

Appendix 2 Swansea Bay University Health Board Management Response October 2019:
WAST Handover of Care at Emergency Departments - follow up Internal Audit Report 2019

Current findings 1 - Patient care during handover delays	Risk
<p>Whilst the rating of the finding was rated low, the health boards engaged in this review considered this a high priority as patient care and patient experience was considered of utmost importance. With regard to procedures implemented by the health boards, they have confirmed that responsibility for monitoring of the patient whilst in the ambulance lies with the health board once triage has been actioned by Emergency Department staff in the ambulance. Delays in handover will extend the time from triage to physical transfer in to the Emergency Department. The health boards noted that the applicability of the finding to their individual operations varied depending upon the timeliness with which patients were being handed over from the ambulance to their respective Emergency Departments. Where the vast majority of patients were transferred from the ambulance within the 15 minutes target time, the applicability of the finding was less relevant. They also commented that patients were assessed and processed based on acuity and need so those patients that remained in an ambulance over the 15 minutes target time were less acute and were more likely to be mobile, limiting issues regarding bed sore management and continence concerns. Standard Operating Procedures in respect of handover were in place at each health board, however these did not specifically refer to nutrition, hydration and continence. All health boards have provided an update to WAST on the arrangements in place to provide patients with dignified care if patients are delayed on ambulances whilst awaiting handover of care at emergency departments.</p> <p>One health board, Hywel Dda University Health Board (HDUHB) has developed a flow chart which details the care priorities for patients in ambulance offload delays, for inclusion in the next iteration of their ambulance off-load policy.</p> <p>This finding is considered PARTIALLY IMPLEMENTED to reflect that Standard Operating Procedures need to be updated in some instances. Standard Operating Procedures need to be updated to reflect reality, the finding remains OPEN. The priority level remains LOW.</p>	<p>Safe and dignified care is not provided to patients during handover delays.</p>

Considerations going forward	Priority level
<p>1. All health boards should ensure that their Emergency Department Standard Operating Procedures are current and reflect actual practices regarding the provision and recording of nutrition, hydration and continence needs of those patients in the period between being triaged in the ambulance and being handed over.</p> <p>2. All health boards should undertake compliance checks to confirm that Emergency Department staff are acting in accordance with Standard Operating Procedures regarding the provision and recording of nutrition, hydration and continence needs of those patients in the period between being triaged in the ambulance and being handed over.</p>	Low
Management Response 1	Responsible Officer
<p>Arrangements are in place within Emergency Departments at Morriston hospital to ensure food and drinks are available to patients who may experience handover delays. While the new documents mentioned above are being finalised for hospital completion, ambulance crews will record nutrition and hydration events onto their Patient Clinical Records (PCR), this information is conveyed to ED staff at the point of handover and entered onto ED records.</p> <p>In respect of continence, if a patient is mobile they will be assisted to the hospital toilet facility by WAST staff. Where the patient is immobile or has any specific needs ambulance staff will seek nursing support to undertake with patient toileting. This would need to be undertaken within the hospital due to ambulance CCTV and privacy issues.</p>	ECHO Service Manager, & Head of Nursing ECHO Morriston
Current findings 2- Conveyance to ED	Risk
<p>GP Referrals WAST has undertaken a number of initiatives in conjunction with health boards in an attempt to positively impact upon conveyance to the Emergency Department. WAST performed a two-day trial in October 2018 with Aneurin Bevan University Health Board (ABUHB), to assess the impact of Health Care Professional (HCP)</p>	Ambulance conveyance not being managed effectively by Health Boards and WAST

calls being handled by a clinician. This resulted in a reduction in the number of patients being conveyed to hospital.

