



AMBULANCE HANDOVER AT NNUH - REPORT TO NHOSC - 24 MAY 2018

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For: Norfolk Health Overview and Scrutiny Committee - 24 May 2018

The NNUH have been asked to update the committee on ambulance handover delays at the Hospital during the winter period and be prepared to answer four specific questions. The questions and response are shown at end of this paper.

Background

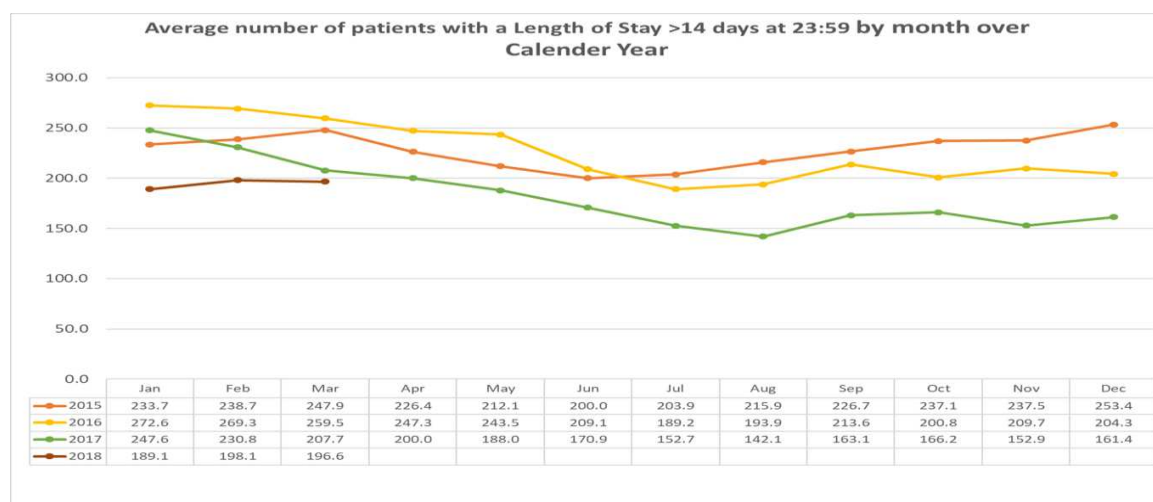
As recognised at section 1.2 of the NHOSC briefing paper when ambulance handover delays occur at the NNUH it is usually symptomatic of pressures across the local health and social care system

Winter 2017/18 was a particularly challenging period for the NHS, Central Norfolk system and the NNUH. Pre winter a significant amount of planning was undertaken in the summer/autumn of 17/18 to identify key schemes to address 4 themes and objectives as follows:

1. Managing and avoiding congestion through consistent and improved discharge practices (including weekends and holiday periods).
2. Increasing capacity – specifically in OPM.
3. Optimising schemes to avoid admission i.e. Ambulatory unless proven otherwise.
4. Learning from previous risks and issues i.e. Clinical ownership and opening of an escalation ward.

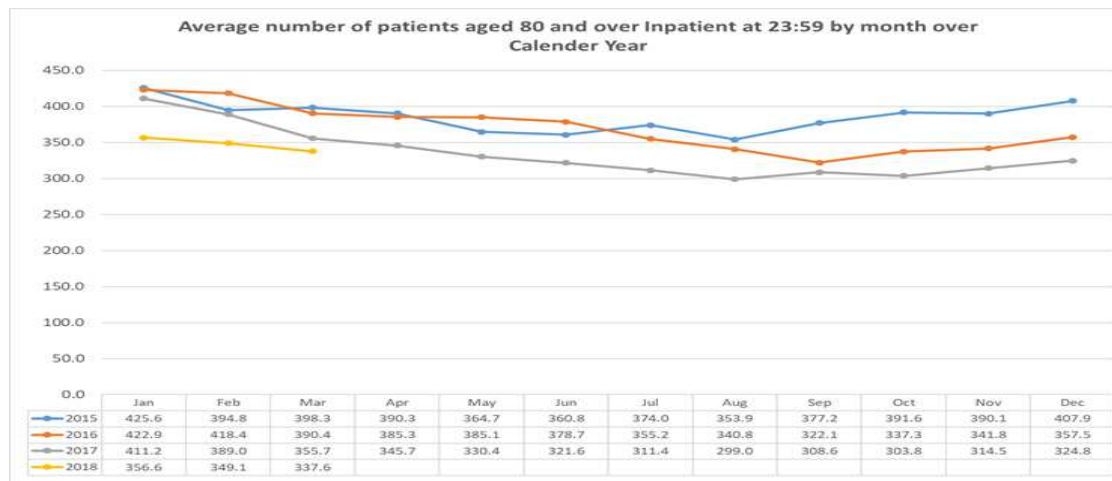
1. Managing & Avoiding congestion - Improved Discharge

