



Zero tolerance

Making ambulance handover delays a thing of the past



Project partners

This report has been produced through a partnership involving the following organisations and groups:

The NHS Confederation

The NHS Confederation represents all organisations that commission and provide NHS services. It is the only membership body to bring together and speak on behalf of the whole of the NHS.

We help the NHS to guarantee high standards of care for patients and best value for taxpayers by representing our members and working together with our health and social care partners.

We make sense of the whole health system, influence health policy, support our members to share and implement best practice, and deliver industry-wide support functions for the NHS.

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The following NHS Confederation networks and fora have contributed to the development of the report:

Ambulance Service Network (ASN)

The ASN is part of the NHS Confederation, and it works to:

- provide a strong and independent voice for UK ambulance services
- help ambulance services work more closely with the rest of the NHS and other key stakeholders in health and social care.

National Ambulance Commissioners Group (NACG)

The NACG is hosted by the NHS Confederation. It was set up to enable ambulance commissioners to address common issues and challenges together and to instil an ethos of partnership working across ambulance commissioning bodies. Its role is to:

- help strengthen ambulance commissioning by sharing and developing best practice between members in a way that endorses the national vision to integrate urgent and emergency care
- enable members to work collaboratively to inform and influence national health policy relating to ambulance service provision and its role in the wider emergency and urgent care system from a commissioners' perspective.

Hospitals Forum

The NHS Confederation's Hospitals Forum provides a thoughtful, strong, and authoritative voice on the issues facing hospitals and acute services in the immediate and long term. It works on behalf of all types of hospital, integrated hospital and community service providers to help shape the policy and politics that affect them.

Association of Ambulance Chief Executives

The Association of Ambulance Chief Executives (AACE) has also been involved in the handover project and the production of this report, alongside the NHS Confederation. AACE provides ambulance services with a central organisation that supports, coordinates and implements nationally agreed policy. It has a number of national work programmes and subgroups, including the National Ambulance Services Medical Directors Group and the National Directors of Operations Group, which have led AACE's contribution to this work.

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Foreword

Ambulance handover and turnaround delays are not good for anybody – least of all patients. National policy direction on this issue is clear: long delays in handing patients over from the care of ambulance crews to that of emergency department (ED) staff are detrimental to clinical quality and patient experience, costly to the NHS, and should no longer be accepted.

We agree. The NHS should work towards a “zero tolerance” approach in which these delays are viewed as unacceptable incidents that local healthcare leaders should be working together to eliminate.

We also recognise the scale of the challenge this poses to the NHS. Over the last decade we have seen unprecedented increases in the demand for urgent care services. Calls to 999 ambulance services have been rising, with an increase of around 5 per cent in 2011/12 compared to the previous year¹, and this growing pressure on the ambulance service has an inevitable knock-on effect on hospital EDs.

Across the country NHS organisations, along with their partners, have been redesigning their systems and services to respond to this growing demand. Due to improvements in the assessment of patients’ needs and the development of alternative care pathways and community-based services, increasing numbers of people who ring 999 for an ambulance are now being advised and cared for without being taken to an acute hospital. In many areas, initiatives to improve communications between ambulance crews and ED staff, implement rapid assessment and triage processes and manage patient flows across hospital sites more effectively have also helped to improve experience and outcomes for patients who do need to be conveyed.

But despite the progress that has been made, we still have work to do. Ambulance turnaround

delays are a symptom of a system that is not coping with the pressure being placed upon it.

Too often, attempts to address this issue have focused on simply managing these symptoms – or worse, apportioning blame for the problem – rather than understanding the underlying causes and seeking shared solutions from the whole system.

We all have a responsibility to ensure we have a safe, effective and high-quality urgent care system that puts the patient at the centre of what we do, and avoids delays that waste resources and result in poor patient experience.

In this report, we have looked at ambulance turnaround delays on a national and whole-system basis for the first time. We firmly believe that this is the right approach if we are to deliver the improvements that are needed, and we will continue to work together to maintain this shared focus and commitment at a national level.

We hope that you will find the examples and recommendations set out in the report useful as they implement local commissioning and service redesign strategies, and endeavour to make ambulance handover delays a never event.

Mark Docherty, Chair, National Ambulance Commissioners Group, NHS Confederation

Dr Anthony Marsh, Chair, Association of Ambulance Chief Executives

Dr Mark Newbold, Chair, Hospitals Forum, NHS Confederation

Heather Strawbridge, Chair, Ambulance Service Network, NHS Confederation

Introduction

Nobody wants to see ambulances stacked up outside hospitals waiting to hand over patients. Not paramedics, not emergency department doctors and nurses, not hospital managers, ambulance service controllers, commissioners or politicians – and least of all patients.

Handing over a patient from an ambulance to an ED is expected to take no more than 15 minutes.² But as the National Audit Office highlighted in its review of ambulance services in June 2011, only around 80 per cent of handovers meet this expectation. Each failure to meet this standard means a delay and poor experience for the patient waiting to be received. It also means a delay in an ambulance crew being available to dispatch to a new emergency call – posing a potential safety risk to the next patient waiting for an ambulance in the community. And it is also costly, with one ambulance service estimating that such delays cost it £4 million a year.³

Ambulance services and hospitals have been working to improve patient handover for more than a decade, and in many areas proactive, collaborative approaches to tackling the issue have been effective in reducing incidences of long delays. However, while significant problems may no longer be widespread, they have persisted in some areas, and in June 2012 David Flory, then deputy NHS chief executive, wrote to the NHS demanding improvement and setting out a zero tolerance approach to handover delays.⁴

'It's not good to be a patient stuck on an ambulance trolley in a corridor, but the patients at risk are the road traffic accidents or heart attacks still waiting for the ambulance service to respond'

Dr Anthony Marsh, Chair, Association of Ambulance Chief Executives (AACE)

Ambulance services, hospitals, commissioners, primary care and community service providers were all called upon to acknowledge they share a joint responsibility for eliminating handover delays and to take proactive steps to address the issue together. It was also reported that Monitor and the Care Quality Commission (CQC) were asked to consider how the foundation trust compliance regime and quality regulation respectively might be used to help achieve this.⁵

This report is intended to support healthcare leaders in their efforts to make handover delays a never event in their local health economies.

Building on existing policy and guidance, the content is drawn from discussions that took place during regional summit meetings organised by ambulance trusts during the summer of 2012, and a subsequent national event held in October 2012, organised by the Ambulance Service Network (ASN), the AACE National Ambulance Services Medical Directors Group and National Directors of Operations Group, and the National Ambulance Commissioners Group (NACG). This has been supplemented by a series of interviews with ambulance service providers, commissioners, GPs, hospital managers and clinicians and patient representatives, and the collation of case studies and examples of good practice from organisations that have made progress in tackling the issue.

Each section of the report outlines a theme or key message that emerged from the meetings, interviews and case studies, and contains recommendations that should be useful in supporting local work to eliminate delays and make handover clinically safe, efficient and effective. The ten key recommendations are summarised in the box overleaf.

