Handover of Care at Emergency Departments Follow-up Health Board Related Recommendations

Internal Audit Update Paper

2018/19

Welsh Ambulance Services NHS Trust

NHS Wales Shared Services Partnership

Audit and Assurance Service

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1. Introduction and Background

The follow up review of the Handover of Care at Emergency Departments was completed in line with the Welsh Ambulance Services NHS Trust ('WAST') 2018/19 Internal Audit Plan. The review sought to provide all six health boards that have Emergency Departments, with assurance that operational procedure is compliant with Welsh Health Circulars issued by Welsh Government.

The purpose of the review was to assess whether health boards have taken appropriate action in response to the findings raised following the Handover of Care at Emergency Departments review in 2017/18 where we gave an opinion of 'limited assurance'. While the review was included in the WAST Internal Audit Plan, all six health boards that have Emergency Departments were engaged in the fieldwork of the review and the draft report was issued to the six health boards for response to relevant recommendations in January 2018. Note that Powys THB was excluded from the review, as it does not manage any Emergency Departments.

The statement of intent section of the Welsh Health Circular titled 'NHS Wales Hospital Handover Guidance' (reference WHC/2016/029) states:

'The safety, effectiveness and dignity of care of patients must be at the forefront of systems of emergency care. The best care is provided to patients in the correct care environment. When ambulance crews take a patient to hospital it is essential that they are released swiftly so they can continue to provide a safe and efficient service to the local community.

Health boards are responsible for ensuring the safe emergency transport, and timely treatment, of citizens in their local area. When a patient is conveyed to a hospital by ambulance care must be handed over to the hospital team within 15 minutes, and health boards are responsible for ensuring that this happens reliably. All members of the health board Executive team have a special responsibility to communicate the importance of handover.

Patients and their carers are important partners in the process of handover and admission. Their involvement should be a key part of planning emergency care, and when delays occur they should be kept fully informed of the reasons and the progress being made in resolving them.

Staffing arrangements in hospitals should ensure the safe care and treatment of patients. Hospital sites should have effective Escalation Plans in place to ensure ambulances can be offloaded at times of peak pressure. Senior clinical decision makers should be present routinely at the hospital front door and their presence strengthened as part of the escalation plan when pressures build in the system.

The planning of Unscheduled Care must be given a high priority by health boards. Delays in hospital handover is frequently associated with blockages to patient flow further upstream, and work across the whole pathway of health and social care is necessary to address this properly.

Key actions to support hospital handover have been highlighted and summarised. They are intended for implementation by the health boards and Trusts in the NHS across Wales in local policies and protocols, and should be incorporated into local site Escalation Plans as they are revised in line with the latest Welsh Government advice.'

2. Scope and Objectives

The scope of this follow up review does not aim to provide assurance against the full review scope and objective of the original audit. The follow-up review does not provide an assurance level against the action taken by health boards in response to the original report findings raised.

The follow up review engaged all six health boards included in the scope of the 2017/18 audit with the exception of Cardiff & Vale University Health Board, where permission to engage was not received. Note that this follow up review was performed prior to the restructure of Cwm Taf and Abertawe Bro Morgannwg University Health Boards and their renaming as Cwm Taf Morgannwg and Swansea Bay University Health Boards respectively.

The 2017/18 report included the following caveat:

'*A draft version of this report was presented to the WAST Audit Committee in March 2018. While management responses to our recommendations have been received from WAST, responses are still awaited from health boards on the seven out of eight recommendations that apply to both WAST and health boards.*

We have received assurances from WAST that it will continue to work with health boards to encourage management responses and work to implement these joint responsibility recommendations.'

The 2017/18 review assessed compliance with the following key actions highlighted within the Welsh Health Circular to support hospital handover:

- planning for emergency care should involve patients with recent experience of care and must be clearly visible in the IMTP;
- ambulance conveyance should be actively managed by health boards and WAST;
- pathways for emergency care that bypass the Emergency Department should be in place;

- safe, sustainable, staffing levels for emergency care, able to flex to meet demand, must be in place, with appropriate levels of supervision;
- health boards and WAST should meet weekly to manage emergency care flow. These meetings should ensure that care pathways that reflect the five step ambulance model used to commission ambulance services in Wales are in place;
- health board executives must visibly and repeatedly communicate the importance of ambulance handover to staff;
- hospital clinical staff must ensure that any patient waiting more than 30 minutes has been assessed and moved immediately into hospital is there is a risk to patient safety; and
- wards must increase their ability to pull patients safely from Emergency Departments at times of peak demand. If significant ambulance delays occur, health boards must ensure that effective site escalation arrangements allow ambulances to be released promptly.