Enhancing on the above, Betsi Cadwaladr University Health Board (BCUHB) has also implemented a Single Integrated Clinical Assessment and Triage service (SICAT) which went live on 12th November 2018. This service sits co-terminus within WAST's CCC in North Wales. It is currently manned by an experienced General Practitioner (GP) working alongside an APP. The service focuses on Health Care Practitioner (HCP) demand – though this is not exclusive, where calls of higher acuity are identified, to avoid ambulance deployment or patient conveyance. As at March 2019, the service had managed almost 200 calls. Analysis of these calls identified that the initiative had delivered an 80% stand down for deployment of WAST crews and 65% avoidance of conveyance to ED – of these almost 50% have been returned to their GP for routine follow up and 20% had been given self-help advice. The scheme also saw a 25% increase of ambulance conveyances to the health board's Minor Injuries Units (MIU) through the month of November 2018 and this continued into December. The service recruited an additional four GPs to work within the service, and is currently training an Advanced Pharmacist who will soon support both SICAT and GP Out of Hours (OOH). This is a joint venture with WAST working through advanced risk sharing arrangements.

We were also provided with a highlight report for the GP transport pilot which was undertaken within ABUHB. The purpose of the pilot was to reduce the delays incurred when transporting patients referred into acute hospitals from GP's, and to diarise suitable patients to improve flow through the assessment units. The intention was for ABUHB to take over the allocation and management of GP transport crews during the busiest times (Monday-Friday, 8am-8pm) to ensure that patients are transported to an acute assessment unit in a timely manner following a referral and to diarise suitable patients to support effective flow. The transport crews would also support discharges from assessment units in order to create capacity to offload new patients arriving. The initial pilot ran for 6 weeks during February and March 2018 but had mixed success due to a number of reasons, including no dedicated coordinator (a paramedic on light duties covered 8.00 – 4.00 for 4 weeks), the crew being pulled to do emergency jobs and not every shift being covered. The highlight report detailed that data analysis of the initial pilot was not statistically significant, but did show a general reduction in the time from booking to arrival at assessment units. The highlights report proposed that the trial be run for 6 months from October 2018 to April 2019, the decision was taken to defer due to significant pressures. We acknowledge that this work is also reliant on the health boards working with their primary care services to ensure that patients are being referred in line with the health board's demand and capacity. ABUHB was involved in a Falls

resulting in patients being conveyed to ED inappropriately.

Response pilot in conjunction with WAST to reduce the number of patients who have fallen, which represents one of the 'Big 5' unscheduled care demands, being transferred to the ED. This pathway has been rolled out to several health boards and many of the health boards reviewed confirmed that they have taken part in the Falls Response vehicle scheme commissioned by WAST from December 2018.

SBUHB has undertaken a lot of work to reduce unnecessary conveyance from care homes. This has included providing training on the 'I Fell Down' tool to four care homes in the NPT Local Authority area, which at the time of our review, was in the process of being rolled out to Swansea Local Authority homes, with the aim of reducing conveyance from care homes to ED for patients who have fallen.

The health board had also agreed to participate in the National Collaborative Commissioning Unit's (NCCU) 'National Early Warning Score (NEWS) project' to ensure the use of regular NEWS scoring in two or three nursing homes in the Swansea Bay area to support conveyance and discharge decisions. NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

SBUHB was also involved in a Bevan Exemplar project of the 'Integrated Response Model' during 2017/18, with the Bevan Commission evaluation report being published in 2018. Bevan Exemplars are NHS professionals who are supported to trial and test out their innovative ideas to improve resource efficiency, patient experiences and health outcomes. The project involved the Acute Clinical Team (ACT) in Neath Port Talbot Hospital alongside WAST colleagues piloting a scheme to redirect appropriate 999 emergency calls where the patient would be better suited to receiving community based care from the Acute Clinical Team. The project took place between October 2017 and March 2018 and included a sample of 40 patients who were either referred into, or proactively brought into the care of the ACT by WAST. The average length of stay with the ACT was 5.4 days. 87.5% of patients were safely cared for in the community rather than admitted into an acute hospital. The report recognised the cost saving per patient and the patient / carer / staff satisfaction and the increased autonomy for the Acute Clinical Team and nursing home staff. The report concluded that the project "reduced the number of patients needing transport by the ambulance service and admission to hospital, and it is recommended that it is adopted and spread more widely across Wales".

