Health Overview and Scrutiny Committee Task Group

Ambulance Hospital Handover Delays Scrutiny Report (November 2021)

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The Reasons for the Review

1. Ambulance handover delays at Worcestershire hospitals was identified as an area for further scrutiny following the attendance of Ambulance Service representatives at a meeting of the Council's Health Overview and Scrutiny Committee (HOSC) in October 2021. Representatives from West Midlands Ambulance Service University NHS Foundation Trust (The Ambulance Service) highlighted hospital handover delays as a serious concern to the HOSC, and in particular the regular and significant delays at Worcestershire Royal Hospital.

2. The HOSC agreed to look further into the issue of ambulance handovers to gain a better understanding of the situation and in view of escalating concerns in Worcestershire but also nationally.

3. It was also agreed that a Task Group (not in public) approach would be appropriate with system partners around the table, so that councillors could understand the complexities of the issue from each organisation involved, gather evidence and ultimately report back to partners. Representatives were invited

from across the local health and social care sector and this report encapsulates the findings and outcomes of that discussion.

4. Key lines of enquiry for the Task Group were to understand the main reasons for the delays in handing over patients to the two Worcestershire Acute Hospitals, the impact of the delays on all related services, the impact on patient safety, escalation processes, the process for declaring a critical incident and how the system is working together to improve and maintain the situation, and any barriers.

The Problems

Ambulance Handover Delays

5. The Ambulance Service representatives pointed out that problems in urgent and emergency care were ongoing and not just a problem this year; a number of other things had changed and ambulance handovers were just part of the jigsaw. Covid-19 was a factor which had expediated the current handover problems, however the Ambulance Service representatives believed the same situation would have arisen, albeit at a later date. Pressure from Covid patients on Ambulance Services was gauged to be 11% of activity and the biggest risk moving forward was around booster take-up. Until recently, handovers in the West Midlands region were twice the problem of the East Midlands region, and worse than the rest of the country put together, although this was now levelling.

6. In terms of how hospital handovers in Worcestershire had changed, the Ambulance Service representatives advised that in an audit ten years ago, Worcestershire Acute Hospitals NHS Trust (the Acute Trust) had performed the best in the region, with some handovers taking place in under four minutes. Subsequently, there had followed a ‘rocky period’ over four-five years, but big improvements had been made as a result of considerable efforts by partners, and the Ambulance Service had written to the organisations involved to express their thanks. At the start of the pandemic, handovers in Worcestershire were in a good place and remained so for six months. During the early lockdown periods of the pandemic, handover delays were effectively eradicated, and Worcestershire performed exceptionally well.

7. The Ambulance Service representatives explained how patterns of activity had changed. Previously, the numbers of 999 calls would increase during the day, however any significant delays in the evening and night would have cleared by morning. This was no longer the case and there could still be 300 patients waiting for an ambulance in the morning across the region. January 2020 had been the start of deterioration. Availability of ambulances in the system was diminishing and the growing slide was a concern. It was at the point where any pattern in activity became irrelevant; out of 400 ambulances, none would be available.

8. Around the time of the HOSC meeting ie 18 November at 11am, the highest level of pressure would be reached (level 4), where around 200 people were in need of an ambulance across the region with none, available to send and at a time when staff meal breaks were required. At the time of being questioned, in Worcestershire, there were 38 ambulances with one free. In current times, the Service was never at level 1 and levels 3 or 4 were the norm. In the West

Midlands region there were usually 350–450 ambulances in circulation, with around 250 at night. Calls were categorised so that ambulances were directed appropriately meaning that those of less need would keep being pushed down the list.

9. At level 1, the Service would have access to several hundred paramedics who could be called on if needed. Response times for calls had targets according to the category of need, for example within 7 minutes for category 1, 15 minutes for category 2 and 60 minutes for category 3. Response times for category 2 used to be 50 minutes whereas currently, 15 hours was not unusual for category 3 and 4 calls, such as patients with falls.