Recommendations

Recommendation 1

Patient handover delays should be seen as a jointly-owned whole-system issue. Leaders from all parts of each local health economy should commit to work as partners to reduce delays in order to improve patient experience, care and safety.

Recommendation 2

Hospitals, ambulance services and clinical commissioning groups (CCGs) should each identify specific individuals who commit to work together – and with social services colleagues and other partners – to explore, understand and address the causes of handover delays in their area and the impact they have on patient experience, safety and costs. Particular efforts should be made to involve primary care and community service providers. Progress in tackling handover delays should be monitored at board level by trusts/foundation trusts and by CCGs.

Recommendation 3

Lead commissioners should actively seek support for a zero tolerance approach to handover delays in their health economy, in which significant delays of 60 minutes or over are regarded as unacceptable. Associated financial penalties should be agreed to reinforce this approach, and should be consistently applied.

Recommendation 4

Ambulance services, hospitals and commissioners should adhere to agreed, explicit and well-understood definitions for describing, recording and monitoring handover processes, including key performance indicators (KPI) start and stop times.

Recommendation 5

Ambulance services and acute trusts, with the support of commissioners, should develop common KPIs to support adherence to the national standard of 15 minutes for both arrival to handover and handover to crew clear targets. These KPIs should allow room for some 'flex' rather than being absolute 100 per cent targets.

Recommendation 6

Ambulance services and acute trusts, with the support of commissioners, should develop systems that capture data automatically and transparently against agreed definitions, including start and stop times. This data must be considered the single source of truth and be accessible by all partners. Data collection and reporting processes must include a validation process to ensure data is accurate and agreed by all partners.

Recommendation 7

Partners should work jointly on local process-mapping exercises, involving acute, ambulance and commissioning staff at all levels to review current handover and discharge pathways, identify where efficiencies can be made, pinpoint how processes can be streamlined and suggest areas for development. The issue of patient safety and achieving a high-quality clinical patient handover should be central to any work.

Recommendation 8

Acute trusts should model their maximum hourly ambulance attendance capacity in partnership with ambulance trusts. They should review internal mechanisms for managing patient flow across the hospital and examine how this can help to mitigate against significant and lengthy delays as a direct result of multiple attendance surges.

Recommendation 9

Ambulance services and acute trusts, with the support of commissioners, should seek to develop common escalation plans and ensure that these function as well out of hours as they do in hours.

Recommendation 10

All regions should seek to develop and implement a regional capacity management system (where they have not already done so) and undertake local work to understand patient flow across the whole health economy.

Patient handover delays are everyone's business

Patient handover is a complex process and managing it well and consistently across the peaks and troughs of demand over time is difficult.

Causes of handover delays vary widely and can range from poor triage processes to limited wheelchair availability at the ED receiving point. They may reflect pressure on beds within the hospital as a whole and a system that is struggling to discharge patients to community settings. Sometimes too many ambulances arrive at one hospital during a short period of time when they could have gone to an alternative, appropriate care provider. In some hospitals it is a four-minute walk from the ambulance arrival point to the ED reception, adding eight minutes to each ambulance turnaround.

Factors impacting on patient handover include:

- management of patient flow across the system, including outflow of patients from EDs into wards, as well as into the ED
- bed management, discharge management and capacity within hospitals
- seasonal pressures
- behaviour of professionals in primary care (volume of healthcare professional referrals)
- resources, equipment and capacity in EDs
- major incidents
- availability of alternative, appropriate community service provision
- design, signage and physical environment of hospital sites and EDs.

'Patient handover delays occur for a myriad of reasons. While they can undoubtedly result from poor communication by ambulance crews or inefficient processes within EDs on some occasions, they are often symptomatic of other pressures and behaviours in the wider system'

Patient handover delays therefore occur for a myriad of reasons. While they can undoubtedly result from poor communication by ambulance crews or inefficient processes within EDs on some occasions, they are often symptomatic of other pressures and behaviours in the wider system.

So who is responsible for tackling this problem?

Sometimes delays occur because there are too many ambulances arriving at once for hospital processes to manage. Many of these peaks of activity are predictable, such as in the early afternoon when GPs carry out home visits and request ambulances, often for frail elderly patients. Is it the responsibility of GPs to smooth the flow of patients? Is it up to EDs to devote more resources to handover at these times? Is it up to commissioners to design new pathways for these patients to avoid emergencies arising in the first place? Or is the answer better cooperative working across the system to achieve all of these?

The national policy position on this is clear. In his letter to NHS leaders earlier this year, David Flory not only called for a zero tolerance approach to patient handover delays, but

‘Where attempts to address handover delays have worked, the solutions have often relied on individuals within trusts leading on this work and continually maintaining the focus and momentum. We need a more sustainable, system-wide response’

Georgie Cole, Senior Project Manager,
South Central Ambulance Service
NHS Foundation Trust

reminded organisations of their “duty of cooperation” to ensure effective working at the interface of healthcare organisations. He wrote: “Where local handover delays continue to be problematic, both Monitor and the CQC have the responsibility to assure compliance with this duty and I have encouraged them to take appropriate action where organisations fail to do so.”

Participants at the regional and national events that have fed into this report also strongly agreed that tackling patient handover delays is everyone’s business. They concluded that reducing handover delays clearly does require individual ambulance services and EDs to undertake tactical operational actions to make their part of the handover process as efficient, smooth and safe as possible. But it also requires a strategic whole-system approach with clear leadership from commissioners, and active involvement of partners across the wider health and social care community.

Recommendation 1

Patient handover delays should be seen as a jointly-owned whole-system issue. Leaders from all parts of each local health economy should commit to work as partners to reduce delays in order to improve patient experience, care and safety.

Moving towards zero tolerance

At the 2012 Ambulance Leaders' Forum, Sir David Nicholson, chief executive of the NHS, made clear his frustration that in some parts of the country significant delays in the transfer of patients from ambulances to EDs are frequent and persistent. He told senior ambulance service leaders and commissioners that he would like to see long ambulance handovers treated as seriously as patient safety "never events" and was considering how it might be achieved.⁶

The health service leaders involved in this report welcomed such support from the top of the system for a message they have been promoting at a local level for some time. However, the term "never event" has a specific meaning within the NHS policy and contracting context, where such an event is defined as a "serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers." There are specific criteria that must apply for an incident to be classified as a never event, including that it either resulted in severe harm or death or had the potential to cause severe harm or death.

Examples of official never events included within the national policy are wrong-site surgery, suicide using non-collapsible rails in a mental health facility, and death or severe harm as a result of entrapment of an adult in bedrails. On the basis that the NHS should not pay for care that is so substandard as to result in a never event, national policy states that "commissioners should seek to withhold payment for the cost of the episode of care in which a never event has occurred and any subsequent costs involved in treating the consequences of a never event."⁷

The organisations collaborating to produce this report are not specifically recommending that ambulance handover delays should be added to

'The term "never event" is powerful in providing a focus and setting out the aspirations of NHS commissioners and providers to make handover delay a thing of the past'

the list of never events and captured within the national policy framework. While tackling long handover delays does require more rigorous performance management of providers, including the use of financial penalties in some cases, the often complex causes of such delays mean that blanket responses to all occurrences in all areas may not be appropriate. More work is required to establish at both national and local levels what levers, incentives and penalties will be most effective in eliminating handover delays within particular health economies.

