PhAST.

Pre-Hospital Ambulance Support Team

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Summary: *The Pre-Hospital Ambulance Support Team (PhAST) is an 11 week pilot, hosted by members of the Borough Based Partnership including; hospital secondary care services at West Middlesex Hospital, Primary Care, Community Services and the London Ambulance Service. Together, through shared decision making, the aim to ensure patients residing in Nursing Homes and Care Homes in the borough of Hounslow receive the best possible care in the most appropriate place. The aim is to reduce unnecessary hospital admissions that potentially increase morbidity and mortality in this cohort of patients.*

Introduction:

According to the Office of National Statistics (ONS) modelling the proportion of the UK population over 65 is expected to be 26% by 2041, estimated at 20.4million people(1). Patients in the over 65 age range are currently the highest users of emergency services nationally. There is a well-accepted correlation between older age and increased risk of frailty. Currently, frailty inpatient activity costs the NHS £5.8bn annually (2) with patients over 75 and frailty occupying c20% of all bed days across England. Morbidity associated with admission must also be considered; it is estimated approximately one in three frailty patients will have a functional decline during admission (3).

Supported by the Long Term Plan and Urgent and Emergency Care Recovery Plan, there has been significant work nationally and locally to try and create sustainable frailty front door services. However, in isolation this is unlikely to provide a solution to the increasing frailty burden on NHS Trusts. Local data collection demonstrated over a thousand Care & Nursing Home ED attendances over a 12 month period of which 46% did not require overnight admission for hospital intervention. This was supported by NHSE and LAS regional data available.

Initial verbal feedback from our local care homes is consistent in that it is often not a medical issue which has led to the patients' presentation and admission to our hospital site. Furthermore, feedback suggested local SOP's at Nursing Homes advise LAS prior to exploring community based options.

This suggested there was an opportunity to intervene prior to the front door which has the potential, for a specific group of frailty patients; to decrease unnecessary hospital admissions, decrease associated morbidity and direct care to community services more appropriate to their need.

Our project was aligned with the recent Darzi report (4) which repeatedly emphasises the need to shift towards proactive community care to support hospital services.

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Methods:

Step 1. Initially, a Project Proposal and Business Case were developed in order to secure Trust Executive Board approval and sufficient funding for the 11-week pilot to test proof of concept around working collaboratively with system partners to improve patient care.

Step 2. Identification and engagement with key stakeholders was a vital step to the success of the project and included; London Ambulance Service (LAS), Hounslow Primary Care Network, Hounslow Care & Nursing Homes, West London NHS Trust Community Services (CS) and Hospital Services. A series of engagement sessions were organised with individual stakeholders, and then with all system partners to develop a shared understanding of drivers, capacity, interactions and future plans.

Step 3. Over a series of stakeholder meetings, together we outlined;

- Service mapping in the borough including current availability and capacity in community and secondary care as well as identifying gaps for future planning *(Diagram 1: Hounslow Service Mapping)*
- A new pathway co-created *(Diagram 2: PhAST Process Map)*. Following LAS attendance at a CH/NH, a process of shared decision-making between a medical consultant, LAS and CS allowed re-direction of care to the most appropriate place. By involving all stakeholders we were able to ensure the process was realistic in terms of finance, capacity, risk and governance.

Step 4. A project plan road map was co-developed and SOP created and signed off by all key stakeholders.

Step 5. Throughout the above, alongside the various communications teams attached to partners, we created the 'PhAST' project name. We felt it encompassed the true team nature of the project and understanding that everyone involved was crucial to success. Further communications materials were developed to ensure the pilot would be well socialised throughout partner organisations to healthcare professionals who would use and interact with the service day-to-day prior to pilot start date *(Poster 1: PhAST)*.

Step 6. Throughout the pilot, weekly touch-points between partners allowed continuous real-time review of data, adaptations and improvements. Following completion a full evaluation was also undertaken.