Using the '14-day-stranded' metric as a proxy for discharge performance, the suite of schemes in this area performed well.



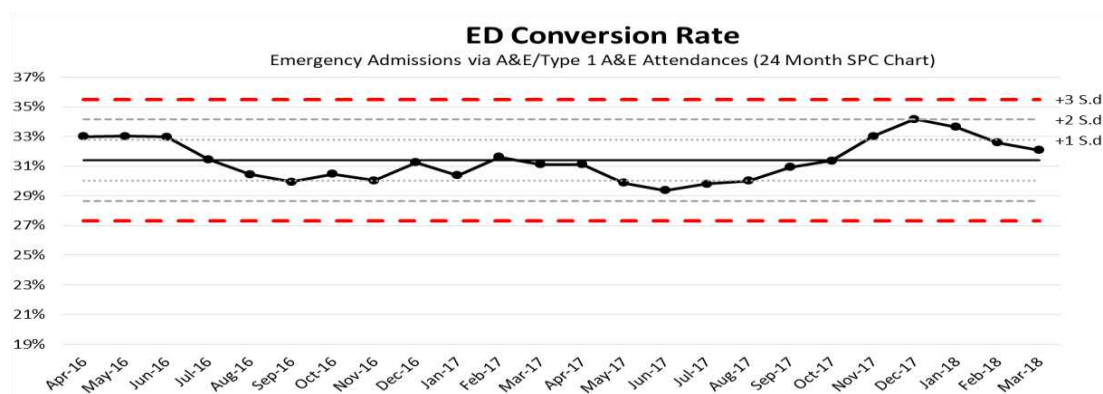
2. Increased OPM capacity

Schemes to actively reduce the numbers of Older People being admitted to hospital worked well with the lowest number of in-patients over 80yrs of age in the last 3 winters.



3. Admission Avoidance

Schemes to optimise admission avoidance were not as effective as was anticipated. The conversion rate of ED attendances to admission was significantly higher in the late Autumn and early Winter period.