10. The current situation was very serious as the Service was running at full capacity, and it was concerning that there was therefore no capacity if a major incident were to occur. In October 2021, 28,000 hours were lost to ambulance handover delays across the region for the month.

Patient Safety

11. The Ambulance Service told the Task Group that the patients most at risk from handover delays are those having to wait for an ambulance to attend because so many ambulances were queuing at hospitals – especially those in the highest categories of need for whom there were no ambulances available, or for whom an ambulance may arrive outside of the medical time window for intervention for conditions such as strokes. Some may not suffer at all from a delay but it was very concerning. The Ambulance Service had a rating system for risks, up to 25, and was now at the point where it was likely that patients would die or come to significant harm because ambulances would not reach them in time.

12. Whilst clearly concerned about patients who required emergency care waiting for hours in ambulances, the representatives from the Ambulance Service and the Acute Hospital Trust reassured the Task Group that there are robust processes in place to monitor them and for concerns about patients to be escalated, therefore those waiting in ambulances being monitored by a paramedic at a ratio of 1:1 were comparatively safe. Nonetheless, all representatives present pointed out that a patient's risk remained increased while they were stuck in an ambulance and the best place for patients requiring emergency care was in a hospital and not in an ambulance, which lacked privacy, heat and food supplies for a patient. Furthermore, the patient at greatest risk of all was the patient waiting for an emergency response, with one not forthcoming due to the level of delays within the system.

13. The current inability to respond to 999 calls because of ambulances queuing at hospitals also led to increased call backs, since people requiring emergency treatment were advised to call back should their condition deteriorate. Additional staff had been hired to answer calls, and resources had been diverted away from the 111 system, further exacerbating the problems. On the busiest day for calls where the Ambulance Services received 6400 calls, around 1600 of those were call backs from patients querying where their ambulance was.

14. If a patient's condition deteriorated whilst waiting outside the hospital, the Ambulance Service and Acute Trust representatives said that processes were robust and that relationships on the ground between the two organisations were

strong. This was mirrored within the Urgent Care staff team, which was not the same at other hospitals. The Emergency Department (ED) staff had good working relationships and escalated any concerns, although clearly it was not good use of their time to go outside the ED.

15. The Medical Director for Urgent Care explained the processes in place for patients in queuing ambulances. When the ambulance arrived, the paramedic would speak to the ED, and patient details entered onto the computer system. Paramedics could also call ahead with any particular concerns. The patient's condition was then checked and recorded every 30 minutes. Whereas previously patients may have been moved to hospital corridors, this was no longer possible due to Covid infection control.

16. The representatives explained that escalation processes were co-ordinated across the system, since it was important not to work in silos.

17. The Ambulance Service's escalation system was called Resource Escalation Action Plan (REAP), which corresponded to other NHS systems, and activity could be predicted on an hourly basis based on historical data, with approximately 95% accuracy.

18. In terms of measures put into place on days when it is known that significant delays were building up with ambulance handovers, the Acute Trust representatives advised that delays were often predictable and patient flow was easily calculated. The Acute Trust triggered a category notification of level 1,2,3 or 4 taking account of the number of ambulances queuing and inpatient capacity, a process used by all Acute Trusts. The escalation process didn't happen in silo, the rest of the support services also needed to escalate to support the flow.

19. The Ambulance Service reported on serious incidents and this had gone up four-fold over the past 18 months. Audits of avoidable deaths were also carried out, and whilst not huge, the numbers were there.

Workforce Fatigue and Capacity

20. Across the board, the Task Group has heard that staffing is a significant concern and the effects of working through the pandemic mean that staff morale, resilience and recruitment is a huge concern. It is a challenge to attract and retain staff and the problems with ambulance handovers are just one of many pressures. The Task Group heard many comments about staff being 'on their knees', unable to take time off and more staff than ever being in tears, including senior staff. It was also highlighted that workforce fatigue meant it was challenging to drive continued improvements and responding to ongoing pressures gave little time to carry out transformational work.

