

GUILDFORD TOWN CENTRE AND
UNIVERSITY

Medical Car

STATS AND REVIEW

MEDIREK SAFETY AND MEDICAL



Purpose

Medirek were asked to provide a mobile medical resource within the footprint of Guildford Town Centre and the University on selected dates that it was perceived that a spike in demand on local services such as South East Coast Ambulance, Royal Surrey Hospital (primarily A&E) and Surrey Police may occur and present an issue in terms of reduced resilience and service availability.

The intention was that through the application of a mobile medical resource with a clinician onboard, this would allow for an effective 'see and treat' facility that can attend patients in the specified area with the aim of triaging or diverting the demand away from SECAMB or the local A&E through either conclusive treatment, or interim treatment and appropriate advice and referral onto non-urgent pathways.

Additionally to this, the resource provides an additional emergency resource within a strictly confined geographical area, allowing rapid attendance at incidents and the ability to provide a rapid update to SECAMB so that they can make an informed decision on whether to upgrade or downgrade their resources that may be assigned to said incident, allowing for an efficient reduction in demand on their service and more appropriate allocation of their resources without the impact of increased 'town centre demand'.



The medical car resource saw a number of patients and members of the public, interacting with those in need of medical assistance, welfare support and safeguarding. Importantly, the resource was used in a varied, joint capacity including responding to incidents alongside Surrey Police and the University of Surrey Campus Safety Team.

Application and Function

Medirek applied this resource in the form of a fully equipped and marked ambulance response car crewed with a clinician of at least the level of an Ambulance Technician (equivalent locally to an Associate Ambulance Practitioner) and supported by an Emergency Care Assistant.

Given the patient and incident exposure, these shifts were also regularly attended by a 'third man' member of staff wanting to gain that additional patient exposure, and this member of staff was provided on the scheme at no additional cost to the ICB.

All staff on this vehicle were fully uniformed, and offered ability to undertake full patient monitoring, including obtaining ECGs and a range of clinical interventions and practice consistent with an equivalent local ambulance resource. The resource could not convey patients to hospital, but this was also not the intention of the scheme.

The resource operated our phone number that was publicised to all the local venues through the PubWatch scheme, as well as having access to the local CCTV control room through the radio network when this was manned. In order to effectively respond across the university footprint, we also obtained a radio from the university campus safety team at the start of each shift.

The majority of our attendances came from requests from the university, who made extensive use of the resource in cases where their alternative would have been to call an ambulance when their attendance wasn't truly necessary. A further large section of patient interactions came from incidents referred by police, or were self generated through the resource consistently 'patrolling' the service area, or stationing at areas of peak demand such as the train station at the point of last train, North Street McDonalds, The High Street and nearby Rubix on the University Campus. We also attended a number of patients that had been flagged by the local Street Angels scheme, where they rightfully had concerns regarding a patient that fell outside of their first aid scope, but equally released them again to be able to attend those needing welfare assistance.

The presentation of a clearly marked ambulance within the town centre was especially useful as it provided a visible point of reference for those needing help, and was easily identifiable by CCTV, The Police and the venues. Previously, a similar sort of service was provided, but at static location. This service was also provided by Medirek but the model subsequently adjusted to this mobile form as many of the attendances our staff made that year were away from the unit and it posed potential staff safety issues, as well as being an inefficient application of skillset as ambulances were still called for the more unwell patients as venues were unaware they could call on the resource. This year, on a mobile model, there were repeated requests coming from the venues.

Data Collection and Analysis

Data collection around the project was achieved through the use of our ePCR system. This system (provided by [Ambunet](#)) covers our staffing, safeguarding and electronic patient contact recording systems and offers us access to quite high fidelity contact data so that we can quite accurately assess the impact of the scheme. There are some limitations in the data, largely based around maintaining patient confidentiality whilst offering detailed analysis. However we are able to clearly demonstrate the impact the scheme had on the footprint area in line with the ICB's aims of maintaining local service resilience over the winter period and reducing the impact of the December spike in demand within the town centre footprint.