Nonetheless, the term "never event" is powerful in providing a focus and setting out the aspirations of NHS commissioners and providers to make handover delay a thing of the past; something that should never be seen as an acceptable or inevitable feature of any healthcare system, and which local partners should be actively and relentlessly seeking to eliminate where it occurs. It is in this sense that the terms "never event" and "zero tolerance" are used in the context of this report.

Making it happen

While there is clarity at a national level and agreement in principle that collaborative action is required, in practice making handover delays a never event will require significant work and commitment. Discussions at the regional and national meetings exploring the issue suggested there are two aspects to making delayed handovers a thing of the past: achieving

'buy in' to the zero tolerance approach at board level in each relevant organisation, and developing systems and processes that make it deliverable operationally. Both 'soft' and 'sharp' levers are likely to be required: changes in mindsets and behaviours are necessary, as are effective financial and performance management tools.

Contributors to this report working in different parts of the system felt that, in many areas, ambulance services and acute providers have worked hard in recent years to develop working relationships that support cooperation and to move away from an 'us and them' mentality. However, there is clearly more to be done to improve trust, communication and relationships.

Ambulance service crews and managers are well placed to identify those parts of local care systems that are poorly coordinated and to anticipate potential pressure points, but often believe there is little they can do to influence the changes or responses required from commissioners and other providers. They can feel their services are inappropriately used to mop up and buffer other organisations from demand that is not being managed effectively.

Hospital colleagues recognise and take very seriously their own responsibility to maximise the efficiency of their ED processes, and to effectively manage patient flows across their sites, but have sometimes perceived ambulance trusts' desire to reduce handover delays as an attempt to simply shift responsibility from their own service to the ED as quickly as possible. They often feel that they receive and are required to provide care to large numbers of patients who do not actually require ED attendance. They argue that better preventative, primary care and community-based support for patients, and more proactive (such as 'hear and treat' or 'see and treat') responses from ambulance services could significantly reduce

'I hope I would not hear anything like this now, but I have in the past had conversations with hospital chief executives who have told me that they view the ambulance service as their 'flex' in the A&E system'
Contribution to national meeting

overall demand in EDs, enabling them to deal more quickly and effectively with those who require urgent care.

Primary care and community service providers are clearly central to any plans to develop more streamlined and responsive services out of hospital, which would reduce pressures on the emergency system. They have a significant role to play in both managing the demand coming in from ambulance service to ED, and in supporting patient outflow from EDs and inpatient services, through effective discharge, follow up, re-ablement and rehabilitation. Given they are such critical partners, there is concern that they have not always been sufficiently well engaged in local planning or review of urgent care provision to date. With the restructuring of the NHS commissioning system still underway, many ambulance services and acute trusts have also yet to develop effective working relationships with emerging CCGs and commissioning support organisations (CSOs). Establishing such relationships and ensuring primary care professionals, as both commissioners and providers, are actively involved in and leading local strategies to reduce handover delays is a key priority over the coming months if a zero tolerance approach is to become embedded.

In short, while there are many examples of excellent working relationships and growing collaboration across the country, in some cases different parts of the system continue to work

in isolation, and without a clear and genuine sense of common cause. Executives and non-executives still need to make and promote the case for a collaborative, whole-system approach to reducing handover delays.

One simple but often powerful way of generating support for a common goal and cooperation between partners is to use narrative – or stories – to illustrate the impact of their actions (or inaction) on service users. Patient stories, such as those set out on page 19, can be used very effectively to focus local health leaders' attention on an issue,

by highlighting experiences they would not tolerate for themselves, their friends or family.

However, although leadership and commitment to change are vital, it is equally important that payment and performance management mechanisms support and reinforce a move towards zero tolerance. While maintaining a sense of joint ownership and responsibility at a system level is important, analysis of the causes of handover delays will inevitably lead to some uncomfortable conversations about the performance of individual organisations.

Case study 1. Applying financial penalties consistently

In August 2012, the NHS across London agreed a performance management regime to facilitate the delivery of sustainable improvements in ambulance handover. This includes applying financial penalties where significant delays have occurred. The regime has been implemented across the capital with executive support and has been endorsed by NHS London.

Essential components include:

- agreed KPIs on the percentage of handovers to be completed in 15 minutes (85 per cent) and 30 minutes (95 per cent)
- agreed KPIs for data compliance (90 per cent in any given month)
- agreement that no patient should wait an hour or more for handover; incidents where this occur are recognised as handover breaches and treated as serious incidents
- clear method for tracking breaches and defined process for validating any breaches identified

- application of £1,000 penalty to the acute trust/foundation trust concerned for each breach identified through this regime (there are plans to introduce reciprocal penalties for 2013/14).

The performance management regime is supported by:

- clear definitions of all performance metrics including clock start and stop
- single source of data capture with an agreed method for reporting performance
- agreed thresholds at which formal performance management regime will apply
- a clearly defined and formal escalation meeting process to discuss issues and relevant actions, which involves directors of performance with further escalation to chief executive or director of performance level if breaches continue.

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A view from the surgery – a CCG chair’s perspective

“The prospect of ambulances stacked outside emergency departments is extremely dismal and is a sure sign of a huge tension within the whole urgent care system. It is also an appalling waste of valuable assets, namely the ambulances and their highly-trained crews.

To my mind, one of the more interesting observations [from the national meeting] was that all EDs have a maximum ambulance hourly ‘flow rate’ with which they can safely deal before delays begin to occur. This points to demand management by all components of the system acting in concert as the only way to deal with this problem effectively.

The commentary at the meeting, and elsewhere, highlights the yawning chasm in understanding between primary care, acute trusts and ambulance services. No single component of this urgent care triangle has a monopoly in understanding or effectiveness, and by acting in isolation from each other and ignoring the others’ pressures and constraints, each has contributed to the tremendous challenges we now face.

At a tactical level, the specific operational and performance management measures that have been proposed to reduce ambulance handover delays at ED are laudable and need swift agreement and implementation. At a strategic level, we need a rapid uplift in engagement from CCGs with the other components of the triangle, and vice-versa in many cases, to open a meaningful, open and honest debate on how the increase in demand can be effectively managed and a true understanding of each other’s problems gained.

We need leadership, a will to change and, above all, to recognise it is the effective, timely and appropriate management of the patient that we are all striving to achieve. In Derbyshire, we have worked hard on this and have identified a number of initiatives that we believe could contribute to reducing the ‘demand’ heat in the system. They include:

- ‘call back’ schemes for ambulance crews both in hours and out of hours to GPs
- increased utilisation of accessible care plans, especially for older people and to all patients in care settings
- increasing and incentivising conveyance to alternative care centres
- joint GP/ambulance staff educational events
- high-volume service users planning
- utilising appropriate clinical referral pathways by clinicians into hospitals that bypass EDs
- falls recovery service
- primary care in ED projects with patient streaming
- emergency care practitioners doing acute home visits on behalf of GPs to avoid admission and admission surge.