21. The Ambulance Service and the Acute Hospitals Trust spoke about staff who were on the verge of burnout at all levels and felt very emotional about the current pressures including handover delays and being unable to attend to patients in need. In terms of Ambulance Service staff, it was currently not unusual for staff to finish a shift four hours after their shift should have ended and there had been incidents where vehicles had crashed where it was possible that this had been a factor.

22. Recruitment was not cited as a problem for the Ambulance Service - the issue was productivity from staff being stuck in queues. Previously, staff would have attended to a job every 1½ hours, currently they may now only complete one job per shift.

23. For social care staff, the Worcestershire County Council representative highlighted the crisis of the care sector, which was a focus nationally, with a major part of the problem being low pay rates as people could earn more elsewhere, for example working in a supermarket. Care staff had worked incredibly hard with very little recognition. Staff were leaving and there was a huge issue with capacity which could therefore lead to delays in providing support for people coming out of hospital, and people were having to rely on friends and family. The Council had worked hard to provide more care at home and prevent people going into hospital, however over the past month around 600 packages of care had been handed back to the Council as the market did not want to handle it anymore.

Pressures on the Emergency Department

24. The Acute Trust representatives were not aware of any particular factors creating pressures in admissions. Generally, the busiest days of the week were Saturday, Sunday and Monday and issues around alcohol and assaults were more prevalent during weekends. The Herefordshire and Worcestershire Clinical Commissioning Group (CCG) representative explained that speeding up the ED assessment process was difficult since the ED was full to the door. Ideally a patient would have a very rapid assessment and be streamlined away very quickly (within 20 minutes). Due to demand this was not happening quickly enough for this to occur.

25. Congestion within the ED was not helped by its location at the centre of the hospital site (the site at The Alex was better). The Acute Trust had Hospital Ambulance Liaison Officers (HALO) staff who worked between WRH and The Alex hospitals.

26. In terms of medium to longer term plans being considered to address ambulance handovers, with partners, the Acute Trust representatives explained that there was very little room to work with and the pressures were relentless – the ED was too small and completion of expansion was a year away. Only 9 beds were being used for elective care, and everything else for emergencies. This week, seven patients had remained overnight in the discharge lounge; the situation was not sustainable.

27. The Task Group was also advised that while the expanded ED would make things easier and improve the patient experience, it would not solve all of the problems such as patient flow through the rest of the system. The experience of the Ambulance Service representatives present backed up this view, since they had worked with other hospital trusts involved in expansion plans.

28. Commissioners (the CCG) were asked how it had reviewed the situation with ambulance handovers in terms of the level of resources available, and the representative was most concerned about levels of confidence. Diverting people away from the ED was important but difficult to achieve as nationally it had been shown that publicity campaigns such as ‘is A&E for me?’ did not work and had the reverse effect – which was the experience of all the organisations present.

29. The Ambulance Service representatives agreed that diverting people away from the ED where appropriate would help but they did not feel this was the root of the problem.

30. HOSC members also asked about the recent move of the majority of trauma care from the Alexander Hospital (The Alex) to WRH noting that an additional 19 emergency beds had been allocated. Members were concerned about the potential impact of this additional pressure on the ED at WRH, however the Medical Director for Urgent Care did not feel this would make a difference, but the situation would be monitored daily.

Inappropriate Use of Ambulance Services and the Emergency Department

31. Although most people used health services appropriately, inappropriate calls to 999 were highlighted as a problem and the Ambulance Service suggested that through the Covid pandemic, people had become more dependent, for instance calling for an ambulance for an inappropriate reason or because they were lonely and isolated. Society used services more, with those aged 20-30 using ambulance services twice as much. Excess alcohol also led to more problems. The 111 service was prepared to deal with two million calls a year, however this service too was now under pressure.