The Delivery Unit (DU) undertook a progress review in 2019 of Ambulatory Emergency Care (AEC) in Wales at SBUHB and stated that Singleton hospital is emerging as one of its national exemplars. The DU highlighted

<p>the following for the hospital, that whilst there is ‘no Ambulatory Emergency Care Unit, there is a clear ambulatory ethos across the whole front door footprint’. The DU’s review noted that Singleton Hospital has an Acute GP Unit (AGPU), Singleton Assessment Unit and Medical Day Unit with multiple pathways in AGPU, which is open 8am – 8pm, calls are taken by GPs, who also provide clinical advice. It noted that 48% of patients are discharged from AGPU. Singleton Assessment Unit (SAU) has 20% of patients treated and discharged the same day, with on-call consultants currently undertaking SAU work. Approximately 25 – 35 patients per day are seen in SAU. There is specialty input, with Gastroenterology in-reach and there a keenness to develop more Cardiology/Diabetes input.</p> <p>Some health boards commented that it has been perceived by front line teams, that a higher number of acutely unwell patients are self-presenting at the ED and are being taken directly to resuscitation area in ED from reception. In Swansea Bay UHB, this is in the context that whilst overall ambulance conveyances have reduced, attendances at ED / MIU / SAU have increased. This may be as a consequence of the pilots to reduce the number of patients being conveyed by a WAST vehicle.</p> <p>This finding is considered PARTIALLY IMPLEMENTED and remains OPEN. The priority level has been reduced to MEDIUM to reflect the progress made regarding avoiding conveyance to ED.</p>	
<p>Considerations going forward</p>	<p>Priority level</p>
<ol style="list-style-type: none"> 1. Health boards, in conjunction with WAST, should evaluate the results of the trials in ultimately reducing conveyance to Emergency Departments, and where found successful, extend the trails across Wales, where appropriate. 2. Health boards should work closely with primary care service providers to ensure that patients are being referred appropriately and in line with the health boards’ demand and capacity. 3. The health boards in collaboration with WAST should assess the impact of any pilot to reduce the number of patients being conveyed to the ED by a WAST vehicle on the demand and capacity of the hospital. 	<p>Medium</p>

Management Response 2	Responsible Officer
<p>Swansea Bay University HB and WAST have continued to work jointly on the development of pathways and services to reduce the number of patients conveyed to Morriston hospital Emergency Department and Singleton hospital's assessment unit. This can be evidenced through an 8.6% and 9% reduction in green and amber calls respectively, when comparing the first 9 months of 2019 with the same period in 2018.</p> <p>This work is reflected in the findings of the follow up review, but additional progress is also being made in that:</p> <ul style="list-style-type: none"> • The Health Board in conjunction with WAST is supporting two level 1 falls response vehicles in Swansea Bay Health Board. This service has a 60% non-conveyance rate. One vehicle has been in place since April 2019, and a second vehicle is being commissioned between November and 1st April to increase capacity over the winter months when the number of falls are predicted to increase. • The Acute GP service in Singleton will be triaging patients on the ambulance stack Monday – Friday until the 31st March following the provision of non-recurrent funding to provide this service. When this service was piloted earlier this year, a significant number of patients (44%) were redirected to alternative pathways that did not require an ambulance response. • Expansion of the COPD service in Swansea Bay HB will enable the further development of respiratory care pathways between WAST and the Health Board that avoid the need to convey patients to ED. • The implementation of the Hospital to Home service for the population of Swansea Bay UHB, from December 2019 will support admission avoidance, as well as improving discharge capacity. 	<p>WAST Head of Ops/ Assistant COO</p> <p>Singleton AGPU lead</p> <p>Singleton DU</p> <p>Adult services transformation board</p>
Finding 3 - Pathways to bypass ED	Risk
<p>Governance of Identification and Approval of Pathways</p> <p>The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) is best known for the production of clinical guidelines for pre-hospital care, often referred to as just the 'JRCALC guidelines'. The WAST's CPAG group looks at national pathways and works to ensure compliance with JRCALC guidelines. These guidelines will</p>	<p>Pathways for emergency care that bypass the ED are not communicated, shared and understood.</p>

outline whether a patient should be taken to Emergency Departments or elsewhere. Where it is elsewhere, the exact location is agreed at a local level with the health board.

