



## Executive Summary

<b>Meeting:</b>	Quality Governance Committee	<b>Date:</b>	1 <sup>st</sup> December 2022
<b>Report Title:</b>	Your Next Patient	<b>Agenda Item:</b>	9
<b>Author:</b>	Ann Marie Riley		
<b>Executive Lead:</b>	Ann Marie Riley		

Purpose of Report			
Information	Approval	Assurance	Assurance Papers only: <input checked="" type="checkbox"/>
			Is the assurance positive / negative / both?
			Positive <input checked="" type="checkbox"/> Negative <input type="checkbox"/>

Alignment with our Strategic Priorities			
	High Quality	<input checked="" type="checkbox"/>	
	Responsive	<input checked="" type="checkbox"/>	



Risk Register Mapping	
	Risks currently awaiting approval for inclusion on the risk register

## Executive Summary

The situation across the NHS in relation to ambulance holds is causing significant harm for patients in the community who are waiting for an ambulance, with a number of reported poor outcomes for those patients. West Midlands Ambulance Service has a risk score of 25 in relation to this

At UHNM we are holding more ambulances than we deem acceptable and have taken significant action as an organisation to support the ambulance service to deliver timely care to those in our community.

At the end of October 2022 the Trust implemented an initiative called your next patient (YNP), which allows us to release capacity in our Emergency Department and assessment portals throughout the day so ambulance crews can be released to respond to 999 calls. This model originated in North Bristol NHS Trust and was been implemented in the 10 Trusts with the most delays of which we are one.

We piloted the YNP approach in Medicine (RSUH) utilising quality improvement methodology to adapt the Standard Operating Procedure as required. The process has now been rolled implemented across both sites.

54 incidents have been reported in total since YNP commenced at end of September. There are no reports of patient harm occurring due to the YNP process.

## Key Recommendations

The Committee is asked to note the information provided and the recommendations made to support continual improvement



# Your Next Patient

1<sup>st</sup> December 2022

## 1. Introduction

The situation across the NHS in relation to ambulance holds is causing significant harm for patients in the community who are waiting for an ambulance, with a number of reported poor outcomes for those patients. West Midlands Ambulance Service has a risk score of 25 in relation to this

At UHNM we are holding more ambulances than we deem acceptable and have taken significant action as an organisation to support the ambulance service to deliver timely care to those in our community.

At the end of October 2022 the Trust implemented an initiative called Your Next Patient (YNP), which allows us to release capacity in our Emergency Department and assessment portals throughout the day so ambulance crews can be released to respond to 999 calls. This model originated in North Bristol NHS Trust and was been implemented in the 10 Trusts with the most delays of which we are one.

We piloted the YNP approach in Medicine (RSUH) utilising quality improvement methodology to adapt the Standard Operating Procedure (SOP) as required. We hold PDSA meetings each week to monitor performance and receive feedback. The YNP process has now been rolled implemented across both sites.

## 2. Process

Every area that accepts a YNP has been risk assessed to ensure there is assurance that there are suitable spaces to receive patients.

A schedule of times and receiving wards is available for all receiving areas, for each site, to enable ward teams to prepare to receive a YNP, which was the preferred delivery method as determined by ward teams. YNP's are allocated to wards in line with the schedule within the SOP.

A patient letter has been circulated to be given to affected patients signed by the Chief Nurse and the Medical Director.

A letter has also been circulated to nursing staff from the Chief Nurse noting the challenges this model poses and asking that any safety concerns are escalated promptly.

In line with the SOP the site team are expected to complete a Datix each day to capture patients affected by the YNP process

