



























Reporting Period December 2020





Situation

The purpose of this presentation is to provide the Hywel Dda UHB Quality, Safety and Experience Assurance Committee with an update on the current patient safety and experience landscape within the Welsh Ambulance Services NHS Trust and Hywel Dda University Health Board area.

Further detail is provided within the appendix

Risks of Delayed Handovers

- Patient harm
- Reduced patient dignity
- Financial risk
- Damage to organisational reputation
- Staff impacts

(further detail provided within the appendix)

An overview of December 2020

In December 2020

- 2,172 handover presentations at emergency departments within Hywel Dda 1,242 outside of the 15 minute notification to handover target time
- 417 patients waited between 1 hour and 10 hours
- 157 patients awaited a primary response in the community between 6 and 20 hours.
- 82 of these patients were in the Amber 1/2 category
- 27patients waited beyond 12 hours to 20 hours for a community response

(further detail provided within the appendix)



Joint Investigation Framework – Appendix b

Joint Investigation Framework – Appendix b (Source: SCIF)

The Joint Investigation Framework includes all Health Boards and Trusts in Wales, and relates to patient safety incidents escalated by The Welsh Ambulance Services NHS Trust (WAST) that have been considered at the Serious Case Incident Forum (SCIF) and where the primary causal factor relates to or as a consequence of Health Board hospital handover delays.

During December there was one incident that was reviewed at the SCIF which met the criteria for the appendix b framework. This is being jointly investigated between WAST and HDdUHB.

HDdUHB also reported one incident to WAST.

Meetings are held regularly, and as required, between the Head of Patient Safety, Concerns and Learning, WAST and the Head of Quality and Governance HDdUHB.



Recommendation

The Hywel Dda UHB Quality, Safety and Experience Assurance Committee is asked to note the Patient Experience Highlight report and the information provided within this presentation.

The Committee is asked to receive assurance that WAST and HDdUHB are working collaborative through mechanisms such as the joint investigation framework to ensure there is shared learning.

Thank you Any questions please

Appendix: Further detail to support presentation































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Introduction

This Patient Safety and Experience Highlight Report provides an 'at a glance' update on the current patient safety and experience landscape within the Welsh Ambulance Services NHS Trust and Hywel Dda University Health Board area. It specifically focusses upon the following key areas:

- Description of risks
- Risk of delayed handovers
- Summary
- Secondary Care
- Delayed community responses
- Joint Investigation Framework Appendix b

Description of the Risks

Description of the Risk	Corporate Risk Register Ref. No.	Current Risk Score
Risk Ref: 224 - Patients unable to access secondary care assessment and treatment (Patients being delayed on the back of ambulances outside Accident & Emergency)	CRR57	25
Risk Ref: 223 - Unable to attend to patients in the community who require See and Treat Services	CRR 58	25

Risks of Delayed Handovers

Patient harm as a result of:

- Delay to diagnostics and/or definitive care
 - E.g. access to time critical medical intervention (thrombolysis) resulting in poor patient outcomes
- Inability to respond to emergency cases in the community
 - Deterioration leading to patients being ROLEd at scene
- Patient deconditioning
- Increased risk of developing pressure sore injury
- Ambulance personnel not trained for provision of nursing services to patients

Reduced patient dignity:

- Confined to ambulance vehicles
- Inability to access appropriate toileting
- Unable to meet patient feeding/hydration requirements

Financial

- Provision of activity to maintain staff welfare
- Lost productive time has financial cost
- Increase in Redress/ clinical negligence and legal claims Kent vs Griffiths

Risks of Delayed Handovers

Damage to organisational reputation

- Erosion of community confidence
- Loss of confidence from key system stakeholders & partners
- Media interest directed at WAST
- Increase in concerns and adverse incidents as a result of delayed attendance
- Increase in Regulation 28s through Coroners Inquests
- Increase in political pressures from AMs and MPs

Staff impacts:

- Ambulance personnel providing care services they are not trained to provide nursing
- Reduced morale
- Rising sickness due to stress and anxiety for ambulance response and CCC staff
- Exposure to conflict due to extended wait times in ambulances or in the community
- Developing conflict between NHS staff
- Reduced management capacity due to deployment at emergency departments

Summary

We can see from the data presented in the following slides, that following 2,172 handover presentations at Emergency departments within Hywel Dda, 1,242 were outside of the 15 minute notification to handover target time.

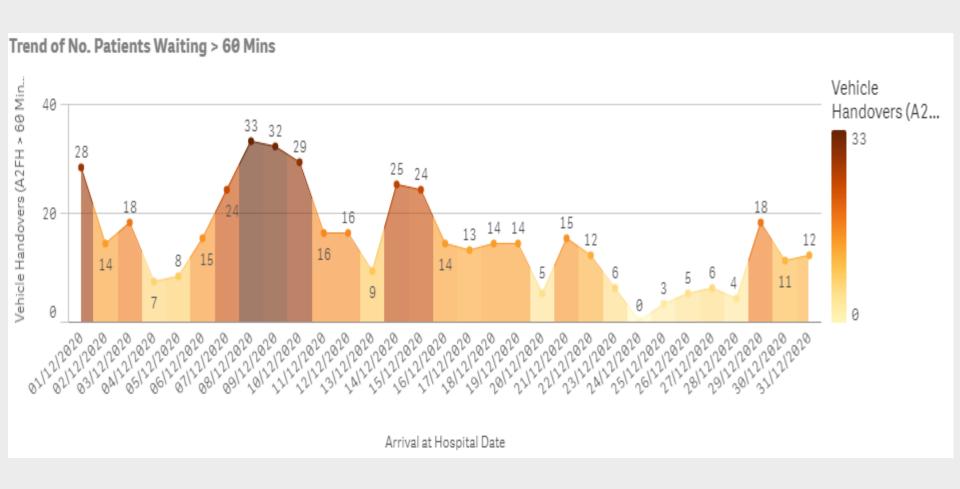
In addition to this, 417 patients waited between 1 hour and 10 hours to handover care to Emergency department staff, with 1 patient waiting more than 10hrs.