Pressures from Covid-19

32. The Task Group asked when pressures on capacity from the ring-fenced Covid wards were likely to improve, and the Acute Trust representatives advised that the trend of Covid-19 patients being admitted to hospital had not decreased and was effectively in the third wave of the pandemic. Compared to previous waves, hospitalisation compared to prevalence of Covid in the community was much lower and the length of hospital stay was much less. However, the majority of those in ITU were unvaccinated under the age of 60. Current modelling suggested Covid figures would start to fall, week commencing 29 November, however this remained to be seen. The effects of increased socialising during October half-term would soon fall away, however there would then be the Christmas period of socialising.

National Mandate to maintain Elective Care

33. Task Group members were aware of the additional pressure this winter to maintain elective (planned) surgery, which was normally postponed allowing services to cope better with additional winter pressures. Asked whether consideration would be given to not following this national mandate, the Acute Trust representatives acknowledged the multiple pressures at play, including numbers of people presenting at the ED, pressures on critical care being exacerbated by the need to separate wards with Covid-positive patients. However, the Trust endeavoured to balance elective care with emergency care and did not feel that pressure to continue elective care was the root cause of problems. There was also merit in maintaining elective care, to avoid cases quickly becoming emergencies. The majority of elective care had been moved from Worcestershire Royal Hospital (WRH), to the Alexander Hospital (The Alex) and Kidderminster Hospital and Treatment Centre.

What is Being Done to Improve the Situation

34. The feedback from the representatives present about what could help to improve the situation included addressing the reason for people coming to the hospital, discharging medically fit patients as soon as clinically possible and informing patients and relatives promptly. It was also important to stop assessments within hospital which should be completed by occupational therapist and Continuing Health Teams in community settings. It was important to be clear about why a patient was in an acute hospital. There were also some issues with partners' access to IT systems across the system in terms of access to discharge data.

35. The Ambulance Service and the Acute Hospital Trust told HOSC members they have good working relationships. In terms of working with stakeholders to improve the ambulance handover situation and the receptiveness of other organisations, the Ambulance Service representatives said that relationships were very good. WRH was the only hospital in the region to invite in the Executive Nurse of the Ambulance Service each month to undertake a walkaround of the hospital with the Acute Trust's Chief Nurse and to jointly talk to both sets of staff about issues and pressures; the Acute Hospitals Trust was exemplar in this respect.

36. All of the organisational representatives expressed their serious concern for the delays in ambulance handovers, in particular the Ambulance Service and the Acute Hospitals Trust, who are most affected. The representatives were aware that and concerned about the fact that patients were at risk from the current situation with ambulance handover delays. The Medical Director for Urgent Care stressed how very concerned the Acute Trust was about the ambulance handover delays and wanted the situation to be fixed. The delays were a symptom of the overloaded system.

37. There was agreement from all of the organisations that patient flow through the hospital system was one of the main areas which needed to improve in order to reduce ambulance handover delays, from diverting people away from the ED if emergency treatment was not required, to discharge of medically fit patients from acute hospital settings as soon as possible. The Task Group was told that significant work had been done, with improvements evident as the Covid-19 pandemic hit, however the system was now overloaded.

38. In general, the Acute Trust was confident that processes were good, and they believed issues to be more with patient flow. The Trust's conversion rate was 26% (numbers of patients coming into hospital versus those coming out) which was good, and in the upper performance levels.

39. Representatives from both the Council and the Health and Care Trust felt that variations in patient flow was an obstacle to ensuring patient transfer within agreed timeframes since the system worked better with a steady flow and was less able to cope with peaks and troughs in demand – this was being worked on across the system, with a good collaborative approach.

40. The importance of managing the public's expectations was also a factor pointed out. The Health and Care Trust representatives explained that since during Covid, many people had been placed in community hospitals according to which sites had capacity, but which may not be their local hospital; the situation was such

that it was no longer possible to accommodate families' preferences as this caused delays in the system.

Reducing the Pressure at the front door (the Emergency Department)

41. There was an acknowledgement of the need to divert people away from the ED where they did not require emergency treatment, however it was also recognised that this was very difficult to achieve. It had been explained that speeding up the ED assessment process was difficult since the ED was full to the door, whereas ideally a patient would have a very rapid assessment and be streamlined away very quickly.

