Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	14th July 2022
Paper number	Enc D

Ambulance Handover Performance Report

For approval:		For discussion:	X	For assurance:		To note:	

Accountable Director	Paul Brennan, Deputy CEO and Chief Operating Officer		
Presented by	Paul Brennan, Chief Operating Officer	**Author /s**	Tracy Pearson, Deputy Chief Operating Officer

Alignment to the Trust's strategic objectives (x)							
Best services for local people	X	Best experience of care and outcomes for our patients	X	Best use of resources		Best people	

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	• **Discuss** our performance in relation to ambulance handovers within the context of the wider urgent and emergency system pressures • **Consider** the specific actions identified to improve performance

Executive summary	The report outlines the current status of our performance in relation to ambulance handovers. Both Emergency Departments (ED) on the Alexandra Hospital (AH) and Worcestershire Royal Hospital (WRH) sites have experienced a significantly deteriorating position. Challenges with capacity and patient flow out of the departments mean that the EDs are holding a large number of patients in the department waiting for beds and therefore creating overcrowding and an inability to offload ambulances in a timely manner. Our urgent and emergency care system is one of the poorest performing systems and specific targeted support is being offered by the NHS England national team. The report provides a summary of the safety measures in place to ensure patients delayed on ambulances are safe and clinically prioritised. The key immediate next steps with system partners are described to improve patient flow.

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Risk			
Which key red risks does this report address?	*19, 20*	**What BAF risk does this report address?**	*4,11, 19,20*

Assurance Level (x)	0	1	2	X	3	4	5	6	7	N/A	
Financial Risk	Status report and actions to address delays of ambulance handovers Financial risks associated with failure to progress patients to wards in a timely manner resulting in lost ward activity, increased staffing in EDs to manage patients.										

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	X	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y		N	X		
If no has the action plan been revised/ enhanced	Y	X	N			
Timescales to achieve next level of assurance	**September 2022**					

Introduction/Background

1. Introduction or background

1.1 Improvement of ambulance handover times to release West Midlands Ambulance Service (WMAS) crews is a Worcestershire urgent and emergency care system priority. WMAS currently rate the handover risk as their highest corporate risk, scoring 25 (5 x 5) on their risk register.

1.2 There is increased national focus on systems and acute trusts due to the local and national deteriorating position of ambulance handovers and the direct risk this has on patients receiving emergency and lifesaving care in a timely manner.

1.3 The regular updates on our performance and improvement work in relation to ambulance handovers are included in HomeFirst Committee Report, Divisional Performance Review Meetings, divisional meetings and included in our Integrated Performance Report

1.4 This paper outlines our current performance in relation to the expected standard of 15 minutes to handover (from the time that a WMAS crew arrives on sites to the handover of the patient to our clinical team) and our current performance. Our ambition is to achieve zero over one hour delays by September.

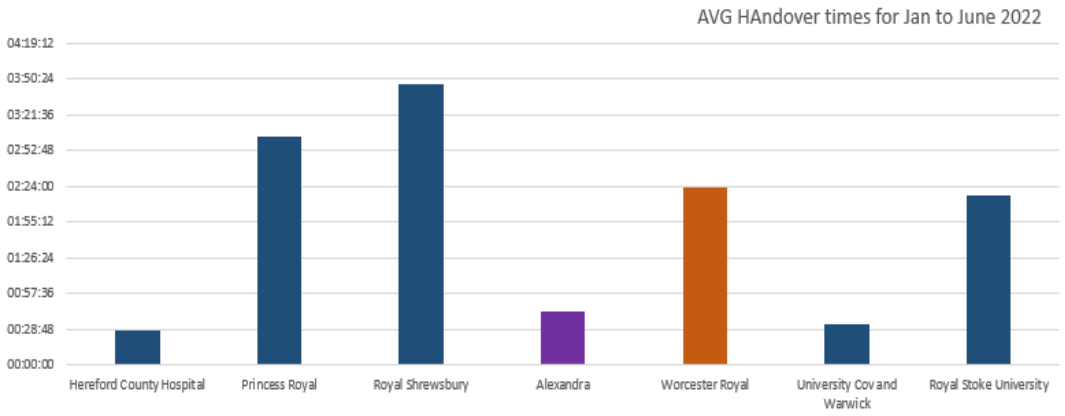
1.5 The report outlines the steps taken to manage safety for those patients who are not handed over within 15 minutes

