Emergency department capacity is an ongoing issue, due to multiple factors including increasing attendances, rising acuity and exit block. Standby for potentially or actually unstable patients are essential to ensure immediate availability of appropriate staff and location. However, standby use was variable, resulting in significant patient safety issues. This prompted multidisciplinary involvement and resulted in review and modification of the wider standby process, with engagement from all stakeholders.

**Aims**

We reviewed the Ambulance Service standby procedures locally. JRCALC provides information on how to deliver a standby call, but no clinical guidance on appropriate patients. A multidisciplinary group consisting of Emergency Department medical and nursing staff, Ambulance Service team leaders and area managers, developed clinical criteria for standbys. These included adults and children requiring urgent resuscitation for physiological derangement, time critical conditions such as CVA and sepsis, and trauma with significant mechanism or associated fatality. These criteria were cascaded to all ambulance staff.

We prospectively audited each standby received, and cases included in the guidance with no standby. Individual feedback was given to Ambulance staff via their team leaders with open discussions of cases. Learning points and recurrent issues were fed back to the wider team. The process of handover in the ED was reviewed, and a SOP produced to support a succinct ATMIST or SBAR handover. Full attention is given from all ED staff, with only essential treatment such as CPR continuing during handover. Feedback is given both contemporaneously and via team leaders, and Ambulance staff are also empowered to feed back to the Emergency Department.

**Methodology**

Emergency department capacity is an ongoing issue, due to multiple factors including increasing attendances, rising acuity and exit block. Standby for potentially or actually unstable patients are essential to ensure immediate availability of appropriate staff and location. However, standby use was variable, resulting in significant patient safety issues. This prompted multidisciplinary involvement and resulted in review and modification of the wider standby process, with engagement from all stakeholders.

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**Results**

Since initiating the criteria and formalising handover, there has been significant improvement in appropriate standby calls and information sharing. Overall the numbers of non standby cases has fallen in terms of overall numbers. Interdisciplinary team working has improved considerably during this process. Audit and feedback are ongoing. Additionally several common presentations have been noted to show improvements both from SAS management and within the ED including CVA and sepsis cases.