

Summary

This report highlights the findings of our review of the experience of patients waiting on board an ambulance outside emergency departments during delayed handovers. The key findings of our review are outlined below.

It is clear from our review that the issue of prolonged handover delays is a regular occurrence outside Emergency Departments (ED) across Wales. Whilst patients were positive about their experience with ambulance crews, it is clear that handover delays are having a detrimental impact upon the ability of the healthcare system to provide responsive, safe, effective and dignified care to patients.

Whilst there are clear expectations and guidance for NHS Wales³ in relation to hospital handovers, and a clear and apparent will to meet and achieve these, there are substantial challenges inhibiting the ability of the NHS in Wales to do so. The problem of delayed handovers is symptomatic of the wider issue of patient flow throughout the NHS, with consequent increased risks to patients associated with prolonged waits on ambulance vehicles outside EDs, impacting the ability of WAST to coordinate responses for patients waiting in the community for an ambulance.

Our review has noted that whilst work is ongoing to try and tackle this issue, with various approaches and initiatives in progress at a national level, such as the development of a National Quality and Delivery framework for Emergency Departments in Wales⁴, which commenced in 2018, it is unclear how effective these activities have been to date. This is not a problem that WAST can resolve by itself, it is a challenge that requires WAST, health boards, and Welsh Government to work together and consider whether a different approach is required to ensure reinvigorated, strengthened and concerted action is taken to make sure that these issues are overcome.

Whilst we found that overall, handover processes at EDs across Wales are broadly similar, some variations exist in processes between individual EDs within health board areas. This was due to a number of local joint Standard Operating Procedures (SOPs) being in place within WAST and EDs, due to geographical layouts of ED environments, staff roles and levels of staffing available. This inconsistency can introduce risk, with our findings indicating that some WAST staff may be unfamiliar with SOPs specific to the ED that they are handing over to.

Further to this, feedback suggests that local handover processes can differ from day to day, depending sometimes on the clinician and or member of ED staff being dealt with. Again, we are concerned that this inconsistency could have a detrimental impact on patient care and safety and requires attention.

It is concerning that our review found that only 41% of WAST staff clearly understood who has responsibility and accountability for the patient at all times. This is despite three quarters of ED staff reporting that they clearly understood who is responsible for the patient. Ensuring absolute clarity over who has responsibility for patient care on board an ambulance following triage, until transferred in to the ED, is an important issue requiring attention to ensure safety of care.

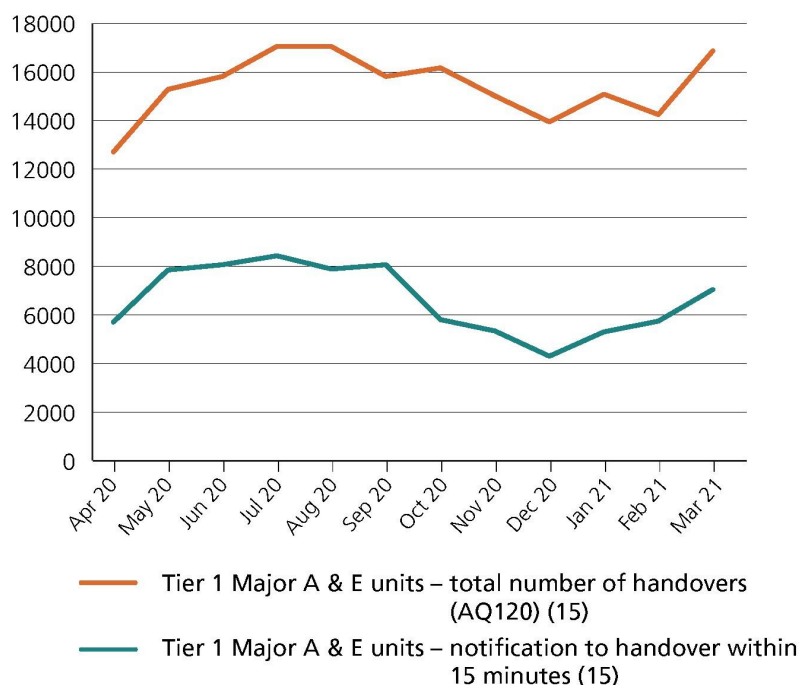
Some health boards have introduced specific roles with the purpose of improving handover processes, such as Ambulance Patient Flow Co-ordinators or Hospital Ambulance Liaison Officers (HALO); these have reportedly had a beneficial impact on handover, and on patient experience by ensuring better coordination of the process. However, these roles are not in place across all EDs, and we believe that all health boards should consider the benefits that these roles may bring.



3 Wales Hospital Handover Guidance 2016 <https://gov.wales/sites/default/files/publications/2019-07/nhs-wales-hospital-handover-guidance.pdf>

4 The Emergency Department Quality & Delivery Framework Programme www.nccu.nhs.wales/urgent-and-emergency-care/framework/

This is highlighted in the chart below and relates to over 105,000 handovers falling outside of the Welsh Government target.



The impact of handover delays is that there are occasions where multiple ambulances are waiting together outside EDs for long periods of time. This can often affect the service to the extent that there are no ambulance resources available to respond to new emergencies within the community, thus increasing the risk to patient safety or life.

WAST data demonstrates that between April 2020 and March 2021, there were 32,699 incidents recorded across Wales, where handover delays were in excess of 60 minutes, of which, 16,405 involved patients over the age of 65. This is a concern since many older adults can be considered more vulnerable and at risk of unnecessary harm due to frailty and pre-existing health conditions which are more common with older age.

Data published by Welsh Government of the recorded number of lost hours as a result of hospital handover delays, highlight that in December 2020, a total of 11,542 hours were lost due to handover delays. This is a further monthly increase in the data published in the 2018 Amber Review Report, as highlighted earlier. These delays have serious implications on the ability of the service to provide timely responses to patients requiring urgent and life threatening care.

Patient flow issues, such as system bottlenecks and discharge problems can negatively impact on the availability of beds within EDs, since the departments cannot transfer patients to wards due to insufficient ward bed availability. These concerns were echoed by numerous WAST and ED staff within our survey. Patient handover delays are not directly a WAST problem, but are a consequence of wider systemic patient flow issues through NHS healthcare systems and social care services. Concerns were also highlighted to us of severe overcrowding within EDs, which leads to the inability to offload patients from ambulances. This is consistent within a number of our findings during previous HIW inspections of EDs across Wales.

We found handover delays impact on the ability of ambulance crew to provide a positive experience for patients. It may also increase the risk to patient safety, through delays in diagnosis and receiving treatment, as well as to the risk to people awaiting an ambulance in the community, with fewer ambulances available to respond to their needs.

During our review of WAST in 2019-20, we made a recommendation to WAST to consider a holistic review with stakeholder engagement, of the handover arrangements in place across Wales, to help address the patient flow issues through NHS healthcare systems.