WAST and the health boards are represented on the bi-monthly National Programme for Unscheduled Care Professional Advisory Group (NPUCPAG), of which all Emergency Departments in Wales are invited to attend. The agenda for this meeting includes changes in pathways linked to developments in medicine / Welsh Government major service redesign.

We were informed that a directory of pathways for every clinical condition across each health board area does not exist within WAST and that this does not exist elsewhere in the UK. Local engagement between WAST and each health board regarding the sharing of pathway developments and changes varies across Wales, examples include:

- WAST are being informed of changes in pathways through the health board's Unscheduled Care Board. Where major changes to existing pathways or development of a new pathway occurs, communications are in place to engage WAST with membership of Project Boards for each development and access to Task and Finish Groups;
- Where pathways are complex with regional variation present, WAST regional representatives are being engaged by the health board to share pathway developments;
- Development of new pathways are being shared with WAST at local operations meetings and are linked to a current major service model restructuring at the health board; and
- a bespoke operation is in progress to review all pathways with WAST, social care and community teams, together with reporting to Welsh Government on the effectiveness of clinical pathways, as experienced in the busy winter months.

In addition, Betsi Cadwaladr University Health Board has asked WAST to perform an audit of activity to identify where and when incorrect pathways have been used and why, to aid improvement in correct pathway usage across the health board by WAST resources.

Regarding out of area transfers within Wales, one Health Board with significant transfer volumes, commented that such transfers are monitored, pathways reviewed, and WAST informed, if and when the correct pathway is not implemented.

<p>With regard to English ambulance transfers into Welsh health boards it was confirmed by another health board that the ambulance crew will not have access to pathway information and will be reliant on WAST CCC being aware of the correct pathway to apply and to instruct English crew accordingly.</p> <p>This finding is considered PARTIALLY IMPLEMENTED and remains OPEN. The priority level has been reduced to MEDIUM to reflect the progress made regarding continued communication of pathway developments and changes to WAST.</p>	
<p>Recommendation 3</p>	<p>Priority Level</p>
<p>We recommend that:</p> <ul style="list-style-type: none"> • WAST and Health Boards undertake a review of the governance arrangements for the identification and approval of all pathways, together with a consistent process for recording, disseminating and measuring outcomes. • WAST ensures that any blocks or breaks that prevent the use of a conveyance pathway to bypass ED are recorded and management action is taken to address any issues. • WAST investigates the opportunity of developing an electronic pathways tool to assist paramedics in following pathways to bypass conveyance to ED. 	<p>Medium</p>
<p>Management Response 3</p>	<p>Responsible Officer</p>
<p>Swansea Bay University Health Board's position in respect of the mapping of alternate pathways is good overall, and reflects the joint work undertaken to date with WAST.</p> <p>WAST colleagues within Swansea Bay UHB have developed an extensive directory of pathways and services which is available on every ambulance vehicle and this has also been shared with Hywel Dda ambulance personnel to support decision making at scene.</p>	<p>Completed</p>