During the month of December, 157 patients awaited a primary response in the community between 6 and 20 hours. From the data contained within slide 8, it can be seen that 82 of these patients were in the Amber 1/2 category. These categories include, chest pain, stroke, dyspnoea, overdose, abdominal pain, allergic reactions, unconsciousness (and fainting). Significantly, the chest pain and stroke patients (if confirmed +ve) would by definition have missed the opportunity for clinical intervention such as PPCI and Thrombolysis

27patients (2 x Amber1, 16 x Amber2, 2 x Green2 and 7 x Green3) waited beyond 12 hours to 20 hours for a community response.



Number of Patients Waiting Outside Hospital in Excess of 60 minutes



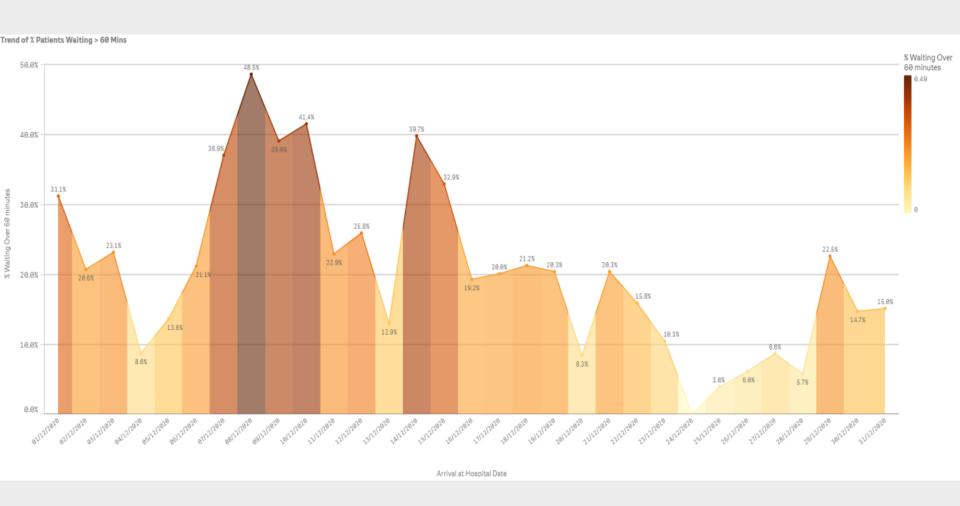


Average Patient Final Handover Time





% of Patients Waiting Outside Hospital in Excess of 60 minutes





	Notification to Handover - Delays by Time Band													
Hospital Health Board	<15 mins	15-30 mins	30-60 mins	1-2 hrs	2-3 hrs	3-4 hrs	4-5 hrs	5-6 hrs	6-7 hrs	7-8 hrs	8-9 hrs	9-10 hrs	>10 hrs	Grand Total
All Health Boards	4,503	3,632	2,599	1,525	810	498	300	181	111	78	49	39	61	14,386
	31.3%	25.2%	18.1%	10.6%	5.6%	3.5%	2.1%	1.3%	0.8%	0.5%	0.3%	0.3%	0.4%	
Aneurin Bevan	238	203	360	213	109	94	76	39	25	22	20	15	17	1,431
	16.6%	14.2%	25.2%	14.9%	7.6%	6.6%	5.3%	2.7%	1.7%	1.5%	1.4%	1.0%	1.2%	
Betsi Cadwaladr	1,102	1,280	884	503	256	143	63	31	14	11	3	0	2	4,292
	25.7%	29.8%	20.6%	11.7%	6.0%	3.3%	1.5%	0.7%	0.3%	0.3%	0.1%	0.0%	0.0%	
Cardiff And Vale	448	493	415	200	100	39	19	5	6	2	0	0	1	1,728
	25.9%	28.5%	24.0%	11.6%	5.8%	2.3%	1.1%	0.3%	0.3%	0.1%	0.0%	0.0%	0.1%	
Cwm Taf Morgannwg	980	558	331	243	130	73	52	46	29	26	10	9	32	2,519
	38.9%	22.2%	13.1%	9.6%	5.2%	2.9%	2.1%	1.8%	1.2%	1.0%	0.4%	0.4%	1.3%	
Hywel Dda	930	582	241	169	109	54	45	19	14	2	3	2	2	2,172
	42.8%	26.8%	11.1%	7.8%	5.0%	2.5%	2.1%	0.9%	0.6%	0.1%	0.1%	0.1%	0.1%	
Out of Area	244	282	147	35	5	5	0	0	0	0	0	0	0	718
	34.0%	39.3%	20.5%	4.9%	0.7%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Swansea Bay	561	234	221	162	101	90	45	41	23	15	13	13	7	1,526
	36.8%	15.3%	14.5%	10.6%	6.6%	5.9%	2.9%	2.7%	1.5%	1.0%	0.9%	0.9%	0.5%	



Delayed Community Responses

