Lincolnshire COUNTY COUNCIL Working for a better future		**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of East Midlands Ambulance Service NHS Trust – Lincolnshire Division

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**17 April 2019**
Subject:	**East Midlands Ambulance Service NHS Trust - Lincolnshire Division Update**

Summary:

The purpose of this report is to update the Committee on the following areas within the Lincolnshire Division of the East Midlands Ambulance Service NHS Trust (EMAS): ambulance response performance information; handover delays at acute hospitals; collaboration with LIVES (Lincolnshire Integrated Voluntary Emergency Service); the urgent care tier; the ambulance fleet; recruitment; blue light collaboration; and the transformation programme within the Lincolnshire Division.

The ambulance response time performance provides a comparison between March 2018 and March 2019 for the Lincolnshire Division. Performance information by for each Clinical Commissioning Group area will be presented at the meeting.

The report also covers EMASs Strategy and Vision and the National Staff Survey Results. EMAS was subject to an unannounced inspection by the Care Quality Commission (CQC) on 2-4 April 2019. The report contains initial feedback from CQC.

Actions Required:

The Health Scrutiny Committee is recommended to consider and comment on the items enclosed in the Report.

1. Performance

Owing to the difference between the workforce required by EMAS and EMAS's actual workforce, commissioners agreed a tapered performance 'trajectory' for 2018/19 to reflect the workforce challenges. The local trajectory agreed for Lincolnshire during 2018/19 is set out below. The target times are shown in minutes and seconds.

	Category 1		Category 2		Category 3	Category 4
	Mean	90th %ile	Mean	90th %ile	90th %ile	90th %ile
Q2 18/19	08:53	17:22	32:52	68:44	185:12	193:48
Q3 18/19	08:04	16:00	29:47	63:38	180:41	189:05
Q4 18/19	07:41	15:21	25:16	56:12	174:21	182:27

Performance Comparison for Lincolnshire Division between March 2018 and March 2019

	Category 1		Category 2		Category 3	Category 4
	Mean	90th %ile	Mean	90th %ile	90th %ile	90th %ile
March 18	10:39	21:01	49:44	111:00	276:00	249:00
March 19	8:45	16:34	33:25	69:00	202:00	208:00
Improvement (March 18-19)	1:56	4:27	16:19	42:00	74:00	41:00

A breakdown of performance by Clinical Commissioning Group will be provided in the presentation to the Committee.

While the performance of the Division has improved considerably between March 2018 and March 2019, it remains a considerable challenge to meet the targets given the rurality of the county, achievement of the workforce recruitment trajectories and continued pressure from acute hospital handover delays. In the interim, steps are being taken to mitigate the gap in response time through the use of private ambulance resource, overtime, bank shifts and transformational programmes of work.

2. Ambulance Response Programme

The National Performance Standards from April 2019 are as follows: -

New Ambulance Response Time Standards				
Category	**Percentage of calls in this category**	**National Standard**	**How long does the ambulance service have to make a decision?**	**What stops the clock?**
1 (Life Threatening Injury or Illness Calls)	8%	7 minutes mean response time 15 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being dispatched • 30 seconds from the call being connected	The first ambulance service dispatched emergency responder arriving at the scene of the incident (There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation)
2 (Emergency Calls)	48%	18 minutes mean response time 40 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being dispatched • 240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first ambulance service-dispatched emergency responder arriving at the scene of the incident stops the clock.
3 (Urgent Calls)	34%	120 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being dispatched • 240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first ambulance service-dispatched emergency responder arriving at the scene of the incident stops the clock.
4 (Less Urgent Calls)	10%	180 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being dispatched • 240 seconds from the call being connected	Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock.

3. Handover Delays at Acute Trusts

Hospital turnaround continues to be a challenging aspect of emergency ambulance delivery locally, regionally and nationally. However it is a significant pressure in a rural county such as Lincolnshire where response times are challenging in normal circumstances, notwithstanding prolonged ambulance delays. The quarterly breakdown of ambulance handover delays and lost operational response hours is shown below.

Average Pre-Handover Time – (The National Standard is 15 minutes)

Hospital Trust	2018/19			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
United Lincolnshire Hospitals	30m 53s	27m 44s	28m 49s	32m 05s
Northern Lincolnshire and Goole	20m 40s	21m 07s	21m 14s	22m 19s
North West Anglia	21m 38s	21m 54s	28m 59s	35m 13s

Lost ambulance responding hours due to pre handover acute hospital delays: -

Hospital Trust	2018/19			
	Quarter 1 (hours)	Quarter 2 (hours)	Quarter 3 (hours)	Quarter 4 (hours)
United Lincolnshire Hospitals	4,081	3,451	3,735	4,562
Northern Lincolnshire and Goole	1,367	1,425	1,513	1,757
North West Anglia	380	405	747	1,013
TOTAL	**5,828**	**5,281**	**5,995**	**7,332**

Whilst we continue to support to acute hospital colleagues in ambulance turnaround delays, the paper contained as Appendix A was presented to the local Accident and Emergency Delivery Boards, including the Greater Lincolnshire Board in January 2019. It details a national requirement for acute trusts to take responsibility for patients conveyed to their sites within a maximum time frame of 30 minutes in order to release crews to assess patients waiting to receive a resource in the community. Urgent work continues between providers and commissioners to ensure acute hospital delays are reduced to a minimum over the coming months. The Division is also currently working with colleagues in relation to the divert put in place to support Pilgrim Hospital as part of the Care Quality Commission Risk Summit process.

4. Collaboration with LIVES

The Division continues to work in close collaboration with LIVES (Lincolnshire Integrated Voluntary Emergency Service), who remain an integral component of urgent and emergency response across the county. Because they are embedded in local communities, LIVES responders are often able to get to a patient more quickly than the EMAS resource, which means the patient often has rapid access to an assessment of their initial clinical need.

During the previous year EMAS have worked closely with LIVES senior management team and commissioners, (both local authority and health) to establish the following services:

Falls Response Partnership (FRP)

In 2017 / 2018, EMAS responded over 8,000 times to patients who had fallen in Lincolnshire. The Falls Response Partnership (FRP) was established with funding allocated by the County Council following the ambulance summit in November 2018. Initially one FRP vehicle was provided using an EMAS marked vehicle and manned by Level 3 / 4 responders from LIVES. This went live on the 19 December 2019 based at Boston Ambulance Station. A second unit was added in January 2019 based at Market Rasen. Both FRP vehicles are now able to respond to all patients who have had a fall.

Data from the Falls Response Partnership

Falls Volumes	**TOTALS Mid Dec 2018 to Mid Mar 2019**
Number of calls referred to LIVES	**164**
Stood down before arrival at scene	**24**
Number attended by LIVES	**140**
Number of responses which result in patient discharged at scene	**102**
Percentage discharged at scene	**73%**
Number of responses which result in an EMAS vehicle being deployed	**38**
Number of patients conveyed to hospital	**36**

Further information is set out in Appendix B.

