Keeping Patients Safe in the Stack (KPSITS) QI Project

In January 2023, a QI project was commenced utilising the DMAIC framework. The purpose of the project was to reduce harm to patients awaiting a clinical call back. Working with colleagues in EOC, the QI project is about keeping patients safe in the stack.

NHS
South East Coast Ambulance Service
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For more information, please contact quality.improvement@secamb.nhs.uk

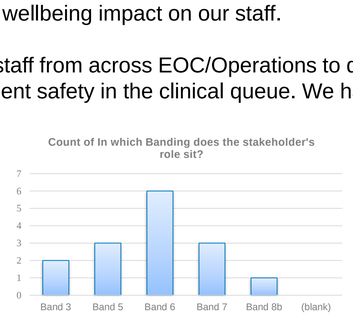
Define

The trust is currently failing to meet the national ARP standards for all categories of call, and this has been the position consistently for two years now.

We are seeing a **high volume of duplicate calls into the service** (mean of 26%) and data from a recent harm review indicates that our **poor performance is having a negative impact on our patients**. For each one min increase in mean response time per month to C2 incidents there are 3.88 more harm DATIX report per average month (70000).

We know that we are not necessarily able to get to patients any quicker due to bigger, system wide issues so we need to focus **on keeping them safe whilst waiting**. We are aware that failing to reach patients in a timely manner is also having a significant wellbeing impact on our staff.

We have engaged staff from across EOC/Operations to date who all want to see improvement in patient safety in the clinical queue. We have also engaged with patients



A large proportion of stakeholders believe that the problem with the clinical queue stems from demand and the volume of calls in relation to the number. of clinical staff available.

The following suggestions were provided from stakeholders to improve management of the clinical queue:

- Use of text messaging to communicate with patients and allow them to cancel calls
- Patients on the floor not to be validated
- Manage expectations by telling people expected wait times
- The ability to ask patients for photographs to support decision making.

A focus group was also set up to understand the views of the patient and reflect the **voice of the patient** in the improvement work.

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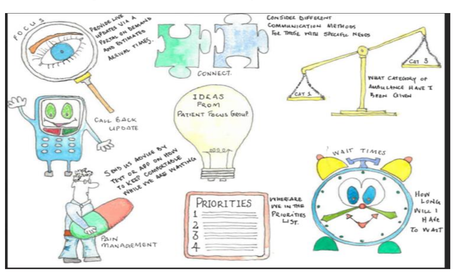


Sketch note showing feedback from patient focus group

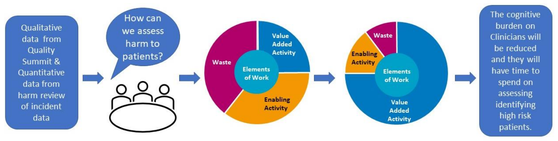
Measure

We undertook process mapping and identified the following opportunities for improvement among others:

- Accepting calls for validation – could this be automated in some instances?
- Variation in risk assessment for priority call back
- Automation of high-risk patients for call back?
- Time spent closing / manually managing duplicate calls for clinicians and dispatch
- Welfare calling

When we started the project, we reviewed over 6,000 Datix incidents but quickly identified looking at incident data alone was not helpful due to **the bias associated with this data.**

As such, the improvement strategy agreed was to focus on **reducing non-value adding activity,** thus reducing the cognitive burden on clinicians and allow them sufficient time to assess and identify high risk patients.



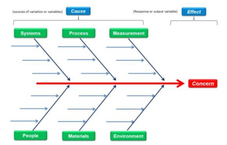
Analysis of the data told us that:

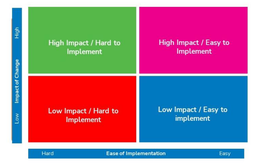
- Automating the closing (or highlighting) of duplicate calls could **save 42.7 clinical hours per week.**
- When patients call back within a 24-hour period the **3rd (26%) and 4th (25%) time they call back are the most likely to be upgraded**
- A patient with **'probable stroke'** symptoms who called back the 2nd, 3rd or 4th time were the most likely to be upgraded (48%) which is more than the priority stayed the same (45%).
- The team have designed a dashboard to track a number of metrics..
- 'A patient with 'lower back pain' who called back the 2nd, 3rd or 4th time **stayed the same priority** 69% of the time (upgraded 27% of the time); blunt leg injuries stayed the same priority 59% of the time (upgraded 16% of the time)
- Identifying the variance in those calls identified for clinical prioritisation could help in reducing variation and increase prioritisation for calls that require prioritisation the most:
    - Probable stroke calls have 0.67 variance which is quite low, however only 8% were prioritised for call back even though the probability of upgrade is high
    - Knee/lower leg pain or swelling have 0.63 variance which is low, and was called back 56% of the time – however these incidents stayed the same when people called back 59% of the time
    - Medical (1.62), Medical Minor (1.52) and Trauma (1.39) have the highest variance for clinical prioritisation, and the majority of patients who call back with these symptoms remain the same priority and the welfare calls stay the same.

Analyse

As part of the analyse phase we undertook root cause analysis and an options appraisal workshop which identified the following areas for improvement. The agreed KPIs/metrics for improvement are to:

- **Automate closure of duplicate calls**
- **Amend call handling instructions**
- **Reduce the number of welfare calls undertaken.**



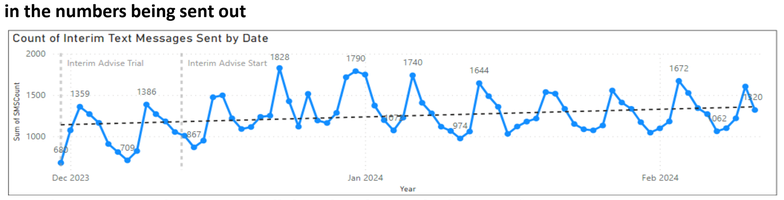


Improve

Progress has been made by the team on implementing interim care advice by text and implementing a new call closure script with the ETA included. These will have an impact on duplicate call volumes and Average Handling Time (AHT). Some of the High Impact Hard to implement initiatives are still outstanding as these are sitting with Cleric for development.

Control

Interim Care advice went live in December with an increasing trend in the numbers being sent out



No improvement in Average Call duration due to the impact of new starters but we will continue to monitor this.