1.6 The graph below provides a benchmark of the AH and WRH against five other hospitals in the West Midlands area with similar demographics and serving both town/city and rural locations. The WRH site is the third worst performing hospital for ambulance handovers in the last 6 months with an average of 2 hours 22 minutes.

Average Handover Times

Table and graph shows the average handover times for the last 6 months for selected Trusts from the West Midlands (data taken from WMAS).

Trust	Site	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	AVG
Hereford	Hereford County Hospital	00:20:13	00:23:10	00:20:23	00:30:54	00:39:20	00:33:29	00:27:55
Shrewsbury & Telford	Princess Royal	03:18:46	02:38:29	03:01:42	03:44:47	03:07:09	02:31:14	03:03:41
	Royal Shrewsbury	02:20:20	04:21:59	04:31:16	03:21:20	04:52:20	03:05:43	03:45:30
Worc Acute	Alexandra	00:32:14	00:26:49	00:25:35	00:27:24	01:11:22	01:13:23	00:42:48
	Worcester Royal	01:55:06	01:58:50	01:37:36	02:40:59	03:38:44	02:23:56	02:22:32
University Cov and Warwi	University Cov and Warwick	00:34:20	00:25:01	00:25:37	00:29:03	00:38:44	00:48:25	00:33:32
Uni Hosp Noth Mids	Royal Stoke University	02:35:03	01:23:16	01:02:32	03:55:45	02:35:59	02:03:06	02:15:57



1.7 The report provides further actions we are taking to improve our ambulance handover times, see section 4.

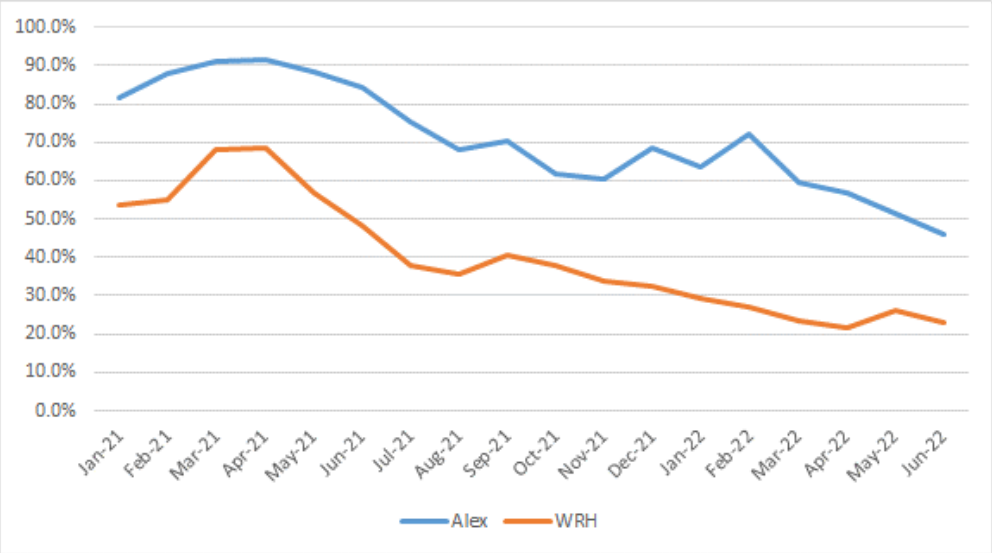
Issues and options

2. Ambulance Handover Performance

2.1 One of the main contributory factors to poor handover times is overcrowding in our Emergency Departments (ED), with the main issue being lack of patient flow out of the ED. If patients were to be moved out of the ED within 30-45 minutes of referral to specialty teams and managed in assessment units, the ED team would have a better chance in managing surges in activity and delivering against emergency access metrics. Section 3 of this paper will outline some of the steps the Trust is taking to address safety and improve the outflow issue.

