



[Redacted]

Technician Response Unit

[Redacted]

SECTION 1: PURPOSE

The purpose of this paper is to report on the latest test of change for the Technician Response Unit.

SECTION 2: RECOMMENDATIONS

Consideration should be given to an expansion of testing to determine if this operating model can be replicated in other areas. Continued testing [Redacted] should focus on operating hours to maximise resource effectiveness and development of the dispatch criteria.

SECTION 3: BACKGROUND

The Technician Response Unit (TRU) is a test of change aimed at providing timely face-to-face assessment of patients who might otherwise face extended wait times during periods of increased demand. The expected benefit for patients is an early recognition of serious illness to get them the right care, in the right place, at the right time. The Technician on the TRU is supported by remote senior clinicians who aide with clinical decision making. With this support, patients can be referred to alternative care pathways, conveyed to hospital using a suitable resource or discharged on scene.

The TRU is also an opportunity to offer a much needed and desirable opportunity for professional development to our Technician staff at a time when their career path is limited. Many of our Technicians have well developed assessment skills and are competent to operate as single responders to incidents. By directing these staff to appropriate incidents, we can realise an opportunity to more effectively utilise Paramedic and Advanced Practitioner resources for other patients where these skills may be of more benefit.

[Redacted]	[Redacted]	[Redacted]
[Redacted]	[Redacted]	[Redacted]

The current dispatch criteria for the TRU are –

- Yellow calls where an ambulance is not immediately dispatched or available.
- Incidents where a remote clinician assesses that a face-to-face assessment will be required, and a Technician or single crew would be of benefit for observation. This will need to be fed back to the clinician within the hub.
- Timed Admission calls where an ACA crew is already on scene and require more clinical support.
- ILT calls where the resource is the closest to the incident.
- Cardiac arrest calls as the third person, and where another more appropriate resource is not available. - THIS MUST NOT BE IN PLACE OF A PARAMEDIC OR 3RU.

██████████ an area with well-developed Professional-to-Professional links that are trusted by the clinicians at both ends of the discussion. SAS staff ██████████ are used to having these conversations and so the requirement, as described in the SAS Clinical Decision Making Framework, for Technicians to have such a conversation in the context of non-conveyance is more readily achieved.

This operating model is a considerable change from how we utilise our Technician workforce and dispatch single responders, and so staff side representatives from all 3 unions were consulted prior to any testing. Unanimous agreement was reached to proceed with testing. A clear request was made by staff side representatives that the Technicians delivering the test should be volunteers, and a recruitment process followed to select Technicians for the test. A person specification was developed as follows –

- Qualified Technicians with 2 years post-qualification experience.
- Able to evidence continuous professional development.
- Competent in Professional-to-Professional discussion.
- Able to demonstrate use of alternative care pathways.
- Demonstrate knowledge and application of the SAS Clinical Decision Making Framework.
- Comfortable in working as a single responder.

A short selection process then followed including a competency-based interview. Successful applicants were also required to undertake Group B/PRU driver training. A total of 4 Technicians are now considered to be TRU Operators and will be used for the testing.

SECTION 4: DISCUSSION

The Technician Response Unit has been tested ██████████ and has completed 2 PDSA cycles.

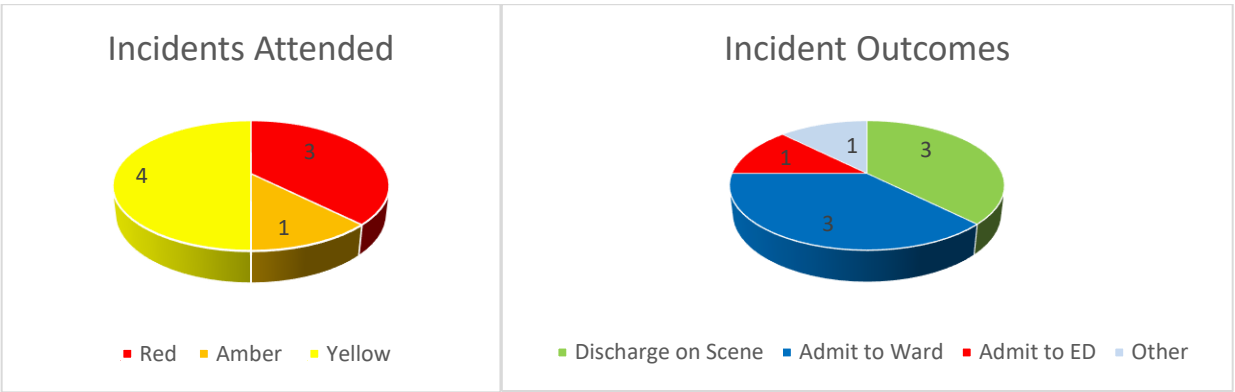
Test 1 consisted of 1 Ambulance Technician operating as a single responder covering a ██████████ shift on ██████████. The days were chosen

██████████	██████	████████████████████
██████████	██████████	██████████

around staff and vehicle availability, wider shift coverage levels and a desire to maintain a consistent approach within the ACC (the same team were on for all 3 days).

8 incidents were allocated to the TRU across the 3-day period. 1 of these incidents was a tasking to drive the [REDACTED] Trauma Team vehicle to an incident. This incident shows the flexibility of this resource in that this meant a double crewed A&E vehicle was not taken out of service to complete this task.

Outcomes for the test were –



Discounting the allocation to drive the [REDACTED] Trauma Team, this leaves 7 incidents of which 4 were conveyed to hospital, resulting in a 43% non-conveyance rate. This is broadly in line with the usual non-conveyance rate [REDACTED]. Of more significance though is that of the 4 conveyed, only 1 attended the Emergency Department resulting in more opportunities to get patients to the right care, in the right place, at the right time.