<p>Additional alternate pathways for GP expected patients in surgery and orthopaedics have been implemented in Morriston Hospital, and the ambulance pathways for Singleton and Neath Port Talbot hospitals have also been reviewed and updated this financial year.</p> <p>Further work is currently underway within the Morriston delivery unit on the implementation of a medical ambulatory care service which in the fullness of time may support direct ambulance admission as this service develops on a sustainable basis.</p> <p>From November the Acute GP service in Singleton will be triaging patients on the ambulance stack Monday – Friday until the 31st March following the provision of non-recurrent funding to provide this service. When this approach was piloted earlier this year, a significant number of patients (44%) were redirected to alternative pathways that did not require an ambulance response.</p> <p>The Unscheduled Care Board signs off pathway developments with WAST, and membership of this board includes the WAST Operational Manager for Swansea Bay UHB.</p>	<p>Completed</p> <p>Morriston Unit Service Director.</p> <p>Singleton AGPU lead</p> <p>USC Board - ongoing approval of alternate pathways</p>
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<p>Previous Finding 6 – Patient flow initiatives</p>	<p>Risk</p>
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<p>We were informed that health boards with poorer AQI handover performance have engaged with health organisations in Wales and in England to identify processes and practices that could be adopted to aid delivery of improved handover performance.</p> <p>A review of CTMUHB practices by other health boards has resulted in adoption of some processes that have not always delivered the expected improvements. It was commented that one solution does not fit all; rather it has been found that a range of initiatives gleaned from a number of health boards have been implemented across the health boards in Wales.</p> <p>Processes and practices have been adjusted within health boards in the light of internal reviews performed and have thought to have contributed to improvement in the performance recognised. There is inevitably a delay between implementing processes and practices and then being able to see the impact in performance</p>	<p>Opportunities for sharing best practice that reduces handover delays may be missed resulting in lost hours.</p>
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<p>via published AQIs. In many instances changes that have been implemented are yet to feed into published AQIs. Consequently health boards consider that improvements in performance have been supported by a number of factors but are not able to necessarily prove causation, for example:</p> <ul style="list-style-type: none"> • Embedding of a Single Integrated Clinical Assessment and Triage service (SICAT) within WAST control centre; • Development of alternative pathways; • Proactive triage processes on arrival with prompt action taken; • Fit to sit assessment; • Corridor waiting (where physical configuration of Emergency Department allows the use of a non-public thoroughfare); • Maximise patient flow through Emergency Department and into hospital; • Improvement in discharge from hospital practices, adoption of SAFER patient flow model, investment in local authority initiatives; • Additional resources for winter period; and • Effective application of standard escalation process. <p>Other opportunities to further improve performance have been identified by health boards, for example, the creation of focussed observation / assessment areas, away from main Emergency Department acute treatment areas, allowing dedicated staff to manage treatment and through flow of patients more efficiently.</p> <p>This finding is considered PARTIALLY IMPLEMENTED and remains OPEN. The priority level remains MEDIUM to reflect the fact that the various projects and actions implemented to improve performance are yet to be evidenced in published AQIs.</p>	
<p>Recommendation 6</p>	<p>Priority Level</p>
<p>1. Health boards should continue to review their handover performance via published AQIs and evaluate how changes in performance achieved over time are a direct result of individual changes in processes and practices implemented.</p>	<p>Medium</p>

2. Health boards should support and develop successful processes and practices, whilst those deemed unsuccessful should be reviewed and reversed where appropriate.



Management Response 6

Responsible Officer

Swansea Bay UHB has a level 1 falls service in place and is expanding capacity in this service between November 2019 and March 2020 in recognition of predicted increases in demand.

WAST/ Assistant COO

Instead of a SICAT model, Swansea Bay has developed the AGPU service in Singleton, enabling experience GP's to access the WAST live stack and to triage patients – which has proven to be successful in redirecting patients to alternative care pathways and also builds upon the successful GP out of hours/111 service model. It is intended that this service will be fully operational by December 2019.

Singleton AGPU lead

In relation to primary care, WAST has met with the Cluster Leads and will be attending the NPT GP training session to discuss winter pressure issues and alternative transport options for patients who do not require an ambulance response or conveyance to hospital e.g. use of taxis for appropriate patients. The Acute GP unit in Singleton also has access to the taxi pathway.

Primary care and community services service director/ WAST Head of Ops.

Swansea Bay UHB recognises the need for a system-wide response to address delays in patient flow which impact on ambulance handover delays at our front doors. The Health Board has recently revised its patient flow policy which reflects the Welsh national SAFER patient flow model, and is also progressing the implementation of models of care that support increased capacity for patients to be routinely discharged to their place of residence to assess and support their ongoing care needs e.g. Early supported discharge and hospital to home models.

COO/ Swansea Adult Services Transformation board.

Swansea Bay UHB was the first Health Board to develop a fit to sit policy based on the implementation of this process at Morriston hospital, and this policy has now been adopted nationally.

