Meeting Date	24th January 2019	Agenda Item	3b
Report Title	Handover of Care at Emergency Departments – WAST Internal Audit Report		
Report Author	Jan Thomas, Assistant Chief Operating Officer		
Report Sponsor	Chris White, Chief Operating Officer		
Presented by	Chris White, Chief Operating Officer		
Freedom of Information	Open		
Purpose of the Report	In the early part of 2018, a Welsh Ambulance Service NHS Trust (WAST) internal audit review assessed compliance with the 'NHS Wales Hospital Handover Guidance' across all Health Boards in Wales. Not all of the findings/recommendations are applicable to ABMU Health Board, however this paper presents an update on the ABMU Health Board's management response as at January 2019 to the recommendations contained within the report.		
Key Issues	The report's high priority recommendations seek to address the avoidable conveyance of patients to emergency departments (ED). The Health Board's management response describes the alternate pathways we have worked with WAST to develop to reduce unnecessary attendance to ED's. It also confirms the joint working arrangements with WAST in developing additional pathways. The key medium priority recommendations highlight the need for improved communications between Health Boards and WAST at operational and strategic levels to enable shared learning of best practice and improve performance – particularly in respect of handover delays. It also recommends improved understanding of roles and responsibilities in recording data. The Health Board's management response sets out the joint working arrangements in place with WAST and describes the actions we are taking in conjunction with Local Authority partners to improve patient flow across the system. The low priority recommendation seeks to ensure systems are in place to support the nutrition, hydration and continence needs of patients affected by handover delays – and that these are recorded. Our management response describes the arrangements in place within our Emergency Departments to ensure these needs are met and recorded as well as the further clarity being provided by the All Wales Director of Nursing Forum on pressure care management.		

Specific Action Required *(please ✓one only)*	Information	Discussion	Assurance	Approval
			✓	
Recommendation	Members are asked to : • **NOTE** the updated management response for January 2019.			

ABMU Health Board Management Response – Updated for monitoring purposes January 2019:
WAST Handover of Care at Emergency Departments Internal Audit Report 2018

Finding 1 - Patient care during handover delays	**Risk**
One of the key feedback improvement themes that has been identified by the WAST Quality, Safety and Patient Experience team is in regards to the provision of nutrition, hydration and continence when a patient experiences a significant delay and is held outside the ED. Although the majority of patients conveyed to ED are admitted within 60 minutes there are over 1,300 patients each month that wait in an ambulance for long periods. In order to address continence concerns WAST now participates with the All Wales Continence Bundle to ensure that pre-hospital patient care is included in their monitoring. The approach regarding the appropriate provision of continence, nutrition and hydration is currently informal and there are no standard operating procedures. Arrangements vary and it would assist ambulance crews if Health Boards had a clearer process in place, particularly at those hospitals that typically experience handover delays in excess of 60 minutes. During our site visits at EDs we observed instances where WAST staff were providing food and drink to patients from stock cupboards held at hospitals. In addition to nutrition, hydration and continence considerations, significant handover delays can lead to patients requiring pressure sore area care.	Safe and dignified care is not provided to patients during handover delays.
Recommendation 1	**Priority level**
We recommend that: • Health Boards undertake a review of the arrangements in place for the provision of continence, nutrition and hydration at each hospital to ensure safe and dignified care is provided to patients during handover delays. • Although handover delays should not occur, where they do Health Boards should maintain a formal record of continence, nutrition and hydration offered and declined or accepted by the patient to evidence that adequate care in these areas was provided at reasonable times.	Low

