Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Welsh Ambulance Services NHS Trust

Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover

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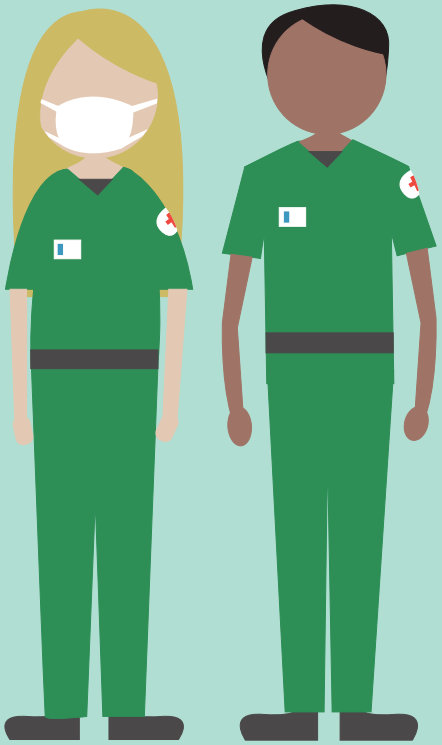

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare.

Our values

We place patients at the heart of what we do.

We are:

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

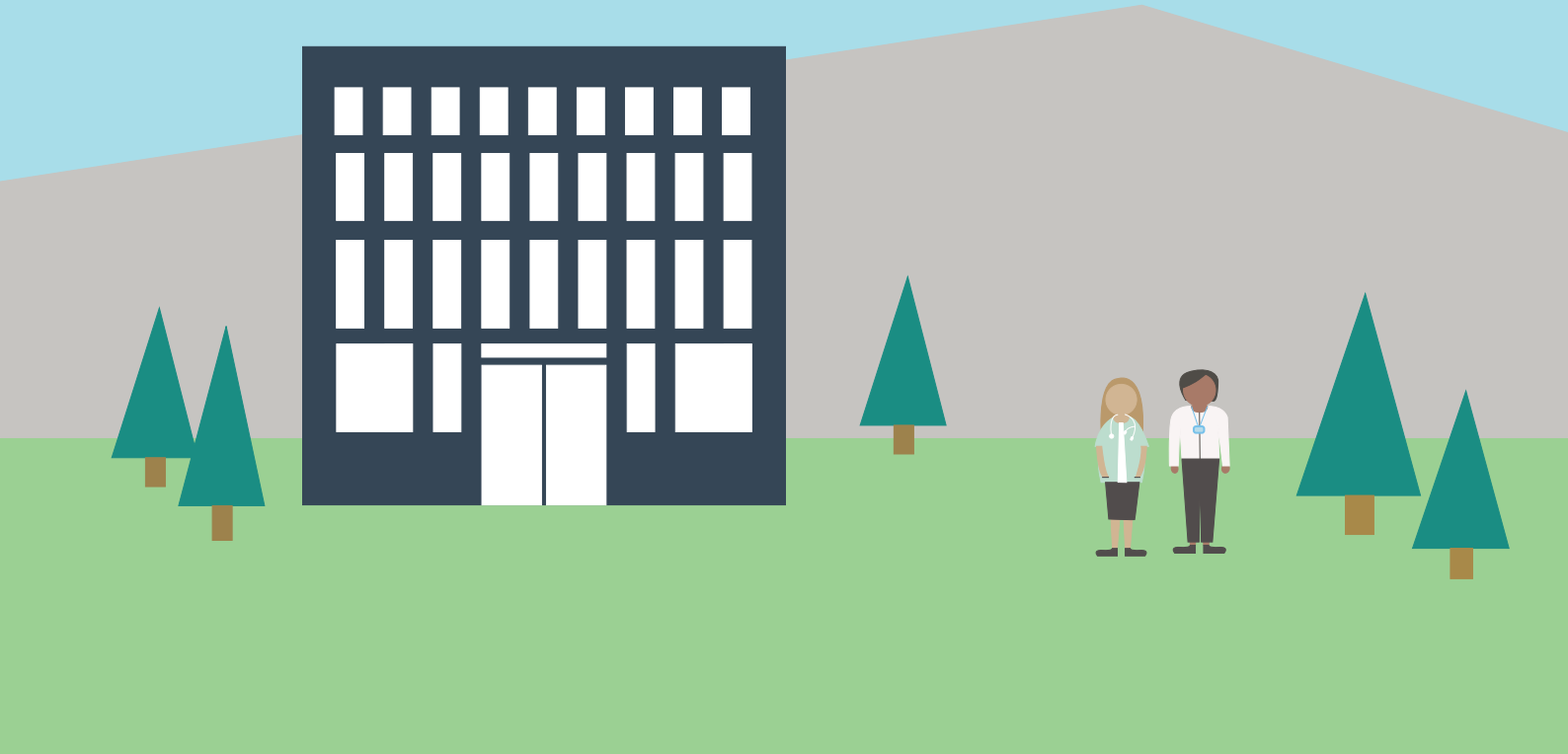
Our priorities

Through our work we aim to:

Provide assurance:
Provide an independent view on the quality of care.

Promote improvement:
Encourage improvement through reporting and sharing of good practice.

Influence policy and standards:
Use what we find to influence policy, standards and practice.



Introduction

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. We are responsible for inspecting, reviewing and investigating NHS services and independent healthcare services throughout Wales against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. In our role, it is important that we maintain an overview of each of the NHS health boards and Trusts in Wales.

The COVID-19 pandemic has introduced unique and unprecedented pressures on the healthcare system, however, it is our continued commitment and goal to check that people in Wales are receiving good quality care, which is provided safely and effectively, in line with recognised standards.

As part of the HIW annual reviews programme for 2020-21, we committed to undertake a review of the Welsh Ambulance Services NHS Trust (WAST). This was due to concerns identified with long handover delays during a previous WAST local review carried out in 2019-20, where we explored how the risks to patients' health, safety and well-being were being managed, whilst they were waiting for an ambulance to arrive. A copy of this report can be found on our website[1].

This review set out specifically to consider what the impact of ambulance waits outside of Emergency Departments is having on the overall experience of patients, which included their safety, care, privacy and dignity. We considered the period between 1 April 2020 and 31 March 2021.

This report sets out our findings and recommendations for improvement. It is our expectation that our recommendations are considered at a system level and are taken forward in the context of broader improvement work underway to tackle the challenges faced in this area over recent years.

We would like to express our thanks to all of the patients who helped inform our review by completing our survey and sharing their experiences with us. We also convey our gratitude to staff working within WAST and health boards across Wales who participated in this review, which included completing our professional surveys and participating in interviews with the HIW review team.

In addition, we wish to thank the Community Health Councils[2] in Wales, which provided their support in developing our questionnaire and with obtaining patient views.

1 www.hiw.org.uk/sites/default/files/2021-09/20200923WASTReviewFinalENG.pdf – WAST Review

2 Community Health Councils (CHCs) are independent bodies who listen to what individuals and the community have to say about the health services with regard to quality, quantity, access to and appropriateness of the services provided for them. They then act as the public voice in letting managers of health services know what people want and how things can be improved.

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 Wales[3] 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 Wales[4], 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/

Attention is required from WAST and health boards regarding some of the specific operational challenges faced by staff during the handover process. This includes the need to address some of the procedural challenges associated with timeliness of handover process. There is also a need to ensure that procedures to provide timely investigations, such as blood tests and X-rays, for patients on board ambulances awaiting handover are strengthened. This would have the benefit of enabling ambulance crews to be released, to undertake their primary role of providing on scene urgent or emergency care.

We found there are appropriate processes in place to escalate a deterioration in a patient's condition to ED staff. It was disappointing to find however, that only 49% of staff we engaged with felt there was a robust process in place. More work is required from WAST to ensure the escalation process is clearly communicated to and understood by its staff.

WAST also needs to ensure that its workforce is adequately supported, and that staff wellbeing is maintained, when they wait for long periods on board an ambulance due to delayed handovers. Some approaches have improved the situation, for instance the introduction of the Duty Operational Manager which has facilitated crews to take their allocated breaks, and to finish their shift on time wherever possible, by taking over the care of patient. However, work remains on WAST's behalf to ensure that it adopts a consistent approach across Wales to support its workforce.

Improvements are also needed to strengthen collaborative working between WAST and health boards in relation to communication and the management of serious incidents arising from delayed handover. This includes the need to ensure health board representatives attend WAST Serious Clinical Incident Forum (SCIF) meetings, to enable timely management of concerns, development of action plans and ensure learning via feedback throughout the organisations.

Concerns were also highlighted to us around the consistency of feedback from incident reporting within WAST. Our findings highlight the need for WAST to identify more effective processes for sharing feedback and learning from incidents with ambulance crew following incident investigations, to improve quality and safety of patient care. In addition, WAST needs to do more to ensure that its staff feel confident that any concerns they raise would be addressed.

Patients were generally positive about their experiences and provided good feedback about ambulance crews, particularly in relation to their kindness, overall communication and management of distressing situations. Patients reported that they were treated with dignity and respect by ambulance crews, and felt safe and cared for. Patients also indicated that they were satisfied with the care and treatment from ED staff. Overall, our findings indicate that the severe impact of the pandemic did not negatively affect the experience of patients who used emergency ambulances services across Wales, and that on the whole patients were satisfied with the care provided.

Whilst patient feedback has been positive, this should not detract from the issues associated with delayed handover. It is clear that there are genuine frustrations held by WAST and health board staff regarding their inability to effectively carry out their roles as a consequence of this issue. The positive experiences shared by patients should also not detract from areas of concern regarding patient care, including the difficulties in facilitating patients to access a toilet during their wait, the risk to patients of sustaining skin tissue pressure damage, and the problems faced in providing them with food and drink. In addition, a number of staff raised concerns about their ability to appropriately achieve and appropriately maintain high standards of hygiene and infection, prevention and control measures on board the ambulance.

We have found that whilst WAST has developed clear systems, which identify risks, provide mitigation and escalate concerns, it is clear that these systems alone are not enough and more collaborative work between WAST and health boards is required to resolve the issue of prolonged handover delays.

Context

WAST is the primary frontline service delivering ambulance transport in Wales. The Trust was formed in 1998, and serves a population of around 3.2 million people across seven health boards in Wales.

WAST responds to more than 1800 emergency calls a day across the country. It operates 24 hours a day, 365 days a year, and provides emergency medical services, advice and appropriate signposting to other healthcare services. In addition to emergency transport, WAST also provides a Non-Emergency Patient Transport Service (NEPTS)[5], as well as hosting the 111[6] service, which consists of the NHS Direct Wales[7] and clinical triage elements of the GP out-of-hours services[8].

The workforce is made up of over 3,500 staff who contribute to the delivery of patient care across Wales. In addition, it has over 300 vehicles based in 90 ambulance stations across Wales which work collaboratively with the three Emergency Medical Service Clinical Contact Centres (EMSCCCs) in Wales.

WAST ambulance crews are highly skilled professionals who are able to treat and stabilise patients before taking them, if necessary, to the most appropriate hospital. The ambulance vehicles hold a wide range of emergency care equipment including oxygen, a defibrillator, advanced life-saving equipment and emergency drugs including pain relief.

A range of information sources indicate that ambulance waiting times, outside hospital EDs, can be excessive, particularly when the healthcare system is under pressure. These information sources include Welsh Government ambulance monthly performance indicators, Serious Incident notifications to Welsh Government, intelligence held by WAST, media reports, and discussions between HIW and senior staff within both WAST, and health boards. In addition, delays in the handover process with EDs resulting in reduced ambulance availability, were highlighted during HIW's local review of WAST during 2019-20, and within the Amber Review report publised by the Emergency Services Committee in 2018[9].

In response to these issues, our review set out to consider the impact of ambulance waits outside of EDs on patient safety, privacy, dignity and overall experience. The review set out specifically to consider the impact that ambulance waits outside EDs are having on the overall experience of patients, and considered the period between 1 April 2020 and 31 March 2021.

As part of our review, we also engaged with all health boards across Wales providing emergency care. This included Aneurin Bevan, Betsi Cadwaladr, Cardiff and Vale, Cwm Taf Morgannwg, Hywel Dda and Swansea Bay University Health Boards. Each of the health boards have between one and three EDs within their localities, with a total of 12 across Wales.

Powys Teaching Health Board does not provide an emergency care service, although does provide minor injury care within its four Minor Injury Units (MIUs) across its localities.

5 Non-Emergency Patient Transport Services are provided to get patients, who are unable to transport themselves due to medical reasons, to and from hospital and clinic appointments.

6 The 111 service is an online or free telephone number available 24 hours a day, providing health information, advice and access to urgent out-of-hours primary care.

7 NHS Direct Wales is a health advice and information service available 24 hours a day. It has operated across Wales for many years and forms the backbone of the 111 service which is currently operating in four of the seven health board areas in Wales and will, over time, be replaced by 111 entirely.

8 The GP out of hours service is for people who need urgent medical treatment but cannot wait until their doctor's practice is open.

9 Amber Review Report 2018 www.wales.nhs.uk/sitesplus/documents/1134/NHS-Amber-Report-ENG-LR.PDF

The map below details the location of each ED and MIU across Wales:

What we did

Focus of review

We reviewed how patient safety, privacy, dignity and their overall experience was managed by WAST ambulance crews and health board ED staff, whilst they waited on-board ambulances during delayed handover to ED staff. To achieve this, we explored the following five areas:

- **Patient handover** – to consider the procedures in place between the WAST and each acute hospital ED for accepting patients from ambulances into the care of health board staff
- **Patient experience** – to assess the overall experience of patients whilst waiting in an ambulance to include their safety, care and any impact on their wellbeing. We also considered how patient dignity is maintained and needs are met, to include nutritional, hydration and toilet needs
- **Workforce** – to consider the impact of handover delays on ambulance crew to include their welfare and support
- **Escalation processes** – to consider the risk management and escalation arrangements of WAST during periods of high pressure as a result of delayed handovers
- **Governance arrangements** – to consider incident reporting, investigation of incidents of patient harm due to delayed handovers and learning from incidents.