In addition we also reviewed the training provided to paramedics and Emergency Departments to support effective hospital handover.

3. Associated Risks

The overall risk to be considered in the follow up review was poor governance arrangements leading to failure to implement agreed audit recommendations and therefore continued:

- Non-compliance with Welsh Government guidance resulting in patients coming to harm; and
- Failure to achieve the most efficient and effective use of resources.

4. Audit Findings

The findings and recommendations raised from the 2017/2018 audit are set out in Appendix A, together with current findings, including health board comments. This report should be read in conjunction with the separate follow up Internal Audit report (ref WAST 1819-20).

The current review considers all recommendations made (high, medium or low priority). This report **does not** provide assurance against the full review scope and objective of the original audit.

During the course of the review we attended meetings with health board nominated key contacts at five health boards, with the exception of Cardiff

& Vale University Health Board (C&VUHB), where permission to engage was not received. We discussed actions and progress made to address the relevant findings and recommendations. Documentary evidence in support of comments has not been received in all instances and as such may not be reflected in the report.

Whilst all health boards received a copy of the original internal audit report, management responses to it varied. Two of the health boards, Betsi Cadwaladr University Health Board (BCUHB) and Swansea Bay University Health Board (SBUHB), formerly Abertawe and Bro Morgannwg University Health Board managed relevant findings and recommendations raised in the report via their respective Audit Committees, reporting on specific actions taken and progress made. The remaining health boards did not manage these findings and recommendations in such a formal manner but were able to comment on actions already in hand or that the specific issues were not considered relevant to their Emergency Department operations, for example where their Ambulance Quality Indicators (AQIs) already evidenced good performance.

There have been continued developments of processes and practices in all health boards, many in conjunction with WAST to improve handover of care and aimed at reducing delayed handover times whilst maintaining or improving patient care and experience. WAST and health boards have engaged in a number of pilot/trials in this regard.

In respect of the recommendations made in the initial report, many of the actions taken either did not commence until late in the final quarter of 2018/19 or, in the case of certain health boards, were not primarily implemented in response to the original report. As such, these actions are either not fully implemented, or have not had enough time to embed to enable us to see the impact on handover delays or an improvement in the AQIs.

	2018-19											
	QTR 1			QTR 2			QTR 3			QTR 4		
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Percentage of notification to handover within 15 minutes of arrival at hospital (AQI20 i)	51.70%	57.00%	58.60%	54.80%	54.80%	52.80%	52.40%	56.20%	53.60%	48.00%	51.80%	51.20%
Number of notification to handover within 15 minutes (AQI20 i)	9,804	11,521	11,398	11,042	10,733	10,144	10,568	11,105	11,309	9,752	9,406	10,297
Total Number of handovers (AQI20 i)	18,974	20,213	19,449	20,149	19,593	19,223	20,155	19,768	21,090	20,324	18,156	21,127
Number of lost hours following notification to handover over 15 minutes (AQI21)	6,134	4,137	3,777	4,562	4,669	5,253	6,020	4,707	6,038	8,781	5,610	6,833
Total lost hours in the quarter		14,048			14,484			16,765			21,224	

We acknowledge that some of the actions to be taken are long-term and also require support and cooperation between health boards and WAST, and as such will take some time to be fully implemented and embedded.

5. Assurance Summary

The following table summarises the extent to which the original recommendations have been implemented and provides classification of current risks:

	Area	Priority 2017/18 audit	Direction of travel	Priority 2018/19 audit
1	Patient Care during handover delays.	Low	Progress made. Further work is required to reduce the risk.	Low
2	Conveyance to ED.	High	Progress made. Further work is required to reduce the risk.	Medium
3	Pathways to bypass ED.	High	Progress made. Further work is required to reduce the risk.	Medium
4	HALO Role.	Medium	This recommendation was prmarily for WAST to implement.	Low
5	Strategic forums.	Medium	This recommendation was prmarily for WAST to implement.	Medium
6	Patient flow initiatives.	Medium	Progress made. Further work is required to reduce the risk.	Medium
7	Delayed handover clinical triage.	High	This recommendation was specifically for Cardiff and Vale University Health Board. The health board did not engage in the audit.	High
8	HAS data.	Medium	Limited progress made. Further work is required to reduce the risk.	Medium

Recommendations 4 and 5 are primarily the responsibility of WAST and have been included in the WAST Handover of Care at Emergency Departments follow up report WAST1819-20.