Management Response 1	Responsible Officer/ Deadline
New documentation for emergency departments is currently subject to discussion at the National Unscheduled Care Board. A section on nutrition/hydration is included within the revised documentation which is being proposed. In the meantime, arrangements are in place within Emergency Departments at both Morriston and Princess of Wales hospitals 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. **<u>Update as at October 2018:</u>** At Morriston, individual labels are to be placed in patient notes as a record that the patient has been provided with food/drinks. 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. Whilst not referenced within the report recommendations, both Emergency Department and WAST colleagues have raised concern over pressure care management during these times of handover delay. This has been escalated and as a result is intended for discussion at the All Wales Directors of Nursing meeting in July 2018. **<u>Update as at October 2018:</u>** Currently, pressure area care is undertaken and passports completed by ED staff. Trolley mattresses are in use as required for high risk patients. Feedback from All Wales DoN meeting to be confirmed.	*ECHO Service Manager, POWH & Head of Nursing ECHO Morriston* ABMU DoN to advise of action required further to All Wales DoN Meeting, July 2018

Update as at January 2019 *The Director of Nursing confirmed that the action in respect of management of pressure areas had been discussed at the All Wales Directors of Nursing meeting and a response had been provided which clarified the agreed responsibilities in respect of WAST/ED staff. This response is to be circulated to operational teams by the Director of Nursing to clarify arrangements.*	*ABMU Director of Nursing and Patient experience*
Finding 2 - Conveyance to ED	**Risk**
Ambulance Quality Indicators (AQI's) There are a number of AQIs that relate to conveyance including the 'number of incidents that resulted in non-conveyance to hospital' under 'Step 4: Give Me Treatment' and the 'number of 999 patients conveyed to hospital', including analysis by type and also those conveyed to hospital outside of the local Health Board area, under 'Step 5: Take me to Hospital'. The Wales Audit Office Review of Emergency Ambulance Services Commissioning Arrangements dated July 2017 highlighted improvement areas for the AQIs. There is recognition that these indicators are still developing and require further refining to ensure they demonstrate key data in a clear way. There are also opportunities to improve the presentation of some indicators so that they become more accessible and understandable to readers and make them more meaningful in understanding patient outcomes and patient experiences. Additionally, the report highlighted that EASC members are not yet fully recognising and making the most of the potential that this information holds to inform decisions for improving the quality of ambulance services for patients across Wales. It is recognised that it would not be appropriate to set a 'target' of reduced conveyance following 'See and Treat' as this could incentivise decision making to the detriment of the patient. However, there could be improved usage of the conveyance data that would enable analysis that should improve handover delays and	Ambulance conveyance not being managed effectively by Health Boards and WAST resulting in patients being conveyed to ED inappropriately.

reduce the cost of lost hours. For example, improved analysis of patients who were seen by the hospital clinician and released without requiring treatment, highlighting that the conveyance was not necessary or identifying patients that were conveyed to ED where an alternative pathway was more appropriate, also known as 'missed opportunities'. Further analysis would also identify if paramedics require training and development and ensure that all crews have the guidance and understanding to reduce conveyance to ED. **GP Referrals** During this audit there was a particular point raised by all of the Health Boards and by WAST regarding the impact on conveyance and peaks in attendance to ED that result in handover delays. GP referrals are unscheduled and occur between GP hours, typically 10am to 6pm which can contribute to bottlenecks outside hospitals. Furthermore, we were informed that the time lost during hospital handover delays, coupled with the way the WAST clinical model is designed to prioritise calls in line with their red, amber, green rating, mean that ambulance crews are often unable convey GP referrals to hospital within the relevant department's opening hours. This is due to GP referrals typically being classified as green priority and results in the patient not receiving timely and appropriate care. It was generally recognised that improvements could be made by having scheduled conveyance for GP referrals where appropriate.	
Recommendation 2	**Priority level**
We recommend that: • WAST, in conjunction with EASC, evaluates how it records, analyses and reports on conveyance and how this information is used to gain assurance that conveyance to ED is restricted to those cases where the presenting condition determines that the ED is the appropriate pathway for the patient. WAST should develop ways of identifying missed opportunities, for example, through undertaking sample audits across a range of indexed conditions and comparing conveyance rates across Health Boards. • WAST and Health Boards undertake a project to investigate whether GP referrals could be scheduled, where the patient condition allows, so that the time of arrival at the ED is more likely to improve the patient experience by being aligned to the demand and capacity models of the hospital.	High
Management Response 2	**Responsible Officer/ Deadline**