Scope and methodology

The pandemic introduced unique and unprecedented pressures on the healthcare system; in view of this, we considered patient experiences between 1 April 2020 and 31 March 2021 in order to understand what impact the pandemic had on this issue.

To review the areas detailed above, we requested relevant documentation and issued a self-assessment document to WAST and each health board. We also considered local and national performance data and statistics.

We held interviews with a variety of WAST staff, and conducted a survey for both WAST and health board staff.

In addition, we conducted a survey of people who used the emergency ambulance service in the 12 month period highlighted above.

Self-assessment

We asked six of the seven health boards across Wales to complete and return a self-assessment document. This helped us to understand the degree of insight each health board has of its strengths and areas for improvement with the process in place for ambulance patient handover, and the management of patients awaiting handover.

We wanted to understand the views of the public and staff on ambulance handover delays, and developed and launched two national surveys to help capture this information.

Staff survey

We developed and launched a staff survey to obtain the views of WAST and health board staff on the patient handover processes in place between ambulance crew and ED staff. This was to help us understand the impact of delays in the process on staff well-being, and to identify any areas for improvement.

We asked WAST and health boards to distribute our online smart survey details to relevant staff, and we also promoted the survey through our social media channels.

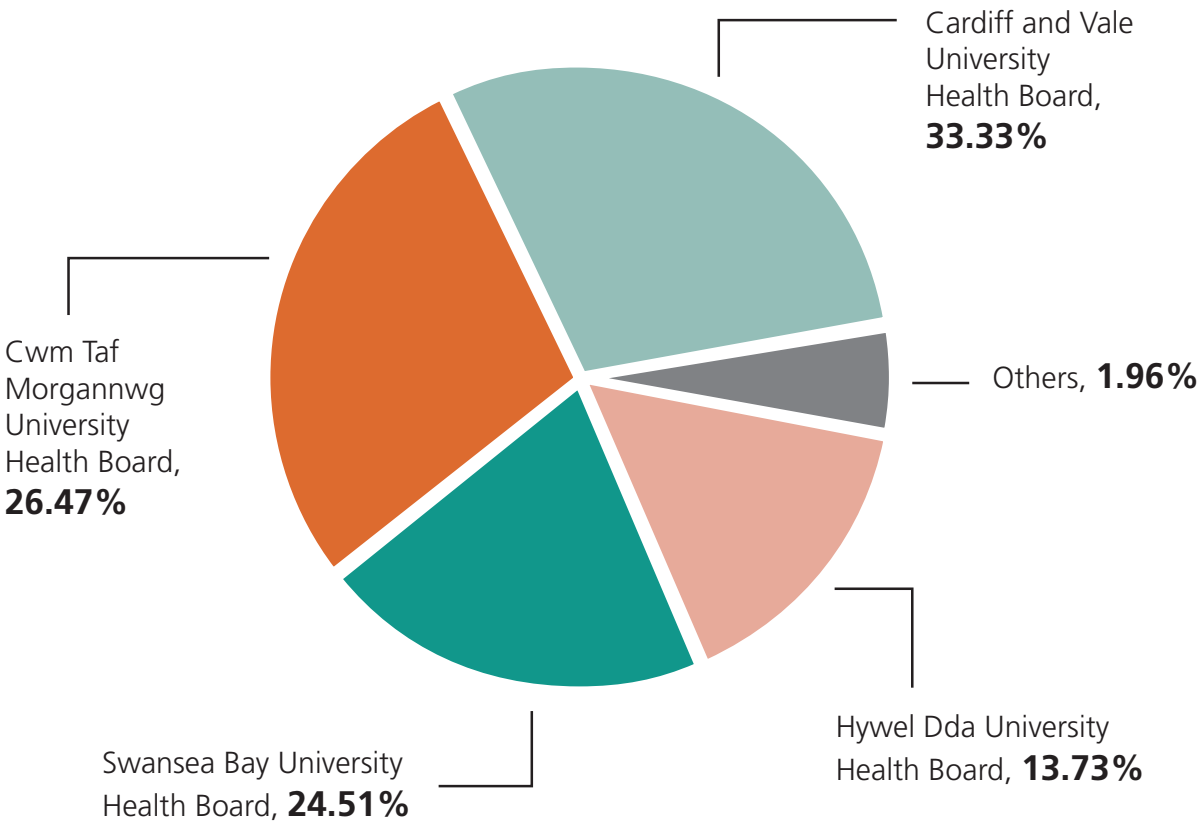
We received a total of 438 responses, which covered a range of staff across Wales, which included:

- 271 WAST Paramedics and Ambulance Technicians
- 64 'other' WAST staff, which included First Responders, Duty Operational Managers and Urgent Care Assistants
- 98 health board ED staff and ED managers
- 5 'other' ED staff which included Patient Flow Managers.

Despite engagement with the six health boards providing emergency services, only staff within four health boards provided a response. We therefore did not receive the opinions from ED staff working within Aneurin Bevan University Health Board and only one response was received from Betsi Cadwaladr University Health Board. These two health boards cover four of the 12 EDs across Wales. Therefore, where reference is made to ED staff survey comments, this may not be reflective of staff within Betsi Cadwaladr or Aneurin Bevan University Health Boards.

Breakdown of staff responses per health board

Which Health Board / Trust are you employed by?



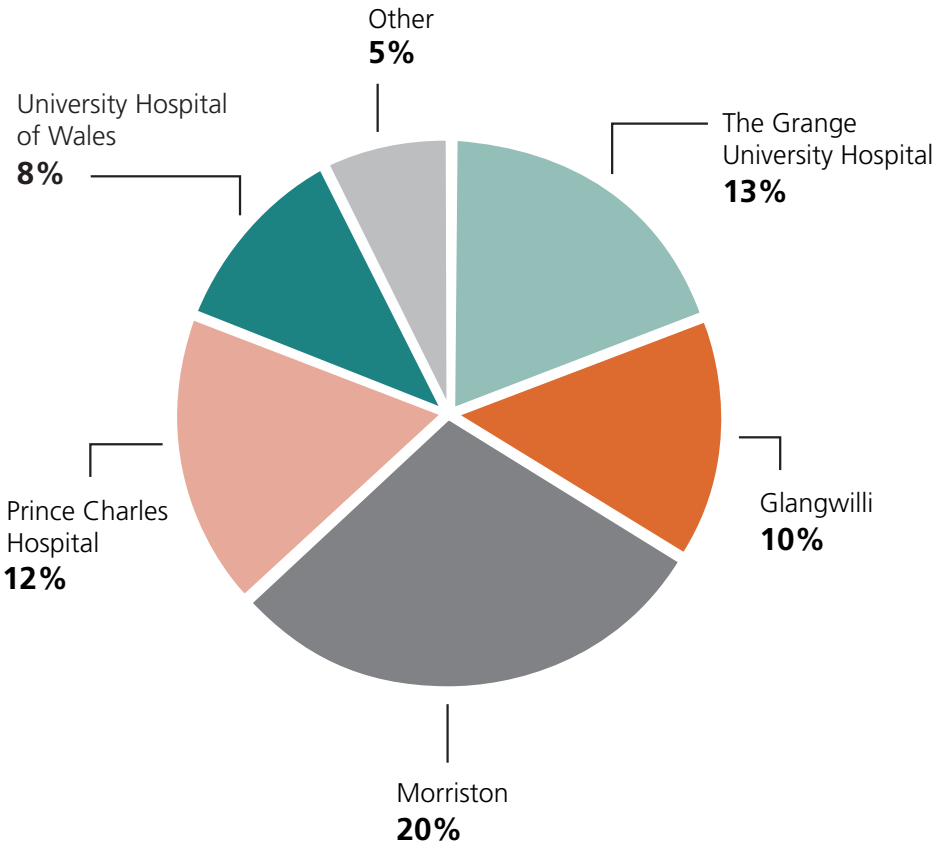
Public survey

In parallel with the staff survey, we also launched a national public survey, to capture the views of patients who had used an emergency ambulance. This was to gain an understanding of their experiences whilst waiting on board an ambulance outside an ED.

The survey was distributed via smart survey and was open to all people in Wales to capture the views of those who used WAST emergency services between March 2020 and April 2021. We engaged with WAST, health boards, and also the Community Health Councils in Wales, who provided their support with obtaining patient views.

We received a total of 137 responses, with 85% having used WAST emergency services within the last 12 months. Representation was from patients who had attended EDs across health boards in Wales.

Public Survey response per hospital



Staff Interviews

Due to restrictions in place relating to the COVID-19 pandemic, the majority of our fieldwork was completed remotely, including most of our staff interviews. Where we completed site visits, each was individually risk assessed to minimise the risks to our staff and healthcare providers.

We held a number of interviews with ambulance crews from across Wales. This included Paramedics, Ambulance Technicians, Duty Operational Managers and Urgent Care Assistants. Staff we interviewed shared their views and experiences of working within the service, which included the main challenges they faced with handover delays.

As part of our fieldwork, we also interviewed senior staff from within the Trust, including members of the Executive Team. We completed a total of 31 interviews and our findings will be highlighted throughout the report.

What we found

The handover process

It is a regular occurrence across Wales for multiple ambulances to be stationary outside hospitals for prolonged periods, waiting to hand over their patients to the health board.

Wales Hospital Handover Guidance 2016[10]

The hospital handover guidance issued by Welsh Government in 2016 stipulates the need for timely handover of patients from ambulance crew to hospital staff, to optimise performance and patient care. The guidance highlights that health boards are responsible for arranging the safe emergency transfer and timely treatment of citizens in their local area.

The statement of intent within the guidance indicates that the safety, effectiveness and patient dignity must be at the forefront of systems of emergency care. In addition, that the best care is provided to patients in the correct care environment. Therefore, when an ambulance crew takes a patient to hospital, it is essential that they are released promptly so they can continue to provide a safe and efficient service to the local community.

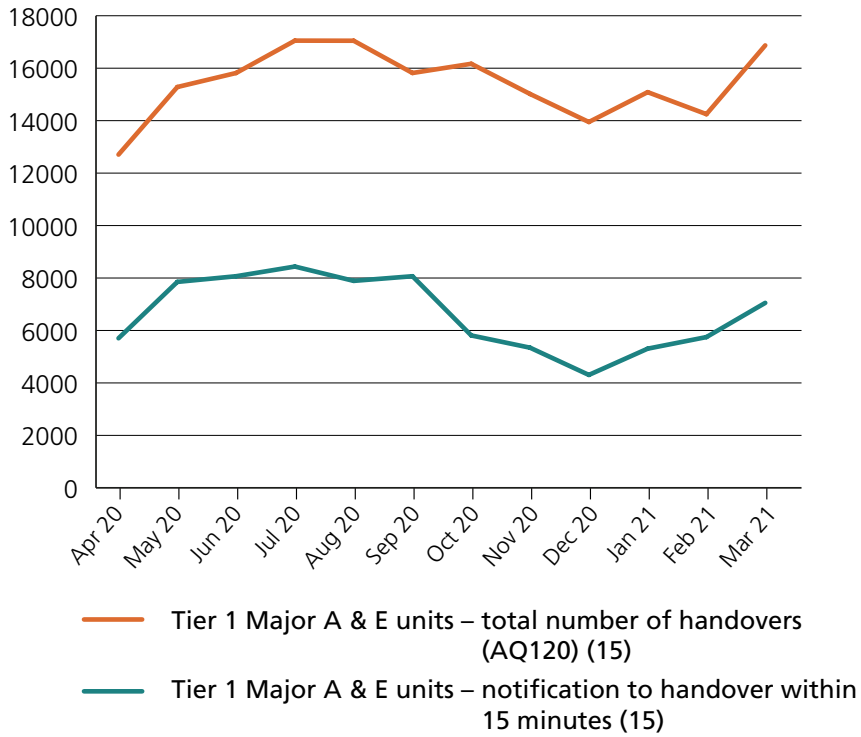
According to the above guidance, when a patient is conveyed to a hospital by ambulance, care must be handed over to the hospital team within 15 minutes. Health boards are responsible for ensuring this happens reliably. Hospital clinical staff must ensure that any patient waiting more than 30 minutes has been assessed and moved immediately into hospital if there is a risk to patient safety. Management of delays of over 60 minutes are unacceptable, and Welsh Government states that they should be the exception.

Data published by Welsh Government on the StatsWales[11] website, highlights that between April 2020 and March 2021 there were approximately 185,000 handovers at acute EDs throughout Wales. Of which, just over 79,500 occurred within the target of 15 minutes.

10 Wales Hospital Handover Guidance 2016

11 Ambulance Quality Indicators – Number of notification to handover within 15 minutes of arrival at hospital Tier 1 Major A&E units (AQI20ii)

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.

The Trust has been working on actions to make improvements in this area and with its stakeholders since 2020. However, our review has found ongoing issues in relation to patient flow within each health board across Wales. We have therefore recommended that Welsh Government considers how this broader issue can be tackled, and to coordinate a collaborative approach to ensure consistency across Wales.

Recommendation

Health boards and Welsh Government should consider what further actions are required to make improvements regarding the patient flow issues impacting on delayed patient handover. This may include consideration of whether a different approach is required by WAST, health boards, and social care services within Wales, to that taken to date in tackling this system-wide problem.

Ambulance arrival at ED

Six health boards were asked to complete a self-assessment regarding ambulance patient arrival and handover procedures within their EDs. The assessment responses helped us to understand the degree of insight each health board has into its own strengths and areas for development with ambulance patient handover.