Data Limitations

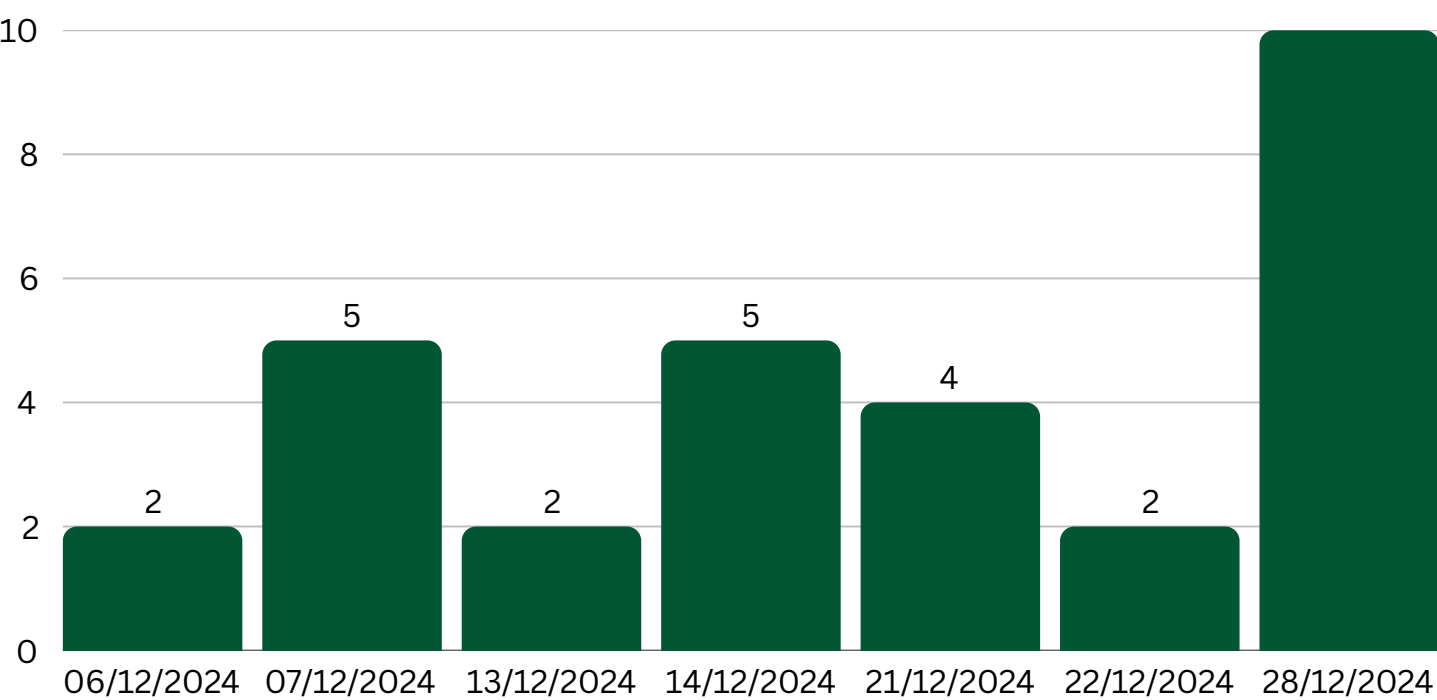
Unfortunately, looking at the scheme from a purely numbers and attendances basis is somewhat flawed owing to the disparity in time that is spent with patients. For instance, we had one case where the team spent in excess of 3 hours with a patient suffering from psychiatric issues, and this extended attendance was required to ensure proper safeguarding in the immediate sense. That said, the patient's presentation did not require A&E admission which would have been the alternative approach had our crew not been available.

Impact

The impact of the scheme was marked, we provided a total of approximately 41 hours (inclusive of overstay due to ongoing incidents) of service across 7 shifts. Initially these were 2200-0400, but these were adjusted for a 2100 start as we rapidly identified demand that we were missing earlier in the shift prior to us coming on duty, particularly on the university campus. In total, we provided approximately 123 staff hours to the scheme, however, only 82 were charged owing to ‘third manning’ staff.

Patient Contacts

We had a grand total of **30** formal patient contacts, broken down by date:



Not included in this data set is a number of points of contact with the public which was more welfare orientated in nature, assisting police or other functions that don’t fall into the category of ‘formal’ patient contact.