Patients arriving at Morriston hospital ED are all triaged. However further training of triage nurses is being planned as part of the Health Board's USC improvement plan, with the intention to provide a primary care

<p>presence in ED during day time hours which will assist in the education of patients and staff on alternative appropriate pathways available in the community.</p> <p>The Health board and WAST in Swansea Bay UHB have jointly reviewed the immediate ambulance release protocol. The immediate release process has been clarified and changed following confusion earlier in the year. WAST control will now contact the triage nurse at the front entrance of Morriston hospital's ED using a direct cisco phone line and will request either an immediate release red or an immediate release amber. The Health Board's Medical Director has confirmed that this Health Board will always comply with a red release request. The HB will work towards the aspiration to release crews for an immediate amber release request. Further work is being undertaken between WAST and Morriston hospital to improve upon the timeliness of the red release to ensure that the category A ambulance response times are achieved.</p> <p>The Health Board's escalation policy is being reviewed ahead of the winter.</p> <p>The Health Board is supporting the provision of a patient liaison role at Morriston ED over the winter months to support improved communication and patient handover between emergency department and WAST at times of heightened escalation. This role will also promote and support the provision of accurate hospital handover information.</p> <p>Ambulance demand and performance data is reported to the USC board on a monthly basis.</p>	<p>Morriston DU and Primary and community</p> <p>WAST /ECHO Service Manager, & Head of Nursing ECHO Morriston</p> <p>Director of Nursing and Patient Experience</p> <p>WAST/ ECHO Service Manager, & Head of Nursing ECHO Morriston</p> <p>Assistant COO</p>
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<p>Previous finding 7 – Delayed handover clinical triage</p>	<p>Risk</p>
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<p>This recommendation relates to Cardiff & Vale University Health Board (CVUHB) as the issue raised refers to the UHW site only. During our current review we were not able to engage CVUHB as permission was not provided. We understand that the Emergency Unit has seen a change in management team who will review their decision around this.</p> <p>However, we have noted the following comments made by CVUHB to the Assistant Director of Nursing, WAST in a letter dated 21 January 2019. Findings 7 — Delayed handover clinical triage.</p>	<p>Opportunities to address All Wales issues and seek to develop consistent approaches may be missed.</p>
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Cardiff and Vale UHB are appreciative that they were the only UHB that did not provide a face-to-face assessment of the patients if delayed outside the Emergency Unit department and rely on the professional handover from the WAST crew. The relationship and interaction between the Assessment Nurse and WAST crew is imperative to ensuring effective and efficient patient assessment. The UHB is committed to improving patient flow throughout the hospital to minimise the WAST delay and subsequent assessment in the back of an ambulance. The UHB is currently experiencing greater improved performance in WAST delays than other UHBs across Wales. As previously mentioned, the Emergency Unit has seen a change in management team who will review their decision around this.

This finding is considered NOT IMPLEMENTED and remains OPEN. The priority level remains HIGH to reflect the lack of any progress made to comply with Welsh Health Circular WHC/2016/029.
 Considerations Going Forward

Considerations going forward	Priority Level
1. In line with the response above, the CVUHB Emergency Unit should formally review the current practice of not undertaking a face to face assessment of the patient before admission to the hospital	High
Current Finding 8 - HAS Data	Risk
Our current review found that the HAS Guidance has not been re-circulated by the Welsh Government to WAST staff as it was felt that the guidance around roles and responsibilities needed to be strengthened. We understand that the process may change following the introduction of the dual pin system which will require WAST and health board staff to complete the HAS together. WAST wrote to the Welsh Government in February 2019 asking that they consider updating the current HAS guidance and clarifying roles and responsibilities. It was evident from discussions with the health boards that there is a need for WAST to refresh learning on the operational use of HAS given the variation in operational views provided and the adverse impact on quality and consistency of HAS data. We obtained a HAS Report for all handovers with delays over 15 minutes for the period February 2018 - March 2019. This included 'NULL' entries, i.e. where no reason code had been entered	Incomplete and inaccurate data could undermine the quality of the management information reported. This could lead to poor decision-making negatively impacting WAST and Health Boards