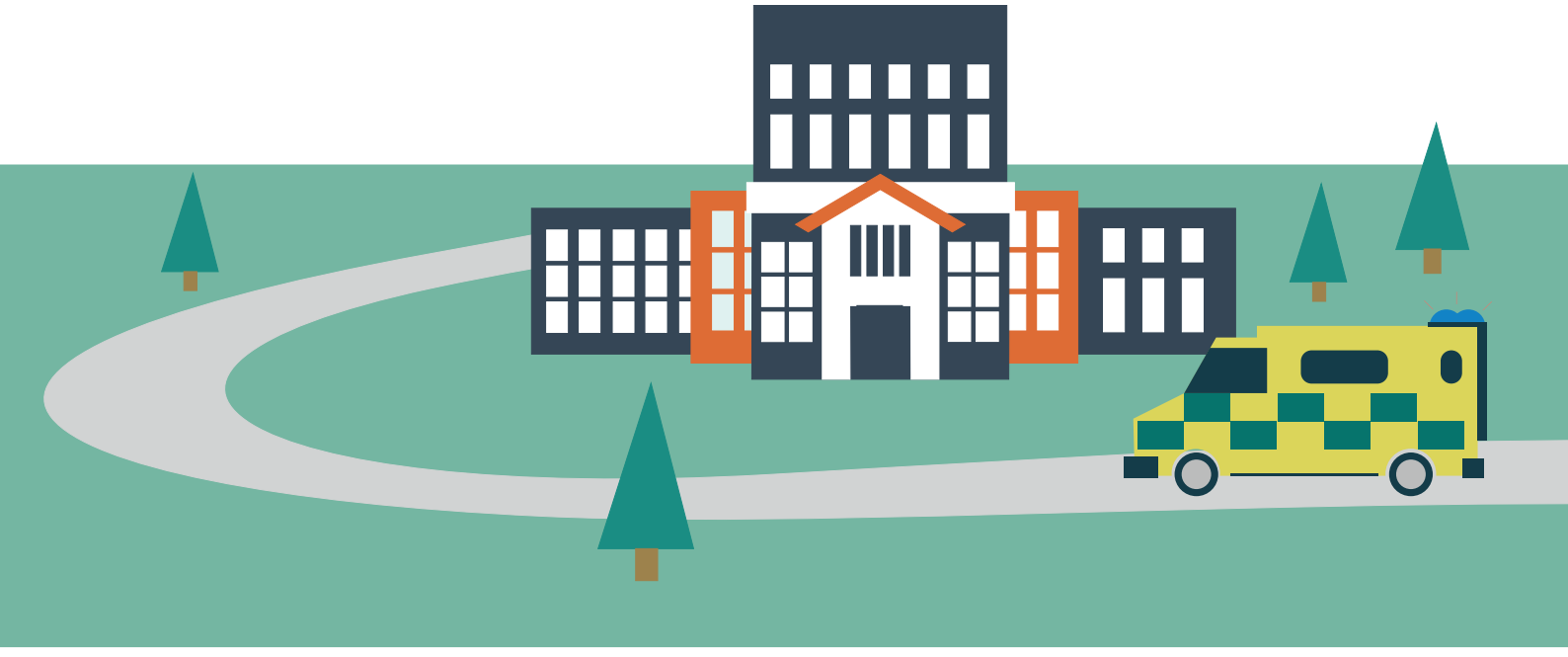
Overall, we found that handover processes across Wales were broadly similar. There were, however, some variations in processes between each individual EDs within health board areas, and some disparities with the processes in place across health boards in Wales. This was due to local joint SOPs being in place within WAST and EDs, due to geographical layouts of ED environments, staff roles and levels of staffing available. We will elaborate further on these inconsistencies and the risks associated later within the report.

Since the start of the pandemic, we found that handover processes were consistently reviewed to meet the evolving national COVID-19 guidance. This included social distancing guidance and admission routes into EDs to support Red and Green pathways, and processes were changed to align with this to maintain patient and staff safety.

Pre-alert calls

In emergency and life threating situations, there are consistent arrangements in place across Wales for ambulance crew to provide pre-alert calls to a dedicated phone in ED, to notify staff of inbound patients who require immediate attention. For example, with patients experiencing cardiac arrest, difficulty breathing or heavy bleeding.

Pre-alert calls allow time for ED staff to prepare and prioritise for the arrival of the patient. Upon arrival to ED, ambulance crew immediately transfer the patient to an allocated space for assessment and treatment by the ED team. Once the patient transfer from ambulance stretcher to an ED trolley is complete, a formal dual pin handover[12] is completed between ED staff and ambulance crew, and is documented on the Hospital Arrival Screen (HAS).



12 Dual Pin Handover refers to an element of the handover process where both a paramedic and ED staff nurse communicate the formal handover of care, with each entering their pin number into the hospital arrival screen. Welsh Government statistics relating to handover times are generated as a result of the timings of the dual pin handover process.

We were informed that ED staff regularly monitor the HAS for inbound ambulances. When patients arrive by ambulance (not requiring a pre-alert), an ambulance crew member registers the patient either at the ED reception, or with a dedicated ambulance receptionist, which in some EDs is a dedicated role. Patients are triaged[13] (assessed) either on board the ambulance or within a designated triage area of the ED, dependent upon capacity.

Dual pin handover process

The handover process involves both a paramedic and ED staff nurse communicating the formal handover with each entering their pin number into the hospital arrival screen. Welsh Government statistics relating to handover times are generated as a result of the timings of the dual pin handover process.

We received negative comments from ambulance crew in our survey regarding the timing of the formal handover to ED staff. They stated that at times, ED staff may complete the dual handover process and patients would be classified as handover complete whilst the formal handover was still taking place.

In addition, we received 15 comments from ED staff who provided an insight from their perspective, around the difficulties that hospital staff are facing with the dual pin process. One comment included:

> *"As ED staff - once the ambulance verbal handover is complete and a patient is in the care of the ED in an appropriate area, I find it very frustrating to have to spend extra time chasing the ambulance crew, often back outside for their PIN number to clear the crew from the HAS handover screen. Ambulance crew are also sometimes reluctant to provide their PIN number to ensure a timely handover. This takes extra time which removes nurses from providing care to patients."*

In response to our self-assessment evidence from WAST, we were told that the dual pin handover process has led to improved data quality when examining the lost hours due to hospital handover delays. However, during our fieldwork interviews with ambulance crew, the issue of inaccurate handover recordings was repeatedly highlighted, which supported our findings from the staff survey. Correct application of the dual pin process will ensure that accurate timings of handovers are recorded and reported on by Welsh Government.

13 Triage is the process of determining the priority of patients' treatments by the severity of their condition or likelihood of recovery with and without treatment.

We also received a number of concerns around the process for dual pin handover from health board self-assessments, where the process is not consistent between hospitals or across health boards. Some said that the processes in place does not always provide an accurate picture of handover timings.

Recommendation

WAST should engage with health board representatives to ensure there is improvement in practice between ambulance crew and ED staff to ensure the dual pin process is consistently followed, and ensure Welsh Government reporting data is accurate.

Patient triage

We found variation across Wales in the staff roles that undertake triage assessments. This ranged between dedicated ED Triage Nurses, dedicated Ambulance Triage Nurses, the Nurse in Charge, or a Rapid Assessment Team (which may include a registered nurse, ED doctor and Healthcare Support Worker).

Across Wales, it is the aim is to commence triage within 30 minutes of patient arrival at ED, in line with the Welsh Government target. Patients are triaged using the Manchester Triage System[14], which enables the triage clinician to assign a clinical priority, according to the patient's presenting signs and symptoms. Data published on the NHS Wales National Collaborative Commissioning Unit (NCCU) website[15] for its Urgent and Emergency Care Programme highlights that on average, between October 2020 and July 2021, patients are being triaged within 30 minutes.

If, following triage, patients are deemed as 'Fit to Sit', meaning people are well enough to sit within the ED waiting area, they are transferred from the ambulance and escorted to the ED waiting area, and a dual pin handover between ambulance crew and ED staff takes place.

When patients are not considered to be suitable to stay in the waiting room, the patients are usually offloaded from an ambulance and transferred to an appropriate area according to clinical priority. If there is no capacity within the ED to accept patients from the ambulance crew, they will remain on board the ambulance until a space becomes available.

Following triage, we found a commonality across Wales where patient investigations commence, such as blood tests, X-rays or Computerised Tomography (CT) scans. Where appropriate, other time critical procedures and/or treatments are also commenced, such as Sepsis and Stroke pathways. This will commence regardless of ED space, and will include patients located on board ambulances.

Mitigating risks for patients arriving by ambulance

We asked health boards how they identify, manage, and mitigate any risks associated with patients arriving on ambulances. Each response highlighted the aim to achieve a 15 minute handover time for patients arriving at ED. When this is achieved, and an ambulance is released, it is beneficial to the patients' condition, positively impacts on their experience, and further benefits those awaiting an ambulance resource within the wider community. However, our review has found that this target is not often met across Wales.

14 The Manchester triage system is an algorithm based on flowcharts and consists of 52 flowchart diagrams (49 suitable for children), that are specific for the patient's presenting problem. The flowcharts show six key discriminators (life threat, pain, haemorrhage, acuteness of onset, level of consciousness, and temperature), as well as specific discriminators relevant to the presenting problem. Selection of a discriminator indicates one of the five urgency categories, with a maximum waiting time ("immediate" 0 minutes, "very urgent" 10 minutes, "urgent" 60 minutes, "standard" 120 minutes, and "non-urgent" 240 minutes)

15 NCCU – Urgent and Emergency Care Programme https://nccu.nhs.wales/urgent-and-emergency-care/experimental-kpis/

During times of increased pressure and numerous ambulances waiting to hand over the care of their patients to ED staff, a WAST Duty Operational Manager (DOM), may attend the hospital site, to provide welfare support to ambulance crews who are unable to offload and handover their patients. This is a new role that has been introduced by WAST. The DOM will provide cover for ambulance crew to take their breaks, and/or help enable crews to finish their shift on time, by taking over the care of the patient. The DOM will also liaise closely with ED staff and the hospital site managers, to plan what action is required to progress and facilitate the handover of patients to the care of the ED staff.

Health boards also highlighted to us the benefits of the role of Ambulance Patient Flow Co-ordinators or HALO within the EDs. Their role is to assist in achieving a timely handover, and to maintain effective communication between ambulance crew, ED staff and patients. In addition, they aim to reduce delays by helping to mitigate risks to patient safety on board an ambulance, by minimising long waits outside ED, which in turn will benefit those waiting in the community for emergency care. Furthermore, the role also aims to improve the overall experience for patients, by working with ambulance crew in providing care. Our review has found that where these roles have been introduced, they have helped to ease some of problems associated with the handover process and have been beneficial to patient experience as a consequence.

During times of delayed handover, we identified that ambulance crews monitor the patient's condition and escalate any concerns to the ED nurse in charge. In the event of a patient's condition deteriorating further, ambulance crew will enact a formal process for escalating a clinical concern with a deteriorating patient outside the ED. We will elaborate further on the effectiveness of this process later within the report.

We also found consistently across Wales, that during periods of high demands on the service, such as multiple delays with handover, each hospital has an internal escalation plan which is actioned, and plans are implemented with the to aim to reduce ambulance offload delays.

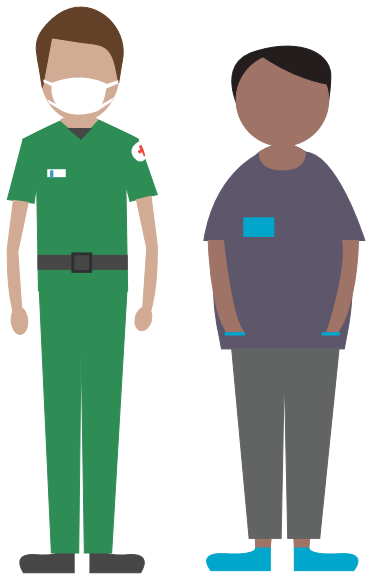
Other consistent measures in place across Wales are regular hospital patient flow meetings and hospital bed management meetings. The meetings allow staff to assess the availability of hospital beds, and to monitor the capacity within ED and the number of ambulances waiting to handover. However, despite these measures, the problem of prolonged handover remains an issue.

Strengths with handover processes

Health boards were asked to tell us about the strengths they have identified as part of their handover processes. Across Wales, there was unanimous agreement that EDs have introduced an effective COVID-19 point of contact testing, where patients are tested for the virus at their point of entry, and are allocated a waiting area based on their expected or predicted status for the virus. Some health boards highlighted an improvement with patient flow, as a result of point of contact testing particularly during the height of the pandemic, which resulted in reduced delays with transferring patients to wards.

During our interviews with ambulance crew, they spoke of the positive impact on handover, as a consequence of the roles of the dedicated Ambulance Triage Nurses or Ambulance First Point of Contact. As mentioned, staff in these roles determine the level of acuity of patients arriving by ambulance, and assist in helping to achieve 15 minute handover targets and to commence triage within 30 minutes of arrival.

Ambulance crew also highlighted that dedicated ambulance receptionists help make the handover process more efficient in enabling them to register patients upon their arrival. The role of the HALO or Ambulance Flow Co-ordinator was also reported to help assist with handover and relieve pressure from the Ambulance Triage Nurse. We found that the introduction of these roles assists in improving the patient experience and welfare by providing positive links for effective communication between ambulance crew and ED staff. However, the presence of these receptionist, liaison, and patient flow roles is not consistent across each ED in Wales.



We were told that patients are re-triaged once clinical interventions have been initiated on board ambulances. As a consequence, any improvements in a patient's clinical condition could expedite their admission to the department, for example if they are assessed as 'Fit to Sit' in the ED waiting area. In addition, in some instances, patients may be well enough for discharge, to recover at home.