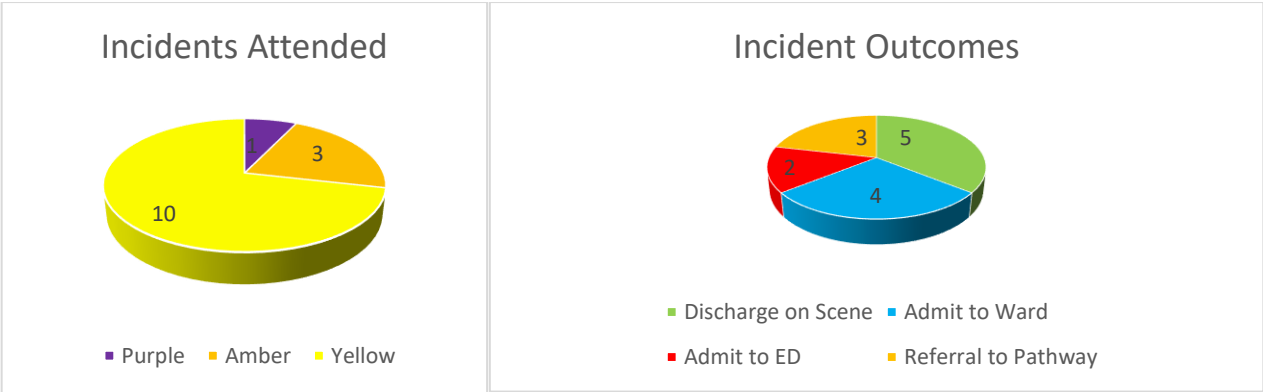
The test was not without its challenges, most notably around timely dispatch to appropriate incidents. A key driver of this work is to reduce the delays some patients experience when demand is high.

Learning from test 1 was taken into test 2 and resulted in a modification to the dispatch criteria, alongside aligning the resource to the Integrated Clinical Hub (ICH). The concept behind this modification was that the ICH perhaps have a better understanding and knowledge of the patients the TRU is intended to respond to. The ICH has an awareness of the remote consultation work ongoing and has an oversight of patients likely to experience a protracted response time.

The test was also increased in duration to 6 days covering the same [REDACTED] period, from [REDACTED]. To facilitate this increased duration this test was conducted with 2 staff members.

Outcomes for this test were –

[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]



14 incidents were attended with 6 of these patients requiring conveyance. This equates to a 57% non-conveyance rate, considerably better than the average rate for [REDACTED] of almost 45%.

In comparison, [REDACTED] an Advanced Practitioner Response Unit (APRU) that was available during the TRU test. Over the same time period, it attended 12 incidents, admitting 5 to hospital resulting in a 58% non-conveyance rate. In addition, it was also tasked to a further 5 incidents but stood down prior to arrival. The TRU was not stood down from any incidents.

A concern reported by the Advanced Practitioner workforce in [REDACTED] was that the TRU would be in direct competition with APRU resources for incidents to attend. During these early tests this does not seem to have been the case. As an example, while the TRU was attending a number of Yellow coded incidents the APRU was free to attend cardiac arrest incidents as a 3RU response or as Paramedic assistance to double Technician crews. These resources should therefore be considered as complimentary rather than as competition.

The use of alternative pathways featured more prominently in this test with 3 patients being referred into other services (OOH GP, Falls and Community Respiratory Team). There was also a wider variety of decision support mechanisms used across this test with the Technicians accessing the FNC, In and Out of Hours GP, Specialist Clinicians and SAS Advanced Practitioners. This range of pathways and access to decision support is fundamental to the success of a TRU model as without them our Technicians would have very few options available to them.

Of significance is the first incident the TRU attended in this PDSA cycle. The TRU had been tasked to attend a Yellow call [REDACTED]. This type of call would usually be categorised as Amber and would receive a conveying response, however the patient did not meet the criteria to receive this type of response. Instead, the TRU was tasked to make a face-to-face assessment and report their findings back. On arrival at the patient it was clear that the patient was experiencing the signs and symptoms [REDACTED]. The TRU was able to request immediate back-up and refer the patient [REDACTED] pathway. A key driver for the TRU is to improve patient safety for patients who triage into lower acuity categories by providing early assessment. This example is an excellent demonstration of this in action by getting a patient into an emergency pathway who might otherwise have faced a delay.

[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]

These first PDSA cycles have successfully demonstrated that the Technician Response Unit can be effectively deployed to the target group of patients and achieve appropriate outcomes.

It is clear from early testing that the TRU had very low utilisation during the period [REDACTED]. Future testing will move the TRU coverage [REDACTED] with a view to being available as the wider demand increases. The second test in particular faced challenges from lower demand [REDACTED] across a number of days of testing. The TRU operator on the first and second days reported almost always being available alongside double crewed ambulances [REDACTED]. Another challenge faced was single crewing of other resources and a dilemma around the doubling up of the TRU and the single crew. For this test it was decided to avoid this, but future occurrences may warrant the stand down of the TRU to achieve double crews.

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

There is also an ambition to roll-out testing to other areas to see if the model is transferable. Existing Professional-to-Professional links [REDACTED] make the TRU a viable concept, but this may not be repeatable in other areas.

SECTION 5: CONSULTATION

This test has been developed in co-ordination with the following stakeholders.

- Medical Director
- Associate Medical Director Urgent & Primary Care
- Lead Consultant Paramedic
- Clinical Governance Manager
- Head of Service [REDACTED]
- Area Service Managers [REDACTED]
- Unite Staff Side Representative
- GMB Staff Side Representative
- Unite Staff Side Representative
- Clinical Hub Manager
- National Clinical Quality Lead
- [REDACTED] ACC Dispatch Manager

[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]