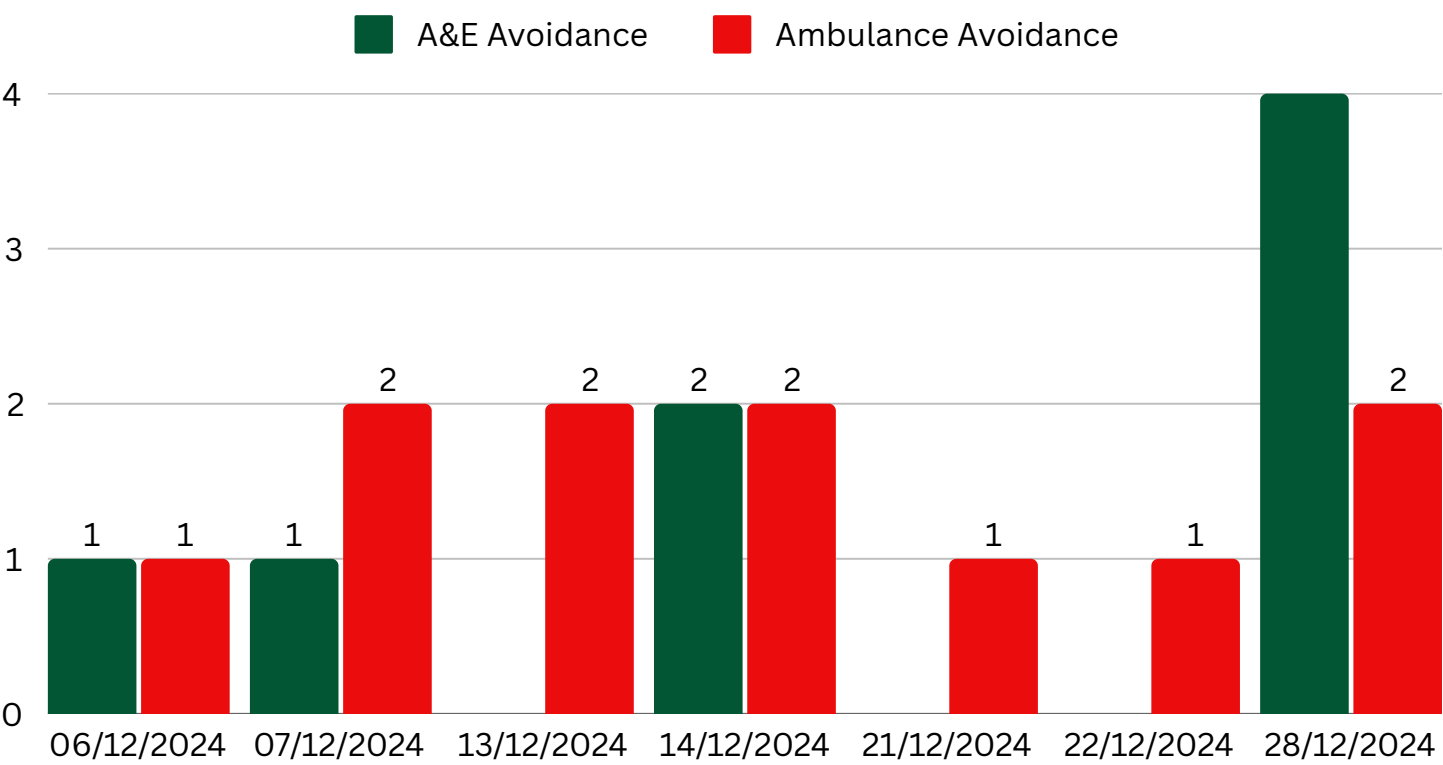
Ambulance/Hospital Avoidance

Amongst our patient contacts, the objective was to avoid hospital admissions and impact on the ambulance services by diverting or meeting the demand where appropriate.

For the purposes of this metric, an A&E avoidance was defined as any incident that without our intervention, likely would have ended up in A&E and instead was either conclusively dealt with, or was referred to a more appropriate care pathway. An Ambulance avoidance is any incident where SECAMB were called and then cancelled owing to our presence, SECAMB

stood down their resource, or we intercepted an incident that would have resulted in a call to ambulance before the call was made.

