens to patients in the weeks following a Paradoc visit, so that we can see if longer term the ParaDoc model provides more effective care than referrals to ED – appreciating of course the diversity of clinical presentations.

**PARADOC BRIEFINGS**

We recommend that ParaDoc send out occasional briefings to share the development of their care model and the challenges they face, e.g. the impact of Covid. These briefings could also highlight the impact of ParaDoc on the urgent and emergency care system.

**DEVELOPING PARADOC**

We recommend that research is carried with patient cohorts at the Homerton Hospital ED, to determine whether there are significant numbers of patients who could have benefitted from the ParaDoc model of care rather that attending ED, and if the ParaDoc service should be expanded to meet the needs of these patients.

**111 REFERRALS**

111/IUC Providers in north east London should be asked why they make so few referrals to the ParaDoc service.

Note: A system of Direct Access is about to be implemented to enable bookings into ParaDoc from 111.

**LAS/EOC REFERRALS**

The number of referrals by LAS Emergency Operations Centre (EOC) to ParaDoc have dropped substantially. The CCG should challenge the LAS and the LAS Commissioners on this issue (North West London CCGs) and explore the adequacy of the DOC in the way it relates ParaDoc.

**UPGRADING OF THE EOC SYSTEM**

The LAS/EOC system should be refined to enable appropriate referrals to routinely be made to ParaDoc. The LAS should be challenged regarding the dysfunctionality of their dispatch system in relation to referrals to ParaDoc and the consequent higher levels of ED dispositions in London’s Hospitals.

**EXTENDING THE PARADOC MODEL OF CARE**

The effectiveness of the ParaDoc model suggests that it should be disseminated across London, especially those areas where there is significant ambulance queuing at EDs. We recommend that the Healthy London Partnership and the Accountable Officers for each of London’s CCG clusters should be advised of the success of the Paradoc model as a means of reducing ambulance queuing.

**PARADOC RESILIENCE**

The CCG should demonstrate how it is supporting ParaDoc, e.g. with administrative support, maintenance of the ParaDoc vehicle and structurally in the way that ParaDoc works within the local urgent and emergency care system and demonstrates accountability.

**ABBREVIATIONS & DEFINITIONS**

**111 IUC** – Integrated urgent care.

**111/ Hot hubs** - A service where patients are directed for face-to-face assessment – which will include GPs – after being triaged remotely by NHS 111 or their GP.

**DNAR** – Do Not Attempt Resuscitation.

**Hatzola** - **A** non-profit, volunteer organisation established in 1979 to provide pre-hospital emergency medical response and transportation to hospital.

**IAT**- Information and Access Team

**IIT** - Integrated Independence Team

**OOH Adastra system** – Out of Hours system for patient information management designed to support urgent and unscheduled care.

**Telecare** - Telecare provides remote care of elderly and physically less able people, providing the care and reassurance needed to allow them to remain living in their own homes.

**CCG CONTACTS FOR PARADOC COMMISSIONING**

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1. A breach is defined as ambulance wheel-stop at ED to clinical handover in excess of 15 minutes. [↑](#footnote-ref-1)