Kingston Hospital
NHS Foundation Trust

Trust Board (Public)	**Item: Addressing Ambulance Delays**
Date: November 2021	**Enclosure: F**
Purpose of the Report: To provide assurance that the actions required by the Trust have been completed.	
For: Information ☒ Assurance ☐ Discussion and input ☐ Decision/approval ☐	
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Risk Implications – Link to Assurance Framework or Corporate Risk Register:	
Legal / Regulatory / Reputation Implications:	
Link to Relevant CQC Domain: **Safe ☐ Effective ☒ Caring ☐ Responsive ☐ Well Led ☐**	
Link to Relevant Strategic Theme:	
Document Previously Considered By:	Executive Management Committee

Recommendations: Note contents of the report.

The Trust Board are asked to;

- Note the NHSE/I letter regarding ambulance handover delay and the UEC Recovery 10 Point Action Plan.
- Note the proposed Kingston Hospital NHS Foundation Trust response and wider partner involvement
- Recommend that impact is reviewed through Integrated report that monitors ambulance hadnovers

Classification: Official
Publication approval reference: BW1101

To: ICS Leads
Acute Trust Chief Executives
Ambulance Service Chief Executives
Acute Trust Chairs

CC: CCG Accountable Officers

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

27 October 2021

Dear colleague,

For action – Addressing ambulance handover delays

We are writing to all Trusts and ICSs regarding delays in handing over responsibility for the care of patients from ambulances to Emergency Departments, recognising that these delays can only be addressed through good system working and cross-organisational cooperation.

In the UEC Recovery 10 Point Action Plan we asked that ICSs "make sure there are robust steps in place to avoid handover delays". We know, and are grateful, that staff within your system are already working incredibly hard to resolve this problem. Given the impact on patients, we must however press to identify further solutions to eliminate all handover delays.

Handover delays

National policy has set out that handovers should take no more than 15 minutes, ensuring patients receive necessary emergency care and allowing ambulances to get back on the road responding to patients in the community.

You will be keenly aware of the risks associated with hospital handover delays.

Acute trusts should take responsibility for patients from when the ambulance arrives and ED staff are informed of arrival, regardless of the patient's exact location. In practice, there is a need for close cooperation and risk sharing between services.

Taking action to eliminate delays

All systems must take action to ensure that ambulances are not used as additional ED cubicles, and that crews are able to safely offload their patient to the care of the ED. It is important that patient safety is prioritised and as a result we emphasise that corridor care is unacceptable as a solution.

We are now asking you to work together as a system and agree what actions you would need to take to immediately stop all delays. We appreciate that this may involve some difficult choices, and that we will need to discuss and involve colleagues, including the CQC, where helpful. For ease of reference we are attaching a list of measures which we know that some of you have implemented which have demonstrated clear benefits.

Today we also are asking Trusts, and their Systems, to report the actions that they have put in place to ensure delays have been eliminated in all Board Meetings, taking time to discuss the challenges with data to support the issue. You may find it helpful to invite clinical staff from the relevant areas to join these discussions.

Initiatives being used in systems

The following is not exhaustive, and a combination of initiatives is likely to be most effective:

- Establish surge capacity / priority admission unit to care for patients out with ED following a decision to admit; this may require conversion of existing space, or temporary accommodation, within the acute trust to accommodate patients prior to admission to the appropriate ward
- Wherever practical implement “fit-to-sit” for patients that do not require a trolley
- Ensure early access to clinical decision-makers to enable prompt admission / discharge
- Establish additional community capacity to enable earlier discharge for patients no longer requiring acute medical care
- Increase capacity of discharge lounge to free beds earlier in the day, accompanied by rapid support from non-emergency patient transport services
- Maximise discharge through following principles within the hospital discharge and community support: policy and operating model
- Increase direct access to GP streaming, SDEC, acute frailty services and medical / surgical assessment units from ambulance crews to reduce direct ED conveyance
- Match community and mental health service capacity and demand to enable reduced conveyance to ED for appropriate patients
- Work with two hour community crisis response teams to offer appropriate alternative pathways to an ambulance response
- Local agreement of staffing models e.g. using acute trust, ambulance service and community service staff in partnership to support surge capacity
- Making use of HALO staff to support handover of care, or working with ambulance services to explore whether Community First Responders are available to take on additional roles to support care for patients
- Work with Provider Collaboratives and ambulance services to support boundary changes and diverts, where this will help to decompress a site

We thank you for taking this necessary rapid action to address the risks associated with handover delays.

Yours sincerely,



Pauline Philip DBE
National Director for Emergency and Elective Care

Professor Steve Powis
National Medical Director

Sir David Sloman
Regional Director

AEDB -Review of actions to address ambulance handover delays at Kingston Hospital Foundation Trust.

