CFOA
Chief Fire Officers Association

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Consensus Statement on Saving Lives and Improving Health and Wellbeing between the Association of Ambulance Chief Executives (AACE) and the Chief Fire Officers Association (CFOA) 17th March 2016

1. This consensus statement describes our intent to work together nationally to encourage local joint strategies for evidence-led partnership working to improve patient outcomes from out of hospital cardiac arrests; other responses related to medical conditions and longer term health and wellbeing.

Headline consensus statement

2 Our organisations exist to respond to the populations' needs in times of crisis and to support the protection and improvement of their health and wellbeing.

3. We will work together locally and nationally to use our collective capabilities and resources to enhance the lives of the people in our communities and increase efficiency through:

- Robust governance of standards and competencies
- Effective Co-responder schemes
- Co-location and shared infrastructure
- Innovative programmes to improve health and wellbeing
- Looking for opportunities to improve efficiency and effectiveness and reduce waste

Introduction

4. Ambulance Services and Fire and Rescue Services share a long history of effective collaborative working and, more recently, we have identified greater synergies to improve our ability to collectively respond to major incidents, including terrorist incidents and large scale flooding. This improved interoperability is reflected through the work of the Joint Emergency Services Interoperability Programme (JESIP) and tested through more challenging multi-agency exercises, such as Amber Exercises, co-ordinated by the National Ambulance Resilience Unit (NARU).

5. Demand for the Ambulance Service to respond to 999 calls continues to rise steadily year on year; ambulance trusts in England received over 9 million 999 calls in 2014-15 (up by over 6% on the previous year) resulting in 6.47 million incidents. A recent academic review commissioned by AACE identified an ageing population, an increase in the number of people living with long-term conditions and co-morbidities, social deprivation and population density among the key factors driving demand.

6. At the same time the number of fires has decreased significantly, largely due to the success of preventative work by Fire and Rescue Services. In 2014-15 Fire Services in England responded to 495,400 incidents; down by 6% compared to the previous year and a reduction of 42% compared to 10 years ago. This has created new opportunities for the Fire and Rescue Service to support the health and social care sector in general and the Ambulance Service in particular. The NHS Five Year Forward View highlights the need for an increased focus on integration and prevention so that resources are utilised more effectively, outcomes are improved and demand is reduced. This consensus statement builds on that premise.

Shared purpose

7. There are common underlying risk factors which increase demands on both Ambulance and Fire and Rescue Services, such as long-term conditions, cognitive impairment, smoking, drugs or substance misuse, physical inactivity, poor diet, obesity, loneliness and/or social isolation, cold homes and frailty. By identifying people with these risk factors and taking a whole system approach to interventions which are centred on peoples' needs, we intend to make every contact count, irrespective of which service it is from.

8. Co-responder schemes to improve outcomes from out of hospital cardiac arrests have been introduced in various forms across the country. Other initiatives involving responding to those with minor conditions e.g. falls in the home, have also been introduced. Our two associations will work together at a national level to identify best practice within the UK and internationally in order to enhance the current provision.

Supporting local action and flexibility

9. We will encourage and support local organisations to work together more effectively in partnership and to improve collaboration between our two Services where possible, while supporting meaningful local flexibility in the way this happens. We will do this by;

- Producing this consensus statement setting out our ambition to work together and encouraging local action to provide more effective responses; developing strategies to reduce demand and improving quality of life out-comes.
- Identifying and exploiting opportunities to work together and improve synergies such as; more effective use of information across organisations, promoting use of existing guidance and best practice; and shared communication.
- Where appropriate to local conditions, and where such arrangements do not denude essential fire cover, seeking to maximise the effectiveness of co-responding schemes.
- Supporting the development of new initiatives and guidance that improve community and individual outcomes.
- Looking at the opportunity for more effective data use across the Ambulance and Fire and Rescue Service.
- Linking our collaborative work to that of others aimed at reducing demand and improving the health and well-being of our communities.
- Looking for opportunities to release financial savings such as co-location of estates, shared control room facilities and control room functionality and joint procurement.

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AACE/CFOA JOINT STATEMENT
CO-RESPONDING SCHEMES

INTRODUCTION

1. AACE support the further development of Co-Responding Schemes (CRS) where appropriate to local conditions, and where such arrangements do not denude essential fire cover and deliver real benefits for patients.