To be successful, all need full ‘buy in’ from all parties and concerted action. This is our challenge.”

Dr Steve Lloyd, Chair, NHS Hardwick CCG

'Although leadership and commitment to change are vital, it is equally important that payment and performance management mechanisms support and reinforce a move towards zero tolerance'

The policy and media discussion around zero tolerance and never events has included some robust statements about financial penalties for organisations that fail to deliver their part of the deal. However, it is far from clear how consistently penalties – or indeed incentives – are currently being applied, and how effective different approaches might be. As noted, commissioners and contract managers in acute trusts and ambulance services need to work across the system nationally to help inform decisions on how penalties and incentives can be used to achieve the desired result. However, there are already some examples they can draw on and learn from, as set out in the case study on page 9.

Recommendation 2

Hospitals, ambulance services and CCGs should each identify specific individuals who commit to work together – and with social services colleagues and other partners – to explore, understand and address the causes of handover delays in their area and the impact they have on patient experience, safety and costs. Particular efforts should be made to involve primary care and community service providers. Progress in tackling handover delays should be monitored at board level by trusts/foundation trusts and by CCGs.

Recommendation 3

Lead commissioners should actively seek support for a zero tolerance approach to handover delays in their health economy, in which significant delays of 60 minutes or over are regarded as unacceptable. Associated financial penalties should be agreed to reinforce this approach, and should be consistently applied.

Agreeing definitions

A good starting point for collaboration in improving patient handover must involve agreement between everyone involved on what it is they are talking about. However, such agreement does not always appear to be in place. A desktop review of handover policies in English ambulance services carried out in mid 2012 by NHS North West London on behalf of the NACG revealed wide variation in the language used to describe handover processes. This creates significant scope for confusion and disagreement, as language can vary even between neighbouring hospitals.

It is important that turnaround definitions are clear, explicit, agreed and understood by ED and ambulance staff at all levels, as well as

their commissioners. It should also be set out clearly who is responsible for patient care at each step of the handover.

The box below sets out the definitions, processes to be adhered to, and respective responsibilities of the ambulance service and ED in relation to patient handover that have been agreed by all organisations across the NHS in London.

Recommendation 4

Ambulance services, hospitals and commissioners should adhere to agreed, explicit and well-understood definitions for describing, recording and monitoring handover processes, including KPI start and stop times.

Definitions

London Ambulance Service (LAS) arrival at hospital: The time that the LAS vehicle parks at the ED off-loading bay and 'Red at Hospital' button is pressed.

Clinical handover: The time at which essential clinical information about the patient has been passed from the attending LAS crew to a clinician within the ED to allow a decision about where ongoing treatment can safely be delivered. This should happen immediately upon LAS arrival in ED/receiving department.

Patient handover: The time when clinical handover has been completed and the patient has been physically transferred onto a hospital trolley bed, chair or waiting area, and the LAS equipment has been returned to crew enabling them to leave. Handover is captured at this point in the process.

Handover to green: The time from when the patient handover has taken place to the time the ambulance is available for further deployment.

LAS green: The LAS crew have notified their emergency operations centre (EOC) they are available for further deployment via 'Green Available' button press.

Improving data collection and performance metrics

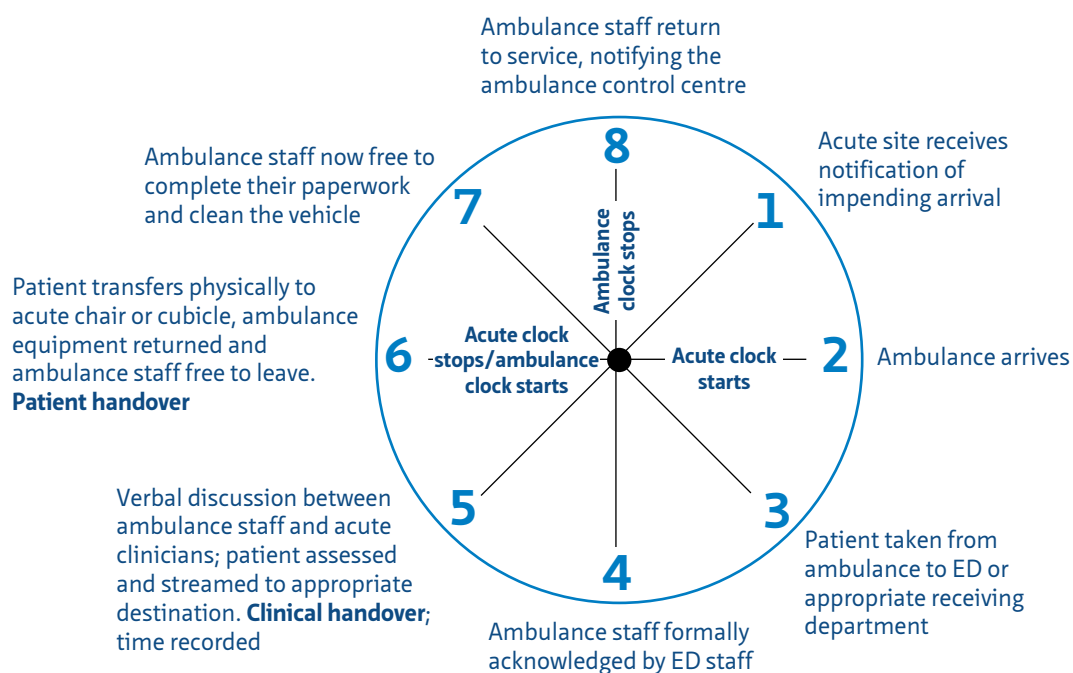
Having established clear definitions, collecting the right data and using them to measure performance against agreed performance metrics is fundamental to reducing handover delays. There is wide variation in the way that ambulance services and EDs currently capture and utilise data. This includes the way data is reported, the tools used to analyse the data, and the KPIs in use.

Developing consistent data collection will take time – both to agree and to implement, and there is a case to be made for some local variation in performance metrics as health communities work on this. There is work underway nationally to develop technical guidance on this.

'I know people say we should not get hung up on clock times, but it is the one thing we have as evidence'
National workshop attendee

The examples of patient handover processes, responsibilities and KPIs set out below and in the boxes on pages 14 and 15, are adapted from work undertaken by the NHS across London and in the south west. They illustrate how the processes and key responsibilities in patient handover might be described, and offer some sample KPIs that could be adopted in other areas, or potentially provide a basis for developing national guidance.

Patient handover process



Commissioners and providers with experience in this area have identified the following as useful guiding principles for developing data collection and reporting systems relating to patient handover:

- agree a single common data source to monitor performance and measure improvement across a region
- adopt a single reporting process with clear governance arrangements in terms of how data is reported, by whom and how frequently. Performance data should be transparent and accessible by all partners. Data should be available in real time and should offer opportunity to drill down to a granular level, such as hour of day, day of week

'It wasn't until we agreed the data and how it was collected that we could get anywhere. Before that, we were always bogged down with the ED challenging our data'

Mick Barnett-Connolly, Hospital Turnaround Lead, East Midlands Ambulance Service

- validation processes should be incorporated to ensure data is accurate and agreed by all partners
- ensure there is regional clarity on who is responsible for managing performance and maintaining a centralised overview.