Regarding recommendation 4, WAST confirmed that Swansea Bay University Health Board was the only health board that recognised the benefit of having a Hospital Ambulance Liaison Officer (HALO) at their hospitals and agreed to part fund a Clinical Team Leader (CTL) as a 'Patient

Flow Co-ordinator' to attend the hospitals whenever WAST experienced delays.

Regarding recommendation 5, WAST confirmed that they had recently undertaken a review of the governance arrangements between WAST and the health boards. Structured interviews were held at each health board. This exercise will form the basis of a stakeholder engagement map.

6 Summary of Audit Findings

Actions Implemented in Full / Superseded	Actions Implemented in Part	Actions Not Implemented
0	**5**	**1**

The prior year report identified three **high priority** findings, two of which are now considered to be partially implemented and the priority ratings reduced to reflect the progress made and positive impact on risk. One remains at high priority as the finding commented on Cardiff and Vale University Health Board procedures. This health board did not engage in the audit and we are not able to provide an updated rating.

- **Conveyance to ED (previous finding 2)**

Our original review identified that both health boards and WAST raised the issue regarding the impact on conveyance and peaks in attendance to Emergency Departments that result in handover delays. In particular, GP referrals are unscheduled and occur between GP hours which can contribute to bottlenecks outside hospitals. Ambulance crews were often unable to convey GP referrals to hospital within the relevant department's opening hours. It was generally recognised that improvements could be made by having scheduled conveyance for GP referrals where appropriate.

Our current review found that WAST had undertaken a number of initiatives in conjunction with specific health boards in an attempt to positively impact conveyance of GP referral to the ED, these included:

- WAST carried out a two-day trial in October 2018 in collaboration with Aneurin Bevan Heath Board (ABUHB), to assess the impact of Health Care Professional (HCP) calls being handled by a clinician. This resulted in a reduction in the number of patients being conveyed to hospital by a Welsh Ambulance Service resource.

- Enhancing on the above, Betsi Cadwaladr University Health Board (BCUHB) implemented a Single Integrated Clinical Assessment and Triage service (SICAT) which went live in November 2018. This service sits co-terminus within the WAST's Clinical Contact Centre (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 shows an improvement in reducing the deployment of WAST crews and the avoidance of conveyance to Emergency Departments. The scheme also saw an increase of ambulance conveyances to Minor Injuries Units.

- WAST in collaboration with ABUHB undertook a GP transport pilot. The purpose of the pilot was to reduce the delays with transporting patients referred into acute hospitals from GP's, and to diarise suitable patients to improve flow through the assessment units. The initial pilot ran for 6 weeks during February and March 2018. The trial had mixed success due to a number of reasons including no dedicated coordinator, the crew being diverted to emergency calls and shifts not being covered, although it did show a general reduction in the time from booking to arrival at assessment units. It was proposed that the trial be run for six months from October 2018 to April 2019, however, the decision was taken to defer due to significant pressures.

- ABUHB was involved in a Falls 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.

- Swansea Bay University Health Board (SBUHB) have undertaken work to reduce unnecessary conveyance to ED from Care Homes. This has included successfully rolling out training on 'I Fell Down' to the Neath Port Talbot (NPT) Local Authority area with plans to roll out to the Swansea Local Authority homes at the time of our review. 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 NEW scoring in two or three nursing homes in the Swansea Bay area to support conveyance and discharge decisions.

- SBUHB was also involved in a Bevan exemplar project on the 'Integrated Response Model' with the aim of redirecting appropriate 999 emergency calls where the patient would be better suited to receiving community based care from the Acute Clinical Team. The project summarised that "*The Integrated Response Model is an innovative new approach, aligned to the principles of prudent healthcare, to reduce the burden of*

emergency 999 calls and A&E attendances by offering an alternative pathway of care that was only limited by the resources needed to deliver it. 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 the following for the hospital, that whilst there is '*no AECU there is a clear ambulatory ethos across the whole front door footprint'*. It highlighted the hospital's Acute GP Unit (AGPU) and the multiple pathways within AGPU which is open between 8.00am – 8.00 pm with 48% of patients discharged from AGPU with calls taken by GPs who also provide clinical advice.