Physician Response Unit

LIVES have been separately commissioned by West Lincolnshire Clinical Commissioning Group to provide a service with a doctor and a paramedic in a fast response vehicle based on the east coast. The delivery model is to attend patients referred to EMAS as requiring input at a Category 2 or 3 level. The team is able to carry out advanced assessment on scene and avoid any unnecessary conveyance to hospital. Early indicators are encouraging in that circa 80% of the patients seen are able to remain at home.

Data from the Physician Response Unit to mid-March 2019: -

Episode of care complete in the community	72%
Emergency Department attendance	17%
Direct Admission	11%

5. Urgent Care Tier

As previously reported to the Committee the organisation has invested in the concept of providing an urgent care tier of staff to support Health Care Professional admission. In Lincolnshire we now have 15 urgent care crews covering the county, based at Boston, Grimsby, Sleaford and Market Rasen stations. The service is provided seven days a week and is proving to be really beneficial in supporting a different tier of response, releasing emergency ambulances for more appropriate duties.

6. Update on Fleet

Lincolnshire currently has 82 Ambulances whose combined mileage totals 28.5 million. The ambulances are now supported locally by 'in house' mechanics who work across the county seven days a week, 365 days of the year. From March 2019 we started to receive the first of 39 new vehicles, which will replace 28 of the oldest members of the fleet and an additional 11 new vehicles to support the expansion in workforce.

In addition to the above 15 new Urgent Care Vehicles have also arrived based out of Sleaford, Boston, Grimsby and Market Rasen stations.

The Division is also working with Fleet colleagues to trial an electric vehicle and undertake a review of the current Fast Response Vehicle (FRV) resource.

7. Recruitment 2018/2019

2018/19 has seen incredible pace of change and developments across East Midlands Ambulance Service (EMAS) both regionally and locally to Lincolnshire. One of the largest but positive challenges has been the large scale recruitment of staff into the organisation; following last year's contract negotiation and demand modelling with our commissioning partners.

During 2018/19 EMAS recruited circa 484 new staff to the organisation through a mixture of transfer from other services, upskilling of existing staff or external recruitment of trainee technicians. The largest proportion was external recruitment with 331 trainee technicians welcomed into the organisation. For Lincolnshire Division specifically this equates to – 91 new ambulance technicians, 8 paramedics and a further 14 urgent care assistants.

The large scale recruitment process continues into 2019/2020, there is a plan to recruit a further 484 staff into the organisation with 114 earmarked for Lincolnshire.

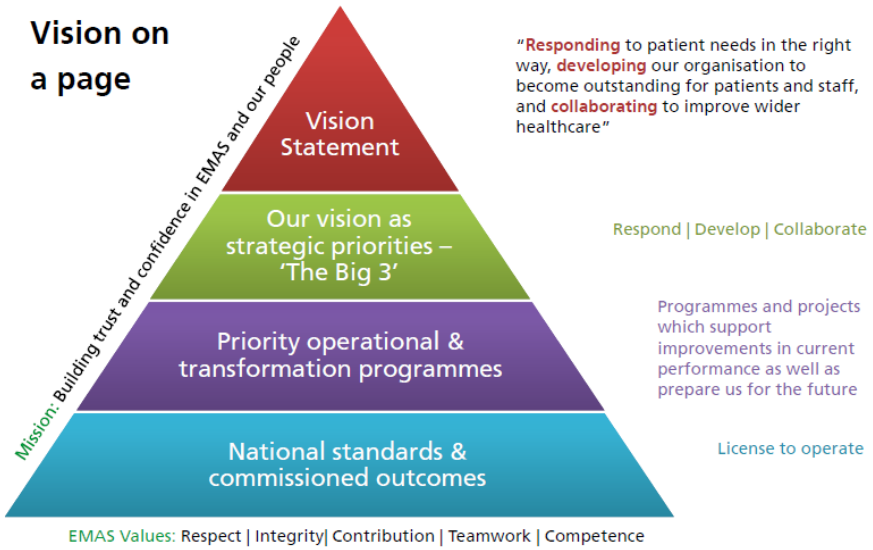
Nationally there is a shortage of Paramedics graduating university, which presents a problem in areas without a local higher education connection; however we are happy to be working in partnership with the University of Lincoln and our first cohort of 20 Paramedics commenced training in September 2018. We are working in close collaboration with the University and the students will be working on placement over the coming months / years within the Division.

8. EMAS Strategy and Vision

During 2018 EMAS engaged with both staff and external stakeholders to formulate and seek board approval for a refreshed vision and strategy across the Trust. This has since been launched during Q3/4 2018/19 as "The Big 3". We continue our vision and strategy development though setting of our new clinical model which will be presented to Trust Board in April / May 2019.

Revised vision

"**Responding** to patient needs in the right way, **developing** our organisation to become outstanding for patients and staff, and **collaborating** to improve wider healthcare"



The Division is working with a much wider group of stakeholders than in previous years as successful transformation projects have raised the profile of the pre hospital of ambulance personnel.

9. Blue Light Collaboration

During 2018/19 we successfully mobilised and opened co-located fire and ambulance stations in Sleaford and Louth. These combined sites allow for new and purpose built properties to better serve the communities around them. Notwithstanding the obvious estates and utilities cost saving that this combined approach achieves, a number of softer benefits have been seen across both agencies:

- joint agency training sessions with a more holistic approach to incident management;
- structured debriefs following traumatic incidents compared to single agency historically;
- combined service management office offering peer support;
- positive behaviour and culture assimilation between agencies; and
- professional role awareness

The largest collaboration project to date will see the opening of the very first 'tri-located' blue light service property in the country located on the South Park site. A phased move for all three services is planned to take place between June and September 2019.

10. Transformation Programme

Details on the transformation programme are set out in Appendix C.

11. Releasing Time to Care

Commencing in February 2019 the organisation introduced a regional change to how we utilise our ambulance staff. The primary focus of this piece of work was to increase efficiency and make available more time to respond to patients. By reducing the time when operational vehicles and staff are unavailable, the aim is to increase the timeliness and appropriateness of our response. Examples from this change process include placing strict limits on when staff can make a vehicle unavailable to respond and late finishing overruns (and conversely late starts to the following shift). This process of releasing time to care has enabled us to put circa 400-450hrs per week back into Lincolnshire emergency response.

12. Staff Survey Results

There has been a 3 fold increase in the number of responses received from the Division to the national staff survey in 2018 – 51% versus 19% in 2017. Initial feedback suggests the Division needs to focus on the following areas:

a) Inclusion of staff in decision making / areas for improvement
b) Communication between senior managers and front line staff
c) Flexible working patterns
d) Valuing staff / staff recognition
e) Acting on feedback

Areas of positive feedback:

a) Training and Development programmes
b) Respecting staff
c) Response to abusive / violent episodes of care
d) Incident Reporting – high reported of low grade incidents

As a result of information contained in the survey the Division intends to:

1. Embark on a series of roadshows over the coming months to raise the profile and visibility of senior managers
2. Listen to staff and discuss ideas on how communication can be improved across such a wide geographical area
3. Consideration to the production and dissemination of a local Divisional Newsletter
4. Potential introduction of an 'Employee of the Month' initiative

13. Care Quality Commission - Unannounced Inspection - April 2019

The organisation was subject to an unannounced inspection by the Care Quality Commission on 2, 3 and 4 April 2019. The inspection undertaken included visits to stations, ride outs with front line clinical staff, focus groups and formal interviews with senior managers in Division.
Initial verbal feedback has indicated that:

a) morale within Division is much improved;
b) there has been a positive change in the culture;
c) all front line staff were caring and compassionate;
d) positive feedback received in respect to the visibility of senior managers and issues related to staff welfare; and
e) there were no major concerns for immediate escalation

The Central / Executive Team will now undergo a 'Well Led' inspection ahead of the publication of the final report later in the year.