Responsibilities during patient handover

For patient care:

- pre-hospital care: ambulance service
- arrival to handover: until the point of clinical handover there must be a shared responsibility between the ambulance and ED service provider
- after clinical handover: ED service provider.

For administrative booking in and data capture:

- ambulance staff responsible for starting clock when they arrive with the patient
- ED staff responsible for stopping clock when the patient has been handed over
- administrative booking in is the responsibility of the receiving trust. Must include a minimum set of patient demographic data, typically name, address, age, GP details and ambulance computer-aided dispatch system
- ambulance staff responsible for notifying control of their availability for next deployment
- everyone should use a single reporting system that collates information centrally and in real time, such as London's hospital-based alert system.

Key performance indicators: A London example

Key performance indicators (KPIs) are the agreed contractual measures of performance, and have been developed in a number of areas. In London, for example, these are set as follows and are incorporated in each acute contract:

KPI 1: Patient handover should be achieved within 15 minutes from arrival 85 per cent of the time.

KPI 2: Patient handover should be achieved within 30 minutes from arrival 95 per cent of the time.

KPI 3: Any patient handover that takes 60 minutes or more must be reported and investigated by the acute trust as a serious incident (SI), with contractual penalties applied.

KPI 4: All acute trusts should ensure patient handover times are recorded via the patient handover button on the hospital-based alert and (web-based) handover system for 90 per cent of all hospital turnarounds.

KPI 5: The difference in performance reported through the ambulance service system and the acute trust's system shall not exceed 10 per cent for KPI 1.

KPIs 1 and 2 are reciprocated in the London ambulance service contract. The ambulance contract also includes associated KPIs regarding 60-minute handover to 'Green Available' delays and data compliance.

Case study 2. Data capture in London

The NHS in London uses the hospital-based alert system (HAS) to capture handover times in real time. NHS North West London has developed and implemented a web-based platform, on behalf of London, to capture the raw data generated by HAS.

The 'patient handover and ambulance turnaround portal' is an interactive tool that provides a single point of access for hospital turnaround data analysis, performance management and reporting as well as supplementary information and guidance. It allows managers to understand how ambulance arrival times link with lengths of wait and has proved useful, for example, in analysing how performance drops as ambulance crews end their shifts. This has yielded significant improvements across the patch.

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Case study 3. Data capture in the East Midlands

East Midlands Ambulance Service (EMAS), like many ambulance services, is seeing increases in turnaround times with all the associated waste of resources and potential for clinical risk. EMAS and the acute trusts it serves have been working hard to resolve this but one stumbling block has been the lack of reliable data. Are the delays occurring in the ED? Or are crews struggling to get ambulances clean and back on the roads? Without good data, these questions could not be answered.

Now EMAS has developed a solution that provides a detailed picture of the time spent in the ED, allowing managers to identify where exactly the bottlenecks and delays are occurring so they can take remedial action. The solution captures various time stamps at different points on the journey, some automatically using an electronic RFID (radio-frequency identification) system, and others entered manually but captured by the various electronic systems used by EMAS to track patients and crews.

Stamp 1

The ambulance arrives at the hospital and ambulance crew press an arrival button that is captured at the emergency control room.

Stamp 2

The patient enters the ED. An electronic sensor (RFID) placed in the ED entrance detects a radio transmitter attached to the trolley or the crew's Toughbook computer. This starts the clock for the 15-minute handover target.

Stamp 3

The receiving nurse signs for the patient following clinical handover, with the time and electronic signature captured on the electronic patient form. The 15-minute clock stops.

Stamp 4

Crews finish off administrative tasks and post handover notes on the electronic patient form. The time is captured automatically.

Stamp 5

The RFID sensor detects the tag on the trolley or Toughbook leaving the ED and the time is captured.

Stamp 6

The EMAS crew press the all-clear button, telling the EOC that they are free for the next call.

A three-month pilot in 2012 showed that the system could accurately capture the different steps in patient handover and show where the delays are occurring. The solution will now be rolled out across 23 hospitals served by EMAS and there is a high level of interest from other ambulance services.

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A view from the region – the lead ambulance commissioner’s perspective

“Commissioners have an unique overview of the whole health economy and as a result have an important role to play in helping address ambulance turnaround issues. As the ‘third party’, commissioners are able to review individual operational processes and relationships (across ambulance and acute trusts), encourage the adoption of best practice, provide common understanding and identify areas of parity.

It is critical that handover management retains a patient-centred approach at its heart. However, the application of consistent mechanisms for data capture, reporting and performance management are key in establishing sustainable improvement and system resilience. It is only then that we can start to move towards zero tolerance with the agreement of all stakeholders.

I think everyone can agree the principles behind handover and everyone understands and accepts a national 15-minute standard, but beyond that there is a wide variation. We find it in the language used to describe the process and many diverse methods for measuring the pathway.

There are huge inconsistencies in the way that data is captured, with some places still using

paper methods that can lead to a delay in analysis and performance management. The reporting of data is fragmented in terms of how frequently managers receive reports and the tools they have for drilling into the data to understand what it is telling them about trends and patterns of demand. There are also significant discrepancies in the KPIs used and the way financial penalties are applied.

As a commissioner I think there is a need to share regional processes and best practice at a national level so that we can implement a consistency in performance management metrics and facilitate a common approach. We need to continue to carry out process-mapping exercises and lead group discussion to streamline handover processes and drive improvement locally and regionally.

I am not arguing for a one-size-fits-all solution but until there is some common understanding of what it is we do before, during and after handover, how we measure it and what might be acceptable performance measurements, we cannot start to move forward.”

Katy Neal, LAS Commissioning Development Manager, NHS North West London

Recommendation 5

Ambulance services and acute trusts, with the support of commissioners, should develop common KPIs to support adherence to the national standard of 15 minutes for both arrival to handover and handover to crew clear targets. These KPIs should allow room for some ‘flex’ rather than being absolute 100 per cent targets.

Recommendation 6

Ambulance services and acute trusts, with the support of commissioners, should develop systems that capture data automatically and transparently against agreed definitions, including start and stop times. This data must be considered the single source of truth and be accessible by all partners. Data collection and reporting processes must include a validation process to ensure data is accurate and agreed by all partners.

Improving triage, patient flow and communication within EDs

Improving the way in which data about patient handover is collected and shared clearly will not in itself lead to a reduction in delays. Data is crucial to understand the extent of any problem and possible causes, but handover times will only improve when ambulance and ED teams, along with their commissioners and other partners, take action.

EDs across the country are testing a variety of solutions to improve the way in which they receive patients brought to hospital by ambulance. These include using dedicated nurses to manage queues, placing arrivals screens in more prominent positions, implementing rapid assessment teams during peak hours of demand, and reviewing patient flows across their sites.