ABMU HB and WAST have been worked jointly on the development of initiatives to reduce the number of Green call/Health Care professional call attendances to Emergency Departments. This work has resulted in the implementation of a number of alternative pathways and actions to avoid unnecessary ED attendances, including: • Mental Health pathway; • Respiratory pathway; • Falls, resolved epilepsy and resolved hypoglycaemic pathways • 111 service pathways; • Acute Clinical Care Teams responding where appropriate; • Direct referral pathway for STEMI's; • A reduction in attendances by frequent attenders. • The development of direct access pathways to speciality assessment units that bypass attendance at ED's As a result of this joint programme of work, the number of green and amber 2 call conveyances to hospital within ABMU HB has been gradually reducing. The proportion of Green call conveyances within the HB is now the lowest in Wales. The Health Board also participated in the national evaluation of amber calls and it is anticipated that this work will identify further opportunities to develop pathways that further reduce the need to convey patients to an ED. This review is due to conclude in September 2018. WAST is undertaking work to ring-fence Urgent Care Support (UCS) Vehicles to support the transfer of HCP calls to hospitals in a timely manner. **<u>Update as at October 2018:</u>** WAST UCS vehicles are now ring-fenced within the 3 localities to undertake HCP calls and convey patients in a timely manner. The WAST Resourcing Emergency HCP & Routine Calls Policy supports this. The only times in which ring-fencing cannot be guaranteed is when WAST enter a high REAP escalation level.	Head of Ops – WAST Head of Ops – WAST

In respect of scheduling of GP referrals, a meeting is being arranged with Primary Care leads to discuss this further and to look for opportunities to improve this route of attendance. **<u>Update as at October 2018:</u>** A meeting with Cluster Leads took place on 26th September 2018, where HCP calls/WAST attendance was discussed in detail, along with the reasons for delayed response. The acuity of patients and WAST Clinical Contact Centre clinician support was also discussed along with the use of alternative transport following appropriate risk assessment against expected prolonged WAST response times during periods of high escalation. ***<u>Update at January 2019.</u>*** *A national Amber Review Implementation programme group is being set up to implement the recommendations of the amber review. It has been confirmed that HB representatives will be sought to participate in this programme of work via Chief Operating Officers. The review findings identified further opportunities to improve amber response times through a shared system wide approach.*	*Emergency Ambulance Services Committee (EASC) in conjunction with Chief Operating Officers.*
Falls response vehicles have been commissioned by WAST from December 2018 through their additional winter funding arrangements, with the intention of reducing conveyance to hospital where appropriate. The impact will be evaluated as part of the winter plan for WAST.	*WAST Head of Operations.*
Finding 3 - Pathways to bypass ED	**Risk**
As part of the audit we were provided with a schedule of pathways managed through the Clinical Pathways Approval & Appraisal Group (CPAG). We were also provided with a list of pathways by each of the six Health Boards. We were unable to reconcile these and were therefore unable to verify that: • There is a clear and consistent process for WAST and Health Boards to formally approve each pathway; • Where a pathway is approved, there is a clear flowchart that has been made available and understood by WAST staff, including the crews and staff within the Clinical Contact Centres;	Pathways for emergency care that bypass the ED are not communicated, shared and understood.

