Urgent and Unscheduled Care

Redesign of Urgent Care

Principles
for Safe Transfer to Hospital: Ensuring the Timeous Handover of Ambulance Patients

April 2023

Acknowledgements:

We would like to extend our grateful thanks to all stakeholders who supported the development of these principles.

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Introduction

There are continued significant delays for ambulances at hospital sites across the country. The Scottish Ambulance Service (SAS) need to maintain their ability to respond to patients in the community. There is potential for clinical risk and harm occurring with patients affected by these delays, with potentially some level of harm being experienced in 85% of patients where the handover is greater than 60 minutes[1], as well as potential moral injury to staff.

The offloading of patients from ambulances into already overcrowded Emergency Departments and receiving areas also has the potential to cause harm. Improving the timeous handover of patients requires a shared aim and whole system ownership.

These principles are intended to support facilitation of the effective and safe Transfer to, and timeous handover at, hospital.

It is acknowledged that some of the principles described in this document may not be considered 'best practice' at times when there are no significant pressures being experienced within NHS Scotland[2]. It is important to note that the principles described in this document are to support immediate pressures at hospital sites and further improvement work is underway to address these wider issues through the Redesign of Urgent Care and the Urgent and Unscheduled Care Collaborative.

This document has been developed in partnership with key stakeholders in NHS Scotland (Appendix A) and describes the overall principles to be adopted when implementing. This document is supported by a national quality improvement approach as a High Impact Change as part of the Urgent and Unscheduled Care Programme, with focussed support within and across boards.

Purpose

This document aims to:

- Identify the key principles, considering triggers, tipping points and actions to be taken
- The points of variation within the principles that may be necessary
- Underpin the Urgent and Unscheduled Care Programme to support the right care, in the right place, at the right time; whilst allowing local flexibility in a way that best fits local challenges and available care provision.

[1] https://aace.org.uk/wp-content/uploads/2021/11/AACE-Delayed-hospital-handovers-Impact-assessment-of-patient-harm-FINAL-Nov-2021.pdf
[2] RCEM_College_Paramedics_Joint-Statement_Handover_Delays_Mar_2021-3.pdf

The Principles

Decision making in relation to escalation should be inclusive of SAS and the site/board.

Data

- There is robust, consistent and visible data for the whole system available to all, including across the site, board and SAS:
    - Pre-arrival data – SAS expected demand (emergency and timed admissions) and site/board demand and status
    - Handover data (Trak – time of booking in patient to time to triage)
    - Risk scoring (throughout day) to track pressures
- Use of ED and non-ED pathways is monitored, measured, reviewed and development opportunities identified

Pre-Arrival

- Patients receive the right care in the right place at the right time, as close to home as possible utilising the following:
    - SAS Hear and Treat (SAS clinician undertakes remote clinical consultation by telephone or video)
    - SAS See and Treat (SAS clinician provides assessment, advice and/or treatment at scene where the patient may be discharged or referred to another healthcare provider)[3]
    - SAS 'Call before you convey' (SAS clinicians contacts the Health Board Flow Navigation Centre to determine the right place for care for the patient)
    - Community pathways
    - Acute pathways
    - Community professionals have professional to professional conversations to ensure patients receive the right care in the right place at the right time [4].
- Use of redirection policy by all sites [5]
- Site capacity protocol undertaken; when identified full capacity (agreement from Exec level) consider 999 bypass. Site duty manager and clinical teams to work through criteria checklist.
- Agreement of bypass is by duty managers, clinical team and exec level to other sites in Board or inter-board with number or time agreed between the

[3] SAS Clinical Decision Making 2022; A Framework for Safe, Personalised Care & Shared Decision Making.
[4] Best Practice Guidance for Professional to Professional Decision Support (www.gov.scot)
[5] Emergency Department Guidance Signposting/ Redirection: Best Practice Guidance (Update) (www.gov.scot)

sites/board and SAS. This will be reviewed hourly or earlier if required. Exceptions are for patients needing specialist treatment at a specific site.
- Shared agreement on the use of ATMIST by SAS to communicate the pre-alert, handover and conversations where patients are deteriorating (see Appendix B)

On Arrival

- All patients will be booked in immediately upon ambulance arrival to ensure that the patient is now visible to the receiving department [6]
- SAS clinician to identify patients unable to wait greater than 15 minutes for handover and highlighted to the receiving team – (Emergency) Physician in Charge ((E)PIC) or responsible clinician on site/on call to be involved in decision making where any dispute
- Consider if the patient is 'fit to sit' – triage: ambulant patients conveyed by SAS to be transferred to a waiting area in the department (department clinical team assumes responsibility for the patient)
- Non-ambulant patients offload from ambulance and handed over to designated cohorting or holding area when initiated (overseen by SAS) - possible limited capacity due to physical space available

