AMHP Leads Conference

Ambulance Service Workshop

Workshop leads
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Thanks to all who attended the workshops and contributed to this guidance.

Introduction

There is no doubt that ambulance waiting times are seen as a problem in many local authorities. Wherever AMHPs meet it is likely that they share frustration about this and also often have not been able to find solutions.

It was positive therefore that some colleagues could share real successes and the workshop aimed to have a problem solving approach.

Defining the problem

Although a 'problem' for many AMHPs, it was striking within the workshop at the real variability in approaches and standards between areas. One example of this is in response times with participants quoting what they had been told were national target times. As this was explored Nick was able to clarify that the department of health performance targets for ambulance services are

- Category A emergencies - which are immediately life threatening, or
- Category B or C emergencies - which are not life threatening

Targets times for A are 75% reached with 8 minutes. Category B are 'urgent' calls and the target for these is in the national ambulance service contract is 'a timely response'. Each area may therefore have interpreted this in different ways hence the variation in conversations with AMHP leads about what the targets times are. It is important to note that next year there will be no timescale targets for category B as the emphasis will be on quality and outcomes. This provides an opportunity to join the dialogue on setting these indicators locally.

It seems clear that there is an inbuilt tension between the requirements of AMHP services and the core business of ambulance services. Ambulance services work to clearly established requirements which are based on national and international good practice. The main focus and performance measures within the service are for 999 life saving calls. Services need to manage their resources at all times to try and make sure that category A calls can always be responded to. There is often a feeling that arguing for responses to AMHP work needs to be a lesser priority than life threatening calls however while this is true ambulance services are also there for other needs. Nick informed us that about half of category A calls do not require admission to hospital so we should approach discussions with ambulance services with confidence and

not be concerned that we might be asking for resources to be diverted from life saving work.

While the main focus was on response times other issues were highlighted and there were areas of practice around the Mental Capacity Act which had caused difficulties in a few areas.

Overall it was a problem finding out who to talk to in ambulance services and we discovered that in some regions several conversations were going on between different local authorities with different people from the same ambulance trust. There were examples of successful working with local stations and also with senior managers.

Positive Working – South West
A colleague from the south west described work they had done which had "transformed services". They have agreed response times with their service of 70% within one hour and 80% within two hours.

The key to this was to work with the commissioners as well as the ambulance service itself. They were looking at the whole of the ambulance contract and were building in a number of performance measures and it was possible to work with them to agree the above.

Working with commissioners
Code of practice provides a useful lever and is a starting point for protocols.

Evidence is an important aspect of conversations with commissioners.

One area had investigated situations where AMHPs reported problems. Going back and finding some details enabled them to present stories and themes including risks.

Combining quantitative and qualitative information is important.

We should also attempt to put a cost on the problem as this helps to quantify the impact of any proposed changes. This is easy to do in terms of time of professional involved. It could include the higher level of involvement required when things do not go well. Examples of this might be ward staff time if the person arrives agitated or goes into seclusion, police time.

It can be hard to put financial figures on things such as stress caused, or upset to family but these are important to capture.

East Sussex had provided information on ambulance responses to Mental Health Act assessments to their multi-agency Adult safeguarding Board. The Board had taken an interest and this helped to raise the profile of the issues.

Several areas report problems as serious untoward incidents through existing reporting mechanisms.

Grading/prioritisation
Even within categories the call operators will need to make judgements on the urgency and how to allocate resources. A few areas had worked with their services to introduce risk assessments for AMHP calls. They had recognised that the standard set of questions which call handlers used for prioritisation did not easily fit with the nature of Mental Health Act situations. Once agreed the AMHP could provide the information which allowed call operators to make the right judgements. A key emphasis was the safety of all parties and if it was indicated that there were risks present then a rapid response was arranged. As this had been jointly produced both sides had confidence in it.

This approach also avoids AMHPs being placed in situations where they are tempted to play the system.

Pilot of non-paramedic transport
One London Borough had been trying out a dedicated resource. Having looked at the level of calls for MHA work and considering the effect on AMHPs and the police, the pilot looked at providing a pre-bookable minibus with two staff. They were trained in first aid and mental health but were not paramedics.

There is a triage assessment before this resource is allocated to make sure it is appropriate. In the vast majority of Mental Health Act situations it appears to be appropriate. One key indicator for paramedic involvement is where restraint may be used. In these situations paramedics have the knowledge and skills to make sure people are not at risk of postural asphyxiation.

The results of the pilot are being analysed but feedback so far was positive and it seems to have improved response times.

Although not raised in the workshop there is a service in East Anglia which is using private ambulance services for conveying. This is an extension of existing arrangements with the mental health trust and the ambulance service which have used private ambulances before. Again this is felt to work well.

Mental Capacity Act
While the main areas of concern surrounded waiting times there were other localised issues. Colleagues reported one ambulance service which had adopted an approach to people without capacity which seemed at odds with the Act and Code. Crews were not willing to intervene or take people who lacked capacity unless they showed consent. Attempts to resolve this had not achieved much but had found that the ambulance service was basing this on their own legal advice. This had proved a barrier to any discussions. Suggested ways to approach this were to use more senior management within the Local Authority to open fresh discussions and seek resolution. To get liaison between the local authority legal advisors and the ambulance service. To adopt a combined approach from all of the local authorities involved with the ambulance service concerned.

On a practitioner level people reported occasional problems around the capacity act and a practical suggestion was to carry cards and summaries around the usual areas of debate. These can then be shown and used for discussion with crews and will offer reassurance that the law/code backs up the suggested course of action. Some legal firms for example do credit card sized guides to the Act.

It is also important to reflect that sometime we can get it wrong or be a barrier. Nick shared an example of a problem in London recently where an AMHP and then their manager raised concerns that an ambulance crew were not willing to transport a person without capacity to hospital informally. An ambulance manager was sent to the call and found that the crew believed the person had a urine infection. They arranged for the GP to come and confirm this and prescribe an anti-biotic, the prescription was collected and treatment at home was given. The crew clearly had understood that they could act in the best interests of the person without capacity but were applying the least restrictive option.

Along with other discussions this raised a key learning point which was the importance of soft skills such as relationship building and communication skills to establish working relationships with crews. By asking for the crew's ideas, checking understanding of the best course of action often you can avoid discussions becoming stuck and confrontational.

Some areas had also done joint training on the Mental Capacity Act and in one case local AMHPs met with staff from the local ambulance service promoting better understanding and working relationships.

Section 135
This has been a significant issue within London with the police insisting on a specific approach if they are to be involved.

A quick question to those present suggested that this was not an issue elsewhere.

Key Learning Points
Local Authorities need to co-ordinate their work with ambulance trusts in order to support consistency of approach.

There may be value in developing national guidelines to try and address variability.

AMHP services need to make relationships with and seek to influence commissioners as well as ambulance trusts.

AMHPs need to use soft skills and be able to find out why ambulance staff may be unwilling to follow a course of action or to work in the way suggested by the AMHP.

Arrangements where non-paramedic transport is used might provide a good solution for the majority of Mental Health Act work which can have benefits for all partners.

Possible Future Work

The AMHP Leads network could usefully gather a national picture and work with commissioners and ambulance colleagues to produce guidance which would address the inconsistencies.

Part of this could be a more systematic survey of the main issues and a gathering of best practice examples.

What seems to be a London specific issue around section 135 might also be looked at usefully from a national perspective.