• Each pathway is underpinned by detailed methodology to enable evaluation and monitoring of its success in reducing conveyance to ED; and • There is a process in place to review and identify pathways that are effective and should be considered for implementation at other Health Boards. We were informed by the WAST Operations staff interviewed, that paramedics have not always been able to follow a pathway as the alternative location did not have capacity or resource to receive and treat the patient at the time. This is currently not well recorded and as such we could not audit this in any detail. We also noted during our visits that the WAST crews have a pathways folder in the ambulance that should enable them to identify and follow the appropriate pathway. Again, we were unable to reconcile that all of the pathways were in the folder and overall we could not be confident that all staff were fully aware of them. In particular, if a crew conveyed across border to another Health Board Area it is unlikely that they would be aware of the local pathways. We were informed that tablet devices have recently been allocated to paramedics. This provides WAST with an opportunity, with software development, to provide an electronic tool of all the available pathways for paramedic's that could increase their ability to utilise a pathway and bypass conveyance to ED where appropriate.	
Recommendation 3	**Priority Level**
We recommend that: • 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.	High

Management Response 3	**Responsible Officer / Deadline**
ABMU Health Board's position in respect of alternate pathways is good overall and reflects the joint work done to date. WAST within ABMU has developed a 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.	USC Board / ECHO Board – ongoing approval of alternate pathways
Additional alternate pathways for GP expected patients are being implemented in Morriston Hospital on a phased basis with effect from 1st July , and pathways in relation to falls / hypoglycaemia / epilepsy are being reviewed.	Morriston service delivery unit
Update as at October 2018: At Morriston Hospital, all surgical, Max Fax GP-expected patients are now going straight to the surgical assessment unit. A start date for the Trauma and Orthopaedic surgical pathway is also to be agreed and this will also avoid attendance to ED.	
The Unscheduled Care Board signs off pathway developments such as these and membership includes the WAST Operational Manager for ABM.	Chief Operating Officer
WAST is intending to introduce a tool for reporting which is intended to be available on personal tablets, this would also provide access to conveyance pathways. A pilot has been ongoing within ABMU for this purpose and is to be evaluated.	WAST Operational Manager
Update as at October 2018: At present the pilot use of personal tablets is continuing within WAST and an initial evaluation is being undertaken. Depending on the outcome of that evaluation, it will be decided whether to roll out the issue of personal tablets to all staff.	
Update as at January 2019	

The pilot of the use of personal tablets is continuing, and is currently being evaluated.	*WAST Operational Manager*
Finding 4 - HALO Role	**Risk**
Each of the Health Boards has meetings with WAST although their frequency varies. Managing delays in hospital handover is a daily activity that is monitored by the minute. There is constant communication and dialogue between WAST and the hospitals, aligned with escalation plans. We were informed by each Health Board that they have a good partnership working arrangement with WAST and meetings occur daily, weekly or fortnightly, typically; • Daily 11am conference call between all Health Boards, WAST and the Welsh Government. • Daily bed management / patient flow hospital meetings ('huddles'). • Weekly or fortnightly meetings between ED staff and the WAST Area Operations Manager. Whilst the frequency and attendance at meetings (both formal and informal) varies, the purpose is the same with hospital staff aware that patient flow is kney in preventing handover delay and bed management forms a fundamental role. We requested minutes of these meetings but were not provided with them and concluded that many of these meetings are indeed not minuted. We were informed at some hospitals that attendance at site meetings by a WAST representative was often limited by the availability of the Clinical Team Leader (CTL). Other hospitals have a designated WAST Hospital Ambulance Liaison Officer (HALO) in place which results in better ongoing oversight of the handovers at the hospital. The feedback we received during our hospital visits was that most would value having a HALO as it provides more opportunity for WAST to liaise with the hospital staff to assist in managing hospital handovers.	Ineffective meetings between staff at WAST and Health Boards to manage emergency care flow. This could lead to poor decision making negatively impacting WAST and Health Boards ability to reduce handover delays and patient health.
Recommendation 4	**Priority Level**
We recommend that WAST undertakes a cost benefit analysis on the potential efficiency gains that may be available through the HALO role. This could be trialled initially at those hospitals with the lowest handover rates to measure the impact it has on improving handover performance.	Medium

