

Addressing hospital handover delays: actions for local accident and emergency delivery boards

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Actions to be taken now and embedded as part of normal working practice to reduce the likelihood of delays

To reduce the likelihood and impact of hospital handover delays, local A&E delivery boards should ensure that:

Acute trusts and ambulance trusts

1. Must appoint a senior lead, directly accountable to the trust board, to oversee the development and implementation of clinical handover protocols for acute departments. These protocols should have a focus on patient safety and hence the need to minimise delays to assessment and treatment.
2. Must avoid the use of ambulance trolleys and ambulance staff to queue patients in a corridor or other areas of the ED or admissions unit, including ambulance triage areas where these are used. Patients should be transferred to a hospital trolley on arrival and hospital staff allocated to provide safe care to these patients.
3. Must avoid the use of ambulance trolleys for patients who are 'fit to sit', and should move them to a chair if appropriate. This can expedite investigations and facilitates discharge assessments. Such an approach assists greatly the use of ambulatory care pathways and reduces the demand on trolley/cubicle spaces. Hospital staff, including handover staff, and ambulance staff should be made aware of the fit-to-sit guidance and a clinical champion appointed to see that this is being implemented.
4. Must book patients onto the hospital patient administration system (PAS) or ED PAS when the patient first arrives in the department.

5. Must ensure that handover standards are applied consistently where patients are transferred directly to admissions units and other clinical departments.
6. Must have an agreed protocol for the timely escalation of handover delays with established warning and trigger responses. This should include a clear policy to manage waiting ambulances safely with regular risk assessments and required actions to deliver a safe waiting environment for patients. For local adoption, please see the [East of England Ambulance Service's protocol](#).
7. At no time should a patient be kept in an ambulance outside a hospital.

Commissioners

8. Must facilitate ambulance services and acute hospitals working together and with partner organisations at STP level to agree effective escalation procedures and interventions for periods of high demand, and agree trigger and response mechanisms. HAS screen information may be a useful source for local monitoring and escalation.
9. Should ensure that they fully understand where high demand increases are being generated, and take appropriate action to assist in reducing demand growth – for example high 111 referral rates to 999, high volume frequent users and other sources of demand resulting from alternative access to services.
10. Must ensure ambulance services have in place regional capacity management systems to be enacted when queues develop. These should provide information to hospitals and ambulance services to know capacity in real time and include processes for diverting patients at times of significant pressure. This allows clinicians and managers to make better informed decisions about patient care and use of alternative care pathways.
11. Should improve general practice input to care homes to reduce unnecessary conveyance and implement care home navigators as a matter of urgency. These should be provided 24/7 or over extended hours wherever possible.
12. Must ensure that there are a wide range of referral options within the community that 999 and the Clinical Assessment Service (CAS) supporting NHS 111 can use as an alternative to the ED. This could include frailty services, ambulatory

emergency care services, falls services and urgent treatment services. These should be provided 24/7 or over extended hours wherever possible.

GP practices

13. Must ensure prompt telephone access for ambulance crews to contact a patient's own GP surgery before deciding whether to convey, as access to advanced care and end-of-life plans, advice or urgent GP review may avoid the need for conveyance and hospital attendance/admission or enable direct referral to the medical or surgical take teams.
14. Should take measures to avoid referred patients arriving in surges as a result of all domiciliary visits, and thus conveyance requests, taking place after morning surgeries. This severely inhibits the ability of ambulance services to convey these patients in a timely manner and practices should have plans in place to run visits throughout the morning, as opposed to batching them.
15. Clinical commissioning groups (CCGs) and GPs should work together with the CCG being responsible for overseeing the daily schedule of GP visits from all surgeries to ensure that large numbers of ambulances do not arrive together.

Community services

16. Should have rapid response teams to see patients in their own homes. Best practice is for teams to reach patients within 60 minutes of a request, and never longer than two hours.

Ambulance services

17. Should implement electronic patient handovers. These must be available to ED staff within 15 minutes of arrival.
18. Must share predicted activity levels with Acute Trusts on an hourly and daily basis to trigger effective escalation when demand increases.
19. Must put in place measures to enable safe reduction of conveyance to the ED, as set out in the 2017-19 CQUIN.

Actions to be taken when ambulances are predicted to queue or are queuing

Ambulance trusts

1. Should escalate all handovers exceeding one hour to the on-call executive director of the responsible acute hospital trust and CCG director on call.
2. Should consider the range of vehicles in their fleet to convey patients to the emergency department, but only where it is safe and appropriate to do so.
3. Reassess clinically appropriate alternative options to ED transfer.

Acute trusts

4. Must enact a handover escalation protocol where time to handover is exceeding 30 minutes (for local adoption, please see the [East of England Ambulance Service's protocol](#)). This should include contacting the on-call hospital director so that immediate action can be taken to release ambulance resources. Where time to handover is exceeding 60 minutes, the on-call CCG director and on-call NHS England director must be contacted and those individuals should put in place whole-system local escalation processes to release ambulance resources. Over winter the regional winter on-call director should also be informed 24/7.
5. Must not place restrictions on ambulances in order to limit or regulate access to the ED or the handover of patients arriving by ambulance.
6. Should report ambulance handover delays at site-wide bed meetings to ensure that there is a whole-system response when required.
7. Must ensure that all patients handed over from the ambulance service are managed in a clinical space that reflects their acuity as assessed by prompt clinical triage.

8. To avoid corridor care, in some sites and at particular times ED patients who have completed their ED assessment and initial treatment will need to be moved to a pre-admission area while waiting for a ward bed. Patients in this pre-admission cohort must:
 - a. be accommodated in an environment with appropriate equipment and facilities to maintain their privacy, dignity and safety at all times
 - b. receive regular review
 - c. escalation plans should include how the extra nursing staff required to safely staff such a pre-admission cohort area will be provided.

9. Whenever it is still not possible to off-load ambulance arrivals into an appropriate ED area and patients therefore remain in a corridor, the following steps must be followed:
 - i. These patients must be assessed and prioritised according to acuity not arrival time.
 - ii. Additional trust staff must attend to oversee the care of these patients, thereby releasing paramedic crew for frontline duty.
 - iii. Each patient must benefit from application of the ED safety checklist.
 - iv. An incident form should be completed.
 - v. Weekly review of such incidents should inform the necessary steps to increase ED staffing/clinical space and/or the capacity of the pre-admission cohort area.

10. Must put in place a clear process for reporting significant clinical concerns by staff and carers.

11. Must ensure that where normal processes are delayed the effects of such delays are mitigated by pre-emptive interventions (where appropriate) and investigations such as blood tests, ECGs, X-rays and CT scanning.

12. Must raise a Serious Incident for all incidents where a handover longer than 60 minutes has occurred.

Emergency department staff

14. Should assess the 'pre-alert' patient information provided by paramedics regarding acute severe injury or illness so they can anticipate resource utilisation.
15. Should undertake regular reviews whenever at or near full capacity. A serious handover problem is sufficient reason for escalation of the issue to senior managers and executive officers.
16. Ensure prompt referral for inpatient care as soon as it becomes clear that admission will be necessary.

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