Areas that require improvement

Health boards highlighted some areas that require strengthening with handover. There was unanimous agreement across Wales that improvement is required with patient flow through hospitals, in order to improve bed availability and trolley space capacity within EDs. This included improvement in the timely discharge of patients from hospitals, to assist with patient flow. This would lead to improved patient handover times from ambulance crew to ED staff, an improvement in the overall patient experience, and benefits to timely care with emergency responses in the community.

We found that improvements need to be made in relation to collaborative working between WAST and health boards, particularly in regards to communication and the management of serious incidents arising from delayed handover. There is a need to ensure health board representatives regularly attend WAST SCIF meetings, to enable timely management of concerns and to develop action plans and feedback throughout the organisations. This is referred to in more detail later within this report. Whilst there appear to be robust processes in place for triage, initiating treatment and handover process, issues remain with delayed handover due to the lack of bed space within ED and the wider hospitals, which significantly affects patient flow.

Recommendation

Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process the handover of patients from ambulances.

Health boards must ensure that appropriate representation is present at WAST Serious Clinical Incident Forum meetings, to aid with the timely management of concerns and service improvement.

Staff perceptions of the handover process

We considered the perspective of ambulance crew and ED staff of the handover process. This was achieved through our staff survey and our interviews with ambulance crew.

Through our staff survey, we found that 90% of ED staff were familiar with the handover policy for their hospital. This was slightly less for ambulance crews, with just over three quarters of them aware, although with a slight increase in number for their most frequented hospital. These numbers give rise to concern, as it is suggestive that some ED staff and ambulance crews are unfamiliar with handover policies.

The majority of ambulance crew respondents also expressed frustrations of their experience of waiting outside hospitals and their dissatisfaction with the handover process in place both at a local level and nationally. We had a strong response on the comment section for this area with almost half of WAST respondents providing additional detail when sharing their experiences.

The comments enabled us to identify some key themes such as, some ambulance crews told us that handover processes frequently change and they are not familiar with current practices. Ambulance crew who regularly attend more than one ED also face the challenge in different local practices. Some said that processes differ day to day, and that each clinician and member of ED staff implements them in different ways therefore, making it difficult for staff to remain up to date with current processes. There are variations in processes due to local SOPs, geographical layout of each environment, job roles and levels of staffing. It was also highlighted to us that the impact of the pandemic on practices has been that it is challenging for staff to stay up to date with current processes.

Recommendation

If and where local standard operating procedures are absolutely necessary, WAST and health boards must work together to ensure that ambulance crew are familiar with the handover policy for that ED.

Ambulance crews also provided their comments in our survey on their view of the effectiveness of the hospital guidance issued by Welsh Government in 2016 process. These included:

"The process seems to be centred around ambulance turnover rather than a focus on patient care. This in turn creates more delays for ambulances as the processes put in place differ day by day, nurse by nurse as there is no full understanding of what the procedure should be. My experience has been waiting upwards of 30 mins just to notify the hospital of our patient. That's before they are booked into the department and triaged."

"ED staff are excellent and do as much as they can to assist/handover patients however they cannot do this when there are not beds available. It is not appropriate to manage patients on the back of an ambulance for several hours and should be avoided where possible."

"There is a reluctance to follow the 'Fit to Sit' agreements that the Welsh ambulance service have in place."

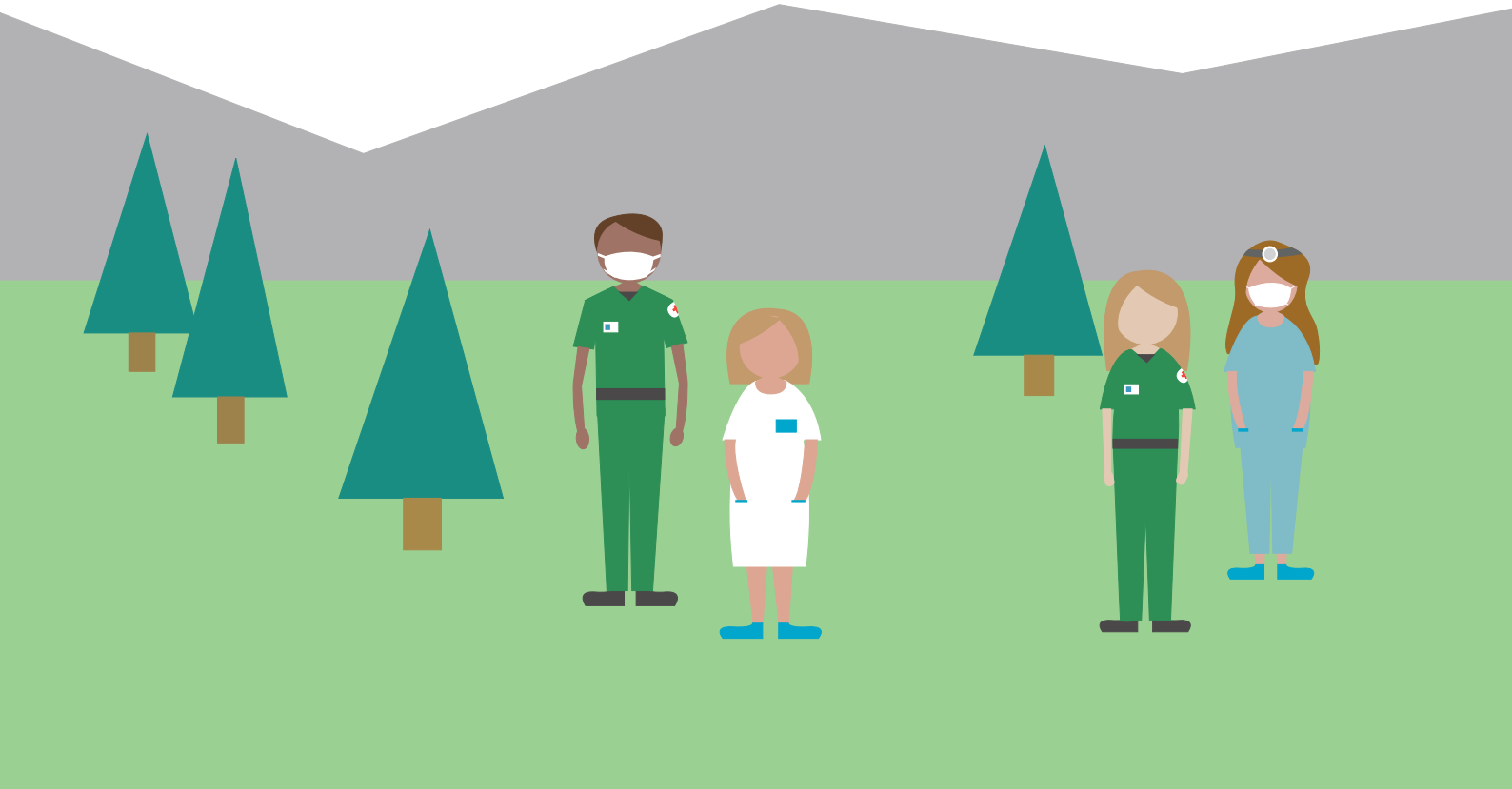
Our staff survey responses noted ambulance crew sometimes attend EDs within England. Concerns were highlighted that handover delays have become routine in Welsh hospitals, and are less frequent in England. A number of ambulance crew provided their opinions to us during interview, that handover processes within EDs in England are more efficient than the processes in place in Wales, which compound the frustrations with handover delays across Wales. Comments from ambulance crew included:

"Patients waiting in the community are coming to a wide range of harm due to no ambulances to send to them due to the ambulances being queued outside hospitals. I've recently transferred to Wales from England and this problem very rarely happens in England but is a daily problem in Wales. Very poor."

"When I visit other ED outside of Wales, we take the PT straight in to EDs, even large City EDs. But for some reason Welsh EDs struggle with this."

Relationship between ambulance crew and ED staff

Throughout our interviews, ambulance crew told us that in general, positive relationships had been formed with ED staff across Wales. We were told that both parties were working towards the same goal of achieving early handovers to release ambulance crews to respond to emergencies. However, this was not consistent with our survey results, with 71% of ambulance crew stating that they did not feel ED staff and the service provided by ambulance crew worked together to provide seamless patient treatment and care. However, 69% of ED staff felt they work together with ambulance crew to provide seamless patient care.



One comment received from a member of ED staff highlighted:

"There is no single issue which would resolve the problem, neither is it solely a problem of a specific group. Again, I would like to reiterate that ED is locked between a rock and a hard place; trying our best but with many obstacles in our way. We used to have a really positive working relationship with our WAST colleagues which has deteriorated over time."

The findings from our survey and interviews suggests a mixed relationship, and issues can occur on a case by case basis. We recognise the pressure and intensity that handover delays must have on both ambulance crew and ED staff to minimise risks to patients, and that working relationships may be strained as a consequence. However, this can have a negative impact on the overall patient experience.

We also found through our interviews and staff survey that ambulance crew feel their vehicles are used inappropriately, and as an extension of the ED. The term 'warding' was commonly used to refer to this. Ambulance crew told us that ambulances are used as waiting rooms or additional beds, with many staff elaborating that a bed shortage within ED is the reason for this.

We also learned that patients are often taken off an ambulance for scans or other investigations, and returned to the ambulance due to no capacity in the EDs. We were also told about occasions when following investigations and treatment, patients who did not require hospital admission, were transported home by the same ambulance crew who had responded to the initial emergency call. Some ambulance crew also said that hospitals manage their own risks by keeping patients on the ambulance. Comments from ambulance crew included:

"The feeling that the patient isn't the problem of the hospital until they get in through the front doors is widespread. We are extended waiting rooms for the hospitals and this shouldn't be the situation."

"The current system is not working, emergency departments are using ambulances to treat patients in and this is not what they are intended to do. While this is happening and we are waiting to handover our patients there is patients within the community not getting the medical help needed for many hours."

"The problems with handover are not due to WAST. The issue is severe overcrowding of the EDs which then leads to lack of ability to offload. The systems in the hospitals prioritise patients who have been seen and treated (inpatients) over patients who have not been seen or treated by the ED which is wrong and unsafe. As well as this, having ambulances stacked outside causes there to be increased response times by WAST. So in turn, we are prioritising seen and treated patients (inpatients) over those waiting for an ambulance…..The subsequent problems of even more overcrowding that will cause, will lead to innovation within the hospital. Unless we bring the problem into the hospital, the hospital will not solve it."

As highlighted earlier, the role of ambulance crew is to provide an emergency response and transportation for patients to EDs. Welsh Government guidance is clear that patient care should be handed over to hospital staff within 15 minutes of their arrival, but most certainly before 60 minutes.

Ambulances are designed as a pre-hospital environment and are equipped to transport ambulance crew and other first responders to the waiting patient. The vehicles carry equipment for administering emergency care to treat patients at the scene, and transport patients when necessary to EDs for advanced treatment. They are not designed and equipped for patients to be cared for during periods of extensive waits outside EDs. The impact of patients remaining within the back of an ambulance can negatively impact on the patients' experience and their safety.

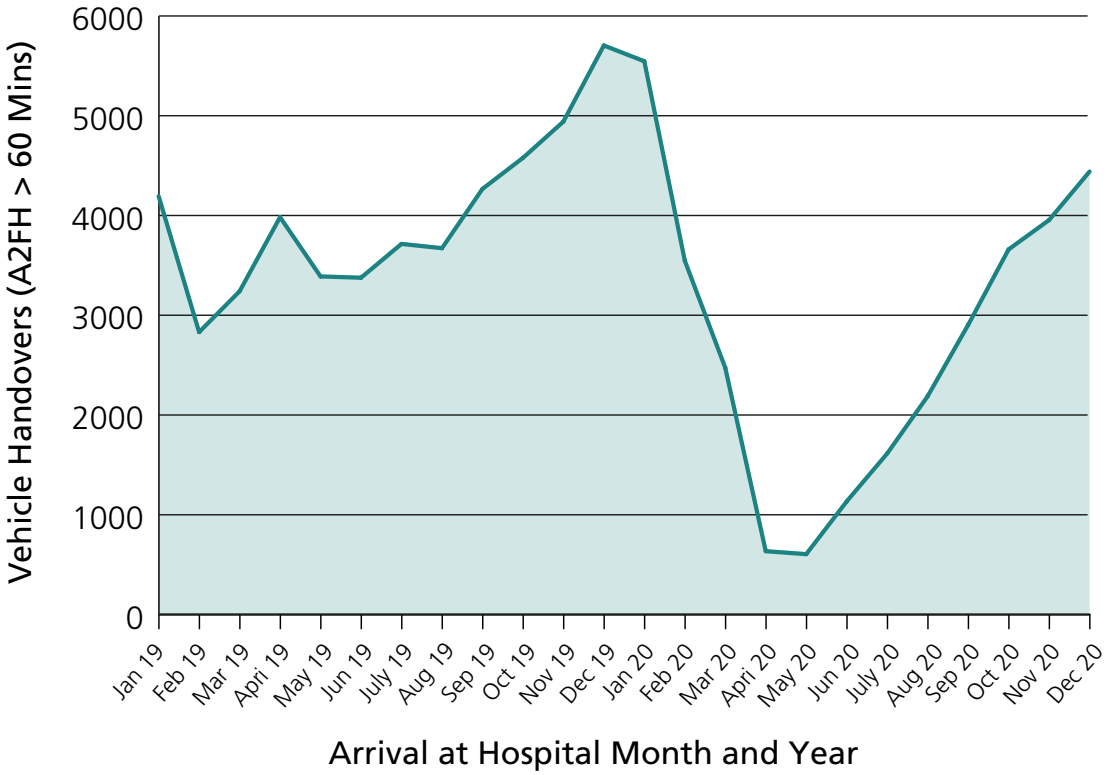
Patient experience

Impact of the pandemic on patient experience

The NHS Wales activity and performance summary highlights fewer attendances to all NHS Wales EDs during the first wave of the pandemic, with April 2020 seeing the lowest number of attendances at ED since current reporting began in 2012.