Management Response 4	**Responsible Officer / Deadline**
ABMU Health Board have trialled HALO roles at both Morriston and Princess of Wales Hospitals – these roles were WAST-funded through winter pressures allocations for a period of 2 months. A full benefits analysis is to be undertaken nationally before any longer term arrangement is recommended. **<u>Update as at October 2018:</u>** The HALO role that was trialled in Feb/March 2018 no longer exists and following the review of this function it has been decided that the it will not be continued under the same Job Description. WAST and ABMU have recently agreed the principles of Patient Flow Co-ordinator (HALO) deployment within the Health Board to assist with patient handover delays in periods of high escalation. The details are currently being discussed ahead of agreed commencement of the arrangement in November 2018. ***<u>Update as at January 2019</u>*** *ABMU HB and WAST agreed to jointly fund a patient flow co-ordinator role to assist with patient handover delays at periods of high escalation. The Health Board contribution for this role was funded non recurrently through the winter pressures reserve.The benefits of this role within ABMU Health Board will be evaluated as part of the winter plan evaluation.*	WAST – Director of Operations/ EASC *Chief Operating Officer and Head of Service for WAST.*
Finding 5 - Strategic forums	**Risk**
Whilst there is communication between WAST and Health Boards on operational matters, as highlighted in finding 4 above, there was little evidence of strategic direction and related forums. Such would assist in leading on and managing the issues of handover delays, conveyance, pathways, patient flow, HAS data quality and enable better uniformity and best practice sharing.	Opportunities to address All Wales issues and seek to develop consistent approaches may be missed.

Recommendation 5	**Priority Level**
We recommend that WAST identifies all meetings that are held between WAST and Health Boards at hospital, Health Board and national level and determines the need for less or more and how they are recorded (agendas, minutes, action plans). In particular, how strategic decision making and sharing of best practice is performed in respect of handover of care at Emergency Departments.	Medium
Management Response 5	**Responsible Officer / Deadline**
This recommendation is largely for WAST to respond to, however within ABMU the appropriate forums for these discussions already include WAST representation within their membership (Unscheduled Care Board / ECHO Boards at Morriston & POWH, Winter Planning Group, Stroke services redesign group). In addition, the WAST Operational Manager within ABM meets monthly with the Assistant Chief Operating Officer and is involved in wider discussions that take place within the Health Board. Best Practice in respect of handover documentation is shared through the Unscheduled Care Board. **<u>Update as at October 2018:</u>** The position remains unchanged from the above and the forums detailed above continue to be where decision-making and sharing of best practice take place. ***<u>Update as at January 2019.</u>*** *In addition to the meetings outlined in the management response, an Executive to Executive teams meeting to discuss shared learning from winter was held on 14th November 2018.* *Our Director of Nursing and Patient experience has also agreed with his counterpart in WAST that the Health Board and WAST will undertake joint reviews of any serious adverse incidents which may arise as a result of a delayed ambulance response.*	WAST Operational Manager / ABMU – ongoing recording of attendance at meetings/ involvement in relevant discussion. Unscheduled Care Board – no end date. Director of Nursing and Patient experience.

Finding 6 – Patient flow initiatives	**Risk**
We reviewed Board meeting minutes for each Health Board and found that delayed handovers are included in performance reports. It was clear that all Health Board executives are aware of the problem of handover delays and set targets and actions to reduce them. As noted in Action 1 above, we have also reviewed the IMTP's for the six Health Boards and found that emergency care is included with reference to developing joined-up health and social care services. Whilst this is noted as a priority by all Health Boards, the AQI's over the past 12 months have shown little improvement in performance on handover delays. The only Health Boards that are near the 15-minute handover target of 100% are Cwm Taf University Health Board achieving almost 90% each month and Hywel Dda University Health Board achieving circa 80%. Cwm Taf University Health Board's performance may be attributed to its project to reduce delays and improve the flow of patients across hospital, GP and community services. The 'Focus on Flow' project won the NHS Wales Improving Patient Safety Award 2014. It should be acknowledged that all of the Wales NHS Health Boards have undertaken projects and initiatives to improve unscheduled care and address patient flow. Many of these are currently in operation. What is clear from the AQI's is that the initiatives applied by Cwm Taf University Health Board have been very effective in respect of the impact on WAST and lost ambulance hours as a result of handover delays. It is surprising, given the transparency of this performance information over the past 3 years with each Health Board receiving the quarterly AQIs showing Health Board comparative data, that those lower performing Health Boards have not done more to emulate models of the higher performers, notably, Cwm Taf.	Opportunities for sharing best practice that reduces handover delays may be missed resulting in lost hours.
Recommendation 6	**Priority Level**
We recommend that WAST and Health Boards evaluate the key factors adopted by Cwm Taf University Health Board that resulted in their handover performance improving from circa 50% to 90% since 2013 and work together to drive similar improvement.	Medium