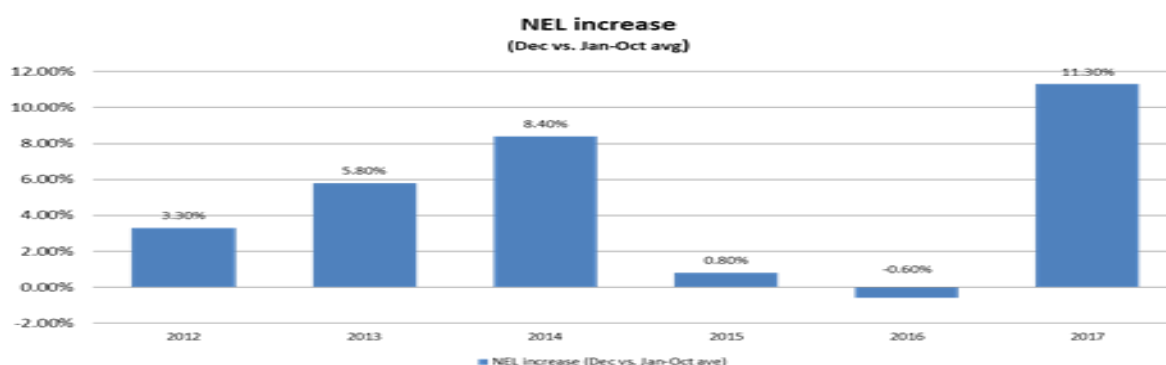
4. Lessons Learnt

Whilst the lessons-learnt from the previous winter in relation to the use of the refurbishment decant ward for temporary escalation seemed to work well, the ability to protect the DPU from in-patient use failed; DPU was used for in-patient escalation in the period 1 January until 11 April.

A sustained (16-month) period of effective NEL reduction was significantly reversed in Quarter 3.

The unexpected rise in Non Elective admissions during November, December & January was driven by a 24% rise in 70-79yrs patients (typically 1-6 day length of stay) – not representative of previous years profile (demand or demographic). The most common presenting condition was 'Respiratory Illness'.

Non Elective Admission trends 2012 -2017

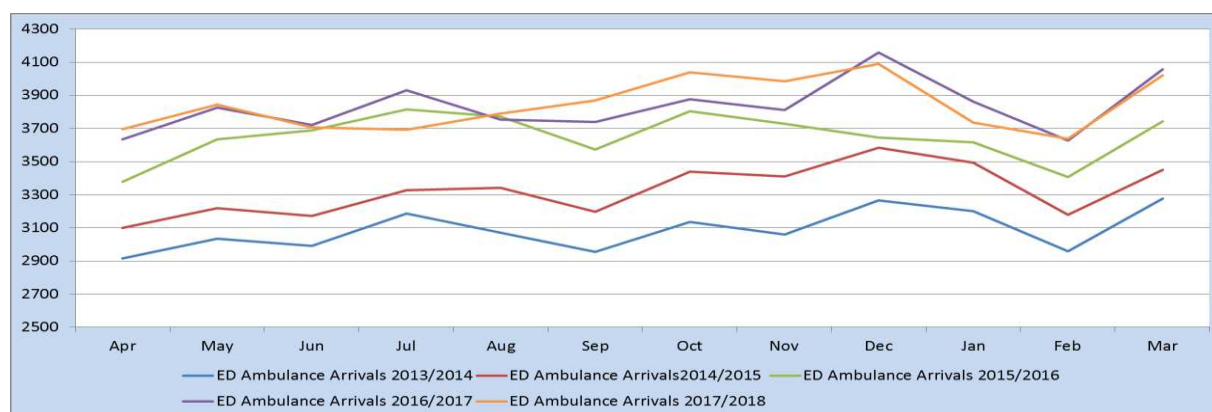


The winter plan was affected by the unexpected increases in emergency admissions and the relative failure of the Ambulatory Emergency Care service to identify sufficient patients suitable for rapid treatment avoiding the need for an inpatient bed. The pressure within the Central Norfolk system manifested at the hospital and resulted in congestion and ambulance handover delays

Ambulance Activity

In 2017/18 Ambulance arrivals at the NNUH represent 45.1% of the total attendances at the A&E department, compared to 45.5% in 2016/17.

Table 1. Ambulance arrivals at ED Apr 2013 – Mar 2018



Ambulance Conveyance rates – Norfolk Acute Trusts

	Average Daily conveyance	Range	Conveyance %*
JPH	69	55~86	47%
NNUH	144	105~182	61%
QEH	64	41~80	46%

The rate of conveyance by ambulance to the NNUH is higher than our near neighbours predominantly due to the specialist nature and size of the NNUH.