- 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. 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.

We acknowledge that the response to this finding is also reliant on health boards, in conjunction with WAST, evaluating the results of the trails in reducing conveyancing to Emergency Departments. Where successful, and appropriate, extending across Wales and health boards working with their primary care services to ensure that patients are being referred appropriately and in line with the health board's demand and capacity.

This finding is now considered **partially implemented** with priority reducing to **medium**.

- **Pathways to bypass ED (previous finding 3)**

Previously, we were unable to reconcile the schedule of pathways managed through the WAST Clinical Pathways Approval & Appraisal Group (CPAG) to the list of pathways for each of the health boards. Paramedics had not always been able to follow a pathway and this was not well recorded. We were informed that tablet devices had recently been allocated to paramedics which would provide WAST an opportunity, with software development, to provide an electronic tool of all the available pathways for paramedics that could increase their ability to utilise a pathway and bypass conveyance to ED where appropriate.

During the current review we were informed that 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 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 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 areas 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. Work is in hand at several health boards to actively review whether correct pathways are being applied in all instances. At one health board where there is considerable regional variation in pathways, WAST has been engaged to monitor all activity and to identify any incorrect pathways so that both WAST and the health board can clarify and avoiding confusion and repeat errors.

We were informed that where cross border transport occurs, either within Wales or from England to Wales, there is a heightened risk of uncertainty in applicable pathways. In these instances the WAST CCC is key in confirming or directing pathways to be applied. Several health boards are monitoring pathways in such cross border situations to identify any incorrect pathways, and to share details of any instances with WAST.

This finding is considered **partially implemented** with priority reducing to **medium priority**.

- **Delayed handover clinical triage (previous finding 7)**

Previously we were informed that 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.

During our current review we were not able to engage Cardiff & Vale University Health Board 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.

This finding is considered **not implemented** with priority remaining at **high priority** as the procedures adopted at CVUHB remain non-compliant with the Welsh Health Circular.

Our prior year report identified four **medium priority** findings. Two findings are considered partially implemented with priority remaining at **medium priority** to reflect the progress to be made. The remaining two findings were primarily the responsibility of WAST and our follow-up work at WAST has determined the progress made against these findings.

- **Patient flow initiatives (previous finding 6)**

During the original audit 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. We 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 showed little improvement in performance on handover delays. The only health boards that were near the 15-minute handover target of 100% are Cwm Taf Morgannwg University Health Board (CTUHB) achieving almost 90% each month and Hywel Dda University Health Board (HDUHB) achieving circa 80%.

We noted that it was 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, CTUHB.

Our current review found that health boards with poorer AQI handover performance have engaged with other health organisations in Wales and England to identify processes and practices that could be adopted to aid delivery of improved handover performance. A review of CTUHB 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 by health boards with poorer AQI handover performance.

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 via published AQIs. In many instances changes that have been implemented are yet to feed into published AQIs.

This finding is considered **partially implemented** with priority remaining at **medium priority**.

- **Hospital Arrival Screen (HAS) data (previous finding 8)**

Previously, we found some contradiction over the responsibility for completing and at what point the HAS handover entries should be completed. It was apparent that the data was 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. Additionally, the late reason was not always recorded where delays of over 15 minutes had occurred, which could provide both WAST and health boards with information to assist in reducing delays.

Our current review found that the HAS Guidance has not been re-circulated to WAST staff, and onward to health boards, 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 (WG) in February 2019 asking that they consider updating the current HAS guidance and clarifying roles and responsibilities.

We obtained a HAS Report showing all handovers with delays over 15 minutes for the period February 2018 - March 2019. Review of the report confirmed that for 44% of the delays the reason code had not been completed. The percentage rate of 'NULL' entry rate across hospitals sites ranged from 22% in Morriston Hospital to 92% in Maelor General Hospital Wrexham. In the case of Maelor General Hospital the high NULL entry rate is partially explained by the poor physical locations of HAS screens. We understand that WAST has recently relocated a number of HAS screens within several Emergency Departments, including Maelor General Hospital and this should aid reduced NULL entries by allowing Emergency Department staff to access HAS screens efficiently.

WAST's Health Informatics Team developed 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. The value of this exercise to health boards may be limited by the specific late reason options set on HAS. However, as this report was not available until February 2019, we were unable to confirm that this is being undertaken at this early stage of implementation.