for the delay. Review of the report confirmed that out of 105,178 handovers with delays over 15 minutes - 46,664 (44%) of these had 'NULL' entries which indicates that the reason code is still not routinely completed. The 46,664 'NULL' entries were split as follows - 22,143 (approx. 48%) between 15 - 30 minutes delay, 13,611 (approx. 29%) between 30 - 60 minutes delay and 10,910 (approx. 23%) over 60 minutes delays. The percentage rate of 'NULL' entry rate across hospitals sites ranged from 22% in Morrision Hospital to 92% in Maelor General Hospital Wrexham. The latter's poor data completion has been partly explained by the poor physical location of HAS screens in the Emergency Department. Relocation of the HAS screen has now occurred and should improve data completion.

In addition, we acknowledge that the proposed introduction of dual-PIN may further improve these figures. WAST confirmed that a review of delayed handover reasons in December showed that the majority of the reason codes completed related to 'no beds available', which they feel did not give the depth of analysis needed to review causation. WAST's Health Informatics Team produced a self-serve report in February 2019. The report shows, by hospital site, the reasons and time of day for each handover delay. The intention is to use this information to inform discussions with health board colleagues and develop operating models. However, as this report was not available until February 2019, we were unable to confirm that this being undertaken at this early stage of implementation.

Swansea Bay University Health Board commented on the missed opportunity for improved use of the data recorded on HAS and is to provide refresher training on the handover process to deliver consistent practice across all sites. However other health boards have commented that the pre-determined reasons on the HAS screen are too general and do not provide the health boards with sufficiently detailed reasons. The process was not thought to capture sufficiently detailed reasons, limiting the usefulness of any management information forthcoming from the HAS system.

This finding is considered PARTIALLY IMPLEMENTED to reflect that some actions have started and remains OPEN. The priority level remains MEDIUM due to the lack of reinforcement of HAS user guidance by WAST as linked to the impending implementation of the dual PIN process, the need to further consider the usefulness of the pre-determined reasons on HAS for late handover and ensure any developments are consistently applied, and the self-serve report being made available only recently to inform discussions between WAST and health board staff, preventing assessment of how effective it is in addressing handover delays.

ability to reduce handover delays and patient health.

Recommendation 8	Priority Level
<p>1. Health boards should ensure that all Emergency Department staff are provided with consistent and updated HAS operational documentation and learning by WAST, including any proposed dual pin role out.</p> <p>2. Health boards should ensure that delayed handover reasons are always entered on HAS and are used to inform discussions with WAST colleagues and develop operating models.</p> <p>3. Health boards should consider whether the current option of pre-listed delayed handover reasons on HAS are able to usefully inform health boards' management decision making processes.</p>	Medium
Management Response 8	Responsible Officer
<p>Morrison and Singleton hospitals have both reviewed the positioning of handover screens on which the HAS is available and have moved some screens to offer better accessibility.</p> <p>The Health Board in conjunction with WAST has undertaken an audit of the reasons for the longest patient handover delays – this is largely as a result of patient non injury falls and also patients presenting with breathing problems. Consequently the HB has reviewed its falls and respiratory pathways and is expanding capacity in these services.</p> <p>In addition the Health Board implemented the dual pin arrangements at Morrison hospital in August 2019 and this is now embedded practice.</p> <p>An ambulance handover workshop was held on 10th October with partner organisations to implement system actions that will achieve improvements in ambulance handover response.</p> <p>The Health Board is supporting the provision of a patient liaison role at Morrison ED over the winter months to support improved communication and patient handover between emergency department and WAST at times of heightened escalation. This role will also promote accurate hospital handover information.</p>	<p>Completed.</p> <p>WAST Head of Ops /Assistant COO/Singleton DU</p> <p>ECHO Service Manager, & Head of Nursing ECHO Morrison</p> <p>Completed.</p> <p>WAST Head of Ops/ ECHO Service Manager, & Head of Nursing ECHO Morrison</p>