42. Health and Care Trust representatives mentioned that there were regular communications to encourage the public to use Minor Injuries Units (where appropriate) instead of A&E, although changes to opening hours had been necessary during the pandemic, for example to redeploy staff.

43. The CCG representative highlighted the work of the Community Health Services 2-hour Response Team, (provided by Herefordshire and Worcestershire Health and Care Trust), which is key in diverting people from the ED and was now part of the national agenda[1]. HOSC members were aware of recent investment in these Teams, which went out to people's homes to prevent hospital admission. Worcestershire was well placed and capacity was being expanded, working with partners. HOSC was aware of difficulties in recruiting staff to this team, however staffing now stood at 50% although not all staff had started yet. Recruitment was continuing and with 70 staff across a mix of roles, while a further 35 staff would start in December/January. Services ran across 7 days a week, from 8am to 8pm and were currently receiving around 17 urgent referrals a day.

44. The Health and Care Trust hoped that 2-hour response teams would work with 40-45 referrals a day and was continually working to improve understanding, for example work with the Ambulance Service to parachute in support where appropriate with a view to receiving referrals directly from the Service. For September/October 2021, the 2-hour Response Team was the second best performing in the region.

45. The Task Group asked whether consideration had been given to patients being off-loaded from ambulances to a 'reception area' manned by doctors and nurses who could oversee patient care in more comfortable and safe surroundings thereby allowing ambulances to leave. However, the Acute Trust representatives did not support this suggestion, since there was no space for such a facility but also there were potentially more seriously ill patients in A&E who had not been assessed, whereas those in an ambulance had been assessed.

Reducing Pressure off the Back End (Discharge of Medically Fit Patients)

46. All organisations across the system agreed that improving timely discharge of medically fit patients would significantly improve pressures on the ED and

[1] NHSE definition: A crisis response is delivered by a community-based service typically provided by a multidisciplinary team to adults in their usual place of residence with an urgent care need (required within two hours), and involves an assessment and short-term intervention(s) (typically lasting up to 48 hours). This is a national standard.

consequently, the delays with ambulance handovers. The Health and Care Trust advised that work was underway to look at this to make discharge planning and processes slicker.

47. HOSC members queried the numbers of patients still on ward 24 hours after becoming medically fit for discharge (figures circulated for the meeting indicated 205 such patients were still on ward for week ending 31 October 2021). The Acute Trust representatives explained that there was a difference between being medically fit for discharge and being able to go home, to being medically fit for discharge but requiring equipment or reablement etc.

48. The Ambulance Service's Executive Director of Nursing and Clinical Commissioning took part in hospital 'walk arounds' with the Acute Trust's Chief Nurse and believed the solution was to further challenge patients remaining in hospital who no longer needed to be there.

49. The Task Group was advised that the daily cost of a patient staying in hospital was around £700-£800 per day. However, HOSC members are also aware that in terms of patients whose discharge had been delayed beyond national targets (stranded and super stranded), performance in Worcestershire was near the top nationally, as a result of investment, although numbers were increasing.

50. Initial patient assessment occurred at an early stage and the Onward Care Team, which was responsible for facilitating onward care, went into hospital wards. A considerable workforce was needed to support this cohort of patients, which was an issue.

51. The organisational representatives present were in agreement that the needs of patients who were medically fit for discharge but required onward care should be assessed in their home environment, however at present needs were quite regularly assessed while patients were in acute hospital beds – a change was needed, with greater focus on treating the underlying cause which had prompted hospital admission, rather than other health and care issues, which should be responded to once the patient had been discharged.

52. The Task Group asked whether there were any specific obstacles to improving discharge of patients who were medically fit and the reasons cited included workforce capacity and a risk averse approach in some staff.

53. Other reasons cited were peaks in flow to the Onward Care Team which caused problems. Community transport had also received considerable investment and was now available until 11pm. In the majority of cases, it was possible to have pharmacy and transport provision in place to enable a patient to leave.