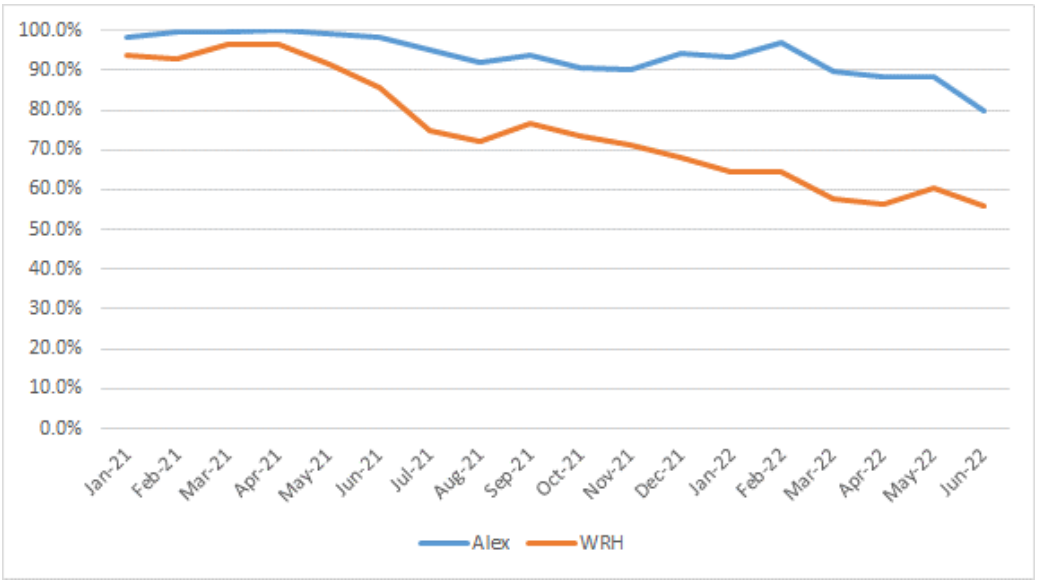
2.2 Percentage handovers within 15 mins (target 100%)

The graph below shows deterioration on both our sites for the number of ambulances handed over within 15 minutes of arrival.



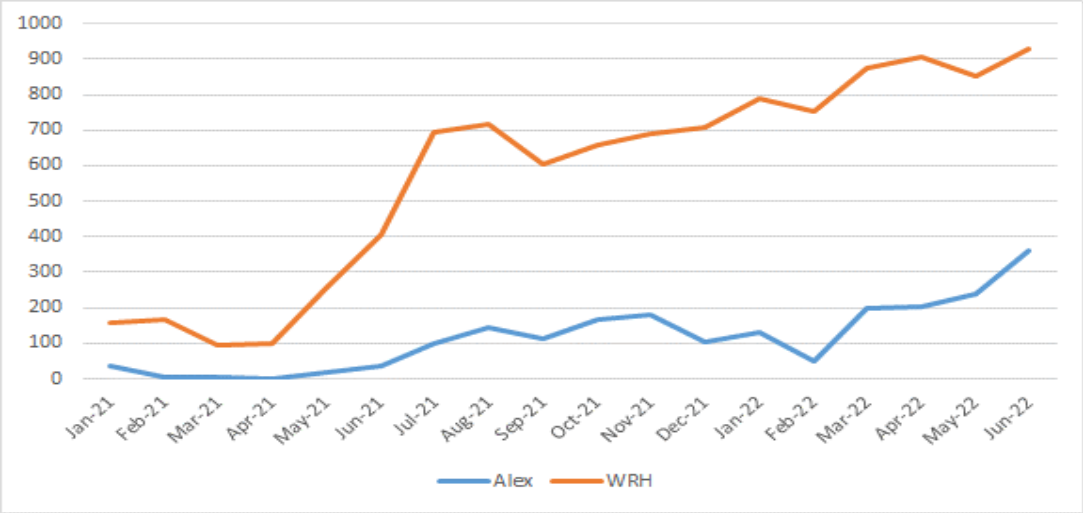
2.3 Percentage handovers within 60 mins (target 100%)

Ambulances handed over within 60 minutes of arrival demonstrates a deteriorating position particularly for the WRH site since April 2021.



