

Addressing ambulance handover delays: actions for local accident and emergency delivery boards

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Foreword

Delays in handover of patients from ambulance services to emergency departments (EDs) result in:

- increased risk to patients on site due to delays in diagnosis and treatment
- increased risk in the community because fewer ambulances are available to respond
- the ability to respond to a serious or major incident being seriously compromised
- reduced ambulance response performance due to time wasted queuing.

Ambulance handover delays can be a symptom of system-wide issues, a mismatch of capacity and demand and inadequacy of patient flow. As such, handover delays must be recognised as a system-wide responsibility. All organisations must co-operate to ensure effective working at the interfaces of healthcare organisations.

Last winter (2016/17) saw record numbers of delayed hospital handovers across the NHS. It is therefore timely to restate the expectation that delayed ambulance handovers should not occur. In renewing our focus on this issue, it will become a sentinel indicator for both winter monitoring and on an ongoing basis.

This document sets out the main points from recent guidance documents, and separates them into actions to be embedded as part of normal working practice, and actions to be taken should ambulances begin to queue. This summary is not exhaustive and local delivery boards should refer to more detailed guidance from NHS Improvement and the Royal College of Emergency Medicine as referenced.

There are four key principles that local systems should note:

- The patients in the urgent care pathway who are at highest risk of preventable harm are those for whom a high priority 999 emergency call has been received, but no ambulance resource is available for dispatch.
- Acute trusts must always accept handover of patients within 15 minutes of an ambulance arriving at the ED or other urgent admission facility (eg medical/surgical assessment units, ambulatory care, etc).

- Leaving patients waiting in ambulances or in a corridor supervised by ambulance personnel is inappropriate.
- The patient is the responsibility of the ED from the moment that the ambulance arrives outside the ED, regardless of the exact location of the patient.

We expect that all local accident and emergency (A&E) delivery boards should therefore ensure that all measures to reduce the impact of handover delays are embedded in normal practice; and regional directors will want to be reassured that appropriate measures are a fundamental component of local winter escalation plans. In the development of these plans, lead ambulance commissioners should be fully engaged and provide a link between A&E delivery boards, sustainability and transformation partnerships (STPs), clinical commissioning groups (CCGs) and regional leads.



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Actions to be taken now, and embedded as part of normal working practice to reduce the likelihood of delays

To reduce the likelihood and impact of ambulance handover delays, local A&E delivery boards should ensure that:

Acute trusts and ambulance trusts

1. Must appoint a senior lead, directly accountable to the trust board, to oversee the development and implementation of clinical handover protocols for acute departments. These protocols should have a focus on patient safety and hence the need to minimise delays to assessment and treatment.
2. Must avoid the use of ambulance trolleys and ambulance staff to queue patients in a corridor or other areas of the ED or admissions unit, including ambulance triage areas where these are used. Patients should be transferred to a hospital trolley on arrival and hospital staff allocated to provide safe care to these patients.
3. Must avoid the use of ambulance trolleys for patients who are 'fit to sit', and should move them to a chair if appropriate. This can expedite investigations and facilitates discharge assessments. Such an approach assists greatly the use of ambulatory care pathways and reduces the demand on trolley/cubicle spaces. Hospital staff, including handover staff, and ambulance staff should be made aware of the fit-to-sit guidance and a clinical champion appointed to see that this is being implemented.

4. Must book patients onto the hospital patient administration system (PAS) or ED PAS when the patient first arrives in the department.
5. Must ensure that handover standards are applied consistently where patients are transferred directly to admissions units and other clinical departments.
6. Must have an agreed protocol for the timely escalation of handover delays with established warning and trigger responses. This should include a clear policy to manage waiting ambulances safely with regular risk assessments and required actions in order to deliver a safe waiting environment for patients.
7. At no time should a patient be kept in an ambulance outside a hospital.

Commissioners

8. Must facilitate ambulance services and acute hospitals working together and with partner organisations at STP level to agree effective escalation procedures and interventions for periods of high demand, and agree trigger and response mechanisms. HAS screen information may be a useful source for local monitoring and escalation.
9. Should ensure that they fully understand where high demand increases are being generated from, and take appropriate action to assist in reducing demand growth – for example, high 111 referral rates to 999, high volume frequent users and other sources of demand resulting from alternative access to services.
10. Must ensure ambulance services have in place regional capacity management systems to be enacted when queues develop. These should provide information to hospitals and ambulance services to know capacity in real time and include processes for diverting patients at times of significant pressure. This allows clinicians and managers to make better informed decisions about patient care and use of alternative care pathways.
11. Should improve general practice input to care homes to reduce unnecessary conveyance and implement care home navigators as a matter of urgency.