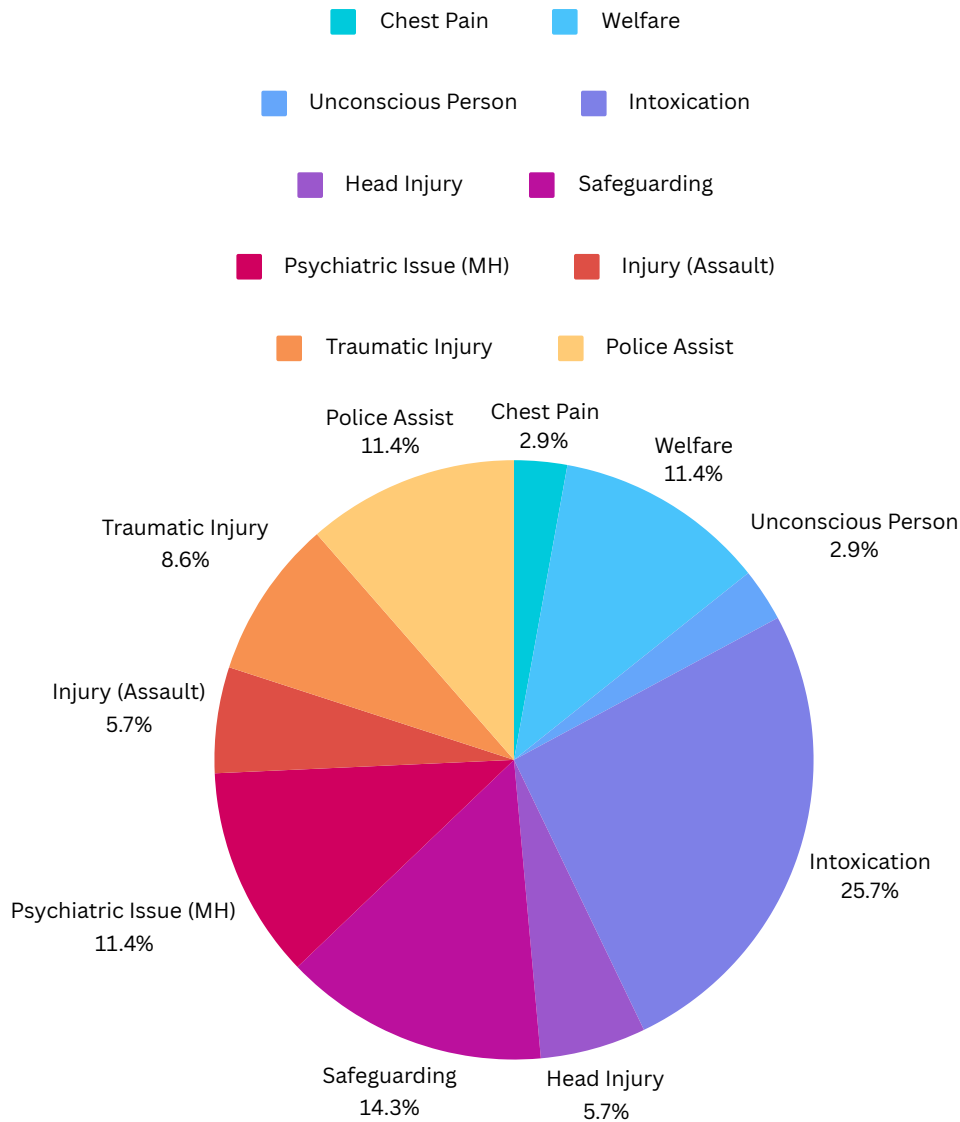
As such, there are a number of patient contacts that do not fall into either category, as the avoidance of demand on the local services cannot be guaranteed, or the incident was fairly minor or more welfare orientated. This decision was made during data analysis so that it keeps the data clarity and accuracy good.



Presenting Complaints and Workload

Our crew had contact with patients for a wide variety of reasons. For a better view on the full range of incidents that our crew was spending time on, we have also included ‘welfare’ and ‘police assist’ contacts. Welfare contacts are those where the crew noticed a person or group in a state of distress or potentially at risk of coming to harm due to intoxication. Police Assist contacts came in a fairly wide selection of incidents, and while the police did ask for the resource to attend various incidents in a medical capacity, there was also incidents that were attended/assisted with on behalf of the police that were non-medical in nature.

This presenting complaint metric is sensitive to incidents that then developed into another incident, for instance, a welfare concern that turned into a safeguarding or mental health issue, and so the total numbers here will not balance against the total formal patient contacts as some contacts will be recorded twice or even three times for the purposes of this metric.

