Delivering prehospital enhanced care: a volunteer solo responder's first year from inception to service development and improvement

12 REGISTRAR IN EMERGENCY MEDICINE

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Background Prehospital emergency care (PHEC) involves provision of hospital level care to patients prehospitally, often beyond the capability of local ambulance services. The availability of PHEC is variable, often delivered by Air Ambulance charities during their operational hours, and when not, by volunteer doctors (BASICS). This abstract relates to BASICS in the Thames Valley region (UK), and specifically, the process of quality assuring and developing such a service with the constraints of limited funding and time. The intervention described is the development of a solo responder, providing independent PHEC with indirect consultant supervision.

Strategy for improvement After sign off, an iterative process for service development started, involving electronic post incident reflections with subsequent face to face discussions. This was key to identifying good practice, development areas and root cause analysis of issues with near-peer review facilitating asynchronous, distance based discussions.

Improvement was based on number of incidents attended, and delivery of enhanced care. Any appropriate activation was taken as an improvement, in that the incident, patients and emergency staff would otherwise not have access to enhanced care other than conveying to hospital. Results are incomplete at present, however preliminary are as follows:

- 91 responses involving 106 patients
- 58 'assists' – attended to, and left care of the ambulance crew
- 23 'escorts' – patients subsequently escorted to hospital
- 4 paediatric and 5 traumatic arrests 3 sedations 1 resuscitative thoracotomy

Conclusions

1. The process from inception to service delivery requires significant financial, time and personal investment from the individual responder
2. Whilst post incident reflections help drive learning, ongoing obstacles include limitations of skillset such as PHEA, expenditure e.g. fuel, continuing professional development and equipment maintenance/upgrading and funding for this.

Quality improvement

13 COORDINATE MY CARE: INCREASING PREVALENCE AMONG COPD PATIENTS

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Backgrounds Coordinate My Care (CMC) is a London-based initiative which aims to make patient advanced care plans

(ACP) accessible across trusts and within the community. Established in 2012, CMC is a relatively new form of ACP and although evidence indicates high usage by paramedics, CMC frequency among patients with life-limiting conditions is low.

Aims We aimed to implement a series of system-based changes to increase the number of CMC records from 22% to at least 50% among chronic obstructive pulmonary disease (COPD) patients known to the Integrated Respiratory Team (IRT) who were nearing the end of life.

Methods We implemented two Plan, Do, Study, Act cycles (PDSA) based on discussions with IRT. Throughout the first PDSA cycle we introduced a palliative care nurse at weekly IRT meetings to facilitate discussion of CMC. During PDSA cycle two we ensured that patient specific pathways (PSPs), a form of ACP kept by the patient in case of emergency, were uploaded onto CMC.

Results Over 12 weeks, we increased the percentage of patients with CMC records to 24.4% after PDSA cycle 1% and 34.2% after PDSA cycle 2 (increase of 2.4% and 12.2% from the baseline respectively).

Discussion Whilst keeping a palliative care nurse in IRT meetings may not be a long-term, maintainable, cost-effective intervention, we hope that uploading PSPs onto CMC will be a sustainable change as it is low-cost and time efficient. Making these procedural changes through identifying problems within the team, we hope that these initiatives could be applied to a wider patient population.

Mendical engagement

14 IMPROVING MEDICAL ENGAGEMENT IN A LARGE MENTAL HEALTH TRUST

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Background Poor medical engagement in NHS organisations has many detrimental effects. Trusts with better medical engagement, do better on a range of measures. These include patient outcome and experience, as well as financial performance.

Avon and Wiltshire Mental Health Partnership Trust (AWP) is a large provider of mental health services in England. Last year our Chief Executive engaged the Trust with 'Listening into Action' (LiA). This is an ethos whereby staff take a bottom up approach to solving issues within the organization affecting staff, patients and carers. LiA uses an innovative '7 step' approach to tackling issues identified through the Pulse Check survey and 'CrowdFixing' events.

When we conducted the initial survey, it clearly identified medics as the most dissatisfied and disengaged staff group.

There have been problems with recruitment and retention because of poor medical engagement.

Engagement as a concept has supplanted what was previously thought of as commitment, motivation and job satisfaction.

Objectives To improve the medical engagement in the Trust and reduce attrition rates and agency spend.

Methods Quantitative assessment via a 'Pulse Check' survey of all staff, repeated after a year. We followed this with