Summary of EAST DCO Ambulance Handover Event Newmarket 23 March 2018

NHS England

The Ambulance Trust deals with 40% of callouts via "Hear & Treat" and "See & Treat" (i.e. only 60% of patients are conveyed). Over 3000hrs were lost to delayed handover in December 2018. At peak, the Ambulance service was holding over 300 calls. This is the single biggest patient safety risk in the UEC pathways and our ability to manage this risk depends on full engagement of all partners within the system, and not only with Hospitals or Ambulance Trust. Further, with every delay in ambulance arrival, frail elderly patients become de-conditioned and more likely to be admitted. Releasing ambulances early will help improve patient safety and ease pressure on beds. It's clear that organisations are deploying different strategies – some of which are highlighted below;

1. **Staff engagement** was reported as key; patients' stories are a powerful tool for engaging with staff
2. Emphasis on the importance of **clear and simple handover processes** that are well understood by staff within the trust and by ambulance crews
3. **Adopt improvement tools to understand what data is telling you**. Lister Hospital used Lean Six Sigma to map and truly understand where delays in the ambulance handover pathway are and as a result reduced the time lost to delays from 192hrs a week to 16hrs over a period of one week.
4. The new **Ambulance Handover SOP widely** rolled out but now needs review to reflect learning since implementation - Task and finish group will be formed shortly to progress.
5. Strong encouragement to systems to have **HALOs in place where this is not currently funded**. HALO relationship pivotal in helping flow and crews. 24/7 HALO service provided by a paramedic appears to be preferred model.
6. **Fit2Sit** – strong advice about constantly reviewing patient's need for trollies - acknowledging importance of clinical risk management. Fit2Sit posters are available on the NHSI website. Continuous review of hospital conveyances to challenge appropriateness. Create a mechanism for feedback to system to ensure learning.
8. **Limitations in Physical Capacity in EDs** can have a negative impact on flow- use the available space innovatively – visit others to learn. Small changes have big impact – computers on wheels, moving crew's printer to complete handover, easy access to trollies.
9. Put in place **early triggers and action cards** to respond to anticipated increases in demand. Work with Ambulance Trust to improve visibility of pressures on system.
10. Systems for **identification of frail patients prior to arrival** at hospital e.g. "Silver phone" - will help reduce unnecessary admissions
11. **Strong and visible leadership** was identified as a critical enabler at all levels; ED, Hospital and System.

Summary of EAST DCO GP Streaming Event Newmarket 23 March 18

An effective GP streaming service will result in a less crowded ED with positive impact on safety and patient and staff experience.

- Strong governance processes are necessary with protocols in place to help streaming nurses – co-designed with ED and primary care clinicians is critical factor for safe and effective GP Streaming service.
- Effectiveness of GP streaming is highly dependent on level of competency, consistency of clinical staff providing the GP streaming service and knowledge of and access to primary care services in place. At L&D streaming is done by a Band 7 Nurse however others view that this may be done as well by lower banded staff but there must be a clearly defined training programme to ensure staff are trained, competent and confident to stream.
- Streaming process must be simple and clear and must well understood by all staff in ED. A number of **misconceptions** may get in the way and may be worth challenging e.g:

1. A large number of patients are being streamed "inappropriately" and therefore ending up back in ED – **Question meaning of "inappropriate" must only refer to where protocol has not been followed. A patients may have been streamed appropriately but end up needing to go back to ED.**
2. We are being mandated to implement a model which does not work for us – **GP streaming model is nationally mandated, however, NHSE has allowed flexibility in the exceptional cases where the system has demonstrated that they have an alternative service which delivers the same or better outcomes.**
3. Will GP streaming lead to increase in demand? - **Yes, it's likely that successfully roll out will attract new patients – plan for this growth**
4. We have no patients suitable for streaming – **Very unlikely. Review your protocols, consider employing a physiological triage rather than pathological (if they can walk & talk - they can see the GP, with exceptions).**
5. Luton & Dunstable (L&D) stream up to 50% of their A&E attendances - **No, L&D stream about 30% of attendances to GP. GP service only accepts patients from ED.**
6. Are we asking staff to take too much personal risk with regards to the own registration – **No, but it's important staff are well trained, competent and confident and comply strictly to defined/written protocols that have gone through a robust governance process.**
7. This model is costing us more money that the system does not have - **The L&D GP streaming model was in part inspired in part by a need to reduce costs and that objective was delivered, the system report that it actually made savings by implementing GP streaming.**