2.4 Number of ambulances held for >60 mins (target 0)

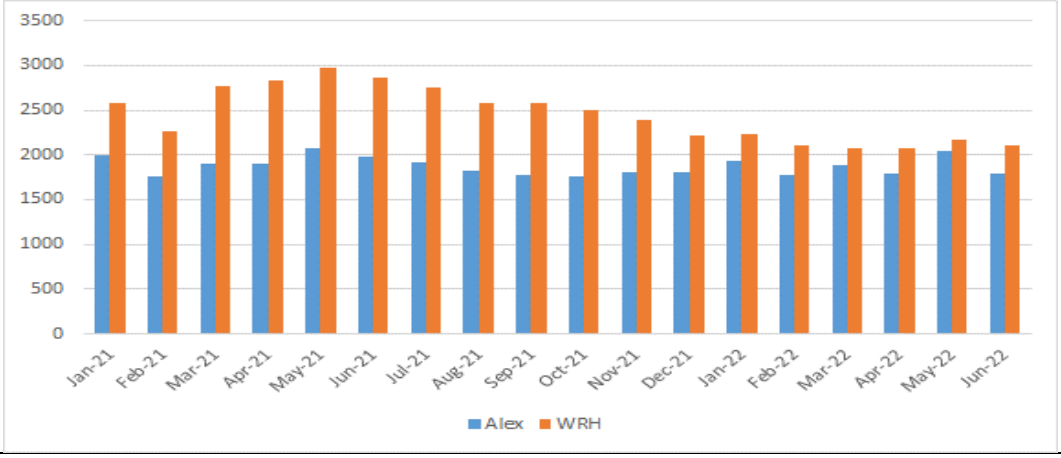
The number of ambulances that were held for more than 60 minutes shows that both sites have an increasing number since April 2021 with a significant increase noted on the WRH site.



2.5 Total number of emergency conveyances.

The graph below demonstrates that WRH has seen a reduction in the number of ambulance conveyances to the site since May 2021, with the AH site seeing a steady increase which can in part be attributed to WRH activity been directed to AH site during times of extreme ED pressures and a post code divert (DY post code) which commenced in quarter Q1.

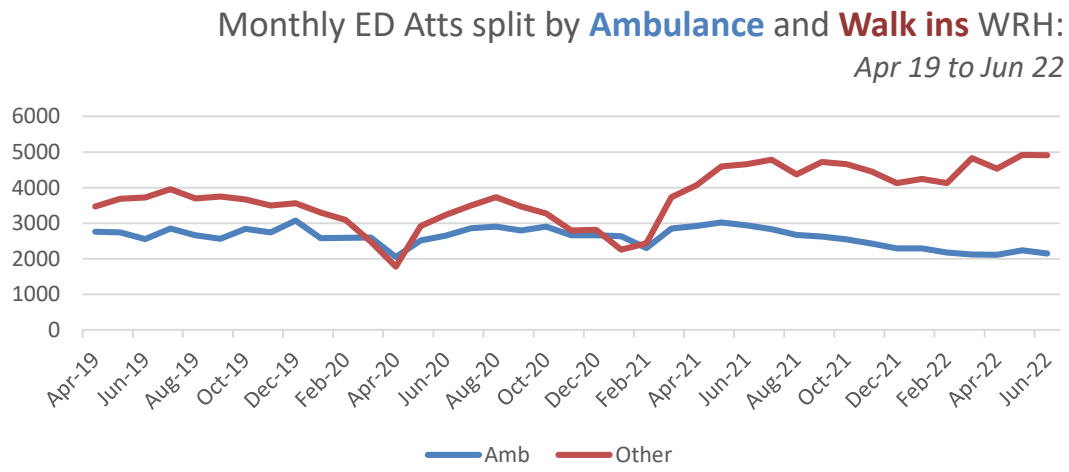
The correlation of increased ambulance handover delays on the WRH site is therefore not as a direct result of ambulance conveyances to site, but instead resulting from patient flow issues and an increasing number of overall ED attendances for patients self-presenting resulting in overcrowding in the department.