Handover delays during the first wave of the pandemic were substantially lower. We were informed that this was the result of a significant decrease in demand, and an initial pandemic response to improve hospital capacity. This is highlighted in the chart below, which reflects the number of patients who experienced handover delays over 60 minutes across all health boards in Wales.

Trend of number of Patiens Waiting >60mins



We considered the views of patients on whether the pandemic impacted on their experience of attending the ED. In the public survey responses, the majority said they were not displaying COVID-19 symptoms, and were not attending ED due to suspected COVID-19.

It was positive to learn that the majority of respondents felt that measures to minimise the spread of COVID-19 were being followed by both ambulance crew and ED staff. The majority of respondents said all staff wore PPE on the ambulance and at hospital, their temperatures were taken on arrival at hospital, and they were transferred to a designated green areas away from suspected or positive COVID-19 patients. However, we did find in a small minority, where some concerns were highlighted in the survey, as highlighted below:

"Unfortunately dad was infected with COVID in hospital."

"We were all asked to wear masks in the house whilst the paramedics were there. However, I noticed that although the crew were wearing masks they weren't wearing any other form of PPE."

Overall, our findings reflect that despite the severe impact of the pandemic, it did not negatively affect the experience of patients who used emergency ambulances services across Wales, and on the whole patients were satisfied with the care provided. Our COVID-19 themed national review report[16] highlights further our understanding of how healthcare services across Wales met the needs of people and maintained their safety during the pandemic.

Patients awaiting ambulances in the community and their arrival at the ED

Standard 5.1 within the Health and Care Standards 2015[17] states that all aspects of care should be provided in a timely way, ensuring people are treated and cared for in the right way, at the right time, in the right place and with the right staff.

Of the 137 responses to our public survey, approximately half waited under an hour in the community for an ambulance to arrive, with most waiting less than 30 minutes. However, 26% of respondents waited between one and four hours, and 22% waited over four hours. For those who waited over four hours, each commented that they felt their health condition deteriorated over this time. Around a third of these patients were admitted immediately into the hospital on arrival, however, another third had a further wait of over two hours on-board an ambulance following arrival at the hospital.

We received several concerning comments from people about prolonged ambulance waits, despite the possibility of them experiencing a stroke, heart attack or other serious health concerns. Comments included:

"I waited over 2 hours for an ambulance after having a stroke. Ambulance never showed. First responder arrived at 2 hours and tried to get an ambulance and was told none available."

"Things could have been a lot worse as Dr said by rights my dad should not still be here after having to wait 3hrs whilst having a major heart attack."

Several people in response to our public survey highlighted long waits of between four and 13 hours for an ambulance after sustaining an injury due to falls at home, particularly in relation to older adults. Long waits in the community were also substantiated by ambulance crew in response to our staff survey and during our fieldwork interviews. Staff highlighted that the risk from handover delays is not only to the patients waiting in ambulances but also to patients in the community, who are waiting for an emergency response.

16 HIW COVID-19 National Review Report
17 The Health and Care Standards 2015

Comments included:

"Patients queuing up in ambulances probably have the same outcomes as patients in the ED, as HB clinicians will always see and treat our patients. It's the patients that are waiting for ambulances that are most at risk."

"Handover delays impact me and my patients negatively as I am often on scene with an unwell patient waiting for an ambulance to become available. It is common to have to wait 2-4 hours for 'emergency' backup. This can be very detrimental to patients and is hugely stressful for me. I have been on my own with patients having multiples seizures, heart attacks or severe breathing difficulties for 1-2 hours. As well as patients likely to come to harm, this is very stressful for me and affects my mental health."

Throughout our fieldwork, the majority of ambulance crew interviewed expressed their frustrations of waiting outside EDs to handover patients, in the knowledge that patients are waiting in the community in need of an emergency response. This is consistent with the findings highlighted in the Amber Review report in 2018. These patients have not been physically assessed by a clinician and therefore, their clinical condition is unknown. This is particularly concerning for conditions such as strokes or heart attacks, where time critical treatment is essential due to specific therapeutic window timescales, and any delays to treatment may negatively impact on their clinical outcome, future rehabilitation or even their life.

People indicated in the survey comments, that due to long ambulance waits they sometimes had to arrange alternative transport, such as driving their loved one to the hospital or arrange a taxi. Comments included:

"Ambulance wait time over 2 hours. This was not made clear at 999 call only that an ambulance has been requested. After 2nd call to 999 after half an hour I was told it could be 2 hours. Took him in the car and hospital was excellent. Could and should have gone sooner if wait time had been honest in the first place."

The risk to patients in the community was a key finding from our previous review of WAST in 2019/2020, and has been repeatedly highlighted by staff throughout this review.

As referred to earlier in this report, a recommendation was made in our previous report that WAST should consider a holistic review with stakeholder engagement, of the current handover arrangements in place, which should include current escalation arrangements during periods of high demand. Whilst we are satisfied that progress has been made, this re-iterates the need for Welsh Government to ensure a prompt collaborative approach between WAST, health boards, and social care services within Wales, to make improvements with the ongoing patient flow issues.

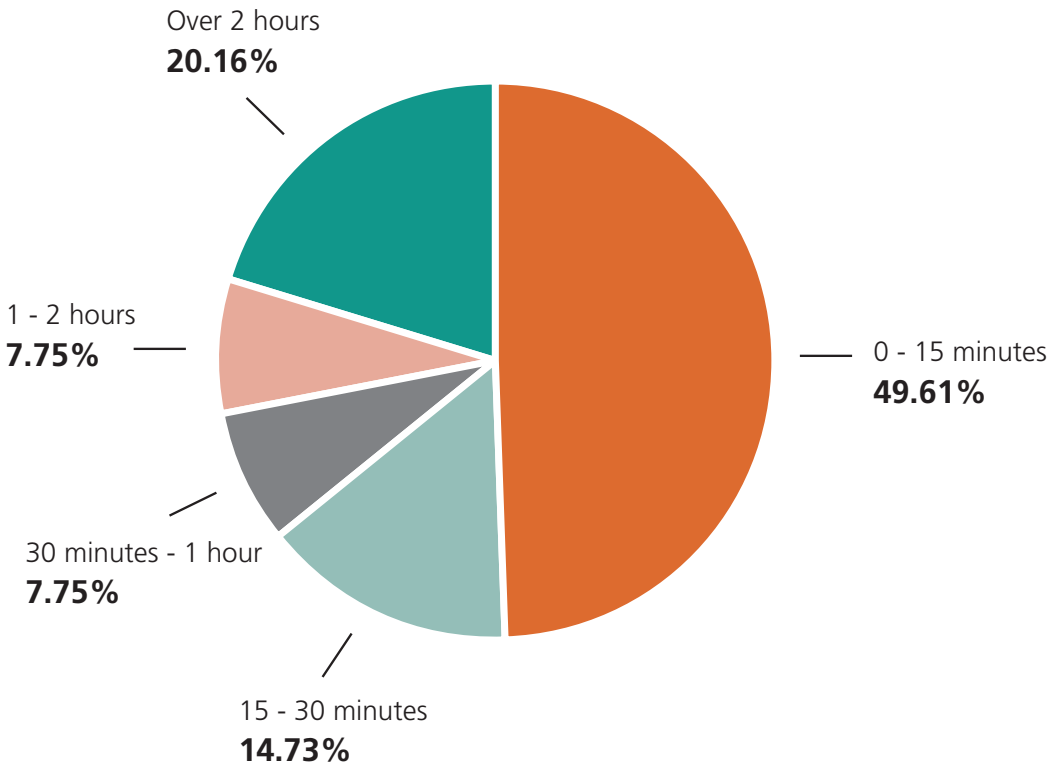
Patient experience with handover and triage

We asked patients in our public survey to tell us about their experience during handover between ambulance crew and ED staff. As highlighted earlier, the Welsh Government target for patient handover to the ED team, is within 15 minutes of arrival at the hospital.

Our public survey identified that only half the respondents said they were admitted to ED within 15 minutes. A further 15% waited between 15 to 30 minutes, and a minority waited between 30 minutes to 2 hours. However, 1 in 5 patients told us they waited over two hours in the ambulance, before being handed over to the care of ED staff.

"I had a four and a half hour wait for the ambulance which had been requested (highest priority) by my GP in the surgery. On arrival at the hospital there were 17 ambulances waiting to hand over the patients. I was waiting for a further three and a quarter hours."

How long did you wait in the ambulance, one it arrived at the hospital, before being admitted into the emergency department?



As highlighted earlier in the report, any delay over 60 minutes should be the exception. Prolonged patient waits on board an ambulance are not acceptable, in particular for those who may have already waited for long periods for an ambulance in the community.

Our public survey highlighted that the majority of people who engaged with us were triaged within 30 minutes of arrival at the hospital. This is in line with Welsh Government targets and data available on the NCCU website for its Urgent and Emergency Care Programme. However, around a quarter reported that it took longer than 30 minutes. Whilst most patients were assessed in hospital, 30% reported that assessment took place on board the ambulance. Only a few patients told us they had been assessed in hospital and then taken back to the ambulance.

We received one comment from a patient who reported 17 ambulances were outside the ED at the time that they attended, waiting to handover patients to hospital staff. This is concerning and reflective of the difficulties ambulance crews and ED staff are frequently facing.

A quarter of patients told us they received treatment from ED staff whilst on board the ambulance, but most remained under the care of the ambulance crew. One patient told us that no ED staff assessed them for the duration of their time on board the ambulance, whilst another said:

> *"I was in the ambulance from 8.30am to sometime around 4pm. A doctor paid a number of visits and also nursing staff to take blood and to give me painkillers."*

We asked patients to provide their views on the triage/assessment process upon their arrival at the hospital. Comments we received were mixed, with some stating that it worked efficiently and they were seen immediately, however, there were a number of comments about how long it took to be seen upon their arrival at hospital. One commented included:

> *"After assessment and excellent care and treatment by ambulance personnel I was treated almost immediately after arriving at hospital by a superb team."*

Whilst it is positive that most patients were triaged within 30 minutes, it is concerning that not all patients were assessed by a health board clinician in the appropriate timeframe. This can negatively impact on the patient experience and clinical condition, when they are not reviewed in a timely manner.

As part of our review, we also considered communication with patients' relatives/carers. We found a clear divide, with half stating that relatives were kept updated, and half stating they were not. Comments indicated that ambulance crew communicated well with relatives, to update them on what was happening. However, only half of the survey respondents said they were kept informed about how long the wait on board the ambulance would be. Our survey highlighted that communication once the person was admitted to hospital was experienced as variable.

Our interviews with ambulance crew indicate that they always endeavour to engage with and build a positive rapport with patients. However, they said that during periods of long delays, there are limitations to the number of times they can apologise to patients and their loved ones, either for the delays they experience whilst waiting for an ambulance in the community, delays outside the hospital, or at both locations.

The hospital handover guidance issued by Welsh Government in 2016 is clear, that when delays occur patients and their relatives or carers should be kept fully informed of the reasons and the progress being made in resolving them. We recognise that it may not always be possible to provide accurate timescales to people, since the clinical priority of patients for handover to ED is continuously assessed and changing. However, the importance of clear communication with patients to ensure they are informed of the reasons for delay, is key in alleviating their anxieties or frustration with waiting.

Recommendation

WAST and health boards need to ensure that when delays occur, patients and their relatives or carers should be kept fully informed of the reasons and the progress being made in resolving them.

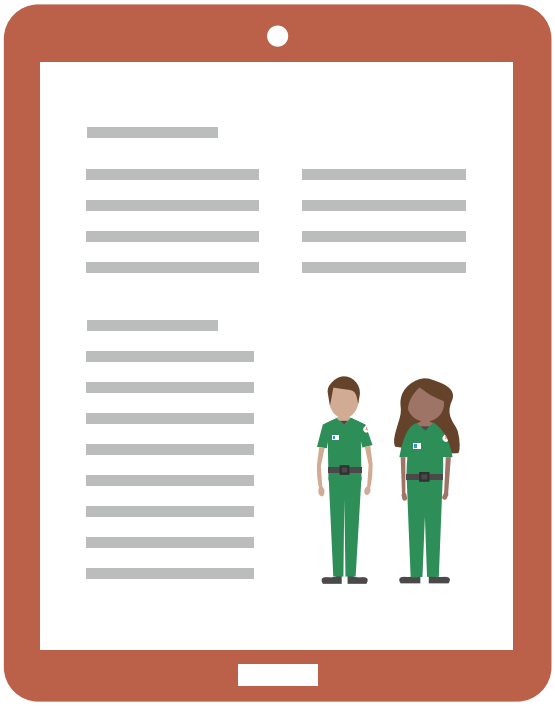
WAST and health boards across Wales should ensure patient feedback is obtained regularly to understand their experiences of long waits on board an ambulance, in order to inform improvement.

Delayed diagnosis and treatment

Although a minority, several views were communicated to us from people in our public survey regarding ineffective diagnoses made by both ambulance and ED staff. It also included a few dissatisfied comments about ineffective diagnosis and treatment of conditions once admitted.

> *"If there's a documented history of sepsis. Surely the sepsis protocols could be followed."*

We also received comments from ambulance crew relating to the delays in treatment and diagnosis for patients by ED staff. The comments included concerns where a patient's health could deteriorate whilst on board the ambulance, such as a patient experiencing chest pain.