Post-Arrival

- The long-term aim for **handover** of a patient conveyed to hospital by ambulance is 15 minutes, in line with the agreed aim for all patients. This is the measurement from the date and time of arrival of the patient to the date and time of triage [6]
- A patient should not queue (cohorting, holding area or ambulance) for greater than 1 hour and should be fully handed over and care transferred to the department clinical team thereafter. By August 2023, 100% of patients should be handed over within 60 minutes.
- Ambulance **hospital turnaround times** are measured from the time of arrival of the ambulance at the receiving site to the time the ambulance is available to respond to another call. This time includes other activities which the ambulance team may require to undertake such as cleaning or restocking their vehicle and is inclusive of the patient handover time
- Decision making in relation to patients should be a **shared responsibility** between SAS and the receiving clinical team /(Emergency) Physician in Charge ((E)PIC), or where required, responsible clinician on site/on call
- Hospital Ambulance Liaison Officers (HALO) or SAS Managers present on sites when ambulance queues are present
- The decision to use a cohorting or holding area is part of the shared responsibility between SAS and the site and should only be used for the shortest time possible, de-escalating as early as reasonably practicable and when below triggers:
    - Ambulance patients in a cohorting or holding area should be initiated when 2 or more ambulances are waiting greater than 30 minutes to

[6] Public Health Scotland (2020); A&E data recording reference manual

    handover patients (although it is recognised that this may vary between sites due to demand and capacity)
  - The use of a cohorting or holding area should only be use as part of escalation in exceptional circumstances
  - SAS will monitor, continually assess and treat (within scope of practice) patients within the cohorting or holding area however responsibility is shared between SAS and the receiving team / ((E)PIC or responsible clinician on site/on call.)
- Contemporaneous patient clinical records should be maintained throughout any delays in handover
- Where a patient deteriorates, clinical concern should be highlighted to the receiving clinical team – concerns acknowledged and a plan developed
- Patients in an ambulance already waiting to enter the site should not be redirected except where best for the patient and should be in collaboration with SAS, site executive on call and the ((E)PIC or responsible clinician on site/on call.

Site

- Visible senior leadership
- Clear, whole system (including SAS) escalation plans to ensure onward flow across the site, including when bypassing to other in board sites or inter board sites is initiated (including consideration of the published guidance) of which executives should be aware[7]
- Proactive and effective early escalation/de-escalation leading to positive actions and outcomes

De-escalation

- Risk scoring returns to 'acceptable' level - shared decision.

Clinical Governance and Risk

Complaints management and adverse event reviews should be undertaken jointly between organisations. Learning should be shared by both parties and joint improvement, education and training developed.

High frequency monitoring, evaluation and rapid reporting should be undertaken during an implementation period to ensure safety and to respond to any unintended consequences. Any learning will be shared and will inform future improvements.

Risks associated with delayed patient handovers from ambulances and escalation is a shared risk between SAS and boards and should be fully reflected on risk registers and issues logs at Board level as appropriate. Learning used to inform future improvements should inform mitigating factors on risk registers to help support active and effective management of risk.

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[7] Emergency Department Capacity Management Guidance - Scottish Government, 2015

Information Governance

Strict adherence to the Caldicott principles and issues of patient confidentiality must be observed. The sharing of information between Health Boards is to be in accordance with the Intra NHS Scotland Information Sharing Agreement (NHS Scotland 2020). A data protection impact assessment (DPIA) should be in place for any new data flows to meet the governance requirements, if required.

Additional Support

The Centre for Sustainable Delivery, Scottish Government Sponsorship Team for NHS 24 and SAS and the Scottish Government Unscheduled Care Team can provide additional support in implementing these principles where required. To access this support, please email: **[redacted]**

Feedback and Further Questions

If you have further questions or would like to provide feedback on this document, please contact the above email address.