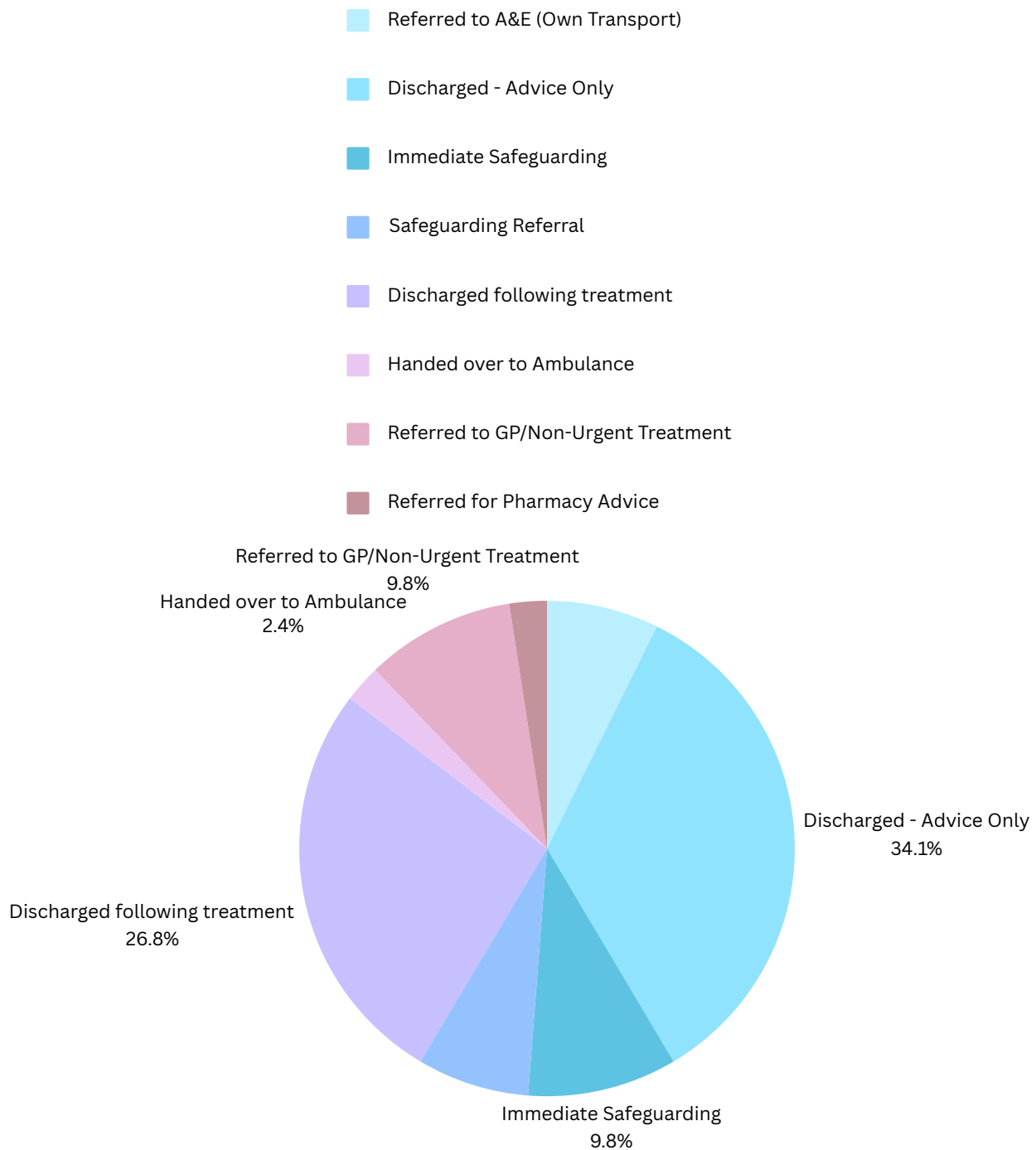


Patient Disposal

Our crew ‘disposed’ of patients through various means, including in some cases handover to trust ambulance crew or advising a patient make their way to hospital. While the aim of the scheme was to reduce demand on the local services, our crew ensured that they selected the most appropriate route of disposal in the best interests of achieving best care for the patient.

In some cases, multiple disposal methods existed for a patient contact. For instance, in the fictional case of an psychiatric presentation, the patient is discharged advice only, immediate safeguarding and safeguarding referral where a patient has been given advice by the crew, a caregiver has been called and attended the location to immediately safeguard the patient and following this, a formal safeguarding referral has been made to local services.

This patient disposal metric does not include contacts where no formal patient contact was recorded, for instance welfare only incidents or police assist incidents.