Other comments from WAST staff suggested that they believe diagnosis should commence whilst the patient is waiting on board the ambulance, such as blood tests and x-rays. This somewhat contradicts the self-assessments completed by health boards which suggest that ED staff do commence investigations, diagnosis and treatment while the patient is on board the ambulance. This suggests that the commencement of investigations whilst the patient is on the back of the ambulance does not consistently happen across all EDs. The comments included:

"Our patients are left stuck on ambulances without having bloods etc. done which could speed up the process for them to discharge patients. There should be a system for WAST staff to take bloods and take patients for x-rays or appropriate investigations whilst waiting outside hospitals as it benefits the patient and the staff at the hospital."

We believe that commencing investigations whilst the patient is on board an ambulance has a benefit of earlier diagnosis, admission or even discharge of some patients, which could enable ambulance crews to be released, to undertake their primary role as providing on scene urgent or emergency care, and urgent or emergency transport of patients to hospitals.

Recommendation

WAST and all health boards across Wales must work together to identify a consistent approach in providing timely investigations and treatment for patients on board ambulances, to enable ambulance crews to be released quickly.

Patient privacy and dignity

Standard 4.1 within the Health and Care Standards 2015, states that people's experience of care is one where everyone is treated with dignity, respect, compassion and kindness and which recognises and addresses individual physical, psychological, social, cultural, language and spiritual needs.

In its handover guidance, Welsh Government states that the safety, effectiveness and dignity of care of patients must be at the forefront of systems of emergency care.

As highlighted earlier, our review considered how delayed handovers impacted on the privacy and dignity of patients on board the ambulance. This included the toilet needs of the patient either within the ED, or on board the ambulance.

Overall, our patient survey highlighted that patients were very positive about their experience waiting on board an ambulance due to delayed handovers. We received very positive feedback about ambulance crew, particularly in relation to their kindness, overall communication and managing of distressing situations. Patient comments included:

"The ambulance service went above and beyond."

"They were excellent, really helped with my mother-in-law's anxiety and kept us fully informed throughout."

Nearly all who engaged in our public survey said they were treated with dignity and respect by ambulance crew, and felt safe and cared for, and that staff were knowledgeable. Most also said they felt ambulance crew treated their condition effectively. Patients also indicated that they were satisfied by the care and treatment from ED staff.

The results of our staff survey, however, were not as positive in relation to their ability to maintain patients' dignity during delayed handovers. For ED staff, whilst 78% felt that patients were well cared for on board ambulances, only 68% said that the patient's privacy and dignity is maintained. In addition, only 62% of ambulance crew were felt that patient privacy and dignity is maintained.

This was also highlighted in our interviews with ambulance crew, with some specifically raising concerns with their ability to maintain the privacy and dignity of patients. The comments included:

"Patients never provided with reason as to why they are waiting on an ambulance or have to endure the indignity of using a commode on an ambulance."

"The biggest issue I have come across resulting from patients waiting for many hours on the back of an ambulance is that comfort and dignity is compromised. The ambulance stretcher is not designed for patients, especially elderly patients with thin skin to be laying on them for hours. Also, during long waits patients often need to go to toilet and as a result of very poor mobility end up soiling themselves. So to preserve their dignity we clean them up as best we can with very limited items as it's an ambulance and not a hospital ward."

One area of concern consistently highlighted by ambulance crew, was the difficulty in facilitating patients to access a toilet during their wait. Whilst most patients told us they were able to access a toilet, it is concerning that some patients reported they did not have access to facilities. In addition, during our staff interviews, concerns were highlighted by numerous ambulance crew with the difficulties encountered in assisting patients to use a commode or a bedpan on board an ambulance, due to the limited space available. Some also expressed concern over appropriateness, when two male ambulance crew were required to assist female patients with their toileting needs.

Wherever possible, ambulance crew told us they take patients inside the ED to use the department's toilet facilities, and request nursing staff assistance as appropriate. Overall, staff highlighted the issues with accessing toilet facilities as having a negative impact on patient privacy and dignity. Whilst ambulance crew told us that every effort is made to help maintain patient dignity, they described this as not always possible.

It was positive to note in one ED, that the ED sister attends the ambulance bays to enquire whether patients require the use of a toilet, and ensures staff are available to assist them. Patients are taken inside the ED whenever possible, or assistance is provided on board the ambulance.

Good practice in toilet management can help patients to maintain their dignity. Whilst we acknowledge the efforts made by ambulance crew to protect patient dignity, further efforts are required by both ED staff and ambulance crew to ensure all patients can access appropriate toilet facilities to maintain their privacy and dignity at all times.

Recommendation

Both WAST and health boards must ensure that ambulance crew and ED staff work collaboratively to ensure patient privacy and dignity is maintained, and patients are always provided with the opportunity to use private toilet facilities where appropriate, in a dignified manner whilst waiting on board an ambulance during delayed handovers.

Preventing pressure and tissue damage

It is highlighted within Standard 2.2 of the Health and Care Standards 2015 that people should be helped to look after their skin, and every effort should be made to prevent people from developing pressure and tissue damage.

In response to our staff survey, ambulance crew raised concerns around the suitability of ambulance stretchers for patients who experience long handover waits. In particular, for patients who are immobile and lying on a trolley on board an ambulance are at an increased risk of sustaining skin tissue pressure damage. We received numerous comments from ambulance crew which included:

"Patients are regularly suffering due to excessive handover delays. Ambulance stretchers are not designed for prolonged use and vulnerable patients are being put at risk of pressure sores and other tissue viability issues despite the efforts of ambulance staff to turn and adjust their positions."

"Often waiting outside with a patient for extended hours anywhere from 2 to 12 hours with a patient on an ambulance stretcher that is not designed for. Hard to give pressure relief to patients especially the heavier ones."

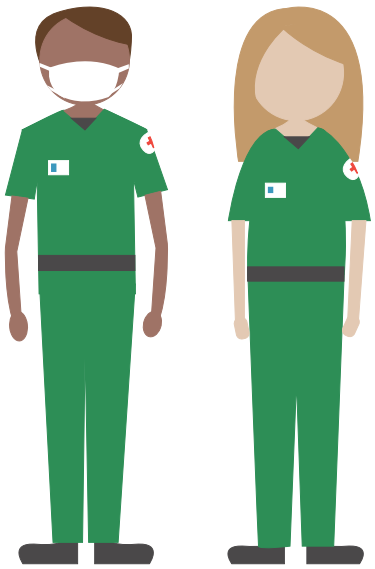
We were told during our interviews with ambulance crew that they are required to undertake an on-line clinical training module on the risk of pressure damage and pressure relief. However, despite their knowledge and understanding of the risks, and crew efforts to mobilise patients where appropriate, staff told us it can be very difficult to prevent skin tissue pressure damage for all patients. This in particular is an issue for patients, such as those with a suspected fractured neck of femur or spinal injury, who cannot be appropriately moved.

In addition, there is an increased risk of skin tissue damage with patients over 70 years of age, as a result of frailty and/or decreased mobility and/or poor nutrition and hydration on board an ambulance. Given the patient demographics provided to us by WAST, the majority of patients taken to EDs by ambulance are aged 65 and above, which highlights additional concerns associated with long patient waits outside ED.

We acknowledge the efforts made by both ambulance crew, and ED staff who support them, to help provide pressure relief and assess patients' skin for signs of pressure damage on arrival to ED. However, we are concerned that the risk of skin tissue damage remains for all patients experiencing long handover delays, in particular older adults, and will continue until prolonged handover delays are resolved.

Recommendation

During prolonged handover delays, WAST and health boards must work collaboratively and consistently, to minimise the risk of skin tissue damage for patients.



Nutrition and Hydration

Standard 2.5 of the Health and Care Standards highlights that that people should be supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury.

During our review, we considered how patients' nutritional and hydration needs are met whilst they wait on board an ambulance.

As highlighted earlier in the report, the purpose of ambulance crew is to provide urgent or emergency care to patients in the community and where necessary, to transport them to hospital on board an ambulance. Ambulances are therefore not equipped to provide food and drinks to patients. One member of ambulance crew commented:

"Hospital delays have been allowed to happen without any care or thought to keeping patients hydrated, fed and toileted appropriately whilst in the Ambulance. Ambulance Staff are not provided for, and often left hours without access to food and drink."

In our public survey, it was concerning to find that half of the respondents said they did not receive sufficient food and drink during their wait for handover to the ED. However, we are mindful that there are occasions when patients are designated as 'Nil by Mouth' due to their clinical condition, and therefore cannot consume food or drink, unless assessed as safe to do so. This may include examples with patients with gastric complaints, such as diarrhoea and vomiting, or severe abdominal pain, or for those who are suspected as required urgent surgery.

We found positive examples during our interviews with staff, where the majority told us that patients were supported by British Red Cross workers, who were contracted to work within EDs, who provided assistance to patients with food and drinks, and offered emotional support through engagement with patients.

It is concerning that patients who are waiting on board an ambulance are reliant on others for the provision of food and drink, to ensure their nutritional and hydration needs are met. We also acknowledge the difficulties that ambulance crew and ED staff face in providing food and drink for patients. The uncertainty of when patients may be able to eat and drink will negatively impact on them physically, especially given the uncertainty around timescales of when they may be handed over to hospital staff.

Recommendation

WAST should work with health boards to ensure that patients' nutritional and hydration needs are consistently met whilst waiting in the back of an ambulance due to delayed handovers.

Pain Management

During the review, we considered how patients' pain was managed on board the ambulance during triage and thereafter. Our public survey provided mixed comments, though overall, patients reported that ambulance crew managed their pain well. This is consistent with the findings within the 2018 Amber Review report. There was also a good response from ambulance crew in relation to the management of the patient's pain, with 81% stating they had access to pain relief should the patient require it. However, this was not consistent with their hospital experience, where patient comments indicated that their pain was at times not managed well once admitted to the ED. The comments included:

"The paramedics ensured I received additional pain relief in the ambulance on arrival."

"Unfortunately the hospital left me in a great deal of pain for quite some time."

It is reassuring that ambulance crew are acting positively in managing patients' pain. This is imperative, given the uncertainty of the length of handover delays. This may be reflective of the one to one care patients receive from the ambulance crew in comparison to staff-patient ratio in the ED. Health boards should reflect on these findings, and consider how pain management can be appropriately maintained, for patients experiencing pain once admitted in to the ED.

Infection Prevention and Control (IPC)

Standard 2.4 of the Health and Care Standards 2015, highlights that effective IPC is everybody's business, and must be part of everyday healthcare practice and based on best available evidence, so that people are protected from preventable healthcare associated infections.

Our staff survey highlighted a generally positive response to IPC from ED staff. Whilst 83% said that IPC procedures are followed, almost all said there is a sufficient supply of PPE, and 89% highlighting decontamination arrangements are in place for used equipment and relevant areas.

However, the survey response from ambulance crew was less assuring with 79% saying that IPC procedures were followed, and only 70% highlighting they felt there are adequate decontamination arrangements in place on the vehicle.

During our interviews with ambulance crew, concerns were highlighted by a number of staff regarding their ability to appropriately maintain safe IPC measures on board the ambulance. They provided examples with patients requiring a commode on board the ambulance, and with patients needing to eat and drink within the vehicle during long delays. In addition, crew members who may assist patients with enabling a patient to use a commode or bed pan are unable to change their uniform (if required), and may attend further emergency calls during their shift.

These examples highlight the difficulty in maintaining a safe and infection free clinical environment. The vehicles are a confined environment, and are not appropriate to provide adequate care for patients during periods of long delays with handover. This not only increases the risks with maintaining IPC, but can be considered detrimental to the patient experience.

Recommendation

WAST should consider how ambulance crew and patients can be supported to achieve and maintain high standards of hygiene and IPC, in particular during periods of delayed handovers for patients on board an ambulance.

Safe Care

People's health, safety and welfare actively promoted and protected. Risks are identified, monitored and where possible, reduced or prevented.

Within our staff survey, we asked whether staff were satisfied with the quality of care, treatment and diagnosis they give to patients during periods of handover delays. It was positive to find that 89% of ambulance crew said they were satisfied with the care they give to patients, although only 74% of ED staff were satisfied with this.

We asked ambulance crew in our survey if patients were monitored and assessed for acute illness; 87% confirmed they were, and this was also reflected in our findings from the ED staff. In addition, more than three quarters of ambulance crew said there was access to higher clinical support should it be required.

We also asked staff whether patients were involved in decisions about their care. Three quarters of ambulance crew and ED staff confirmed they were, however, we identified some negative comments from ED staff in relation to this question. Once comment included:

> *"There are issues with regards to ongoing care of patients who remain on vehicles for long periods of time; as a department we are trying to look after patient's both physically in and out of the ED, sometimes with little support from the crew."*

Despite receiving positive responses regarding the quality of care provided to patients from ambulance crew, it was very concerning that only 41% of ambulance crew said it was clearly understood who has responsibility for the patient at all times. However, three quarters of ED staff said it is clearly understood who has responsibility for the patient at all times. The hospital handover guidance highlights that ambulance crew should not routinely be responsible for monitoring patients for prolonged periods outside ED.

During our interviews with ambulance crew we identified that the lines of responsibility for patients on board an ambulance are blurred, due to ED staff going on board ambulances to assess and treat patients, and ambulance crews moving patients around hospitals for X-rays, CT scans and other investigations.

Overall, we identified from our interviews and staff survey that ambulance crew are not clear at all times as to who has responsibility for the patient prior to the formal handover taking place to ensure the safety of patients.

Recommendation

WAST and health boards must ensure there is absolute clarity, consistency and understanding between both ambulance crew and ED staff, as to where the responsibility and accountability lies for patient care on board an ambulance following triage, until transferred into the ED.

Discharge planning

During our interviews, a theme emerged from both ambulance crew and senior WAST managers that discharge planning could be improved. We were told that the anticipated date and time of patient discharge often appeared to be a 'last minute' decision in some EDs. The implication of this on the system is that a decision to discharge a patient may not take place until later during the day, which results in less time to obtain patient medication from pharmacy to take home, to arrange take home transport, thus impacting on delayed bed availability for patients in ED.