14. Conclusion

The Health Scrutiny Committee is recommended to consider and comment on the information presented by the Lincolnshire Division of the East Midlands Ambulance Service.

15. Appendices – These are listed below and set out at the end of this report.

Appendix A	Hospital Handover Delays – January 2019 – Report to Lincolnshire Accident and Emergency Delivery Board – 18 February 2019
Appendix B	Performance Summary - Falls Response Programme
Appendix C	Transformation Brief

16. Background Papers - None

NHS
East Midlands Ambulance Service
NHS Trust

Paper No.	

Report to: Accident and Emergency Delivery Board – Lincolnshire

Date: 18th February 2019

Report Title:	Hospital Handover Delays – January 2019
Author:	Sue Cousland, General Manager, Lincolnshire Division, EMAS
Presented by:	Sue Cousland, General Manager, Lincolnshire Division, EMAS
Appendices:	Appendix 1 – Letter from Richard Henderson to CEO ULHT re handover delays Appendix 2 - Addressing Hospital Handover Delays: Actions for Local Accident and Emergency Delivery Boards – January 2019 (NHS England and NHS Improvement) Appendix 3 – Managing the Safe Handover of Patients SOP V3.0 .

Purpose of Report

To highlight the content of a recent publication by NHS England and NHS Improvement entitled: Addressing Hospital Handover Delays: Actions for Local Accident and Emergency Delivery Boards – January 2019.

The paper details clear responsibilities and actions for Ambulance / Acute Trusts, Commissioners, Primary and Community Care providers.

Richard Henderson, CEO of EMAS has recently written to the CEO of ULHT

Executive Summary

The paper contained as Appendix 2 is designed to support a national improvement in Acute Hospital Handover processes which in turn will release ambulance crews to ensure they are able to provide a safe, timely and appropriate urgent and emergency care response in the community.

The attached report supersedes all previous documentation and provides detailed responsibilities for all parties namely:

ACUTE AND AMBULANCE TRUSTS

- Hospital trollies and staff to be provided to avoid ambulances queuing
- Fit to Sit champion to be appointed
- Patients must be booked into a Patient Administration System within 15 minutes of arrival
- A standard handover process needs to be agreed
- A timely process for escalation needs to be agreed between both parties – please refer to Appendix 3 previously presented to the A&E Delivery Board in December 2018
- Avoidance of patients being cared for on the back of ambulances

COMMISSIONERS

- To facilitate good working relationships between providers to reduce handover delays and agree triggers for escalation
- To have an understanding of the key drivers for increased activity
- To ensure the ambulance trusts have robust capacity management processes in place
- To ensure Primary Care input into Residential and Care Homes is robust
- To ensure there is a wide range of safe alternative referral pathways in place

PRIMARY CARE

- Provision of prompt telephone access to the surgery for crews to discuss patients prior to any potential inappropriate conveyance
- Home visiting times to be reviewed to avoid 'batching'
- Demonstration of collaborative working relationships with Clinical Commissioning Groups (CCG's)

COMMUNITY TRUSTS

- To have Rapid Response Services in place to facilitate visits within 60 minutes of initial request

AMBULANCE TRUSTS

- EPRF to be provided to Acute Trust within 15 minutes of arrival
- To share predictive activity levels on an hourly / daily basis
- To work towards a safe reduction in conveyance as set out in 2017/2019 CQUIn

Suggested Actions

AMBULANCE TRUSTS

1. Escalation of all crews who have been waiting > 60 minutes to the Strategic Acute and CCG Director on call – as per detail in Appendix 3
2. Provision of a range of vehicles to safely convey patients to the Acute Trust / other referral pathways

3. Reassessment of clinically appropriate alternative pathways to ED

ACUTE TRUSTS

1. Implement escalation protocol for all handovers > 30 minutes and as above if > 60 minutes
2. To establish regular reporting of handover delays
3. To provide an appropriate clinical space for effective triage
4. To avoid corridor care becoming the norm
5. Corridor care by exception should include triage for acuity of patient, use of ED checklist, provision of additional staff as required and weekly review of incidents
6. Implement a process to review any concerns raised by staff, patients or relatives.
7. Have a process to provide pre-emptive diagnostics
8. All waits >60 minutes should be reported as a Serious Incident

ED STAFF

- Review of pre alert processes
- To undertake reviews when approaching peak levels of capacity / demand
- To ensure prompt referral for inpatient facilities should it be clinically indicated

Recommendation(s)

1. The A&E Delivery Board is asked to note the content of the papers attached as Appendices 1-3
2. The System Winter team to be tasked with undertaking a gap analysis of the responsibilities and actions described in Appendix 2 with all parties involved
3. The System Winter team to give a monthly progress update to the A&E Delivery Board until adequate assurance has been provided that safe processes and protocols are in place to ensure the safe handover of patients and appropriate non conveyance pathways are in place.

Appendix 1

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Jan Sobieraj, Chief Executive
United Lincolnshire Hospitals NHS Trust

Sent by email: Jan.Sobieraj@ULH.nhs.uk

4 February 2019

Dear Jan

Re: Hospital Handovers

I am writing following the Trust Board meeting of the East Midlands Ambulance Service NHS Trust where the issue of hospital handover delays has been discussed.

It is our belief that significant patient safety risks to uncovered emergency calls in the community could arise as a direct result of the ambulance handover delays at your Trust. Despite enhanced National Guidance being provided to Acute Trusts, it is evident that on many occasions we are having to care for patients in the back of ambulances until space is available within the Emergency Department.

Whilst I accept that the position within the Emergency Department is reflective of a far greater system issue it remains unacceptable for patients to be held in the back of ambulances. Since the Trust Board discussion we are required to report daily to NHS England about the number of patients that are being held on the rear of ambulances and the duration of such incidents. Many of these episodes last well over an hour and some instances far longer.

The Trust Board is exploring additional actions which can be taken to protect patients waiting in the community and would like to better understand what additional actions are being taken at your Trust. The partnership working between your Trust and EMAS has been observed to be excellent during difficult circumstances and I would like to see this continue.

I would like to discuss the issue of handover delays with you and will ask my PA Laura Carr to make contact with your office to arrange a convenient time.

Kind regards

Yours sincerely

Richard Henderson
Chief Executive

Appendix 2

NHS

Addressing hospital handover delays: actions for local accident and emergency delivery boards

Published by NHS England and NHS Improvement

Updated January 2019

Contents

Actions to be taken now and embedded as part of normal working practice to reduce the likelihood of delays

To reduce the likelihood and impact of hospital handover delays, local A&E delivery boards should ensure that:

Acute trusts and ambulance trusts

1. Must appoint a senior lead, directly accountable to the trust board, to oversee the development and implementation of clinical handover protocols for acute departments. These protocols should have a focus on patient safety and hence the need to minimise delays to assessment and treatment.