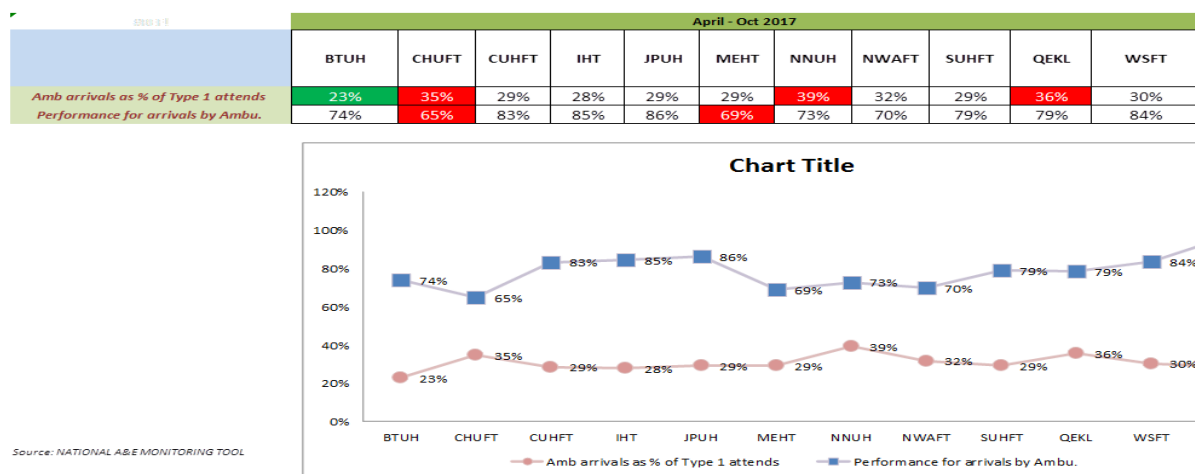
During the period 1 April 2017 – 31 March 2018, the rate of admission of ambulance arrivals at A&E has decreased from an average of 56% in 2016/17 to 51% in 2017/18. The vast majority of those patients admitted have been seen in either the Majors or Resus areas of the A&E department.

Patients requiring Type 1 resus or majors are the patient group with the highest acuity and immediate/urgent care requirements. There has been an 8.5% increase in combined majors/resus attendances 1 April 2017 – 31 March 2018 versus the same period of 2016/17.

This represents an additional 6243 resus/majors patient attendances compared with the same period in 2016/17. That is an average of 17 additional resus/majors patients per day. Assuming that, on average, 180 minutes are required for resus and majors patients, 17 additional patients per day represents 51 additional hours of clinical time in A&E every day. If there is not a consistent uninterrupted outlet to the emergency admission areas it is likely that this level of demand will result in a congested A&E and 4 hour standard breaches and ambulance handover delays.

A disproportionate amount of Type 1 (Resus/Majors) ED activity arrives by ambulance at NNUH

Ambulance arrivals as a % of type 1 attendances – Eastern region



The NNUH fully supports the EEAST quick release protocol but, despite that commitment, the infrastructure to manage more than 8 ambulances per hour has not allowed full compliance in this area. Internal policies and protocols have been re-written to support the achievement of consistently earlier ambulance handover but the space available requires further expansion and modification to ensure sustained improvements in performance.