Poster 1: PhAST

Graph 1: Community Referrals

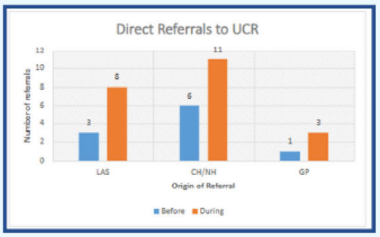

Diagram 1: Hounslow Service Mapping

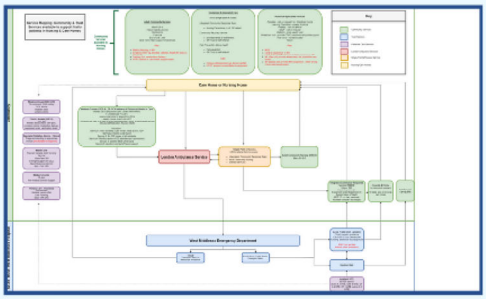

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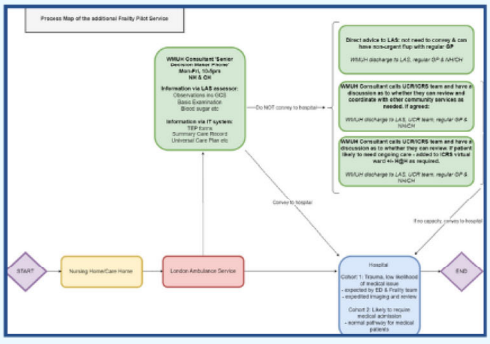
Diagram 2: PhAST Process Map



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Results & Discussion:

Evaluation included review of quantitative and qualitative data. A total of 11 calls were received during the pilot period. 73% of calls received were able to safely avoid conveyance of the patient to hospital and care provided at the CH/NH itself.

There was a significant cost-saving through reduced bed occupancy, which made the pilot effectively cost-saving. At an assumption of c£800 per day and average length of stay of 7 days, from original local data collection, the 8 admissions avoided saved c£45,000.

A review of LAS data for the boroughs CH/NH demonstrated increased number of calls to LAS annually. However, during the months the pilot ran there was a reduced conveyance rate to hospital; eg, in Feb 2025 61% of patients were conveyed compared to 66% in Feb 2024.

Low call volume was an issue identified during weekly touch-points and hence decision made to review the data collected so far. A mid-pilot deep dive into LAS real-time data identified 9 missed opportunities. Each case was reviewed by partners and identified 4 as definite and 2 as potential missed opportunities. This, at a rate of 66%, was consistent with actual calls received which were able to be re-directed to more appropriate community care. Therefore, it was hypothesised that if every call had gone through to the PhAST service in February (n=46) at a rate of 70% there was a potential even larger cost-saving of c£180,000. At this time, the joint decision was made between partners not to expand the remit of the pilot to increase call volume as the aim was for proof of concept over volume and the potential increase in risk of expanding the cohort outside of nursing and care homes.

Review of Community Services data demonstrated an unintended positive outcomes of the pilot with an increase in direct referrals to community pathways (120% increase) hence improving resource utilisation within the system. As a system better use of community capacity available was thought to be directly attributable to all engagement work done for the pilot. *(Graph 1: Community Referrals)*.

Qualitative feedback from partners was exclusively positive and themes focussed around benefit to patients, safety in shared decisions and improved resource utilisation (see below). Further, it was thought that the trust and relationships developed allowed true collaborative working and would benefit future projects. These relationships will be key as local, ICS and national level strategy are aligned towards system working and shifting care towards the community.

"very positive experience talking with the doctor about the most appropriate care for the patient"

"agreeing to plan that all involved was happy with".

"helping reduce hospital admissions which are extremely difficult for our older patients"

"LAS to continue their work".

Improved patient care was a critical measure of success; with patients able to avoid long emergency department waits and have appropriate care whilst benefiting from the reduced morbidity and mortality of hospital admission. Qualitative feedback from patients and relatives was centred around positive experience of receiving safe care in their own environment as a 'hugely beneficial service based on experience', empowering them and being 'so grateful' for respecting their wishes.

Conclusion:

The PhAST pilot has firstly and foremost achieved its goal in improving the care of the frail cohort of patients residing in Care & Nursing Homes and reducing unnecessary hospital admissions.

There was a clear positive outcome of the project as a proof of concept piece of work demonstrating shared decision-making and close working between community and secondary care services can lead to improvement in patient care and experience, more appropriate use of services in an overburdened NHS and learning to drive further nation-wide Pilot Integrated Care Co-ordination (ICC) hubs in development by NHSE.

The key to success of this project was the time spent cultivating relationships with all partners involved. This resulted in a clear shared goal to provide optimum care for our patient cohort, and developed a level of trust and hence willingness to share decision-making and risk in order to do this. While there will be undeniable benefits of economies of scale of the ICC project, it is essential that time is spent cultivating relationships on a larger scale to ensure success.

Local, regional and national strategy are aligned in that collaborative working within the system if essential to ensure the NHS remains sustainable for future generations and the relationships developed on this pilot will enable us to start this journey with our best foot forward.

With the greatest of thanks to all our wonderful partners

NHS Chelsea and Westminster Hospital NHS Foundation Trust
Hounslow Primary Care Networks
HOUNSLOW health and care
Working together for a healthier community
London Ambulance Service NHS Trust
NHS West London NHS Trust

Scan QR codes to read cases & missed opportunities

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CASE VIGNETTE

References:

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