These should be provided 24/7 or over extended hours wherever possible.

12. Must ensure that there are a wide range of referral options within the community that 999 and the Clinical Assessment Service (CAS) supporting NHS 111 can use as an alternative to the ED. This could include frailty services, ambulatory emergency care services, falls services and urgent treatment services. These should be provided 24/7 or over extended hours wherever possible.

GP practices

13. Must ensure prompt telephone access for ambulance crews to make contact with a patient's own GP surgery before deciding whether to convey, as access to advance care and end-of-life plans, advice or urgent GP review may avoid the need for conveyance and hospital attendance/admission or enable direct referral to the medical or surgical take teams.
14. Should take measures to avoid referred patients arriving in surges as a result of all domiciliary visits, and thus conveyance requests, taking place after morning surgeries. This severely inhibits the ability of ambulance services to convey these patients in a timely manner, and practices should have plans in place to run visits throughout the morning, as opposed to batching them.
15. CCGs and GPs should work together with the CCG being responsible for overseeing the daily schedule of GP visits from all surgeries to ensure that large numbers of ambulances do not arrive together.

Community services

16. Should have rapid response teams to see patients in their own homes. Best practice is for teams to reach patients within 60 minutes of a request, and never longer than two hours.

Ambulance services

17. Should implement electronic patient handovers. These must be available to ED staff within 15 minutes of arrival.
18. Must share predicted activity levels with acute trusts on an hourly and daily basis to trigger effective escalation when demand increases.
19. Must put in place measures to enable safe reduction of conveyance to the ED, as set out in the 2017/19 CQUIN.

Actions to be taken when ambulances are predicted to queue or are queuing

Ambulance trusts

1. Should escalate all handovers exceeding one hour to the on-call executive director of the responsible acute hospital trust and CCG director on call.
2. Should consider the range of vehicles in their fleet to convey patients to the emergency department, but only where it is safe and appropriate to do so.
3. Reassess clinically appropriate alternative options to emergency department transfer.

Acute trusts

4. Must enact a handover escalation protocol where time to hand over is exceeding 30 minutes. This should include contacting the on-call hospital director so that immediate action can be taken to release ambulance resources. Where time to hand over is exceeding 60 minutes, the on-call CCG director and on-call NHS England director must be contacted, and those individuals should put in place whole-system local escalation processes to release ambulance resources. Over winter the regional winter on-call director should also be informed 24/7.
5. Must not place restrictions on ambulances in order to limit or regulate access to the emergency department or the handover of patients arriving by ambulance.
6. Should report ambulance handover delays at site-wide bed meetings in order to ensure that there is a whole-system response when required.

7. Must ensure that all patients handed over from the ambulance service are managed in a clinical setting that reflects their acuity as assessed by prompt triage. This action is often referred to as 'cohorting'. Cohorting should occur after assessment to ensure departments are fully aware of the acuity and needs of each patient and any attendant risks.
 - a. Areas used for cohorting must have appropriate equipment and facilities to maintain patients' privacy, dignity and safety at all times.
 - b. All cohorted patients must receive regular review and be subject to an ED safety checklist.
 - c. Escalation plans should include how the extra nursing staff required for any cohort area will be met. Ambulance staff (or managers) must **not** be used to look after cohorted patients.
8. Must put in place a clear process for reporting significant clinical concerns by staff and carers.
9. Must ensure that where normal processes are delayed the effects of such delays are mitigated by pre-emptive interventions (where appropriate) and investigations such as blood tests, ECGs, X-rays and CT scanning.
10. Must raise an SI for all incidents where a handover greater than 60 minutes has occurred.

Emergency department staff

11. Should assess the 'pre-alert' information provided by paramedics regarding acute severe injury or illness patients so they can anticipate resource utilisation.
12. Should undertake regular reviews whenever at or near full capacity. A serious handover problem is sufficient reason for escalation of the issue to senior managers and executive officers.
13. Ensure prompt referral for inpatient care as soon as it becomes clear that admission will be necessary.

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