Guidance Review

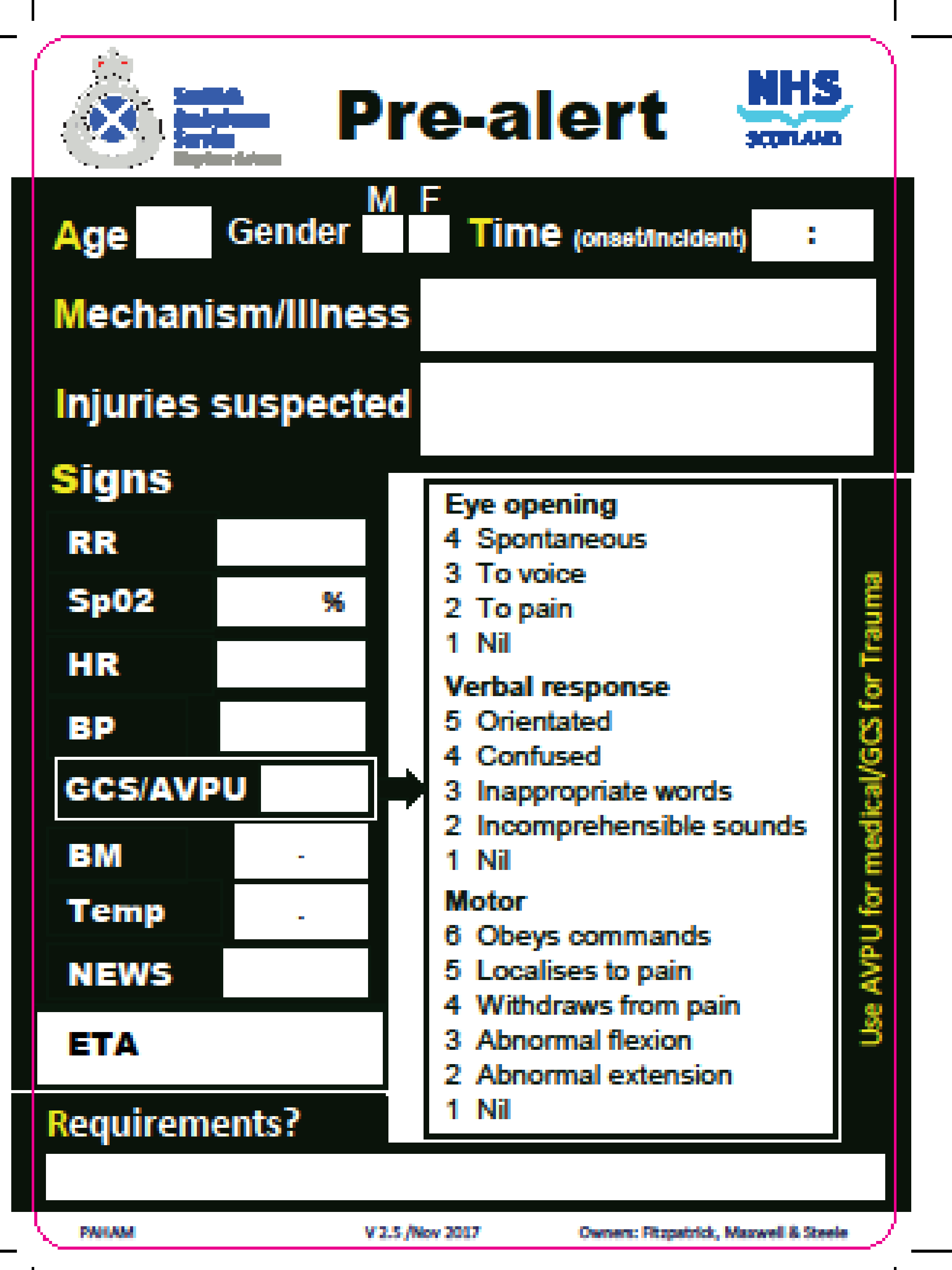
The guidance will be reviewed by October 2023 or sooner, and as part of the wider improvement work within the Redesign of Urgent Care and Urgent and Unscheduled Care Programme.

Appendix A – Stakeholder List

[redacted]

Appendix B – ATMIST Template

It is recommended that organisations educate their professionals / clinicians in ATMIST methodology to support decision making. This will support pre-alerts, handover and conversations where patients are deteriorating whilst waiting to be handed over at hospital departments.



Pre-alert

NHS SCOTLAND

Age | Gender M F | Time (onset/incident) :

Mechanism/Illness

Injuries suspected

Signs

RR

Sp02 %

HR

BP

GCS/AVPU

BM .

Temp .

NEWS

ETA

Requirements?

Eye opening
4 Spontaneous
3 To voice
2 To pain
1 Nil

Verbal response
5 Orientated
4 Confused
3 Inappropriate words
2 Incomprehensible sounds
1 Nil

Motor
6 Obeys commands
5 Localises to pain
4 Withdraws from pain
3 Abnormal flexion
2 Abnormal extension
1 Nil

Use AVPU for medical/GCS for Trauma

PAHAM | V 2.5 /Nov 2017 | Owners: Fitzpatrick, Maxwell & Steele