2. Must avoid the use of ambulance trolleys and ambulance staff to queue patients in a corridor or other areas of the ED or admissions unit, including ambulance triage areas where these are used. Patients should be transferred to a hospital trolley on arrival and hospital staff allocated to provide safe care to these patients.

3. Must avoid the use of ambulance trolleys for patients who are 'fit to sit', and should move them to a chair if appropriate. This can expedite investigations and facilitates discharge assessments. Such an approach assists greatly the use of ambulatory care pathways and reduces the demand on trolley/cubicle spaces. Hospital staff, including handover staff, and ambulance staff should be made aware of the fit-to-sit guidance and a clinical champion appointed to see that this is being implemented.

4. Must book patients onto the hospital patient administration system (PAS) or ED PAS when the patient first arrives in the department.

5. Must ensure that handover standards are applied consistently where patients are transferred directly to admissions units and other clinical departments.

6. Must have an agreed protocol for the timely escalation of handover delays with established warning and trigger responses. This should include a clear policy to manage waiting ambulances safely with regular risk assessments and required actions to deliver a safe waiting environment for patients. For local adoption, please see the East of England Ambulance Service's protocol.

7. At no time should a patient be kept in an ambulance outside a hospital.

Commissioners

8. Must facilitate ambulance services and acute hospitals working together and with partner organisations at STP level to agree effective escalation procedures and interventions for periods of high demand, and agree trigger and response mechanisms. HAS screen information may be a useful source for local monitoring and escalation.

9. Should ensure that they fully understand where high demand increases are being generated, and take appropriate action to assist in reducing demand growth – for example high 111 referral rates to 999, high volume frequent users and other sources of demand resulting from alternative access to services.

10. Must ensure ambulance services have in place regional capacity management systems to be enacted when queues develop. These should provide information to hospitals and ambulance services to know capacity in real time and include processes for diverting patients at times of significant pressure. This allows clinicians and managers to make better informed decisions about patient care and use of alternative care pathways.

11. Should improve general practice input to care homes to reduce unnecessary conveyance and implement care home navigators as a matter of urgency. These should be provided 24/7 or over extended hours wherever possible.

12. Must ensure that there are a wide range of referral options within the community that 999 and the Clinical Assessment Service (CAS) supporting NHS 111 can use as an alternative to the ED. This could include frailty services, ambulatory

emergency care services, falls services and urgent treatment services. These should be provided 24/7 or over extended hours wherever possible.

GP practices

13. Must ensure prompt telephone access for ambulance crews to contact a patient's own GP surgery before deciding whether to convey, as access to advanced care and end-of-life plans, advice or urgent GP review may avoid the need for conveyance and hospital attendance/admission or enable direct referral to the medical or surgical take teams.

14. Should take measures to avoid referred patients arriving in surges as a result of all domiciliary visits, and thus conveyance requests, taking place after morning surgeries. This severely inhibits the ability of ambulance services to convey these patients in a timely manner and practices should have plans in place to run visits throughout the morning, as opposed to batching them.

15. Clinical commissioning groups (CCGs) and GPs should work together with the CCG being responsible for overseeing the daily schedule of GP visits from all surgeries to ensure that large numbers of ambulances do not arrive together.

Community services

16. Should have rapid response teams to see patients in their own homes. Best practice is for teams to reach patients within 60 minutes of a request, and never longer than two hours.

Ambulance services

17. Should implement electronic patient handovers. These must be available to ED staff within 15 minutes of arrival.

18. Must share predicted activity levels with Acute Trusts on an hourly and daily basis to trigger effective escalation when demand increases.

19. Must put in place measures to enable safe reduction of conveyance to the ED, as set out in the 2017-19 CQUIN.

Actions to be taken when ambulances are predicted to queue or are queuing

Ambulance trusts

1. Should escalate all handovers exceeding one hour to the on-call executive director of the responsible acute hospital trust and CCG director on call.

2. Should consider the range of vehicles in their fleet to convey patients to the emergency department, but only where it is safe and appropriate to do so.

3. Reassess clinically appropriate alternative options to ED transfer.

Acute trusts

4. Must enact a handover escalation protocol where time to handover is exceeding 30 minutes (for local adoption, please see the East of England Ambulance Service's protocol). This should include contacting the on-call hospital director so that immediate action can be taken to release ambulance resources. Where time to handover is exceeding 60 minutes, the on-call CCG director and on-call NHS England director must be contacted and those individuals should put in place whole-system local escalation processes to release ambulance resources. Over winter the regional winter on-call director should also be informed 24/7.

5. Must not place restrictions on ambulances in order to limit or regulate access to the ED or the handover of patients arriving by ambulance.

6. Should report ambulance handover delays at site-wide bed meetings to ensure that there is a whole-system response when required.

7. Must ensure that all patients handed over from the ambulance service are managed in a clinical space that reflects their acuity as assessed by prompt clinical triage.

8. To avoid corridor care, in some sites and at particular times ED patients who have completed their ED assessment and initial treatment will need to be moved to a pre-admission area while waiting for a ward bed. Patients in this pre-admission cohort must:

    a. be accommodated in an environment with appropriate equipment and facilities to maintain their privacy, dignity and safety at all times
    b. receive regular review
    c. escalation plans should include how the extra nursing staff required to safely staff such a pre-admission cohort area will be provided.

9. Whenever it is still not possible to off-load ambulance arrivals into an appropriate ED area and patients therefore remain in a corridor, the following steps must be followed:

    i. These patients must be assessed and prioritised according to acuity not arrival time.
    ii. Additional trust staff must attend to oversee the care of these patients, thereby releasing paramedic crew for frontline duty.
    iii. Each patient must benefit from application of the ED safety checklist.
    iv. An incident form should be completed.
    v. Weekly review of such incidents should inform the necessary steps to increase ED staffing/clinical space and/or the capacity of the pre-admission cohort area.

10. Must put in place a clear process for reporting significant clinical concerns by staff and carers.

11. Must ensure that where normal processes are delayed the effects of such delays are mitigated by pre-emptive interventions (where appropriate) and investigations such as blood tests, ECGs, X-rays and CT scanning.

12. Must raise a Serious Incident for all incidents where a handover longer than 60 minutes has occurred.

Emergency department staff

14. Should assess the 'pre-alert' patient information provided by paramedics regarding acute severe injury or illness so they can anticipate resource utilisation.

15. Should undertake regular reviews whenever at or near full capacity. A serious handover problem is sufficient reason for escalation of the issue to senior managers and executive officers.