54. In terms of the Council's role in managing patient flow and keeping residents out of hospitals, the representative explained that it was a graduated process and staff would know when a patient was at the point of getting ready to come out of hospital. It was explained that council systems would not know when someone went into hospital, since only 15% would need social care and it would be inappropriate to share personal information at this stage. The process was to alert the Onward Care Team as soon as possible after admission to hospital if a potential need was identified. Covid had disrupted some ways of working, but now Onward Care Teams were back onto hospital wards.

55. The Task Group was advised that the Council's staff worked 7 days a week and time taken to arrange onward care depended on the complexity of the person's needs, for example 1 day for a simple case and 203 days for more complex cases.

56. With regard to suggestions to improve efficiency of processes, for the Council, it was not ideal when a patient was discharged from a setting late in the day and there came a point where it was better for the patient to be discharged the next morning, although this did cause delays. Discharge planning from day 1 in hospital was important, for example to gauge whether a patient may need assistive technology, and earlier planning was something being worked on across the system.

57. The Council representative advised that the process of transferring patients from community hospitals to a care setting for ongoing support was constantly under review, although differences may not be dramatic. Streamlining health discharges had been the focus of work over recent months and Covid had brought a lot of change. Whilst this was working, an obstacle to improvement was capacity since domiciliary care was almost broken and demand had increased dramatically over the previous 4-5 months, from the previous steady increase.

~~58.~~ The important role of the Onward Care Team was explained in assisting patients' onward care needs. The Teams, which comprised social workers and nurses would be alerted as soon as possible after someone was admitted to hospital if a potential need was identified. The Health and Care Trust could see patient lists being looked at by its Onward Care Team, on a daily basis.

59. Speaking on behalf of the health and care system, the CCG representative reassured the Task Group that while there had previously been a huge problem with patients moving into care homes from acute hospital settings, this was no longer the case, since they would transfer to community hospitals.

60. Review of processes for transferring patients into community hospitals was a continuous process and managers were involved in calls every day to assess workload, with further checkpoints during the day to assess patients, 7 days a week. From personal experience of being on call at weekends, the Health and Care Trust's representatives knew that Covid made work so much more challenging and praised the Health and Care Trust's capacity management team which was constantly reviewing patients' status and whether they were ready to be discharged and maximising use of the community hospital estate.

61. Ambulance Service representatives pointed out that pushing to discharge someone late in the day was not necessarily helpful to the patient or staff.

62. The Task Group was reassured that the issue of determining whether someone's needs would be funded by health or social care was never an obstacle to discharging a patient as this would be finalised after their discharge.

63. The Ambulance Service representatives explained that the number of ambulances in circulation at any one time was being changed until handover delays were more under control. There would now be around 370 - 380

ambulances available in the west Midlands Region across 24 hours, whereas normally there were 350 - 450 during daytime and around 250 at night.

64. It was also important to fix the 111 Service, and considerable investment had been put in, with staff recruited in July and tangible improvements should be seen by Christmas.

65. The Acute Trust and CCG representatives said there was no clear evidence that increased numbers of people coming to the ED was due to them being unable to access face to face GP appointments. The CCG told us about early plans for hubs to give extra capacity and work to divert people to 111 to be able to book appointments. However, access to GP appointments was not felt to be a factor and there were 20% more appointments available now than in 2019/20, with half of them in Worcestershire being face to face.

What more is needed?

66. The main areas of the discussion with health and social care partners were around patient flow, the challenge of preventing people coming into the ED who did not require emergency care but alternative pathways, timely discharge of medically fit patients from acute hospital settings, assessments in a community setting, and workforce pressures.

67. Task Group members observed that discharge and admission of patients takes a lot of resource and that improvements in these areas would mean shorter hospital stays, more discharges and admissions, and therefore there will be a greater pressure on resources.