Ambulance Handover <15 Minutes – Eastern Region

	2016/17	2017/18										
A to H % <15 m in A&E of those recorded												
Hospital ED	March	April	May	June	July	August	September	December	January	February	March	
Addenbrookes Hospital	50.8%	48.9%	47.1%	43.1%	46.3%	44.2%	43.8%	55.5%	59.5%	55.3%	53.8%	
Basildon & Thurrock Hospital	41.7%	43.1%	38.7%	40.6%	39.9%	46.0%	40.6%	31.7%	30.7%	28.0%	28.5%	
Bedford Hospital South Wing	62.0%	63.8%	66.5%	72.3%	65.1%	72.0%	63.6%	57.2%	61.5%	59.2%	64.9%	
Broomfield Hospital	45.1%	46.4%	45.6%	36.6%	41.7%	42.6%	40.3%	17.9%	18.5%	19.6%	27.4%	
Colchester General Hospital	30.1%	21.6%	19.4%	15.9%	15.3%	16.9%	18.6%	14.5%	18.2%	23.0%	32.1%	
Hinchingbrooke Hospital	25.7%	22.2%	24.9%	23.8%	30.8%	52.9%	44.5%	23.3%	20.3%	18.2%	23.2%	
Ipswich Hospital	34.9%	36.8%	39.3%	38.9%	39.8%	37.2%	32.9%	24.9%	32.7%	35.7%	44.1%	
James Paget Hospital	48.5%	50.6%	53.3%	48.1%	50.8%	51.2%	48.4%	55.1%	50.8%	49.9%	43.6%	
Lister Hospital	43.9%	40.4%	65.7%	75.4%	69.5%	62.3%	52.8%	41.0%	41.2%	39.6%	42.8%	
Luton And Dunstable Hospital	43.8%	45.7%	52.2%	46.9%	50.6%	44.1%	45.4%	47.7%	41.2%	31.6%	35.2%	
Norfolk & Norwich University Hospital	57.3%	58.7%	66.5%	62.2%	63.7%	56.6%	44.5%	20.9%	18.4%	26.7%	24.5%	
Peterborough City Hospital	34.4%	34.8%	33.3%	41.8%	40.5%	36.6%	30.6%	22.0%	24.6%	23.9%	30.6%	
Princess Alexandra Hospital	34.3%	31.6%	30.8%	28.3%	31.1%	31.4%	29.8%	22.5%	18.5%	17.8%	18.3%	
Queen Elizabeth Hospital	19.6%	21.7%	22.0%	18.0%	17.2%	16.1%	18.6%	16.5%	14.4%	11.8%	15.4%	
Southend University Hospital	50.0%	57.8%	44.5%	41.5%	44.1%	38.8%	37.8%	33.5%	42.8%	46.2%	50.0%	
Watford General Hospital	24.0%	20.5%	26.1%	31.6%	25.2%	19.5%	25.0%	17.5%	12.3%	22.4%	27.7%	
West Suffolk Hospital	32.1%	35.1%	31.6%	34.5%	31.2%	26.5%	27.8%	22.1%	28.3%	29.7%	28.8%	

The Winter period was challenging for most trusts in the Eastern Region with even the highest performing only achieving 64%. Improvements in March and April are beginning to take effect however periods of peak activity continue to represent a challenge and ambulance handover will remain a key area of focus until further action on improving the handover environment and the supporting processes is completed in late 2018.

It should be noted that the higher dispatch to conveyance rate at NNUH - 61% vs circa 46-47% in other parts of Norfolk may represent an opportunity, with the right early assessment infrastructure, to further redirect a proportion of ambulance patients away from ED majors in future'

Major Actions Implemented to improve ambulance handover

Overall ambulance offload infrastructure and arrangements were severely tested in trying to support the ambulance Trust to respond to whole-system pressures in winter 17/18. The current physical ED infrastructure is too small to deal with volumes and variability of arrivals to enable offloading within 15-minutes.

Plans to improve urgent and emergency care are embedded within a system wide recovery plan that is led by CCGs and has agreed contractual performance trajectories. The trust has also agreed an improvement trajectory with NHSE. A summary of the actions that will assist with ambulance handover is shown below:

1. A project to significantly increase the size and staffing within the ED was launched in April 17.
2. Construction work has been completed on the following:
 - Relocation of the Acute Medical Units
 - Relocation of Older Peoples Medicine short stay ward
 - Creation of new AEC
 - New Children's ED with expansion from 4 – 15 assessment spaces
 - Creation of Older Peoples Emergency Department
 - New Front Entrance with enhanced Triage area
 - Isolation/Mental Health suite
 - Additional Urgent Care Centre treatment room
3. Further Construction is planned in 18/19 to create:
 - New Clinical Decision Unit
 - 8 Rapid Assessment Treatment Service (RATS) Cubicles
 - Dedicated Children's entrance