16. Ensure prompt referral for inpatient care as soon as it becomes clear that admission will be necessary.

References

Zero Tolerance. Making Ambulance delays a thing of the past. NHS Confederation in association with the Association of Ambulance Chief Executives 2012.
www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Zero_tolerance061212.pdf

Reducing patient handover delays from ambulances to hospitals, Department of Health 2012.
www.gov.uk/government/uploads/system/uploads/attachment_data/file/126787/Ambulance-handover-delays-19062012-gw-17718.pdf.pdf

Tackling emergency department crowding, Royal College of Emergency Medicine 2015.
www.rcem.ac.uk/docs/College%20Guidelines/5z23.%20ED%20crowding%20overview%20and%20toolkit%20(Dec%202015).pdf

Quick guide: clinical input into care homes, NHS England 2016.
www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick- Guide-clinical-input-to-care-homes.pdf

Patient flow guidance, NHS Improvement 2017.
https://improvement.nhs.uk/resources/good-practice-guide-focus-on- improving-patient-flow/

2017/19 CQUIN.
https://www.england.nhs.uk/nhs-standard- contract/cquin/cquin-17-19/

Ambulance handover: tactical advice to hospitals and ambulance services, NHS Improvement 2017.
https://improvement.nhs.uk/uploads/documents/ECIP_Reducing_Ambulance_Handover_Delays_March_2017.pdf

Are your patients fit to sit? NHS Improvement 2017.
https://improvement.nhs.uk/resources/are-your-patients- fit-sit

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This publication can be made available in a number of other formats on request.

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Appendix 3

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Managing delays in the safe handover of patients Standard Operating Procedure

Links

The following documents are closely associated with this procedure

- Operational Strategy
- EOC Strategy
- Risk and Safety Policy
- Clinical Strategy
- Improving Ambulance handover – NHS England
- Capacity Management plan
-

Document Owner :	Director of Operations
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Equality Impact Assessment	

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Version	Date Approved	Publication Date	Approved By	Su
1.0	20 March 2015	31 March 2015	Risk, Safety and Governance Group	New procedure
2.0	29 June 2017	11 July 2017	Risk, Safety and Governance Group	Changes to Command Str England Escalation Trigge
3.0			Risk, Safety and Governance Group	Change to document own Changes handover proces Changes to crew escalatic Changes to Escalation flo Revised guidelines for ma

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1. Introduction

1.1. Delays due to turnaround times between the ambulance service and acute hospital services represent a poor patient experience of the NHS and a clinical risk. This has been highlighted by Ambulance Services as a national issue and has resulted in the production of specific guidance by the Department of Health and NHS England. As a consequence of spending less time at hospital; Ambulance Services will be able to reduce their response times to critically ill or injured patients leading to improved clinical outcomes.

1.2. Patient delays, ambulance handover waits and crews failing to book available promptly on completion of each case impact on patient care and wastes valuable NHS resources. These delays occur throughout the year and are exacerbated during the winter months as pressure builds in the acute setting.

1.3. National policy direction on 'Arrival to Handover' is clear that all Emergency Departments (ED) will take a clinical handover (i.e. off trolley) **within 15 minutes for every patient.** National guidance also states that if cohorting is necessary then the hospital is responsible. EMAS will no longer routinely provide this service.

1.4. Acute Site leadership is mandated by national guidance to ensure that this standard is always met. Where this has failed rapid escalation commences from the 30 minute point (i.e. 15 minutes beyond the expected maximum time). This document describes the associated escalation procedure.

2. Objectives

2.1. The key objectives to this procedure are:

2.1.1. To ensure a consistent and responsive escalation of Pre handover hospital delays.
2.1.2. To give guidance on any Hospital specific handover delays escalation plans.
2.1.3. To ensure that East Midlands Ambulance Service (EMAS) responds dynamically to service pressures.
2.1.4. To ensure EMAS continues to maintain a safe and clinically appropriate level of care at times of increase hospital handover delays.
2.1.5. To ensure that EMAS is able to responds to the most seriously ill patients in an appropriate timescale

3. Scope

3.1. This plan is predominately applicable to those managers who are required to deal with Hospital pre handover delays.

3.2. The plan is also applicable to all operational and clinical directorates of EMAS and has been developed in order to ensure operational consistency and ensure a coherent approach to escalations levels across the organization.

3.3. This plan will need to be understood by the EMAS Managers taking the role of Trust Strategic Commander, Tactical Commander (Ops and EOC), Clinical Managers and the function of the Medical Director whether on duty or on-call. This will include

managers and staff acting in a HALO capacity within the hospital setting. Action card for the managers acting in the HALO role is shown on annex .

3.4. Where actions cards refer to roles these should be translated to On-call and day to day roles.

4. Definitions

4.1. The following definitions are;

- CMP - Capacity Management plan
- EOC – Emergency Operations Centre
- HALO – Hospital Ambulance Liaison Officer
- ROM – Regional Operations Manager
- TSC – Trust Strategic Commander
- DOC – Director on Call

5. Responsibilities

5.1. The Director of Operations has the overall responsibility for this policy/procedure to ensure that patients are clinically safe during periods of pre handover hospital delays and that our activity is managed effectively.

5.2. The Deputy Director of Operations will be delegated responsibilities by the Director of Operations and will act on their behalf as and when required.

5.3. The Deputy Director of Operations will lead on all changes made to this procedure and is responsible for ensuring compliance across the operations directorate.

5.4. Regional Operations Manager is responsible for the daily monitoring of this procedure and escalation to the appropriate managers in hours and on call managers.

5.5. All managers who are required to deal with Hospital pre handover delays are responsible for familiarising themselves with this document and compliance with its content.

5.6. Any managers or staff who are required to act in the role of HALO are responsible for familiarising themselves with this document and compliance with its contents in respect to their role.

5.7. Trust Strategic are responsible for the strategic management of this procedure and escalation to executive on call.

6. Handover process

6.1. Patients who are 'Fit2Sit' should not be brought into the Emergency Department (ED) on an ambulance trolley. The ED is responsible for ensuring that there is availability of appropriate facilities at all times. Clinicians must ensure they have access to and follow the approved flow chart set out in Appendix 1 at all times.

6.2. The attending ambulance clinician or EMAS manager deployed to the hospital, will be focused on achieving clinical and physical handover of the patient within 15 minutes. Where this appears unlikely, they must alert the Emergency Operations Centre (EOC) immediately using the flow chart below in Appendix 1

6.3. The attending ambulance clinician or EMAS Manager if deployed will be focused on achieving handover within 15 minutes and where this appears unlikely will alert the Emergency Operations Centre immediately if arrival to handover is likely to exceed 30 minutes

6.4. Where arrival to handover times are reaching 30 minutes or have reached 30 minutes, the lead attending clinician will inform the EOC and escalate the matter to the senior Emergency Department Nurse on duty for immediate action.

7. Escalation procedure for delayed patient handover at Hospital

7.1. The flow chart shown in Appendix 2 illustrates the various stages of escalation for delayed hospital handovers. It highlights the need to formally escalate the issues and provides a consistent approach to who, how and when this escalation should take place.

7.2. The ROM will review the presenting situation when any Acute Trust is showing delays in handover and liaise with the relevant managers, both EMAS and Hospital, to ensure plans are in place and are being implemented to try and prevent any further determination in handover delays.