68. The CCG representative acknowledged that there was still work to do in terms of slicker working practices and checklists to improve prompt discharge of patients who were medically fit, whether it is to a community hospital or home. Discharging patients earlier in the day before 10am is also important as this prevents bottlenecks in the middle of the day, as had been shown to work well before. Some assessments are still being done in acute hospitals, which needs to change.

69. Working with partners such as the Health and Care Trust, the CCG said there were some big things on the table, in terms of doing things differently, which were being considered in view of the ongoing pressures being faced.

70. When asked what one thing was needed to bring ambulance the situation with handovers under control, the CCG representative highlighted the need for a stable, fresh workforce and staff having the time to transform the situation.

71. The Ambulance Service told us that availability of wraparound services 24 hours a day, seven days a week would be really helpful especially over the festive period. All of the organisations told us that staff worked across 7 days a week, and some were looking at evenings and nights.

The National Picture - Experiences of what is working in other regions

72. The Ambulance Service's Executive Director of Nursing and Clinical Commissioning was a member of several national groups. From experience, Walsall Hospital Trust seemed to cope in a way which other Trusts were unable to, although it was unclear whether this came from a change in culture but the nurses in the ED were extremely quick to get people through the system. In general hospitals which were coping better were smaller Trusts with less acute care. Walsall was mentioned and the fact that their patient flow works well. Stoke only transferred a third of 999 calls to hospital. The Acute Trusts representatives and the CCG representatives advised that they had looked at the hospital examples referred to, and the Acute Trust participated in peer reviews.

73. It may be that rural areas required different solutions, and the representatives cited the example of Scotland where people in rural areas accepted long waits. In terms of preventing hospital admission in the first place, schemes such as New Zealand's befriending service were referred to, which proactively identified vulnerable people living alone, especially over holiday periods. However, representatives also highlighted the work of Neighbourhood Teams and social prescribing in Worcestershire, as well as the tremendous effort from the voluntary sector.

Recommendations

74. The Task Group has identified a range of measures that could be put in place to help improve the situation. It is recommended that the Health Overview and Scrutiny Committee receives an update on the progress against the recommendations adopted and progress to improve ambulance hospital handover delays in 6 months' time from this report, in May 2022. The recommendations are:

    Recommendation 1 – Discharge of Medically Fit Patients by 10am

    Discharging patients who are medically fit for discharge earlier in the day will free up much needed bed space and improve patient flow, it is recommend that for those patients who are medically fit to leave hospital, an early discharge target of 10am is set and monitored accordingly.

    Recommendation 2 – Extra Resources to Facilitate Patient Discharge

    It is recommended that consideration be given to allocating additional resources to the areas which support discharge of patients and onward care, in order to facilitate the 10am focus on patients who are medically fit for discharge. It is acknowledged that a significant amount of resource has recently been invested to support discharge, however it is understood that improving patient flow provides a cost saving on unnecessary patient stays in hospital at around £700-800 a day per patient.

    When the update on the Task Group's recommendations is received in 6 months' time, it would be helpful to include data relating to how the resources are achieving the relevant outcomes, including length of time taken to discharge patients, according to their condition or onward care needs.

    Recommendation 3 – Signposting to appropriate Services from the Emergency Department Front Door

Whilst appreciating that there is evidence to suggest that publicity campaigns about the circumstances when it is appropriate to A&E can be counterproductive, the Task Group nevertheless thinks that educating the public and signposting to the most appropriate services is worthwhile. Therefore, the Task Group recommends that when people present at A&E they should be signposted at the front door to the most appropriate service if it is not A&E.

The Task Group also recommends that opening hours and services eg X-ray facilities available at the County's Minor Injury Units are standardised so that members of the public develop confidence in using them and there is an awareness of opening times and services offered.

Recommendation 4 - Patient Assessments

Providing hospital staff have established that the basic needs of a patient are in place to enable them to go home safely or to onward care eg transport, family/carer, immediate medicines, it is recommended that detailed assessments take place outside of the acute setting either on the day of discharge or the following day at the latest.