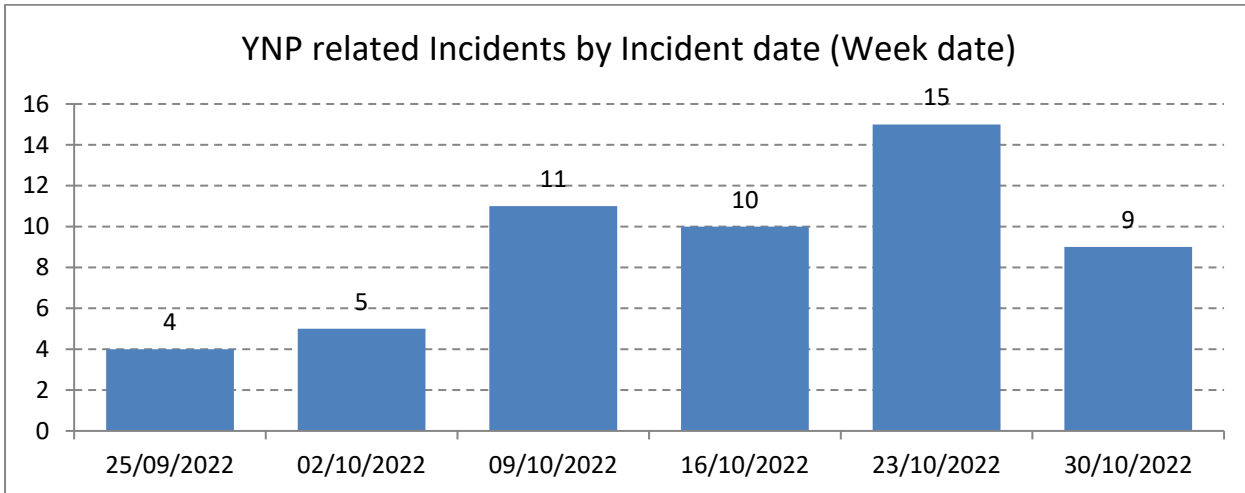
We are collating any related adverse patient outcome and/or experience data and will report this to the committee quarterly.

## 3. Your Next Patient related Incidents and Complaints

54 incidents have been reported in total since YNP commenced at end of September:

- The first reported incident 26.09.2022 and last incident reported 25.10.2022
- 2 formal complaints received regarding the YNP process

- The CQC have not received any complaints re the YNP process
- To date no patients have come to harm due to the YNP process



### Incident category by location

	RSUH ED	Ward 122	FEAU (W123)	Site Management Team	Trust Premises	Ward 113	Ward 117	Ward 121	Ward 124	Ward 222	Ward 223	Ward 231 (AMU)	Ward 232 (AMU)	Ward 233 Short Stay Unit	Total
Access / admission - delay / failure in access to hospital / care	0	0	0	4	0	0	0	0	0	0	0	0	0	0	4
Access / admission - unplanned admission / transfer to specialist care unit	0	0	0	8	1	0	0	1	0	4	0	0	0	0	14
Delay or failure to monitor	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Handover of care	0	0	0	0	0	0	0	0	1	1	0	0	0	0	2
Inappropriate admission / transfer of a minor to an adult setting	0	0	1	0	0	0	0	0	0	0	0	1	0	0	2
Infection - Tests - failure / delay to undertake Isolation Processes/Protocols for Infected Patients failed or delayed	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Lack of / delayed availability of beds (general)	0	0	0	1	0	0	0	0	0	0	0	1	1	0	3
Lack of suitably trained / skilled staff	0	0	0	0	0	1	2	1	0	0	0	0	0	0	4
Transfer - delay / failure / inappropriate	1	1	0	1	0	0	0	2	0	0	1	3	0	1	10
Unsafe / inappropriate clinical environment (including clinical waste)	0	0	0	0	0	2	1	1	3	1	0	0	1	0	9
Pressure Ulcer - Not Hospital acquired	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Loss of privacy/dignity	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Non pressure ulcer	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
<b>Total</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>14</b>	<b>1</b>	<b>3</b>	<b>3</b>	<b>9</b>	<b>5</b>	<b>6</b>	<b>1</b>	<b>6</b>	<b>2</b>	<b>1</b>	<b>54</b>

### Incident harm/actual impact by location

	RSUH ED	Ward 122	FEAU (W123)	Site Management Team	Trust Premises	Ward 113	Ward 117	Ward 121	Ward 124	Ward 222	Ward 223	Ward 231 (AMU)	Ward 232 (AMU)	Ward 233 Short Stay Unit	Total
Near Miss	0	0	0	0	0	2	2	0	1	0	0	1	1	0	7
No harm	1	1	1	12	1	1	1	7	4	4	1	4	1	1	40
Low Harm	0	0	0	2	0	0	0	2	0	2	0	1	0	0	7
<b>Total</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>14</b>	<b>1</b>	<b>3</b>	<b>3</b>	<b>9</b>	<b>5</b>	<b>6</b>	<b>1</b>	<b>6</b>	<b>2</b>	<b>1</b>	<b>54</b>

## Conclusions

The YNP process undoubtedly affects both patient and staff experience however, to date, we have not seen any patient harm caused by this process. We will continue to closely monitor incidents and complaints and proactively seek potential trends in outcomes.

## Recommendations

The Committee is asked to note the information provided.