2. AACE will seek to maximise the effectiveness of co-responding schemes and will work with CFOA and other organisations to explore the benefits that these arrangements can deliver for patients. This document builds on the commitment already given by AACE alongside the Chief Fire Officers Association (CFOA) and Association of Chief Police Officers (ACPO) in our joint position statement on blue light collaboration in response to the Knight Review:

   "We are jointly committed to exploring ways in which FRS and Police might contribute further in terms of co-responding with the Ambulance Service and will work with our members to encourage this where it is cost effective and adds value to patients".

3. AACE welcomes the support of partner agencies in contributing to improving patient outcomes through CRS which offer clear benefits to patients in line with those seen through similarly trained and equipped Community First Responder (CFR) schemes.

4. It is important to ensure that appropriate clinical governance arrangements are in place to maximise the benefits and to ensure patient safety. This document offers further guidance to assist ambulance trusts in ensuring that appropriate clinical governance arrangements are in place.

BACKGROUND

5. For over 15 years' ambulance trusts have worked with local volunteers to develop Community First Responder (CFR) schemes. CFR volunteers are trained to provide emergency care, including defibrillation, to seriously ill patients whilst an ambulance is en route to the scene. The chance of survival for a patient in cardiac arrest if defibrillated immediately is 85% with the odds decreasing by 10% for every minute that passes with no treatment. Early defibrillation is therefore a potentially life-saving intervention which CFRs can perform whilst the ambulance is en route.

6. A number of clinical papers stand as testament to the efficacy of both Public Access Defibrillation (PAD) CRS and CFR schemes.
   Other organisations which have endorsed these strategies include;

- British Heart Foundation
- St John Ambulance
- British Red Cross
- Royal Lifesaving Society
- Resuscitation Council UK

7. Ambulance trusts developed a shared clinical governance template for CFR schemes in 2008. This template offers guidance to ambulance trusts which has further strengthened clinical governance arrangements. The guidance has been regularly reviewed through AACE and has recently been re-issued to trusts.

CO-RESPONDING SCHEMES

8. Ambulance trusts have worked in partnership with other organisations to extend the benefits that have been demonstrated through CFR schemes. Most ambulance trusts in England have arrangements in place with their local Fire & Rescue Services (FRS) and a number of trusts are also supported by police and other uniformed/emergency service organisations such as the RNLI. All three devolved administrations also have schemes in place. These arrangements are usually modelled on CFR schemes and have grown organically at a local level under governance arrangements agreed between individual trusts and partner organisations.

9. Training for personnel involved in CRS covers the competencies for CFRs and FRS staff typically receive other casualty care training linked to their core role. The combination of a basic level of first responder training combined with the use of modern, simple to use, Automatic External Defibrillators (AEDs) puts co-responders in a position where they have the potential to save the lives of people experiencing cardiac arrest through early defibrillation. Co-Responding is defined by AACE as follows:

- *A member of a professional body (e.g. police, fire, military, coastguard, mountain rescue) who responds to 999 calls on behalf of the ambulance service to a level specified by that Trust."*

10. The term "Co-Responding" was chosen in order to clearly signal that, as with CFR schemes, any response provided to high acuity patients by partner agencies is intended to supplement the ambulance response and in no way replaces the need for the attendance of a fully trained ambulance clinician.

11. With particular reference to FRS it is recognised that the dispersal of FRS resources and their lower utilisation (relative to ambulance trusts) due to their successful fire prevention strategies puts them in a position where they may have capacity to engage in CRS as part of their prevention, community safety and health strategies.

12. FRS have engaged positively in co-responding. CFOA have a designated national lead Chief Fire Officer for CRS and have developed a statement of intent which supports and aligns with the AACE position:

CFOA statement of intent:

- *Contribute to improved patient outcomes in out-of-hospital medical emergencies.*
- *Facilitate and encourage joint working with the Ambulance Service, and voluntary sector, with the aim of developing a national network for co-responding and emergency medical care.*
- *Provide advice, guidance and recommendations to the FRS on Co-Responder Schemes signposting exemplar practice and case studies.*

CLINICAL GOVERNANCE

13. As statutory NHS providers, ownership of and clinical governance arrangements for CRS should remain with ambulance trusts. AACE have developed a national framework for CRS clinical governance arrangements (attached) which is similar in structure to the existing framework for CFR schemes. This provides guidance to ambulance trusts in the development of their own local arrangements with CRS providers. The framework also makes recommendations relating to minimum training levels for CRS personnel.