7.3. Whilst it is anticipated that there will be a chain of command for escalation it may be necessary to escalate earlier than identified on figure 2 due to other issues which may be affecting the Trust which hospital turnaround is having an influence on ie prolonged patient waits / outstanding activity

8. Capacity Management plan (CMP)

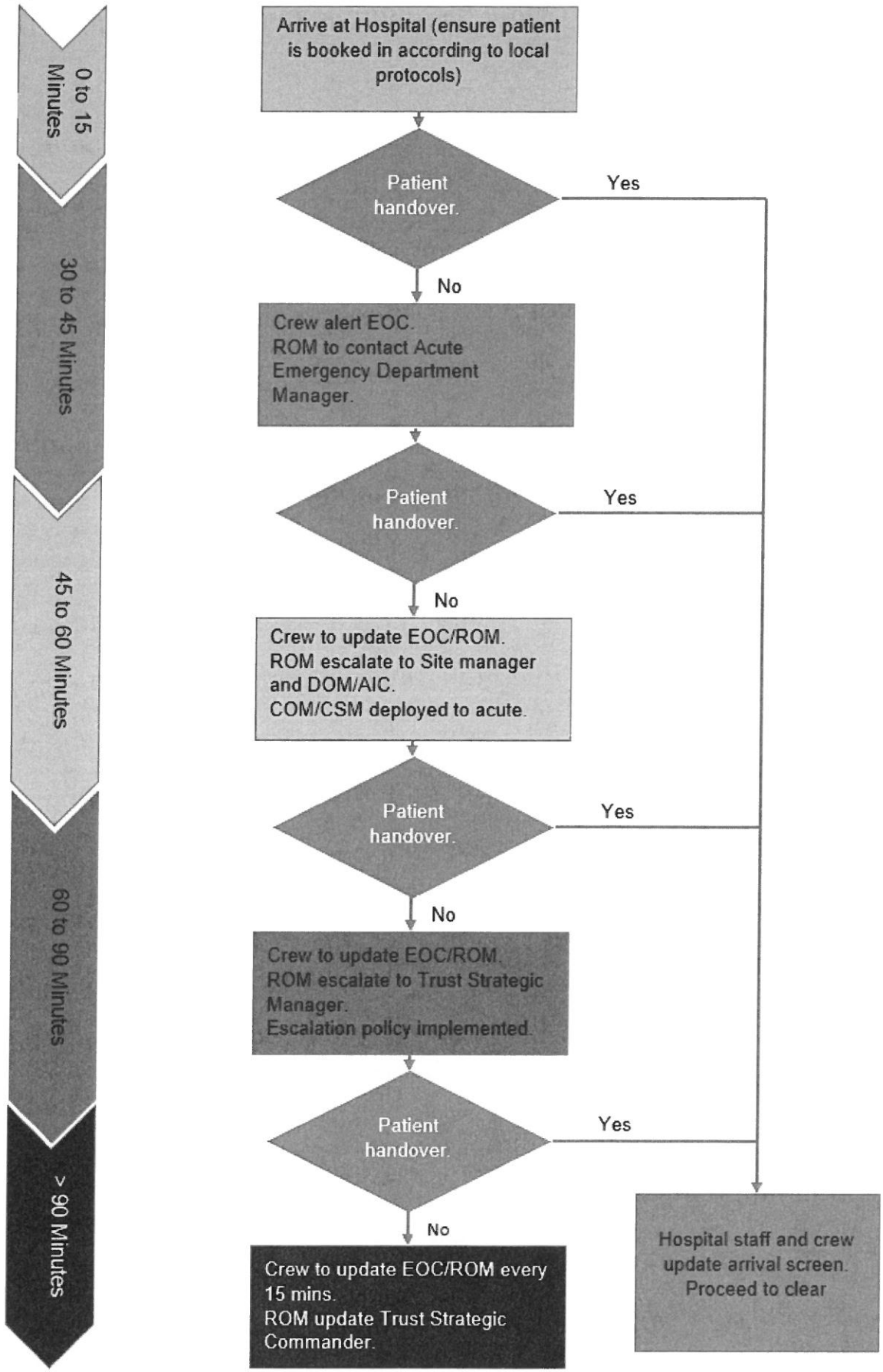
8.1. Whilst outstanding activity and subsequent CMP levels can be related to hospital delays, however this CMP plan is a separate plan and aimed at managing capacity and not hospital delays directly.

8.2. CMP can be escalated in isolation without any hospital pressures as well as hospital pressures can be a contributing factor of a reason to escalate. These levels should only therefore be used as a guide when comparing hospital turnaround issues as it may be necessary to escalate earlier through CMP dependent upon wider issues also affecting the Trust

9. Monitoring Compliance and Effectiveness of this Procedure

9.1. Handover performance will be monitored on a daily basis by operational senior managers within the Ambulance Service and Acute Trusts.. When this procedure is implemented an exception report will need to be developed and submitted at the next Risk, Safety and Governance Group.

Appendix 1


0 to 15 Minutes
30 to 45 Minutes
45 to 60 Minutes
60 to 90 Minutes
> 90 Minutes
Arrive at Hospital (ensure patient is booked in according to local protocols)
Patient handover.
Yes
No
Crew alert EOC.
ROM to contact Acute Emergency Department Manager.
Patient handover.
Yes
No
Crew to update EOC/ROM.
ROM escalate to Site manager and DOM/AIC.
COM/CSM deployed to acute.
Patient handover.
Yes
No
Crew to update EOC/ROM.
ROM escalate to Trust Strategic Manager.
Escalation policy implemented.
Patient handover.
Yes
No
Crew to update EOC/ROM every 15 mins.
ROM update Trust Strategic Commander.
Hospital staff and crew update arrival screen.
Proceed to clear

Appendix 2

DELAYS > 30 Minutes but <45 minutes

- ROM escalates to the Acute Emergency Department Manager to agree plan to release crews

DELAYS >45 minutes but <60 minutes

- If no resolution from agreed plan ROM escalates to Acute Hospital Site Manager
- COM/CSM deployed to acute hospital to engage with hospital managers for release of resources
- DOM to be informed that COM/CSM has been deployed to site (divisional AIC if DOM not available). DOM/AIC on standby to attend Acute if required

DELAYS >60 minutes if no resolution to agreed plan is in place to release resources

- ROM escalates to EMAS Trust Strategic Commander
- Trust Strategic Commander will review agreed plan set by Acute Hospital Site Manager inconjunction with ROM
- Trust Strategic Commander may request a conference call to be set up with Acute Hospital Director on Call & CCG Director on Call for resolution if agreed plan ineffective.

DELAYS >90 minutes if no resolution to agreed plan is in place to release resources

- EMAS Trust strategic commander will consider escalating to the EMAS Director on Call where engagement with acute hospital has failed to resolve delays
- EMAS Director on Call will request for a conference call to be set up with Acute Hospital Director on Call, CCG Director on Call and NHS England Director on Call for system wide resolution.
- Load levelling maybe enacted at this point.

Appendix 3

East Midlands Ambulance Service NHS
NHS Trust

HALO Guidance – EMAS Wide (Excessive pressures / Major Incident)

1. If alerted to building pressures at an Acute site – immediately gain an understanding of the current situation before committing to deploy.