However, discussion of such initiatives during the regional and national handover workshops highlighted the importance of ensuring that new systems and processes are properly evaluated, and in particular that by focusing on turnaround times, providers do not lose sight of other aspects of patient safety and experience. Some concerns are emerging that as handover processes are scrutinised more closely, speed will become the only issue of concern, and indeed some have argued for minimum handover times to be applied to ensure this does not happen.

Early results from ongoing research being carried out at Warwick Medical School on improving the quality of handover suggest that interruptions during clinical handover, and the use of intermediaries such as using nurses or paramedics to manage queues of patients offloaded by ambulances to trolleys in corridors, can be clinically risky.

“One of the things we know about clinical handover is that the more we can pass directly from the person who was dealing with a patient directly to the person who will be dealing with the patient, the safer it is. In the ED we pass information via intermediaries such as triage nurses. The ideal would be for ambulance crews to hand over directly to the doctor or senior nurse dealing with the patient.”⁸

This observation found widespread support at the national meeting of commissioners and providers. Not only was the use of nurses to manage queues felt by many to be clinically undesirable, it is also considered to be unsustainable and professionally unsatisfying – i.e. it is not a role that nurses want.

It is important that as ambulance services and ED teams work together to tackle delayed handovers, the issue of timeliness is still considered as just one element of service quality and patient experience. As the case study opposite describing the experiences of patients illustrates, the fact that a patient has been conveyed to and received by an ED does not necessarily mean they have had a ‘good’ outcome.

Case study 4. Patient experiences

The following patient stories have been adapted to ensure they are anonymous, but recount real experiences of patients that have been reported to local involvement networks (LINKs).

Patient experience 1

Taken from a LINK 'Enter and View' visit report.

- Patient arrived at XXX by ambulance.
- Found by 'Enter and View' representatives sitting in a chair in the waiting area holding his notes.
- The paramedics had told him he would be seen to, and to hand the notes to the hospital staff.
- He had visible injuries from a fall – cuts, scrapes and blood on his face and hands.
- He had been waiting 45 minutes when the 'Enter and View' team spoke with him; no one had approached or spoken with him during this time.
- He regarded the ambulance people "first rate", "kind and friendly", but stated that no one had spoken to him since arriving at XXX. He did not know what to expect.
- He did not have his hearing aids on and was unsure if his name had been called.
- He had not had anything to drink or eat.
- He needed to go to the toilet, but was worried he would miss his name being called if he went to find it.
- The gentleman informed the 'Enter and View' team he had wanted to go home after the accident, but had been advised to wait for the ambulance. He considered his injuries minor and the ambulance "just a precaution".
- He rated his general health as 7/8 (out of 10) stating he had many illnesses, but was generally very active and well.

Patient experience 2

"When we finally got to the hospital, they could not find the new entrance to A&E. They said that it was because they were 'out of area'. The ambulance staff took about ten minutes to get me into the building, after parking. I don't think they knew the procedure. Then it was about another ten minutes before I saw the hospital staff while waiting in a corridor."

Patient experience 3

"My handovers by ambulance staff have always been very good, it's the hospital staff that have worried me. While the ambulance staff have been handing over, the A&E staff have turned their backs, walked away, answered phones, talked to other staff about other patients/weekend/TV programmes, shown they're not interested by a wave of a hand, and shown they have not been listening by saying what they thought they heard, not what had been said.

The ambulance staff have patiently followed them, repeated what they have said and waited for the interruptions to finish. This has left me frightened and wishing I hadn't come into hospital despite being in severe pain. It also made me not wanting to come back in the next pain crisis."

Case study 5. Improving patient handover in Winchester

In January 2012 Hampshire Hospitals NHS Foundation Trust acquired the Royal Hampshire County Hospital, which had struggled for some time with delayed patient handovers. The trust used the same process to address this as had been previously and successfully used in the Basingstoke and North Hampshire Hospital (BNHFT).

This involved empowering staff by giving them the resources they need to do the job well, and included:

- placing an administrator in the ambulance reception area to support clinicians and remove from them the burden of data input. This amounted to 25 hours a week of administrative time. Not only did this free clinicians but also put a person on the spot who could pick up signs of queues building and provide early warnings
- agreeing the clock start time and using an IT system to support recording clock start and end points
- moving screens showing patient arrivals and waiting times to the ambulance reception area
- agreeing to report breaches immediately and feeding these into daily bed management reports that are made available to all relevant staff via BlackBerry by 7:30am and to daily bed management meetings. This allows managers to understand in real time how pressures are building up in the system.

In April 2012, 69 per cent of patient handovers breached the 15-minute limit. By October 2012 this was down to 37 per cent.

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A view from the acute trust – a chief executive’s perspective

“The issue for us as an acute trust is one of safe handover. When we say we are not able to take a patient we are not being difficult; it is because we are not able to take them safely. We are not prepared to accept a system that involves an interim arrangement, such as leaving patients in the corridor under the care of a nurse, as it is not safe.

Overall this is a capacity issue. The ambulance service only has so many crews it can put on the road and I understand that they do not want crews delayed at hospitals. Equally, we can handle a maximum number of patients per hour and if we have a dozen ambulances arriving per hour, we cannot physically deal with them in a 15-minute handover.

I do not think the answer is to put in a fundamentally unsafe system that simply shifts risk from the ambulance to us. The real issue

is how we manage the totality of demand. It needs to be tackled through a whole-system discussion in our communities. We need to see the ambulance services more closely engaged in local collaborative networks where we spend hours talking about urgent care. We need to work with commissioners to understand the capacity issues and consider how alternatives to the acute hospital can play their part in reducing demand on emergency departments.

Zero tolerance is something we should be aspiring to and I absolutely support the idea if it means a collaborative, collective attempt to manage demand. But if zero tolerance translates into a blame game and higher penalties, then no, it is not the answer.”

Dr Mark Newbold, Chief Executive, Heart of England NHS Foundation Trust

Recommendation 7

Partners should work jointly on local process-mapping exercises, involving acute, ambulance and commissioning staff at all levels to review current handover and discharge pathways, identify where efficiencies can be made, pinpoint how processes can be streamlined and suggest areas for development. The issue of patient safety and achieving a high-quality clinical patient handover should be central to any work.

Recommendation 8

Acute trusts should model their maximum hourly ambulance attendance capacity in partnership with ambulance trusts. They should review internal mechanisms for managing patient flow across the hospital and examine how this can help to mitigate against significant and lengthy delays as a direct result of multiple attendance surges.

Capacity management and escalation plans

Like their ED colleagues, ambulance services are testing a wide variety of solutions to improve patient handover. This includes taking proactive measures to help ease pressures on EDs by reducing the volume of handovers required, such as reviewing the use of 'hear and treat' or 'see and treat' or identifying alternative pathways and community-based services to avoid unnecessary conveyance to EDs.

There is some evidence that this is delivering results and helping. In some areas, trusts report that despite the 5 per cent rise in activity for the ambulance service in 2012 compared to 2011, fewer patients are being conveyed to hospital as ambulance crews increase their use of alternative settings and deliver treatment at the scene.