ED Assessment/Treatment space	2014	2015	2016	2017	2018
Resus	6	6	6	6	6
Majors	16	19	19	16	16
Minors	3	4	6	6	6
Children's ED	3	4	4	9	15
Older Peoples ED	0	0	0	6	18
Urgent Care Centre	0	4	4	5	6
RATS	0	0	0	0	8
Clinical Decisions Unit	0	0	12	12	14
Dedicated ED Mental Health facility	0	0	0	0	3
Total ED Assessment/Treatment space	22	31	45	54	84 (92)

4. The five agreed Improvement 'Themes' with associated SMART actions are:
 - Improve the breach performance of patients arriving by ambulance
 - Improve and eliminate Minors and UCC breaches
 - Maximise the AEC opportunity to reduce overall admission volumes
 - Realign staffing to match demand
 - Oversight of performance
5. Introduction of internal ambulance handover process to support the EEAST quick release protocol.
6. Introduction of a revised internal escalation policy to support flow within the NNUH.
7. Appointment of 10 ED mid-grade doctors in July/August 2018.
8. Establishment of additional senior nursing staff to provide ED Floor Co-ordinator 24/7

9. Extended operating hours of OPED.
10. Additional short stay bed capacity (12 beds) from October 18.
11. Provision of a dedicated winter ward facility (32 beds) following relocation of renal dialysis facility.
12. The system wide Urgent Care Recovery Plan is currently being revised to ensure focus on the 5 new national “mandated actions”.

Norfolk and Norwich University Hospitals NHS Foundation Trust

- (a) Are you satisfied that all the health and social care agencies whose co-operation is required to manage demand for acute care are actively and adequately addressing their part of the problem?

Yes. The Central Norfolk Health and Social Care system partners work together closely on all urgent and emergency care demand pressures. Regular weekly and monthly meetings are scheduled to keep all stakeholder abreast of issues and opportunities.

- (b) Given that the ‘Delayed Arrival to Handover (Keeping Patients in the Community Safe) Protocol’ introduced in February 2018 has relied on an extremely high and potentially unsustainable level of escalation by EEAST leaders to ensure the necessary action occurs to release their crews, what can be done to enable the necessary decision making further down the management line?

The NNUH has introduced a revised internal policy and a specific protocol to improve flow into the hospital from ED in order to facilitate earlier ambulance handover. Longer term the development of an additional 8 Rapid Assessment Treatment Service (RATS) cubicles will provide a much improved environment to manage the volume of ambulances that are expected at the NNUH.

- (c) It is clear from the ambulance turnaround figures that winter 2017-18 has been difficult. To what extent does the NNUH think that the opening of the Older People’s Emergency Department) in December 2017 contributed to or alleviated ambulance turnaround delays at the hospital?

The Older Peoples Emergency Department was established to assess and treat patients 80 years of age and older. The patients that presented the most significant demand pressure on the Hospital in December 2017 was the 70-79 age group. OPED had a positive impact on bed occupancy and patient experience in the >80 year olds but was not a significant factor in ambulance delays at that time.

- (d) In February 2018 there were local media reports of a discrepancy between EEAST’s figures for ambulance delays at the NNUH and figures reported by the hospital for the period between 26 December 2017 and 21 January 2018. The NNUH subsequently corrected its data but said that the original hospital data had shown zero delays because a change in how the ambulance service measures its response times meant the data could not be verified or integrated into the hospital’s systems. Can the NNUH explain how this difficulty arose and give assurance that it now has confidence in both the EEAST data and its own?

*Handover data is submitted by NNUH on a daily basis. This information is provided by EEAST. EEAST updated their process for recording ambulance data including the arrival and handover time stamps in mid-October. At this point the NNUH was made aware that EEAST would not be able to provide accurate data until technical work had been completed. The NNUH did not receive confirmation that the data being supplied was correct until the 21st January and so no data was submitted over this period. The information was sent as a **null** return rather than a zero return.*