2. Ensure that EOC put an appropriate message out to staff on appropriate use of the "ambulance to chair" ethos to free up ambulance trolleys & crews (Fit2Sit).

3. Contact Regional Operations Manager on 0115 8845463 and obtain an update relating to the hospital under pressure ***prior*** to deploying to the Emergency Department (ED).
For example:
- Average handover time for ambulance crews;
- Current updates already received from the hospital and actions in place;
- Obtain call signs and arrival times of ambulance on site;
- Utilise the Ambulance Arrivals screen if available.

4. Make a balanced decision regarding pressure at the Acute vs EMAS operational management cover and escalate to the DOM for assistance with a deployment decision if required.
Once on site make contact with EMAS staff, Nurse in charge and Site Duty Manager

5. Make contact with EMAS staff and:
- Ensure that crews have completed relevant PRFs and are continuing to monitor/provide clinical care;
- Continue to promote an "ambulance to chair" approach where appropriate to rapidly release DCA coverage.

6. Liaise with Nurse In Charge (NIC) of ED and confirm/establish:
- Number of patients in department;
- Number of ambulance patients waiting to handover;
- Location of spare hospital trolleys/chairs (not just ED);
- Any hospital staff shortages or pressures.
- They have provided staff to cohort patients (not EMAS responsibility)

7. Make contact with the Bed Manager/Site Co-ordinator to establish:
- Current Escalation Level;
- Bed availability and potential discharges;
- Any additional bed capacity available to be opened;
- Time and place of next bed meeting within the Trust;
- Immediate and short-term plans (1-4hrs) to alleviate the pressure;
- Any Escalation to hospital Silver or CCG etc that has occurred

8. Ensure the on-going health, safety and welfare of ambulance staff & patients delayed at the department (including organising refreshments if appropriate).

9. On the occasion EMAS has to cohorting due to extreme demand, take action to ensure EOC is updated re transfer of patient care between EMAS clinicians with accurate time stamps.

10. Once actions and mitigations are in place withdraw to normal duties and monitor remotely.

11. Ensure early escalation via the ROM for exceptional events e.g. patients unable to offload from vehicles, known or potential patient harm through delay, significantly long delays outside of the "norm".

Key Points

- Balanced approach regarding efficient use of HALO deployment vs EMAS operational management demand – DOM assisting decision making;
- Trust staff to cohort & EMAS Manager to manage;
- Ambulance to hospital chair where appropriate, to rapidly free DCA resource and equipment (Fit2Sit);
- Assess the situation – Engage with key people – Actions in place – Update wider EMAS – Withdraw and monitor.

Appendix 4: Plan for Dissemination of Procedural Document

Title of document:	**Managing Delays in the Safe Handover of Patients SOP**		
Version Number:	**V2.0**	**Dissemination lead: Print name, title and contact details**	**Pete Ripley**
Previous document already being used?	**Yes**		

Who does the document need to be disseminated to?	• **Operational Management Teams**
	• **Local Resourcing Teams**
	• **Staff in roles in:**
	  • Accident & Emergency (A&E),
	  • Patient Transport Service (PTS),
	  • Emergency Operations Centre (EOC),
	  • Hazardous Area Response Team (HART)		

Proposed methods of dissemination: **Including who will disseminate and when** Some examples of methods of disseminating information on procedural documents include: *Information cascade by managers* *Communication via Management/ Departmental/Team meetings* *Notice board administration* *Articles in bulletins* *Briefing roadshows* *Posting on the Intranet*	**Information cascade by managers** **Communication via Management/ Departmental/ Team meetings** **Notice board Administration** **Posting on the Intranet**		

Note: Following approval of procedural documents it is imperative that all employees or other stakeholders who will be affected by the document are proactively informed and made aware of any changes in practice that will result.

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APPENDIX B

Falls Response Programme

Performance Summary

This new pilot has been funded through the £300,000 allocated by Lincolnshire County Council to develop the response for people who have fallen. The delivery of the pilot is being led by LIVES and is anticipated to run until June 2019.

During 2017/2018, EMAS responded over 8,000 times to people who had fallen in Lincolnshire. This collaborative agreement enables the provision of a service to improve the speed of response to someone who has fallen in the county, thus reducing avoidable admissions to hospital, whilst also allowing our emergency crews to prioritise the most life-threatening patients."

Initially one FRP vehicle was provided and went live on the 19 December 2019 based at Boston Ambulance Station and very quickly followed by a second unit going live in January based out of Market Rasen. Though there have been some teething problems with how the FRP was deployed, we are now in a position for both FRP vehicles to respond to all Falls.

When a 999 call is assessed as a fall, the FRP – a LIVES responder fully trained to deal with this category of patient – will travel to the scene in an EMAS vehicle. For details about the process to be followed, including the observations and patient record details to be taken on scene, please refer to the FRP Standard Operating Procedure (see below)

The FRP operate seven days a week (including bank holidays), from 08.00 to 20.00 hours initially, and will be reviewed on a regular basis to enable amendments in response to changes in demand.

- Approx. 50% increased deployment (across both assets)
- No patient safety incidents
- Positive patient feedback report to LIVES
- New SOP in place
- Some reduced referrals.

Operational Procedure for FRP

Calls being received by the dispatcher for any type of fall can be allocated to the FRP.

Calls that have been triaged by CAT as a category 4 fall will be suitable for an FRP responder with no automatic back up. The potential deployment will be identified by the CFR desk/ CAT or any appropriate dispatcher, but it is the decision of CAT.

The FRP may also respond to C2 and C3 calls if they are nearest and most available. This will still be required to be supported with an EMAS resource and remain a waiting call unless the responder contacts CAT when on scene and the CAT clinician decides otherwise. The CFR SOP provides the governance for the responders to be deployed to these categories of call.

All taskings **MUST** be through EMAS EOC. Tasking from other sources **MUST NOT** be accepted and the caller should be referred to the EMAS EOC.

The FRP will operate between 0800-2000hrs 7 days a week including bank holidays. This may be subject to change/adjustment due to operational needs. If so, this will be communicated to

- EMAS Duty Ops Manager
- Locality Clinical Ops Manager
- LIVES Operational Support Manager
- EOC Duty Manager

The responders will undertake the following operating procedure

Arrive at the vehicle base station no later than 0800 and collect the keys for the vehicle.

Sign on duty using the signing on sheet located on station. The callsign for the vehicle and crew names **MUST** be inputted into this document.
Complete the pre-shift 'daily checks' as per the EMAS Safer Ambulance check SOP (See folder in the cab of the ambulance).

Log on using the terrafix within the vehicle upon shift commencement

Proceed to the patient location when deployed by EMAS EOC. Acknowledge the call on terrafix and press mobile once deployed

Once on scene, utilise the 'At scene' function on the terrafix screen to notify EOC.

Undertake clinical activity as detail within the responders LIVES scope of practice.
Complete an EMAS EPRF, this should be annotated with **'EMAS/LIVES Falls response partnership**. Make a record on the EPRF as to whether a DNACPR or other similar document exists, these must be taken with the patient, if transported. If there is an EPRF failure, revert to paper PRF and report the fault.