14. It is important to ensure that terminology does not inadvertently, and quite innocently, misrepresent the level of response that CRS offer nor the level of training of the staff involved in schemes. For example, “medical” relates to the science or practice of medicine and “medic” relates to a medical practitioner – in essence Doctors who are registered practitioners with the General Medical Council (GMC).

PAYMENT

15. Various arrangements exist nationally. Any arrangements for cost recovery for both or either organisation should be specified within local partnership agreements.

NEXT STEPS

16. Co-responding describes the role that partner agencies can play in helping to save lives through early defibrillation of patients experiencing cardiac arrest. Over recent months there has been local collaboration between ambulance trusts and FRS to look at other schemes which could deliver further patient benefits whilst also making efficient use of resources. For example: The Community Risk Intervention Team (CRIT) in Manchester – a scheme to reduce instances of falls injuries which in turn reduces demand on the resources of North West Ambulance Service with a consequent reduction in A&E conveyances. This successful pilot has now been broadened into a wider strategy of FRS led “Safe & Well Assessments” in the home.

17. AACE is keen to work closely with CFOA to monitor and evaluate new concepts and to jointly disseminate any examples of good practice that are identified.

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CLINICAL GOVERNANCE CONSIDERATIONS FOR FIRE AND RESCUE SERVICES WORKING WITH STATUTORY AMBULANCE SERVICES

1. Clinical intervention by the statutory Fire and Rescue Services (FRS) is becoming more frequent and varied, and it is critical that the clinical governance arrangements keep pace with developments in practice. Suitably trained FRS personnel act in Community First Responder (CFR) roles, deliver immediate casualty care at trauma incidents, provide falls pick up services, and perform 'safe and well' checks on vulnerable and frail members of the community.

2. To distinguish emergency services schemes from lay public schemes the CFR role performed by FRS or Police has been termed Emergency First Responders (EFR) by the Association of Ambulance Chief Executives (AACE).

3. In instances where FRS are tasked by a statutory ambulance service to attend a patient then the clinical governance responsibility ultimately rests with the tasking ambulance service. These scenarios are likely to be CFR-type responses to patients in, or near, cardiac arrest, or to attend as a 'pick-up' service for patients on the floor who have been triaged as low acuity by ambulance service clinicians.

4. When both FRS and ambulance service attend an incident, where the clinical governance responsibility for all patients at the scene ultimately rests with the ambulance service, it is sensible that the statutory ambulance service adopt the clinical governance responsibility for all clinical intervention at the scene. These are likely to be scenarios in which FRS deliver 'casualty care'. Some FRS have adopted the Immediate Emergency Care (IEC) course (developed by London Ambulance Service, London Fire Brigade, Yorkshire Ambulance Service and the FRS of Yorkshire and the Humber) to demonstrate appropriate learning and competence in immediate care. Further development of standards of casualty care is required and should be led by the ambulance services.

5. In collaboration with the Chief Fire Officers Association (CFOA) AACE is recommending that, where FRS are tasked by a statutory ambulance service or work alongside an ambulance response, the clinical governance responsibility for the clinical interventions delivered by FRS rests with the ambulance service. Ambulance service Medical Directors must satisfy themselves that the clinical care delivered by FRS is adequately quality assured; and AACE is working with CFOA to develop a national framework to satisfy these requirements, including exploring the potential requirement for each FRS to be registered with the Care Quality Commission (CQC).

6. Some FRS have arrangements in place to provide fallers' 'pick-up' services and/or 'safe and well' checks directly with community health care providers. Ambulance services are not in a position to provide clinical governance assurance for the provision of these services by FRS, in which case FRS must make their own clinical governance arrangements for these services. It is incumbent on FRS to avoid tensions associated with having more than one clinical governance provider, and consideration should be given to working with the local statutory ambulance service to provide all FRS-delivered clinical services through the ambulance service.

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31/12/15

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