As referred to earlier within the report, the role of patient flow coordinators at some hospitals is seen as having a positive impact on this issue. On a day to day basis, their role includes co-ordinating a discharge time for a patient to understand the time their bed will become available for patients in ED. Some hospitals also provide the service of a discharge lounge, where patients can wait for their take home medication, and transport home. This means that their hospital bed is made available sooner and helps improve patient flow within the hospital.

Earlier patient discharge planning could result in more timely bed availability within the hospital. This could result in improved patient flow and improved ambulance patient handover times. Consequently this could release more ambulances to respond to emergency calls to patients waiting within the community.

Whilst overall we found that patient privacy and dignity may be compromised when patients are confined to excessive waits on ambulances, people who engaged with our survey were generally positive about their overall experiences. The outcome from our public survey is a positive reflection on the professionalism and caring attitude of the ambulance crews towards their patients.

Workforce

Within the Health and Care Standards, standard 7.1 highlights that healthcare services should ensure there are enough staff with the right knowledge and skills available at the right time to meet needs of patients.

Staff numbers and staff pressures

We received a number of comments from ambulance crew relating to perceptions that EDs are under staffed and under pressure, comments included:

> *"Due to low staffing, there can be long delays waiting to hand over. During busy times it feels like the staff aren't listening to us when handing over."*
>
> *"Slow ... ED staff under too much pressure often short staffed or lack of bed spaces."*

This was supported in our findings from ED staff, with only a fifth (23 of 103) of respondents saying there are enough staff for them to carry out their role safely and effectively. This is also consistent with our findings of previous ED inspections across Wales.

These findings are a concern, since insufficient staff numbers within EDs will have an impact on the quality and safety of patient care, and the ability to facilitate a timely ambulance patient handover, thus affecting people waiting for an ambulance in the community. Whilst the scope of our review did not include consideration staffing levels within EDs across Wales, health boards should review, and continue to monitor their staff establishments in EDs, and take action to improve the ongoing issues identified with staffing during our review and in our previous ED inspections.

We identified that during 2020-21, WAST recruited over one hundred additional frontline staff to gain a more timely response to the public's demand on its services. However, it was concerning to find that in response to our survey, only 31% of ambulance crew said there were adequate staff for them to do their job properly. Only 65% said they were able to meet the demands on their time at work. We were informed that there are further plans for WAST to recruit similar additional numbers of staff during 2021-22, however, this may not necessarily result in improved handover times to ED staff. Although, it may help improve the patient experience and staff well-being. It is at present too early to make a judgement on the increase to WAST staff establishments.

Recommendation

WAST and health boards must review and continuously monitor their staff establishments, in order to ensure appropriate levels of staff are maintained at all times.

Impact of hospital handover delays on staff

We asked ambulance crew in our survey whether there was sufficient support available when they wait for long periods on board an ambulance due to delayed handovers. It was disappointing to find that 93% of respondents said there was insufficient support available to them.

Only 36% of ambulance crew said their working pattern allows for appropriate breaks throughout their shift, and that their working pattern allows for a good work life balance. Ambulance crew we interviewed reported that shifts overrunning have become a normal part of their work. The term overruns refers to crews who have no option other than to work beyond their shift end time.

We identified that staff welfare in urban areas is easier to manage than rural areas, since crews are stationed closer to the ED they most often attend with patients, and are therefore able to return to their base station during their breaks and sooner at end of shift times.

In rural areas, we were told that it is not uncommon for shifts to overrun by two to three hours. The impact of delayed handovers is also increased in areas where a high number of tourists arrive during peak holiday times. If ambulance crews are late leaving the ED at the end of their shift whilst awaiting the arrival of a relief crew, at times, crews may be delayed by up to a further two hours before they arrive back at their base station.

These delays mean they have to start their shift the following day at a later time, to ensure they have sufficient down time between shifts. This can have a knock on effect to staff availability in the earlier part of their next shift.

It was positive to find that that 'pool cars' have been implemented at some ambulance stations, to help alleviate the impact of overruns on crew. They are used to transport ambulance crews to return to base for their breaks, and at the end of their shift, once the new crew arrive to take over the patient care on board the ambulance, waiting outside the ED to handover.

As referred to earlier within the report, the role of a Duty Operational Manager (DOM) has been implemented across Wales. The DOM is responsible for the operational leadership and supervision of a defined group of Paramedics, Emergency Medical Technicians and Urgent Care Assistants.

Additionally, they provide proactive and reactive operational leadership as a role model and operational commander at operational incidents, in line with the Civil Contingencies Act 2004[18] and as required to support the wider unscheduled care system. In addition, part of their role is to facilitate crews to take their allocated breaks, and to finish their shift on time wherever possible, by taking over the care of patients, therefore providing relief to crew members. We learned that the role is a relatively new initiative within WAST, and a number of DOMs had only recently been appointed at the time of our fieldwork interviews. The positive impact of this role in supporting ambulance crews is welcomed by those who have experienced this support.

Staff access to food and drink

Our review considered whether ambulance crews have reasonable access to food and drink during their shifts and prolonged waits outside of EDs. Only two in five said they had reasonable access to food and drink.

We established that ambulance crew who attend EDs in rural areas, or those whose ambulance base station is a great distance from their most frequented EDs, have more issues in accessing food and drink, especially during night shifts. This is because they cannot store their food at their base station and return to get it during their breaks, and there are no facilities for them to purchase food, either within the hospital or nearby vicinity. Ambulance crew working within urban areas said access to food was easier, since their base station was near the hospital, which allowed them to return either to their base station, or access food within the vicinity of the hospital, when relieved by Duty Operational Managers. Staff comments included:

"Food or a hot beverage is not available on nights and when working with a less experienced individual you cannot leave the patient when stuck outside hospital for hours on end. Only some hospitals offer the concession of £5. The patient does not get a warm drink or food whilst waiting."

"During night shifts access to food and drink becomes much more difficult and wish this should be addressed."

18 The Civil Contingencies Act 2004 is an Act of Parliament which provides the framework for emergency and disaster planning and response on local and national levels in the UK.

Staff well-being

Our review has highlighted a number of key issues discussed above, which impact on the health and well-being of ambulance crews, as a direct result of delayed handovers and their knock on effect on crews' working conditions, this was also highlighted within the Amber Review report. During interviews, a number of ambulance crew told us that handover delays have a direct impact on their own health and well-being, comments included:

> *"Hospital handover delays are having significant impact not only on patients but on WAST as an organisation, and also on morale, since they [staff] feel they are unable to provide the best service possible to the community that they serve."*

In addition to these issues, staff highlighted further concerns regarding the poor ventilation on board an ambulance. We were told this has had a significant impact during the pandemic, where crews have spent prolonged periods on board ambulances waiting to handover to ED, and were required to wear full PPE whilst caring for suspected COVID positive patients. Furthermore, other concerns were highlighted regarding exposure to exhaust emissions from older ambulance vehicles when waiting outside EDs, where engines must run to maintain power to the vehicle.

During interview, some senior WAST staff highlighted their concerns with the impact handover delays have on ambulance crews. Consequently, actions have been implemented to support patients and staff. These include the initiatives highlighted earlier, such as Red Cross teams supporting patients, DOMs and pool vehicles supporting crews and the provision of concessions at hospital canteens for staff meals, when delayed with handover.

The crews we interviewed expressed their support and gratitude for the initiatives, however not all the measures are available consistently across Wales.

In response to our staff survey, 84% of ambulance crew said they were aware of the occupational health support available to them to support their health and well-being, and around 65% said their work place provides support for their mental health. However, it was disappointing to find that only 39% of ambulance crew said their organisation takes positive action on staff health and well-being, and just over 25% said that their employer provides support for their physical health.

Our survey findings also highlighted that just 73% of ambulance crew feel safe at work, and only 47% were content with the efforts of the organisation to keep them and patients safe. Staff repeatedly expressed their frustrations with the impact of handover delays on the experience of patients, and on their own well-being. Further comments in our staff survey included:

> *"The effects of waits and frustrations are impacting on staff wellbeing."*
>
> *"We are expected to have a good level of fitness to perform our roles yet no access to gyms/PTs/ equipment is made."*
>
> *"WAST have improved in helping with mental well-being but they are very poor at ensuring staff are able to meet the physical requirements of the role. We should have access to gym facilities, discounted gym memberships, a sports club and easy access to physiotherapy. There should be a regular assessment of staff fitness."*
>
> *"I feel all efforts to improve wellbeing are paper exercises only and there is no real support."*

Our staff interviews identified positive comments from ambulance crew regarding access to mental health support at work. The support included referral to TRiM[19], access to the 'Headspace' mindfulness app, and mental health awareness weeks, which promote the services available to staff. Crews also highlighted that following attendance at a serious incident, staff are automatically referred to the TRiM process.

Whilst, in general ambulance crew said that the Trust provides support for their mental health, the majority of DOMs we interviewed said that the support offered to them is limited. They also highlighted that as peers, they provide support to each other, but are not always considered for referral if they have attended the scene of a serious incident, which may have been stressful and upsetting.

Recommendation

WAST should consider how initiatives already introduced can be made consistently available to all ambulance crew across Wales. In addition, consideration should be given to how the welfare and support available to ambulance crews can be further improved.

WAST must ensure that the support for staff mental well-being is consistent across Wales, and that staff are routinely referred when appropriate and aware of how to access support if required.

19 TRiM is a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic event.

Training and development

We considered the training and development of WAST staff. 85% of our survey respondents said they had received relevant training to allow them to undertake their role with confidence. Some ambulance crew comments suggested that despite caring for patients for prolonged periods on board an ambulance awaiting handover, training is not provided to support staff with this. This training issue was also highlighted by the ambulance crew we interviewed. Comments included:

> *"We are not nursing staff, but are expected to look after patients as though they are in the department, this includes having to try and toilet patients."*

Recommendation

WAST should ensure that appropriate training is provided to ambulance crew in providing care to patients on board an ambulance, during prolonged periods of handover delays.

Escalation arrangements

Escalating a clinical concern with a deteriorating patient

Our review considered the escalation process in place should a patient's condition deteriorate whilst they are on board an ambulance awaiting handover to the care of ED staff.

In 2018, following the sad death of a patient who had endured a delay with handover from WAST to an ED, the Coroner, issued the Trust with a Regulation 28[20] letter in December 2019 to implement an escalation process for delayed handover. The process was implemented in February 2021 and stipulates circumstances when escalation is required, and what actions must be taken by ambulance crew and ED staff. As part of the escalation process, a Datix incident (electronic incident reporting system) will be completed. This will flag the incident with senior health board and WAST staff to investigate jointly the delay, to help prevent reoccurrence.

In response to our staff survey, only 49% of ambulance crew said that there was a robust system to alert ED staff should a patient's health deteriorate. This was concerning given that a clear process has already been implemented. In addition, not all the staff that we spoke with during our interviews were aware of the process. One comment received by a member of ambulance crew said:

> *"We have patients who regularly take the turn for the worse and are waiting outside, we raise with hospital staff and management and it's a slow process to get the patient into the department."*

20 The Coroner has a legal power and duty to write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. This is known as a 'report under regulation 28' or a Preventing Future Deaths report because the power comes from regulation 28 of the Coroners (Inquests) Regulations 2013.

Ambulance crew who had an awareness of the new escalation process told us that it is available on the Trust's intranet which is accessible to all ambulance crew via their iPads.

During our interviews, we spoke with a senior manager within the Trust who said that since its implementation, the impact of the escalation process was being monitored. The process had been presented to the Trust's scrutiny panel and an all Wales audit had commenced with Datix incidents being dip-sampled. The effectiveness of the process is to be gauged within the first six months since its implementation. At the time of our interviews, we were told that it was too early to gauge the effectiveness of the escalation process. As part of HIW's review action plan follow up processes, we will seek an update on the Trust's assessment of the effectiveness of the escalation process.

Recommendation

WAST must ensure all relevant staff are fully aware of the escalation process in place should a patient's health deteriorate, in order to minimise risks to patient safety.

WAST must provide HIW with evidence of its assessment of the effectiveness of the escalation process.

Escalation arrangements at a strategic level

Our review also considered how WAST manages escalation arrangements at a strategic level during periods of high pressure and demand during delayed handovers, and the subsequent lack of vehicle resource. In addition, how risks are identified, managed, and mitigated to ensure patient safety is maintained on board the ambulance during delayed handover.

To explore this, we attended the Trust's Operational Delivery Unit (ODU) in Cwmbran. This is the central hub and support network which provides leadership and co-ordination for the unscheduled care system in Wales. The ODU provides a single point of access for the identification and mitigation of risks in relation to hospital handover delays. Where ambulance crews are delayed, early escalation will occur via the ODU to the site manager and senior manager on call when necessary.

National Delivery Managers located within the ODU work collaboratively with health boards, WAST, Welsh Government and wider organisations and networks. Their role is to monitor WAST's status across all health boards in Wales, which includes the number of ambulances delayed outside each hospital, the hours they have been delayed, and the number of calls from patients who are waiting for an ambulance within the community.

We observed a live intelligence led integrated unscheduled care dashboard, which displays the data highlighted above, and provides a clear visual representation of the situation across Wales. The ODU currently operates seven days a week from 08.00am to 08.00pm or 02.00am during peak periods, and planning is in progress for the ODU to be operational 24 hours a day, 7 days a week.

We observed the daily WAST Risk and Safety Huddle, which is a video call chaired by the National Delivery Manager, with operational management representatives from across each region of Wales and specific service areas. This includes but is not limited to Emergency Medical Service Clinical Contact Centre's, 111 and Non-Emergency Patient Transport Services. Individuals provide an update in relation to identified risks to provide mitigation where required to assess and plan for the day ahead.