Management Response 6	Responsible Officer / Deadline
ABMU recognises the need for a system-wide response to address delays in patient flow which impact on ambulance handover delays at our front doors. We have adopted the Welsh national SAFER patient flow model and are reviewing opportunities to develop 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 eg Early supported discharge models. The HB in conjunction with LA partners is working towards reducing discharge delays. A Western Bay workshop is taking place on 3rd July to revisit the 'optimal' community model, to agree standard definitions to code patients who are medically fit for discharge, and to inform the development of a business case for a Total Discharge model. There are opportunities to access the Transformation Fund or Invest to Save funds to develop this approach on a sustainable basis, which will improve patient flow and also improve patient safety across the USC system. It is anticipated that that this work will also feed into the development of the HB winter plan for 2018/19. Service delivery units are also working closely with LA partners at an operational level using a service improvement approach to improve discharge pathways to improve patient flow. **Update as at October 2018:** As referenced above, much work is ongoing to improve the position in respect of handover delays. The Health Board and WAST have agreed to support the continuation of a revised HALO role for the forthcoming winter and there are ongoing discussions to revise handover protocols to ensure there is clarity on this and roles/responsibilities within the handover process generally. The Health Board's Winter Planning for 2018/19 has ensured focus on alternative treatment pathways and management of flow at our front doors. It has also specifically prioritised the expedited discharge of patients, investing in local authority initiatives which will result in some increased domiciliary care capacity and/or improved flow out of our hospitals.	Chief Operating Officer

Continued work on developing and enhancing models of care that support delivery of care at home and avoid admission. For example, the ESD Team commenced service in NPTH in October, with positive initial results in achieving more timely discharges. ***<u>Update as at January 2019.</u>*** *Constraints remain in community capacity despite increased non recurrent investment from winter pressures funding to aid discharge.* *Following the findings of the bed utilisation audit that took place on 3rd October 2018, discussions are currently taking place with Local Authority partners to explore opportunities to develop models of care that will provide increased capacity on a sustainable basis.*	*Director of Strategy/ Chief Operating Officer*
Finding 7 - Delayed handover clinical triage	**Risk**
The Welsh Government health circular clearly states that *"WAST crews should not routinely be responsible for monitoring patients over prolonged periods outside A&E, and hospital clinicians should be responsible for overseeing the assessment of patients."* The University Hospital of Wales (UHW) was the only hospital of the 6 visited that did not undertake a face to face assessment of the patient before admission to the hospital. In all other cases the clinician carried out an initial patient assessment in the back of the waiting ambulance as required. We were informed by staff at UHW that that the ambulance triage by ED clinicians is not one supported by the Royal College of Emergency Medicine and that whilst nurses do not enter the ambulance, the risk to patients is managed through the protocols and processes in place; a clinical assessment by the Majors Assessment Nurse (MAN) through communication with the paramedic. The current practice at the UHW is contrary to Point 3 of the Welsh Government guidance above. This is a conscious decision by the hospital, as outlined above, and results in greater responsibility on the paramedics	Patients are not clinically assessed resulting in them coming to harm. There is also a missed opportunity for the ED clinician to undertake an assessment at an earlier stage that could have resulted in the patient being redirected, avoiding an unnecessary wait for the patient and lost hours to WAST.