Service Utilisation

This metric looks at how much ‘dead time’ the scheme had, but is fairly non sensitive just working on the number of incidents to the total number of service hours and then from this, calculates on average, how many hours were spent per incident. Again, given the fact that the data is sensitive to ‘developing’ incidents, the metric is not necessarily 35 individual incidents:

Total Incidents	35
Total Hours	41
Hours Per Incident	1.2
Incidents Per Hour	0.85

Scheme Costs and Approximate Savings

This metric is relatively rough, but allows a degree of visibility as to how much it roughly costed for the unit to attend the various incidents in the town centre.

Total Cost	£4100
Total Hours	41
Total Incidents	35
Cost Per Incident	£117

As a point of reference, [Hudgell Solicitors](#) undertook some [research](#) in 2020 in regards to approximate costs to the NHS for various services. This research suggested that an ambulance attendance costs the NHS approximately £259 on average to attend an incident and provide treatment at scene. Adjusted to account for inflation, and inflation alone, this cost will look more like £333 per attendance.

Furthermore, the same research suggests that an attendance at A&E costs the NHS on average (again, adjusted for inflation) £521. Using this data, albeit, not very well referenced, we can make an estimation of what it would have costed to attend and deal with these incidents through more traditional means.

Total Incidents	35
Cost Per Incident	£333
Total Attendance Cost By NHS Resources	£11655
Total Cost of A&E Avoidances	£4168
Total Saving Made	£11723

The actual saving is likely to be a little lower than this, as the total incidents are not necessarily individual incidents, but this statistic is intended to be purely indicative of the net positive benefit of the scheme.

Conclusion and Improvements

Overall, we are incredibly pleased with how the scheme turned out. We noted an steady increase in terms of engagement from the partners in the town centre, likely as they got more used to our presence and remembered they had the resource for use.

The university made excellent use of our resource, but conversely, this demand actually dropped off towards the end of the scheme as the student population declined due them returning home. The team at the university remarked that the presence of our unit allowed them to make more informed decisions around the best management of incidents involving the student population and they were actively looking to ask for our attendance and advice prior to making a call to ambulance in order to divert demand away from SECAMB.

Unfortunately, we didn't receive very positive engagement from SECAMB themselves, but this was likely due to a lack of understanding of the capabilities and status of the unit, and while there was no proactive contact from SECAMB, they were glad to accept the increased information from scene we were able to provide them. This lead, in a number of cases, to the SECAMB control room then making the decision to stand their resource down, allowing it to be used for other calls outside of our service footprint.

We did also experience an assault on one of our crew members from a member of the public suffering from the effects of what appeared to drug intoxication, and this patient spat at our clinician whilst he was trying to ascertain if the patient was experiencing potentially life threatening Acute Behavioural Disturbance (ABD) following the concern being raised by police who were already dealing with the patient for a separate incident. This person was rapidly controlled by police (assisted by our crew nonetheless) and has since been formally dealt with by the police service.

The key difficulty with this scheme is knowledge of incidents within the footprint, as we have no ability to be alerted of any calls made that fall within the scheme's footprint and so the crew has to undertake a form of proactive patrol in order to identify and find issues. It is our belief that if the scheme was to be active on a more regular basis, this level of engagement would only improve as the venues and partners would have a much better awareness of the scheme and it availability.

Whilst the scheme is far more effective as a mobile resource, the ideal would be a hybrid service occupying a regular space in the town centre. This would allow for 'walk-ins' for welfare cases and provide a visible place of safety to attend (rather than calling police or ambulance), whilst still having an active resource that can attend to incidents all over the scheme footprint, provide a reassuring presence and proactively identify welfare/safeguarding issues, increasing the overall safety of the town centre. Furthermore, such a scheme development would provide excellent support and assistance to the Street

Angels scheme which is already present in Guildford and deals with a grand majority of the welfare cases in the town centre. The presence of our unit, and more importantly, the medical professionals aboard it, allow the street angels to refer patients to us and provides them with support and top cover in terms of increased skillset without the delay of awaiting a statutory ambulance.

Medirek would gladly provide this scheme in its current form, or adjusted form in the future and thanks the Surrey Heartlands ICB and partners for the funding and support that has allowed it to happen. Furthermore, if the data regarding the cost of attendance is to be trusted, this scheme delivered a net positive to the NHS in terms of costs saved of approximately £11,000 even considering the cost of outlay for the scheme in the first place!



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