Ensure that the vehicle is cleaned between each patient and restocked as necessary as detailed in the EMAS Safer Ambulance check SOP

Ensure that the vehicle is thoroughly cleaned, restocked and refuelled at the end of each shift. Replace any consumables from station at the end of shift or when required.

The vehicle must be refuelled with bunkered fuel only at. In extreme circumstances where fuel is required off station due to significant miles, then the fuel card may be utilised. This must be logged with the duty COM.

Upon returning the vehicle to station, the Responder should ensure that it is ready for the following day, securely locked and the keys must be returned to the key safe. Ensure the fuel card is present at start and end of shift and report any loss as early as possible.

Detailed Performance Table

FRP Volumes	19-12/18 - 13/1/19	W/C 14/1/19	W/C 21/1/19	W/C 28/1/19	W/C 4/2/19	W/C 11/2/19	W/C 18/2/19	W/C 25/2/19	W/C 4/3/19	W/C 11/3/19	TOTAL	
Number of calls referred to LIVES	44	12	12	9	11	9	15	18	11	23	**164**	
Stood down before arrival at scene	8	1	1	2	3	2	3	0	1	3	**24**	
Number attended by LIVES	36	11	11	7	8	7	12	18	10	20	**140**	
Number of responses which result in patient discharged at scene	28	8	7	3	7	4	11	11	9	14	**102**	
Percentage discharged at scene	78%	73%	64%	43%	88%	57%	92%	61%	90%	70%	**73%**	
Number of responses which result in an EMAS vehicle being deployed	8	3	4	4	1	3	3	7	2	3	**38**	
Number of patients conveyed to hospital	8	3	4	4	1	3	3	7	2	1	**36**	
Time from receipt of 999 call to LIVES response dispatch (Average)	Not Available	01:59:01	02:25:32	02:21:21	01:35:47	01:00:24	01:34:14	03:56:12	01:33:42	01:30:44	**01:59:40**	*Average*
Time from LIVES response dispatch to discharge or conveyance to hospital (Average)	Not Available	02:04:54	02:13:28	01:47:03	01:38:14	01:19:33	01:49:43	02:36:25	02:17:47	02:01:37	**01:58:45**	*Average*

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Appendix C

Transformation Brief

April 2019

1. Home First:

- Second phase of Home First complete with outcomes being taken forward for the 100-day challenge.
- The 100-day challenge commences on the 2nd April with an emphasis of supporting the Frail and Elderly within the community in 4 specific areas:

a) Gainsborough to support Frail patients being looked after locally rather than go to A&E by utilising community Nursing teams and direct access into Scotter Ward Transitional beds
b) Stamford to improve a Falls referral service cross border
c) Lincoln City to see how better we can look after homeless
d) Mablethorpe to concentrate on the very frail

2. Grantham Emergency Assessment Unit (EAU):

- Regular meetings are very productive as we continue to use this facility
- 33 patients admitted in March and Nurse teams very keen to support an admission criterion for Low Acuity falls
- Grantham EAU has formed part of the agenda for the Ambulance Handover and conveyance group to support the ULH ED's with the acceptance criteria for patients within the Grantham area.

3. Lincoln County ED:

- Discussions around EMAS having direct admission to the Frailty Assessment Unit. Plans to introduce a formal SOP process criterion
- Ambulatory Emergency Care Unit (AEC) looking at allowing access for EMAS crews if they meet the criteria which will be developed between ULH and our Clinical Improve Lead.
- New Urgent & Emergency Care (UEC) Improvement lead recruited for both LCH & Pilgrim Hospital
- Ambulance Handover and conveyance group. EMAS are supporting ULH and the CCG with the work to support the active handover. This group is chaired by NHSi

4. Pathways in and out of hours Primary care (North & North East Lincs)

- Unscheduled Care Teams – North Lincs – Rotating Paramedic – Writing up proposal. More discussions required
- Care Plus Group – Still ongoing work to improve referral process
- Home First discussions in relation to mirror a similar event in Scunthorpe & Grimsby as we did with Lincolnshire. Talks still ongoing with proposed plans and dates to be confirmed.
- North & North East Lincolnshire CCQ are engaged with this project to support ED avoidance. The North area has the highest conveyance to ED's
- Lindsey Lodge Hospice have advised that they have received some funding from NHS England to work with care homes in the North & North East to provide training and support for end of life care. EMAS have been invited to be part of this work to look at care homes that are higher users of the 999 service.

5. Peterborough Hospital

- Working with PCH ambulance handover and conveyance group to support demand with the system. The East of England Ambulance service have a HALO and we are supporting them with the work that they are undertaking.
- Utilising the pathways that East of England Ambulance service use with direct access to wards and other departments to avoid ED.

6. Care Home Initiative

- We are working in partnership with Marsh Medical Practice where we have introduced Specialist Paramedics (SP's) to support the GP's by attending Care Homes to reduce hospital admissions.
- 2 x SP's will work across 5 GP practices covering 56 Care Homes on the East Coast funded by NHS Resilience funding for a year.
- Established in late January 2019, the initiative is already receiving good feedback with the aim of offering support and education to Care Homes, reducing inappropriate clinical admission to Hospital and the introduction of robust advanced care planning.

7. Rotating Paramedic Pilot

- National funding from Health Education England secured to be one of 5 pilot sites in the country
- Specialist Paramedics embedded in Primary Care carrying out GP Home Visiting and Cat 2 / 3 calls for the patients registered at the Practice
- Advanced discussions with GP Surgeries in the North East, West, East and South of the county to part fund posts following the end of the pilot

- SP's embedded to work collaboratively with a range of providers within the community with the aim of keeping patients with complex needs in their own homes
- The success of the scheme has attracted national attention and has recently been seen on BBC National news
- Huge recruitment and retention potential for the organisation / Division
- Provision of system wide support

8. <u>Alternative Care pathways for Non-Conveyance</u>

- Paramedics making appointments through CAS
- Refresh knowledge of crews to remind them of pathways available
- Take yourself to hospital SOP introduced in October 2018

9. <u>Clinical Assessment Services – (CAS)</u>

- Plans for GP practices to be open Monday-Friday 0800-2030 and at weekend but times still to be confirmed.
- Telemedicine discussions around Q-Doctor & Q-Health and looking at further use of telemedicine technology. Trials ongoing in Lincoln Care Homes.

10. <u>Care Home monitoring: *whzan*</u>

a. There is a pilot being conducted within a care home in Lincoln to use telehealth monitoring equipment called WHZAN (see link below) where we can monitor a patient through a web address without the need to be on scene and take appropriate action if the condition deteriorates. This pilot is still in its infancy, but early indications are very positive. HomeHealth are also involved in supporting the project

https://www.whzan.com/public/Home.aspx

b. St Michael's are actively using this system and whilst it is early days yet, initial feedback is that both the care home and HomeHealth team are finding it beneficial. We have had one example where the resident's NEWS2 score was high and they called EMAS straight away, rather than routing it through the HomeHealth Team, and it proved to be absolutely the correct thing for them to have done. It gave them the confidence to make a good choice.

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