Recommendation 5 – Monitoring the Impact of the 2 Hour Community Response Service on Ambulance Handovers

It is recommended that in order the assess the impact of the 2 Hour Community Response Service on Ambulance Handovers, targets relating to the number of patients who would have otherwise needed to go the ED should be set and monitored accordingly.

In addition, the Committee requests a report back in May 2022 both on the progress of the Service target monitoring and long-term viability.

Recommendation 6 – Monitoring the fragility of the Care Sector workforce

The Task Group recommends ongoing monitoring of the situation with workforce fragility and fatigue through the Council's meetings of the Health Overview and Scrutiny Committee, as well as the Adult Care and Well Being Overview and Scrutiny Panel.

Following a Scrutiny Review of Care Work as a Career by a Task Group of county councillors in 2020, regular updates have been provided to Scrutiny on the care market and on the Council's work to promote care work as a career. The most recent update was to the Adult Care and Well Being Overview and Scrutiny Panel in September 2021.

Recommendation 7 – Continuous learning from best practice and what is working elsewhere

Acknowledging the sharing of best practice to date, the Task Group encourages ongoing research of areas where new ways of working have helped with the priority areas identified (patient flow, workforce, prompt patient discharge, alleviating pressure on the ED).

Recommendation 8 – Healthwatch Worcestershire work on Urgent Care and the ED

The HOSC is aware that Healthwatch is starting a piece of work on Urgent Care and the ED, to gather feedback from patients to understand their reasons for attending A&E, what factors contributed to this choice and what, if anything, can be done to influence patient's choice to attend A&E and provide the public with better information about the urgent care services available. Health colleagues are therefore asked to take on board the outcomes and any recommendations from this work.

Recommendation 9 – Education awareness relating to the night-time economy

It was highlight to the Task Group that there was an increase in alcohol related incidents, during the night-time economy, particularly at weekends, which led to an increased demand on services (especially in 20-30 age group). Whilst appreciating the diversity of Worcestershire's night-time economy and the freedoms of almost 24hour access to alcohol, this should not adversely impact the healthcare system.

It is therefore recommended that partners work together to educate and inform the public about responsible use of drink and reducing drug related harm, which could help reduce demand on healthcare services. This includes Public Health, the Police and District Councils to review public health campaigns and licencing and communications as necessary.

Conclusions

The Task Group found the scrutiny discussion about ambulance handover delays extremely helpful and informative. The brief insight gained into the working lives of staff working in the health and care system is sobering and in setting out this report, Task Group members are very mindful of the immense pressures on staff across the sector over such a prolonged period of time. Task Group Members are extremely grateful to the representatives for their time and input to this exercise, but also to all health and social care staff for their ongoing contribution through unprecedented pressures.

There are escalation processes in place (which are triggered accordingly) when there are delayed ambulance handovers, however it is clear that there are no quick fixes to the current situation and it is concerning that whilst there is also consensus about the areas where improvements can be made, the system is extremely pressurised. It is important to note that prior to the pandemic, significant work had been done by partners to improve pressures on ambulance handovers, which was having a positive impact.

Information provided by System Partners

The Task Group has been provided with the following information from Health Partners for consideration:

- Summary Report provided by NHS Herefordshire and Worcestershire Clinical Commissioning Group, Worcestershire Acute Hospitals NHS Trust, Herefordshire and Worcestershire Health and Care NHS Trust and Worcestershire County Council (as at 12 November 2021)
- Presentation (including data) provided by NHS Herefordshire and Worcestershire Clinical Commissioning Group, Worcestershire Acute Hospitals NHS Trust, Herefordshire and Worcestershire Health and Care NHS Trust and Worcestershire County Council (as at 12 November 2021)
- Information provided by West Midlands Ambulance Service
- Examples of Media Articles
  Lives at risk from 'unacceptable' ambulance waits - BBC News
  Worcester patient died after five-hour wait in ambulance - BBC News
  People's Experiences of leaving hospital during Covid-19 (March 2020-April 2021) – Healthwatch Worcestershire (Summary August 2021)