For those patients who do need to be conveyed, ambulance services can help minimise handover delays by:

- reviewing patients' conditions and needs en route and sending details ahead to the receiving ED
- reviewing the use of ambulance trolleys for patients who are able to walk into the department
- reviewing use of alternate vehicles for conveying patients to the ED
- assessing the use of electronic patient handover
- sharing their predicted activity levels on an hourly and daily basis to support effective escalation when demand rises.

Escalation is how the system gears up to cope with surges in demand. At the moment this is sometimes dealt with using blunt instruments that can be counter-productive. For example, hospitals experiencing a surge might close to ambulances, creating pressure elsewhere in

the local system – the domino effect. Many, however, take professional pride in never closing to ambulances.

While acute trusts and ambulance services can collaborate to develop agreed escalation plans and mechanisms, some surges in demand are predictable and need tackling by the wider system. An example of this is the lunchtime surge in demand as GPs carry out their home visits at the end of the morning, leading to a peak in ambulance activity between 12pm and 3pm.

The rising number of healthcare professional referrals to EDs was viewed by participants in the regional and national handover meetings as one of the most urgent issues to tackle. Smoothing this demand requires joint work by EDs, acute trusts, primary care providers and CCGs. Similarly, there is a need for joint work involving local community providers to ensure clear and prompt discharge arrangements of inpatients to ensure a smooth flow of patients through the hospital as a whole.

Escalation plans need to be agreed jointly across the whole system and linked back to demand and particularly the predictable surges. Improving escalation processes will require:

- regional capacity and information systems that allow EDs and ambulance services to look across a patch in real time. Many regions now have regional capacity management systems that provide clinicians and managers with a web-based view of capacity across their local health system and that help them to make better informed decisions about patient care and alternative care pathways
- hyper-local (i.e. ED or ambulance reception-level) systems for spotting and responding to surges without waiting for system-wide decisions. This might be as simple as having an empowered receptionist placed in the

ambulance reception area and placing ambulance arrival screens strategically in the ED (see case study 5 on page 20)

- ambulance services, acute trusts, primary care, community providers and CCGs to examine how they can smooth demand where surges are predictable and avoid the need for escalation.

'We have one GP practice where a GP spends the day doing home visits. This has reduced the spike in demand and been very helpful for us and the ED'

Bob Williams, Deputy Chief Executive, North West Ambulance Service

Case study 6. Rapid escalation in Leicester

East Midlands Ambulance Service (EMAS) and University Hospitals Leicester (UHL) have developed a system for escalating their response to surges in demand to avoid delayed handovers.

When either the hospital or the ambulance service detects a surge in demand that could potentially lead to delayed handover, either can call a designated HALO (hospital ambulance liaison officer). This will usually be a paramedic team leader or operational support manager who has the authority to look at the situation and act accordingly. It is a system that works well locally and is predicated on a good working relationship between UHL and EMAS.

A number of solutions are available and these include putting in place a RATING team – rapid assessment and triage – at the hospital ED. This team receives the patients, accepts the clinical handover and carries out basic observations before signposting the patient to the appropriate clinical setting for their needs. The system is working well with EMAS reporting that queues of ambulances are no longer building up – or that when queues do build up they are cleared more rapidly.

Commissioners are now reviewing whether the HALO system should be rolled out regionally and, if so, what underpinning governance is required.

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Case study 7. South Central Ambulance Service (SCAS) – hospital handover delays escalation process

SCAS has agreed a local escalation plan with all its acute and PCT partners. In line with DH sitrep (situation report) reporting requirements in place when the plan was put in place, it was agreed that a handover delay of over 45 minutes should be considered as serious. When this occurs SCAS has the option to escalate the situation to both the duty director of the acute hospital and the PCT director on call.

Time period	Acute response role	Ambulance response role	Reporting arrangements PCT response
Handover within 15 minutes	Standard operational procedure		
	On arrival, ambulance crews to be greeted and patient registered. Destination for patient identified. Transfer of clinical care to senior nurse/clinician. Paperwork transfer between organisations.	Identify any special requirements. Hand over patient details to clinical team. Move patient to bay as identified. Collaborate with acute care team on completion of handover process.	Standard operational reports should report no unnecessary patient delays at ED or any other receiving areas in the hospital – no escalation to the PCT necessary.
Handover between 15 and 45 minutes	Escalation to NHS trust lead for emergency care		
	Notification to hospital operations team giving verbal update on status of receiving unit and likelihood of further breaches recurring.	EOC to begin escalation process. Inform OS/Bronze and ALO by phone if on duty or by email if not. OS/Bronze contacts BNHFT operational on call manager. OS/Bronze to site if appropriate. If handover exceeds 30 minutes, escalate to Silver response. Liaise with trust lead for emergency care. Advise EOC of delay and reason.	Record length of handover duration and ensure that number per day and week is included in any required local or national reporting. PCT commissioners notified via weekly management process patient delays via email.
Handover over 45 minutes	Escalation to executive trust		
	SCAS director on call to contact BNHFT. Director on call via switchboard and agree next steps. Seek to provide additional operational capacity to alleviate pressure. Breach report complete for each recipient by team on duty capturing all elements of delays to be sent.	Liaise with SCAS on-call director and agree next steps to manage operational pressure. If there is continued 999 demand and continued queueing persists, the hospital, PCT and ambulance service will put in place a procedure allowing ambulance crews to leave the patient after 15 minutes (after arrival at hospital) to free them. This decision can only be made by a director.	Situation to be escalated to PCT directors on call for NHS Hampshire. Any exception delays (as locally determined) to be reported personally by NHS trust chief executive to SHA chief executive within next working day.

The escalation plan has been used to good effect, although it did take some time to embed the process into normal business in SCAS emergency operations centres (EOCs). The introduction of the EOC summary screen, linked to the system to pre-alert the hospitals to incoming ambulances and record handover times, helped this process and also helped SCAS manage clear up times. Large screens displaying the hospital status were installed in both of the SCAS EOCs.

EOC hospital ambulance status screen

Hospital	Waiting to handover			Waiting to clear up		
	0-15 minutes	15-45 minutes	Over 45 minutes	0-15 minutes	15-45 minutes	Over 45 minutes
HPNHH	1					
HPQAH	4					
HPRBH						
HPRHCH				1		
HPSGH	1				2	
HPSTM	1					

Most recently, SCAS has started to record the impact of handover delays on patients in two ways:

1. By recording any delayed responses to patients in the community due to queueing.
2. By recording any adverse clinical effects on patients while in the queue.

These forms also record any problems experienced by the SCAS on-call director in contacting the acute on-call director.

These reports are followed up the next working day by both a letter from the SCAS chief executive to the hospital chief executive with the commissioner copied in and forwarding any adverse clinical incidents to the commissioner for the hospital to ask the hospital to raise a SIRI. SCAS have found these processes to be effective when applied consistently in both immediate response from the acute trust to release resources to deal with the immediate queueing issues, and raising the profile of the impact of hospital delays on both patients in the community and those with delayed handover of care.

With the introduction of CCGs, these plans are currently being reviewed to incorporate the new management structure of the NHS.