This finding is considered **partially implemented** with priority remaining at **medium priority**.

Our prior year report identified one **low priority** finding. The finding is considered partially implemented with priority remaining at **low priority** to reflect the progress to be made.

- **Patient Care during Handover Delays (previous finding 1)**

Previously we noted that one of the key feedback improvement themes 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 Emergency Department. Although the majority of patients conveyed to Emergency Departments are admitted within 60 minutes there are over 1,300 patients each month that wait in an ambulance for long periods.

During our site visits at Emergency Departments we observed instances where WAST staff were providing food and drink to patients in ambulances from stock cupboards held at hospitals. We noted that 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.

Our current review has identified that health boards engaged in the follow up review considered this issue a high priority as patient care and patient experience was considered of utmost importance. With regard to procedures implemented by the health boards, they 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.

Standard Operating Procedures in respect of handover were issued at each health board, however these did not specifically refer to nutrition, hydration and continence. Hywel Dda University Health Board (HDUHB) has recently 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. 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.

This finding is considered **partially implemented** with priority remaining at **low priority**.

The priority ratings of the open findings is summarised in the table below:

	2017/18	2018/19
High priority	3	1
Medium priority	2	4
Low priority	1	1
Total	**6**	**6**

The findings of our current review are detailed in Appendix A, together with the original recommendations and considerations going forward.

Previous Finding 1 Patient care during handover delays

Original Finding (Original Priority Rating: LOW)

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.

Original Recommendations

1. 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.
2. 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.

Current Findings	
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.. 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. 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**.	
Considerations Going Forward	**Priority Level**

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. 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.	**Low**

Previous Finding 2 Conveyance to ED

Original Finding (Original WAST Priority Rating: HIGH)

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 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.

Original Recommendations

1. 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.

2. 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.

Current Findings

GP Referrals

WAST has undertaken a number of initiatives in conjunction with health boards in an attempt to positively impact 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) 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 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 NEW 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 redirecting 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 the following for the hospital, that whilst there is 'no AECU 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.

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. 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.

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.

Considerations Going Forward	Priority Level
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.	**Medium**

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.	

Previous Finding 3 Pathways to bypass ED

Original Finding (Original WAST Priority Rating: HIGH)

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;
- 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.

Original Recommendation

1. 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.
2. 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.

3. WAST investigates the opportunity of developing an electronic pathways tool to assist paramedics in following pathways to bypass conveyance to ED.

Current Findings

Governance of Identification and Approval of Pathways

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 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 identity 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.

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.

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.

Considerations Going Forward	Priority Level
1. Each health board, in conjunction with WAST, should proactively assess whether pathways are being correctly applied. 2. Where the application of an incorrect pathways is identified, the reasons should be investigated and corrective action taken to ensure that such errors are not repeated and that WAST are always provided with up to date pathway documentation.	**Medium**

Previous Finding 6 Patient flow initiatives

Original Finding (Original WAST Priority Rating: MEDIUM)

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, now Cwm Taf Morgannwg University Health board (CTMUHB), achieving almost 90% each month and Hywel Dda University Health Board (HDUHB) achieving circa 80%.

CTMUHB'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 CTMUHB 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, CTMUHB.

Original Recommendation

1. WAST and health boards evaluate the key factors adopted by CTMUHB that resulted in their handover performance improving from circa 50% to 90% since 2013 and work together to drive similar improvement.

Current Findings

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.

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.

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 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:

- 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.

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.

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.

Considerations Going Forward	Priority Level
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. 2. Health boards should support and develop successful processes and practices, whilst those deemed unsuccessful should be reviewed and reversed where appropriate.	**Medium**

Previous Finding 7 Delayed handover clinical triage

Original Finding (Original WAST Priority Rating: HIGH)

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 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.

Original Recommendation

1. WAST seeks confirmation from Welsh Government regarding responsibility for undertaking a clinical assessment of patients prior to admittance to the ED.

Current Findings

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.

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

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	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**

Previous Finding 8 HAS data

Original Finding (Original WAST Priority Rating: MEDIUM)

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.

Original Recommendation

1. 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.
2. 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.

Current Findings

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 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 Morriston 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.

Considerations Going Forward	Priority Level
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. 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. 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.	**Medium**

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Trust. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised / strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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