Initiatives being used in systems:	**To action:**
Establish surge capacity / priority admission unit to care for patients out with ED following a decision to admit; this may require conversion of existing space, or temporary accommodation, within the acute trust to accommodate patients prior to admission to the appropriate ward	The AEDB has considered this and has concluded that this is not possible, due to a lack of suitably equipped space and staff to support the provision of additional clinical areas in ED.
Wherever practical implement “fit-to-sit” for patients that do not require a trolley	In place - Patients are assessed as to whether they are fit to sit at handover and are directed to a dedicate area in the ED
Ensure early access to clinical decision-makers to enable prompt admission / discharge	In place - This is provided by the EPIC and on call teams . In addition ED benefits from a frailty service and SDEC .
Establish additional community capacity to enable earlier discharge for patients no longer requiring acute medical care	In place - Twice daily community bed meetings are in place 7 days a week. These include acute, community, social care and continuing health care team members. The use of community , TADD beds and additional beds via the bed bureau (from Nov 1 2021) are monitored through these meetings as are discharges home with packages of care. A clear process for the escalation of delays is fully embedded. In addition a full capacity protocol is being introduced in the community inpatient facility to allow for earlier transfer there from the hospital
Increase capacity of discharge lounge to free beds earlier in the day, accompanied by rapid support from non-emergency patient transport services	In place - the use of the discharge lounge is monitored through the three times per day bed meetings . In addition the Trsut has a well established and routinely used "Full Capacity Protocol" where patients waiting for beds in ED are boarded on inpatient wards (with the support of Matrons and Site managers) ensuring that there is a rapid mechanism to release space in ED - mittigating the risk of ambulance delays.
Maximise discharge through following principles within the hospital discharge and community support: policy and operating model	In place - the Trust has undertaken a full review of this policy and has implemented the recommendations, including the recording and analysis of a patient's criteria to reside . A transfer of care hub has been established, led by a coordinator who reports to an executive director.
Increase direct access to GP streaming, SDEC, acute frailty services and medical / surgical assessment units from ambulance crews to reduce direct ED conveyance	Opportunity to develop - The Trust has both an SDEC and Frailty team - neither services currently have direct access from ambulance crews . **SDEC** - ED has committed to work with the Service Engagement Manager to share the current live SDEC pathways and operating hours with a view to enabling the ambulance service to access SDEC directly. **Frailty** The Frailty team self-select patients according to their Rockwood Frailty score. ED has committed to work with the Service Engagement Manager to facilitate the direct access of the ambulance service to the frailty unit. UTC - The ED team has committed to working with the Service engagement manager to facilitate the direct access of the ambulance service to the UTC.
Match community and mental health service capacity and demand to enable reduced conveyance to ED for appropriate patients	In progress. (1) SWL community mental health teams transformation and investment in place. Programme of developing integrated access to and support from community mental health services for new and existing patients ongoing. There is a context of significant increasing MH demand for community services (+30% adults) and additional resources for winter are being allocated to assessment teams. (2) Enhanced MH crisis pathway put in place including Coral mobile integrated MH crisis hub with access via the MH Crisis line, available 24/7 with clinical staffing and open access. Crisis service can assess patients in their homes, community settings, or the crisis hub as an alternative to conveyance to ED. Crisis service working in partnership with Acute ED / Psychiatric liaison services and Lotus Psychiatric decision unit to support diversion and swift support to patients in MH crisis. (3) Significant investment made into CAMHS Eating disorders community services and Tier 3 teams to support community management of patients. Additional staffing for extended hours and more capacity for CAMHS Emergency care service support CYP presenting to EDs.
Work with two hour community crisis response teams to offer appropriate alternative pathways to an ambulance response	Within K&R crisis response services we are scoping alternative care pathways with LAS that would enable direct contact with this service provision alleviating the need for LAS to attend/remain with an individual more suitable for this response. Working towards an 8-8pm service pending recruitment
Local agreement of staffing models e.g. using acute trust, ambulance service and community service staff in partnership to support surge capacity	In progress - work is underway to identify a pool of staff who can work across organisational boundaries. The AEDB has a surge plan which includes clear actions for each organisation and which enables the redirection of staff where required.
Making use of HALO staff to support handover of care, or working with ambulance services to explore whether Community First Responders are available to take on additional roles to support care for patients	Very limited need for this but review as required
Work with Provider Collaboratives and ambulance services to support boundary changes and diverts, where this will help to decompress a site	In place - the Trust works in collaboration with the provider collaborative and the ambulance services to identify actions to decompress the site.