We also observed the daily National Risk and Safety Huddle, which is a video call with senior hospital managers within each health board and Welsh Government leads. This is chaired by the WAST Strategic Lead or the Head of the ODU. During the huddle, we observed how intelligence is gathered, performance and risk information is shared nationally, and the regional health system plans for the day are set to maintain the public and patient safety and identify risks, and plan for mitigation of these.

Information is submitted by health boards prior to the meeting which includes hospital escalation status and risk level, hospital bed capacity, and speciality bed numbers, such as those available in critical care. During the call, WAST provides an update on the levels of activity, demand, performance, escalation status and pressures within the unscheduled care system. Areas with significant handover delays, and areas within the community experiencing lengthy patient ambulance response times are prioritised, and health boards report the risks and their plans for mitigation of handover delays. Risks and action plans are agreed and a regional escalation stage is agreed based on demand.

The development of regional escalation protocols has ensured risk is balanced across the healthcare systems. When hospital handover delays are causing issues with vehicle resource and the demand for beds at a hospital has reached maximum capacity, decisions can be made dynamically to divert ambulance resources across geographical borders, to help maintain patient safety. Each health board will take responsibility for ensuring that all appropriate actions have been taken to manage demand within their own boundaries before cross border or regional actions are implemented in line with those defined within their own escalation plans, supported by regional escalation stages.

During periods of high demand on WAST emergency services, ambulance waiting times will inevitably increase. During these periods, WAST utilises the Demand Management Plan (DMP) framework. The DMP is used to deal with real time acute operational issues, which are not likely to have any long term service impact. There are eight DMP levels (DMP-1 to DMP-8) which are reflective of the scale of demand experienced by the service. The DMP aims to reduce demand and increase capacity of the service, which requires decisions at operational, tactical and strategic command level, in-line with the DMP level.

During any handover delay of more than six hours, alerts are automatically generated to the WAST Director of Operations and Chief Executive, to ensure key organisational leads can act on the issues identified and plan to mitigate the risks to patient safety.

During late 2020, WAST commissioned a Quality Governance Report associated with hospital handover delays. The report detailed the background, complexity, and significance of handover delays with the aim to embed robust governance processes, to monitor and manage the issues. The report also provided an account of activities undertaken to promote improvement, an assessment of the likely outcome of improvement actions being undertaken and significance of negative patient experience or patient harm.

WAST also has a Notification and Escalation Procedure, which provides guidance on the incident notification procedures followed within WAST. It also articulates the escalation process for hospital delays and/or patients awaiting an ambulance response within the community. To provide a consistent process, as to when, and to who, hospital handover delays need to be escalated.

In order to ensure the safe handover of patients to secondary care, WAST has developed systems, which identify risks, provide mitigation and escalate concerns, through timely, efficient and safe processes. The development of the ODU has had a significant impact in providing system oversight, and enabling effective management and practice across the healthcare system. The ODU is able to focus on immediate 'red release requests of ambulances from hospitals, hospital diversions to less busy sites, and enabling ambulance crews to handover patients in a timely manner.

Governance Arrangements

The Health and Care Standards stipulate that governance, leadership and accountability should be in keeping with the size and complexity of the healthcare service, are essential for the sustainable delivery of safe, effective person-centred care.

Reporting handover incidents

We found a robust process in place for managing handover incidents which may result in patient harm or death. Daily reviews of the Trust's electronic clinical incident system 'Datix' is undertaken by patient safety officers and managers. The Trust's SCIF, also meets twice weekly to review any serious incident reports, for investigation, and to identify any actions, lessons learnt and themes or trends.

WAST local management teams meet regularly with health board clinical leads to escalate any concerns, present data and discuss local mitigation. A Joint Investigation Framework process is also in place, and guides the Trust and health boards across Wales to review and investigate serious patient safety incidents identified within SCIF.

The process involves a collaborative investigation between WAST and the relevant health board. WAST staff highlighted issues with inconsistency in engagement in the joint process from all health boards, where identifying and sharing of learning from incidents is inconsistent across Wales. However, they did acknowledge that positive steps have been made, to improve engagement from all health boards.

Within our staff survey, only 63% of WAST respondents said they felt secure in raising concerns about unsafe clinical practice, although almost all staff knew how to report it. In relation to patient safety incidents, 64% of WAST respondents said they had seen a patient safety incident, near miss or an error, and of these almost all said they or a colleague had reported it.

It was disappointing to find that only 41% of WAST respondents said they believed their organisation would address their concerns. Our staff interviews supported this finding, with some staff highlighting that any response or feedback they receive as a result of reporting an incident, is a generic response. This therefore does not provide the reporting person with any action plan or learning as the result of a reported incident.

Comments included:

> *"Items are reported, there is no feedback and the issue is recurrent."*
>
> *"Handover delays and long response times are not seen as near misses anymore. They are normal."*
>
> *"Not confident in reporting any concerns due to backlash."*

Despite an overall negative response to incident reporting management, good practice was reported from staff from one ambulance base, which reported a process in place for a designated member of staff to provide feedback to the teams regarding Datix incidents and reports. This has a positive impact on staff, with the feedback encouraging teams to report any incident that occurs.

Our findings highlight the need for WAST to identify more effective processes for sharing feedback from incidents. This was discussed with senior staff who acknowledge improvements can be made to ensure incident investigation outcomes are effectively shared with staff, to help improve the quality and safety of care.

Recommendation

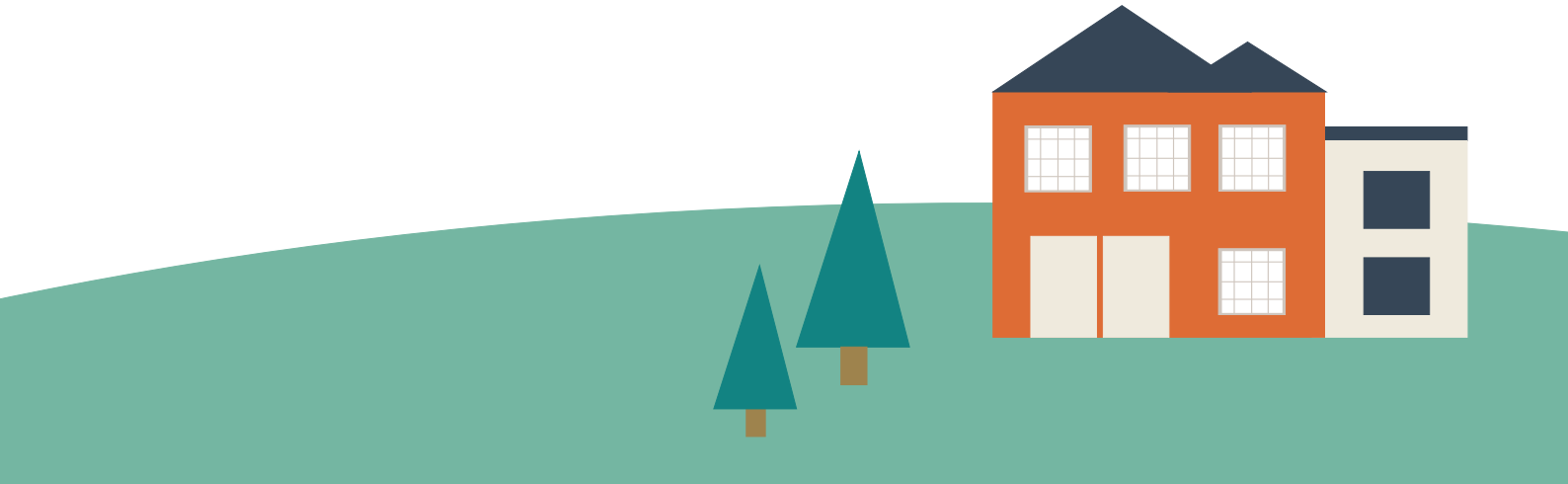
WAST must do more to ensure that its staff feel able to, and are confident in raising concerns. It must also ensure that robust processes are in place to share the learning with staff following incident investigations, in order to improve quality and safety of patient care.

Risk Registers

Hospital handover delays are identified by WAST as a significant corporate risk, which has been assessed at the highest score on its risk register. The risk relates to patients not being able to access secondary care assessment and treatment due to prolonged handover delays. In addition, the consequence of emergency response vehicles unable to attend patients requiring and ambulance in the community.

Such situations place WAST in a position where it is managing the consequence of handover delays. These delays are generally caused by a wider set of factors within the hospital setting including patient flow issues.

It is clear that WAST cannot, alone, improve patient flow through hospitals, to support the prompt transfer of patient care in to EDs. The significant level of risk to patient safety associated with delays handovers including the risk to patients in the community, cannot be one that is accepted any longer. It is essential that WAST, each health board across Wales, including Powys Teaching Health Board, consider whether actions taken to date have gone far enough to resolve this issue.



Conclusion

The aim of our review was to consider the experience of patients, including their safety, care, privacy and dignity whilst waiting on board an ambulance outside EDs during delayed handovers.

Despite finding that patients were, on the whole, positive about their experience, we have identified a wide range of evidence that handover delays have a significant impact on the ability of ambulance crew to provide a positive experience for patients. This included negative impact on the dignity of patients, and potential increased risks to patient safety.

It is clear that the issue of delayed handover has a hugely negative impact on the unscheduled care system as a whole. Each ambulance that encounters a prolonged stay at an ED potentially means fewer ambulances available to respond to emergency situations elsewhere.

National guidance is clear on the targets and expectations regarding handover and there is an apparent clear will to meet and achieve these expectations. However, it is clear that the issues around handover have not been resolved to date, with inconsistency in approaches apparent across Wales introducing risks to patient safety.

Whilst WAST has a role to play in addressing the issues described within this report, it does not have the ability to unilaterally resolve these problems. The whole healthcare system has a role and part to play in addressing the issues that we have highlighted in our report, and it is imperative that a reinvigorated, strengthened and concerted approach is taken to ensure that these problems are overcome.

HIW plans to undertake a National Review during 2021-22 which will focus in more detail on the issue of patient flow, examining in greater depth the cause and impact of patient flow issues.

What next?

We expect the Welsh Ambulance Services NHS Trust, health boards, and Welsh Government to carefully consider the findings from this review and the recommendations set out in Appendix A. We hope that this information will be used to further improve the service being provided by the Trust, and to inform further work and investigation across Wales, as highlighted within the report.

The Trust, health boards and Welsh Government will be required to submit a joint action plan in response to the recommendations highlighted within our report. HIW will undertake follow-up activity on recommendations made. This is to ensure that the Trust, health boards and Welsh Government are being vigilant in addressing the matters raised and taking all necessary action to improve the issues highlighted in our review.

Appendix A – Recommendations

As a result of the findings from this review, we have made the following recommendations in the table below.

Recommendations	Action
Health boards, and Welsh Government should consider what further actions are required to make improvements regarding the patient flow issues impacting on delayed patient handover. This may include consideration of whether a different approach is required by WAST, health boards, and social care services within Wales, to that taken to date in tackling this system-wide problem .	
WAST should engage with health board representatives to ensure there is improvement in practice between ambulance crew and ED staff to ensure the dual pin process is consistently followed, and ensure Welsh Government reporting data is accurate.	
Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process of the handover of patients from ambulances.	
Health boards must ensure that appropriate representation is present at WAST Serious Clinical Incident Forum meetings, to aid with the timely management of concerns and service improvement.	
If and where local standard operating procedures are absolutely necessary, WAST and health boards must together ensure that ambulance crew are familiar with the handover policy for that ED.	
WAST and health boards need to ensure that when delays occur, patients and their relatives or carers should be kept fully informed of the reasons and the progress being made in resolving them.	
WAST and health boards across Wales should ensure patient feedback is obtained regularly to understand their experiences of long waits on board an ambulance, in order to inform improvement.	
WAST and all health boards across Wales must work together to identify a consistent approach in providing timely investigations and treatment for patients on board ambulances, to enable ambulance crews to be released quickly.	
Both WAST and health boards must ensure that ambulance crew and ED staff work collaboratively to ensure patient privacy and dignity is maintained, and patients are always provided with the opportunity to use private toilet facilities where appropriate, in a dignified manner whilst waiting on board an ambulance during delayed handovers.	
During prolonged handover delays, WAST and health boards must work collaboratively and consistently, to minimise the risk of skin tissue damage for patients.	
WAST should work with health boards to ensure that patients nutritional and hydration needs are consistently met whilst waiting in the back of an ambulance due to delayed handovers.	

Recommendations	Action
WAST should consider how ambulance crew and patients can be supported to achieve and maintain high standards of hygiene and IPC, in particular during periods of delayed handovers for patients on board an ambulance.	
WAST and health boards must ensure there is absolute clarity, consistency and understanding between both ambulance crew and ED staff, as to where the responsibility and accountability lies for patient care on board an ambulance following triage, until transferred into the ED.	
WAST and health boards must review and continuously monitor their staff establishments, in order to ensure appropriate levels of staff are maintained at all times.	
WAST should consider how initiatives already introduced can be made consistently available to all ambulance crew across Wales. In addition, consideration should be given to how the welfare and support available to ambulance crews can be further improved.	
WAST must ensure that the support for staff mental well-being is consistent across Wales, and that staff are routinely referred when appropriate and aware of how to access support if required.	
WAST should ensure that appropriate training is provided to ambulance crew in providing care to patients on board an ambulance, during prolonged periods of handover delays.	
WAST must ensure all relevant staff are fully aware of the escalation process in place should a patient's health deteriorate, in order to minimise risks to patient safety.	
WAST must provide HIW with evidence of its assessment of the effectiveness of the escalation process.	
WAST must do more to ensure that its staff feel able to, and are confident in raising concerns. It must also ensure that robust processes are in place to share the learning with staff following incident investigations, in order to improve quality and safety of patient care.