National Enhanced Service

Provision of immediate care and first response care

Introduction

1. All practices are expected to provide essential and those additional services they are contracted to provide to all their patients. This enhanced service specification outlines the more specialised services to be provided. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

Background

2. The provision of pre-hospital immediate care and first responder roles to victims of trauma and life threatening illness is a service primarily fulfilled through the statutory ambulance services usually by State Registered paramedics.
3. In certain geographical, operational, or clinical circumstances, an ambulance service or a paramedic may request the attendance, assistance and support of an appropriately trained general medical practitioner at the scene of a clinical emergency to provide clinical support and skills beyond those normally practised by general practitioners or paramedics.
4. Currently where general practitioners provide an immediate care/first responder role, their assistance is through a variety of structures, either as an individual commitment, a practice commitment independently or through commitment to an organised immediate care scheme. In some parts of the UK (although GPs currently receive no remuneration for the immediate care/first responder role), PCOs have fully funded the training of GPs for such work and ambulance services have issued relevant equipment and supplies.

Service outline

5. This national enhanced service will fund providers to:
   (i) augment the ambulance service paramedic at the request of the ambulance service in the management of cases (actual or expected) such as:
      (a) extended on-scene time or prolonged transit time to definitive care
      (b) entrapment
      (c) clinical or operational considerations exceeding the paramedic protocol, training, or experience
   (ii) provide a trained response to immediate life-threatening illnesses within the accepted response times
   (iii) provide rapid, skilled medical triage when there are a number of casualties

(iv) provide trained Medical Incident Officers (MIOs) at the scene of major incidents
(v) occasionally support the ambulance service during periods of extreme demand in meeting clinically critical target times
(vi) log on or off call with control according to their other workloads
(vii) maintain contemporaneous clinical records including relevant mission times in accordance with the local format of the ambulance service/immediate care scheme report forms. A copy should be kept for the doctor's own records, audit and revalidation as well as medico-legal purposes. A copy of the record of the patient must travel with the patient at all times, and data shall be entered into the GP patient record. The value of digital photography and physiological parameter recordings is not to be underestimated.

Accreditation

6. Those doctors who have previously provided services similar to the proposed enhanced service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the enhanced service shall be deemed professionally qualified to do so.
7. Practitioners will normally be expected to:
   (i) as a minimum, possess the Pre-Hospital Emergency Care Certificate of the Royal College of Surgeons of Edinburgh (PHEC) or other equivalent pre-hospital emergency medicine qualification
   (ii) undertake a local orientation and familiarisation programme
   (iii) undergo such advanced driving tuition as required by the Ambulance Service
   (iv) undertake such communications systems training as required locally
   (v) undertake such refresher training as dictated by good clinical governance and the need to remain accredited
   (vi) accept and obey the local statutory emergency service command structures
   (vii) if the NES is operated locally through a local immediate care scheme, accept its rules and operational standards
   (viii) maintain appropriate communications with the tasking control room concerning personal availability for call-out
   (ix) be familiar with the scope and limitations of paramedic practice
   (x) be willing to work in a team
   (xi) accept the ambulance service tasking policy.
8. Practices which or individuals who are contracted to provide such services should be able to demonstrate competencies in all the above areas, and in addition should be able to show active participation in service development through CPD, audit, and critical case analysis. The keeping of an individual log of incidents attended and interventions is mandatory. Accreditation may be achieved by meeting the standards set by a mutually agreed third party such as a local immediate care scheme, British Association for Immediate Care

(BASICS), or the Faculty of Pre-Hospital Emergency Care of the Royal College of Surgeons of Edinburgh (FPHECRCSEd). This should occur on an annual basis and be summarised in an annual report. Such professional organisations should be asked to review a doctor's performance if there is any doubt or dispute over an individual's or practice's status.

9. Where an MIO role is planned, then this should be reflected in the training undertaken. This should include attendance at major incident practices normally within the previous twelve months, and the possession of current Major Incident Medical Management and Support certificate or equivalent training.
10. Doctors must agree to undergo regular clinical training especially to maintain skills in infrequently used but life-saving interventions. The need for refresher training is imperative and a condition of the PHEC certificate validity.

Driving

11. Practitioners must ensure that:
    (i) they undergo a period of initial advanced driving training followed by at least annual reappraisal and remedial tuition where necessary
    (ii) their vehicle is roadworthy and appropriately insured at all times
    (iii) all communications equipment is "hands free" in operation
    (iv) when responding to a call they operate their vehicles within the criteria laid down in agreement with the ambulance service including relevant road traffic act legislation.

Training and organisation

12. The following training would be required by each GP participating in the NES:
    (i) initially (as a one off) a three day PHEC (or similar) course and three to five days' response driving tuition
    (ii) annually, a one day driving and other skills course and a one-day clinical refresher
    (iii) annually a one to two days per practice data collection, audit and preparing report
    (iv) every five years, a three day clinical revision course. This amounts to a total of 22 sessions over a five-year cycle.

Costs

13. In 2003/04 GPs contracted to provide this service will receive an annual retainer of £1200 to £1500, the exact level depending upon whether supplies are provided by the PCO or funded by the practice, plus £60 to £90 per in-hours call and £120 to £150 per out-of-hours call. These prices will be uprated by 3.225 per cent in 2004/05 and again in 2005/06.

References

The following references were used in writing this specification.

British Medical Association. *Immediate* Care Schemes. London: Board of Science, 1993

Joint Royal College Ambulance Liaison Committee. *Pre-hospital Guidelines* for 2002

National Audit Office*. A Life in the fast lane: The emergency ambulance services*. 1999

National Audit Office. *Facing the Challenge: NHS Emergency Planning in England*. 2002

NHS Executive. Modernisation of Ambulance Services. HSC 1999; 091

NHS Executive*. NSF for Coronary Heart Disease*. March 2000

NHS Executive. *Reforming Emergency Care- practical steps*. April 2002

NHS Executive*. Planning for Major Incidents: The NHS Guidance*.1988 and September 2002