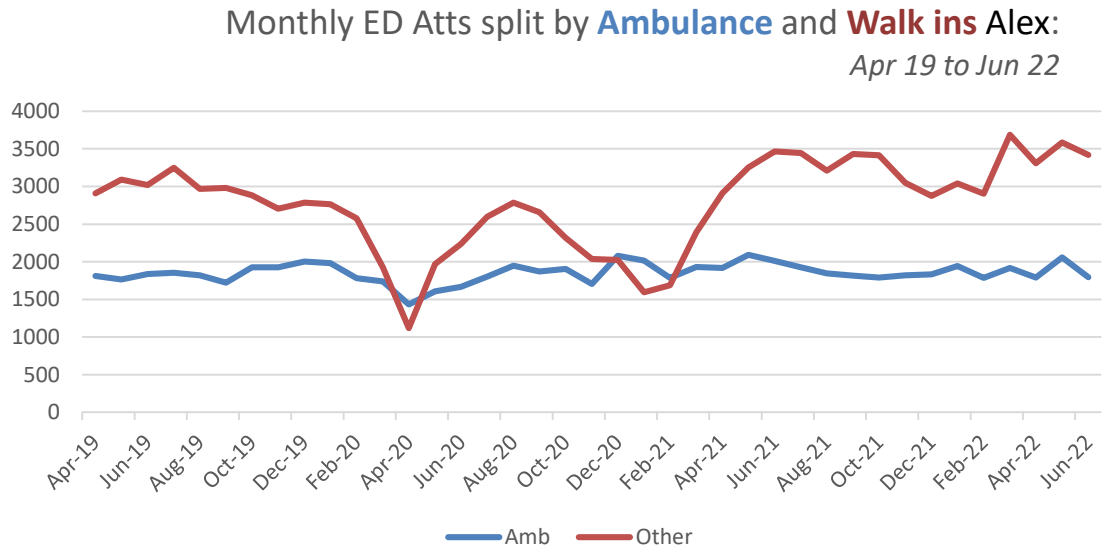
2.6 Increasing Attendances

The graphs below show a marked increase in ED attendances on the WRH site and AH sites. Reducing ambulance attendances are likely impacted by the delays in handover and patients are increasingly self-presenting with overall ED attendances showing an increasing trend.

This increase in overall attendances is contributing to the overcrowding experienced in ED, though the primary issue remains with flow to inpatient beds which in turn is impacting on the department's ability to take handover of patients arriving by ambulance in a timely manner.



At WRH you can see the reducing Ambulance conveyances compared to the significant increase in walk in patients



At AH there is a steady position of ambulance conveyances with a significant increase of walk in patients evident.

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3. Patient Safety Measures

Maintaining patient safety is the number one priority for the Trust and ensuring patients do not come to harm whilst waiting in ambulances has been a focus for the Urgent Care Directorate.

Measures in place to support patient safety include:

- Any patient waiting 1 hour plus to offload has a global risk assessment tool (GRAT) risk assessment completed by a trained ED nurse.
- Hospital Ambulance Liaison Officer (HALO) on site 5 days a week 10am to 6pm to liaise with ambulances outside
- Escalate to site lead when resus corridor becomes full
- ED Safety huddles between GRAT nurses and consultants to review which patients are 'fit to sit' and which could be streamed elsewhere
- Consultant completed a GRAT pilot study to see if a consultant working on ambulances would improve turnaround times and length of stay. The impact on patient care was minimal as once patients entered the ED, they were found to be waiting for hours for a specialty bed.
- Home First work streams
- NHSe/MoD review Nov 2021 which showed an urgent need to open additional capacity providing an acute medical unit (AMU)
- Daily performance monitoring
- Urgent Care Transformation Plan providing 30 extra beds going live on 11/07/22 with the opening of 8 extra AMU spaces in the white space and 21 spaces in the pathway discharge unit. It is envisaged that this reconfiguration will support enhanced SDEC-level pathways and shift focus onto non-bedded care through outpatient areas.