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A view from the ambulance service – a deputy chief executive’s perspective

“Demand is always a problem during the winter period. I am concerned that this year it is going to get even worse and that handovers will be seriously affected, as there are several factors driving demand.

I believe one of the biggest issues we face is the rise in healthcare professional (HCP) referrals. In my region we have seen a 25 per cent increase in HCP referrals from 2011 to 2012. The common practice is for GPs to do all their visits in one go in the morning from 11am. This leads to a surge in activity for the ambulance service from 1pm to 3pm, and a consequential surge into the hospital A&E or medical assessment units. We are dealing with HCP calls as 30 per cent of all the activity over this one four-hour period, and we can have 18 ambulances just sat in a queue waiting to hand over patients by 3pm daily. This leads to a blockage in the ED and a surge in delayed handovers. In the middle of the day, handovers are 30 minutes or more and that is too long. It is also expensive. In the last quarter we lost nearly 2,000 hours of ambulance time to these delayed handovers at a cost of over £1 million. That’s the equivalent of one 24-hour paramedic ambulance just sitting waiting to hand over patients. Then there is the impact on

patients to consider and it is neither dignified nor good quality care to lie on a trolley in a corridor.

We need to look at this from different angles, but together. We need to look at alternative access to urgent care and the primary care HCP surges. We need to understand why calls to 999 are escalating so much this year and what we can do to bring them down. We need to look at the process issues, such as access to the ED and the pull through from ED to the rest of the hospital that sometimes does not seem to work. We need to look at how quickly the system can escalate when there are spikes of activity and how these work not just in hours but out of hours too, when there are fewer senior managers around to make things happen. We need joint initiatives rather than perverse incentives in the system.

Historically, we have never all sat down together – ambulance services, acute trusts, primary care and commissioners – to map the whole process and that’s really what we need to do.”

Bob Williams, Deputy Chief Executive, North West Ambulance Service NHS Trust

Recommendation 9

Ambulance services and acute trusts, with the support of commissioners, should seek to develop common escalation plans and ensure that these function as well out of hours as they do in hours.

Recommendation 10

All regions should seek to develop and implement a regional capacity management system (where they have not already done so) and undertake local work to understand patient flow across the whole health economy.

Conclusion

The need to reduce and ultimately eliminate handover delays is firmly on the policy agenda and is now a 'must do' for chief executives and boards both in ambulance services and acute trusts. Increasingly it will become an agenda item for CCGs as they take over responsibility for commissioning from April 2013. There is now a need for hospitals, ambulance services and CCGs to develop shared ownership of this agenda. It is vital that they also make efforts to engage other partners from across the wider system, including social services but in particular primary care and community service providers.

It is time for a collaborative strategic approach between local commissioners, ambulance services, acute trusts/foundation trusts, and primary care providers – an approach that sees delayed handover as a symptom of wider pressures in the system. These pressures are now such that a more holistic approach is needed, one that takes account of downstream issues such as timely discharge from hospital so that there are beds free to take patients arriving in the ED, and upstream issues including access to and the organisation of primary and community-based care. Within this, there needs to be a focus on hard data, patient experience and clinical safety.

A tactical approach is also needed to support managers and clinicians who are tackling operational and performance management issues that are specific to reducing delayed handovers. This should include:

- agreeing definitions around handover processes
- agreeing what data should be collected and in what IT system
- agreeing local KPIs
- developing IT systems to support performance management and breach analysis
- developing capacity management systems in all regions with associated escalation plans and clear trigger points for action.

At a policy level, work to develop guidance and performance indicators should be continued to help maintain the focus on achieving zero tolerance. The national groups and leaders involved in producing this report are also particularly aware of the need to work more closely with representatives of primary care and community service providers as policy and practice in this area is taken forward, to ensure their critical role in managing urgent and emergency care systems is better understood and developed.

Ambulance services, hospitals and commissioners are already working hard to reduce delayed handovers. It is time for an even more collaborative approach with a collective focus and senior executive support that drives improvement and delivers a system in which lengthy waits for patients really do become a thing of the past.

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Acknowledgements

This report was developed as a result of wide and very fruitful collaboration at regional and national level and we would like to thank everyone for their involvement in organising and attending workshops, feeding back their recommendations to the national working group, participating in interviews, and commenting on the draft as it was developed. In particular we would like to thank:

- Mick Barnett-Connolly, Hospital Turnaround Lead, East Midlands Ambulance Service NHS Trust
- Susie Bleeker, Associate Director of Site and Corporate Projects, Hampshire Hospitals NHS Foundation Trust
- Daloni Carlisle, report writer and editor
- Georgie Cole, Senior Project Manager, South Central Ambulance Service NHS Foundation Trust
- Professor Matthew Cooke, Professor of Emergency Medicine and Director of Warwick Clinical Systems
- Mark Docherty, Ambulance Commissioning Director (West Midlands) and Chair, National Ambulance Commissioners Group
- Mick Jones, Service Delivery Manager, East Midlands Ambulance Service NHS Trust
- Neil Kennett-Brown, Director of London Ambulance Commissioning, NHS North West London
- Dr Steve Lloyd, Chair, NHS Hardwick CCG
- Dr Anthony Marsh, Chair, Association Ambulance Chief Executives and CEO West Midlands Ambulance Service NHS Trust
- Katy Neal, London Ambulance Service Development Manager, NHS North West London
- Dr Mark Newbold, Chief Executive, Heart of England NHS Foundation Trust
- Jonty Roland, Policy Manager, NHS Confederation Hospitals Forum
- Sangeeta Sooriah, Senior Policy and Research Officer, Ambulance Service Network
- Heather Strawbridge, Chair, Ambulance Service Network and Chair, South Western Ambulance Service NHS Foundation Trust
- Barry Thurston, Director of Service Delivery, West Midlands Ambulance Service NHS Trust and Chair, National Directors of Operations Group
- Elizabeth Wade, Head of Commissioning Policy and Membership, NHS Confederation
- Dr Alison Walker, Medical Director, Yorkshire Ambulance Service NHS Trust and Chair, National Ambulance Services Medical Directors Group
- Jo Webber, Director, Ambulance Service Network and Deputy Policy Director, NHS Confederation
- Mary Whyham, Chair, North West Ambulance Service NHS Trust
- Bob Williams, Deputy Chief Executive, North West Ambulance Service NHS Trust.

Zero tolerance

Ambulance services and hospitals have been working to improve patient handover for more than a decade, and in many areas proactive, collaborative approaches to tackling the issue have been effective in reducing incidences of long delays. However, while significant problems may no longer be widespread, they have persisted in some areas, and in June 2012 David Flory, then deputy NHS chief executive, wrote to the NHS demanding improvement and setting out a zero tolerance approach to handover delays.

Ambulance services, hospitals, commissioners, primary care and community service providers were all called upon to acknowledge they share a joint responsibility for eliminating handover delays and to take proactive steps to address the issue together. It was also reported that Monitor and the Care Quality Commission (CQC) were asked to consider how the foundation trust compliance regime and quality regulation respectively might be used to help achieve this.

This report is intended to support healthcare leaders in their efforts to make handover delays a never event in their local health economies.

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