to assess the patient condition and monitor that condition for over 30 minutes and sometimes several hours. There is also a missed opportunity for the ED clinician to undertake an assessment at an earlier stage that could have resulted in the patient being redirected, avoiding an unnecessary wait for the patient and lost hours to WAST.	
Recommendation 7	**Priority level**
We recommend that WAST seeks confirmation from Welsh Government regarding responsibility for undertaking a clinical assessment of patients prior to admittance to the ED.	High
Management Response 7	**Responsible Officer / Deadline**
Within ABMU Health Board, we comply with Welsh Government guidance and therefore no further action is required on our part.	
Finding 8 HAS Data	**Risk**
Through discussion with paramedics and hospital clinicians (i.e. Nurse in Charge) we found some contradiction over the responsibility for completing the HAS handover entries. Some thought it was the responsibility of the other party, particularly when the entry had not been completed. Others felt it was the responsibility of both parties which had on occasions resulted in the paramedic finding the entry had already been made by the hospital. It was also found during observation at site visits that the point at which the paramedic updated the HAS varied. Some 'notified' as soon as they entered the ED and then notified the Nurse in Charge, others the other way around. Whilst this finding is mainly anecdotal it was apparent that the data is not as accurate as it would be if there was clear guidance and understanding on HAS roles and responsibilities and a consistent approach at all hospitals over exactly what point the paramedics or clinicians update the HAS. We analysed HAS data covering a sample of 7 days (Mon-Sun) over 7 weeks in September and October 2017. The analysis highlighted that the late reason is not completed over 25% of the time. If this data was complete and accurate it would provide both WAST and Health Boards with information to assist in reducing delays.	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 ability to reduce handover delays and patient health.

Recommendation 8	**Priority Level**
We recommend that WAST and Health Boards; • WAST and Health Boards ensure that the roles and responsibilities for recording data on the HAS are clearly understood. This should be supported by clear guidelines and protocols to ensure that the data can be relied upon as fair and accurate with consistent application of the time recording for the notification and handover. • The Health Boards and WAST undertake an assessment over the use of the 'late reason' data and where and how it provides management information that can assist in managing handover delays, e.g. addressing issues such as a lack of beds.	Medium
Management Response 8	**Responsible Officer / Deadline**
Our Emergency Departments have undertaken a review of handover screens on which the HAS is available and have moved some screens to offer better accessibility. The Health Board in conjunction with WAST will be conducting a review of its standard operating procedures for the handover process to ensure consistent application across all sites, which will be reinforced via "Perfect Day" events on each site. In addition we believe there are opportunities for improved use of the data recorded on the HAS and will be undertaking refresh training sessions on the handover process. **<u>Update as at October 2018:</u>** At the Princess of Wales Hospital's Emergency Department, the HAS screen is to be relocated to improve notification to handover times and encourage early face-to-face discussion with WAST.	ECHO Service Managers Morriston & Princess of Wales Hospitals/ Head of Ops for WAST in ABMU.

The review of operating procedures for handovers at both Emergency Departments is a continual process as such procedures are working documents and therefore adapt as required to reflect changes in departments. At Morriston the process document has been rewritten following discussions between WAST/ED Service managers and approved by the ECHO Board Perfect days have been discussed locally. These have not yet been facilitated due to other ongoing priorities, but they remain an intended action and will take place as soon as possible. ***<u>Update as at January 2019</u>*** *The HAS screen has been relocated at the Princess of Wales hospital.* *Following the temporary relocation of the SAU at Singleton, interim arrangements to enable the ambulance handover acceptance in the temporary location, have been put in place.* *Perfect training days remain outstanding but WAST colleagues are actively participating in 'Breaking the Cycle' between 7th and 20th January 2019 which will reinforce the handover process with operational staff. The provision of the patient liaison role also provides the opportunity to reinforce the handover process with ambulance and hospital staff.*	