4. Next Steps and Further Actions

A system wide approach is required to improve patient flow and decompress the emergency departments. The below provides a series of further actions aimed at improving outflow from ED which will have direct and positive impact on the departments ability to complete ambulance handovers.

- Development of a new AMU providing an additional 8 spaces to support flow – opened 5th July
- Opening additional capacity at WRH site for a pathway discharge unit (PDU) 11/07/22 providing 21 additional bed spaces.
- Working with system partners to extend opening hours and the breadth of on-site services in MIUs around the county
- Further work via the Rapid Improvement Cell to support earlier in the day discharges
- Development of system wide plan to meet the '100-day challenge' by 30th September.
- As part of the 4ward improvement system, patient flow and discharge is a prioritised stream of work.
- System actions have been agreed and are summarised in table below

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System actions for eliminating over hour ambulance delays by 01/09/22:

System Leaders
Enhance daily Urgency Emergency Care (UEC) dashboard with further granularity of data to be monitored by senior execs across the system each am – include a trajectory for improvement week by week.
Develop a 7 days a week senior leadership function devoted to delivery of daily/hourly actions to reduce delays and implement actions at pace.
Enhance real time use of escalation/action modules on SHREWD and training to be delivered / refreshed
Implement ambulance handover protocol
Weekly clinical case review, including WMAS to review cases / taking learning to improve practice and feed back to system clinical teams
Worcestershire Acute Hospitals Trust Actions
New bed management process being implemented 5/7/22 aligned to best practice designed to embed accountability/responsibility – target for movement out of ED hourly, and targets per ward for simple discharges with senior exec consistent messaging and urgent training
Update full hospital protocol and train staff groups urgently
Pharmacy 7 days a week to support discharge
Health and Care Trust Actions
If more than 5 pathway 2 patients ready to go and awaiting capacity for general rehab on WRH site the HACT to absorb patients into bed stock at risk
2 hour response lead to contact SOC hourly, go through stack and pull patients into 2 hour response – 10-6, 7 days per week
Senior Exec to hold weekly DTOC meeting and escalate to partners real time
Social Care Actions
If more than 5 pathway 1s ready to go and awaiting capacity on WRH site PW1 to absorb patients sharing the risk
Senior lead focus working with HACT on back door waits for long term care reporting daily to the system
Confirmation on rapid response in the community provision and ensuring this is well publicised
Confirmation of rapid response in ED and ensuring service provision is well publicised
Integrated Care Board Actions
Reducing delays in the ‘ Fast Track ‘ Discharge Process
Revisit protocols to deliver single point of contact for GP referrals within the Acute Trust to prevent GP referrals attending ED
Delivery of 100 day system discharge challenge

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Conclusion

Worcestershire Acute Hospitals Trust EDs are experiencing extreme pressure due to patient flow and as a consequence are experiencing lengthy delays for patients arriving by ambulance. Whilst the number of ambulance conveyances are lower, the total number of ED attendances has increased significantly particularly on the WRH site. This is impacting on both sites as ambulances are frequently diverting to the AH site.

A number of safety measures have been in place for some-time and continue to be monitored and refined to ensure patients experiencing delays into ED are managed safely.

A series of improvement measures have been developed and are coming online to support outflow from the ED department. These actions are both Trust and system wide focussed.

Recommendations

- **Discuss** our performance in relation to ambulance handovers within the context of the wider urgent and emergency system pressures
- **Consider** the specific actions identified to improve performance