Southern Health and Social Care Trust

TOGETHER, IMPROVING CARE, TRANSFORMING LIVES

TRUST BOARD COVER SHEET

	The cover sheet purpose is to provide the Trust Board/Committee with a clear summary of the paper being presented, how it impacts on the people we serve, key matters for attention and the ask of the Trust Board/Committee *The Accountable Director must satisfy themselves that the cover sheet is accurate and fully reflects the paper. The expectation is that the Accountable Director has read and agreed the content of both the cover sheet and paper.*	
Meeting and Date of meeting	Trust Board 28 May 2026	
Title of paper	**Release to Rescue (R2R)**	
Accountable Director	**Name**	Debbie Burns (Elaine Wilson presenting)
	Position	Director of Operations Adult Community & Acute Services (Director of Planning, Performance & Informatics)
Report Author	**Name**	Andrea Turbitt
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This paper sits within the Trust Board role of:		Accountability
This paper is presented for:		Assurance *(Notes on completion at end of document)*

Links to Trust Strategic Priorities 	☒	Collaborative Working
	☒	Learning Organisation
	☒	Safety, Quality & Experience
	☒	Community First
	☒	Whole-Life Approach

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1. Reason for Presentation of Paper / Report	
The attached paper provides a Trust Board Summary Report on the Trusts response to the implementation of the NIAS Release to Rescue initiative.	
2. Detailed summary of paper contents:	
• Introduction and context for the regional approach to Release to Rescue • Trust performance against the R2R since its introduction • Changes implement in the Trust to support R2R • Closing summary	
3. Areas of improvement/achievement:	
• 2hr Ambulance hand over • Reduced time spent in ED • Improve patient flow	
4. Areas of concern/risk/challenge:	
• Maintaining performance	
5. Impact on Statutory Duties: Provide details on the impact of the following and how.	
Financial Impact	***Safety and Quality Impact***
No, there are no Financial Impacts	Yes, there are Quality, Safety or Experience Impacts
6. Risk Assessment (Risk level and state if a risk assessment be completed)	
Each service areas is considered in its own right. There is no additional risk assessment required in relation to this update.	
7. Other Business Intelligence/data (If appropriate)	
N/A	
8. Impact: Provide details on the impact of the following and how. If this is N/A you should explain why this is an appropriate response.	

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Corporate Risk Register	N/A – this is a Summary Update on the Trust's response to the implementation of the NIAS Release to Rescue initiative noting that specific areas of escalation may be separately noted on the Corporate Risk Register as is outlined in the attached paper.
Board Assurance Framework	Finance & Performance Committee and Trust Board.
Equality and Human Rights	N/A - There are no equality / HR implications identified as a result of this paper.

Reasons for Paper Presentation

Approval	*Used when an item requires a formal agreement or endorsement by the meeting / committee members. Examples are approving minutes, budgets, proposals or policies.*
Assurance	*Used when an item can be measured against a certain criteria / standard. Examples are a project is on course with delivery or financial targets are being met.*
Information	*Used when an item is presented for the purpose of updating or informing the attendees without requiring a decision or action, such as reports, updates, or announcements.*
Discussion	*Used when an item is listed primarily for open discussion, brainstorming or gathering input from the members without requiring an immediate decision.*

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Trust response to NIAS Release to Rescue (R2R)

Confidential Trust Board Summary Report – May 2026

Purpose

The purpose of this paper is to provide Trust Board with an update on the Trust response to the NIAS Release to Rescue (R2R) initiative.

Background

From Monday 27 April 2026 the region introduced Release to Rescue (R2R), an initiative to get ambulances back into the community faster so patients in need of help are not left waiting.

When ambulances are delayed outside Emergency Departments (EDs) it affects both the patient waiting to come into ED and patients in the community waiting for an ambulance to arrive. R2R aims to improve safety for both groups of patients as it sets a clear standard that no patient arriving by ambulance will wait longer than a maximum of 2 hours outside an ED. This is the first step in a longer-term ambition to move towards a 45-minute handover. If the 2-hour threshold is reached, a formal handover to ED staff will take place so the ambulance crew can return to the community to respond to other calls.

Whole System Approach to Success

This is a whole system change which depends on all staff working together. Everyone working across acute, community and support services has an important part to play in keeping our patients moving safely through the system.

What we are asking staff to do

- Prioritise patient flow and safety.
- Maintain space within our EDs to receive these patients.
- Escalate delays early before they impact ED capacity.
- Support timely moves, transfers and discharges when clinically appropriate.
- Work collaboratively across teams and service to remove avoidable delays.

Introducing R2R will be challenging at times but it is an important and necessary step to ensure the safety of patients both in EDs and in the community. Success will depend on everyone working together with a shared responsibility and shared purpose – to improve the safety and dignity of patients in our care.

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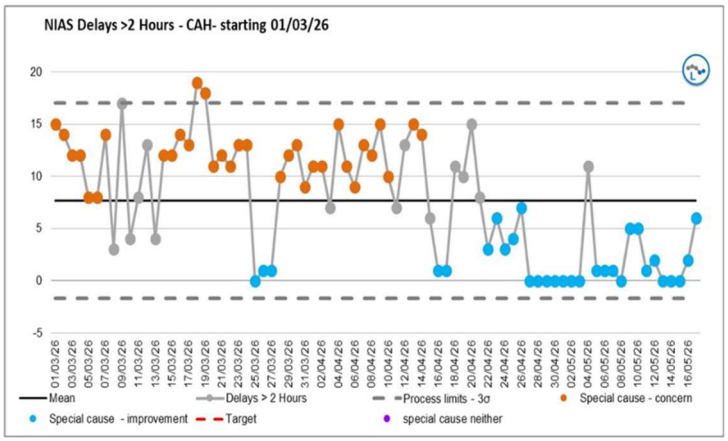
Current Status

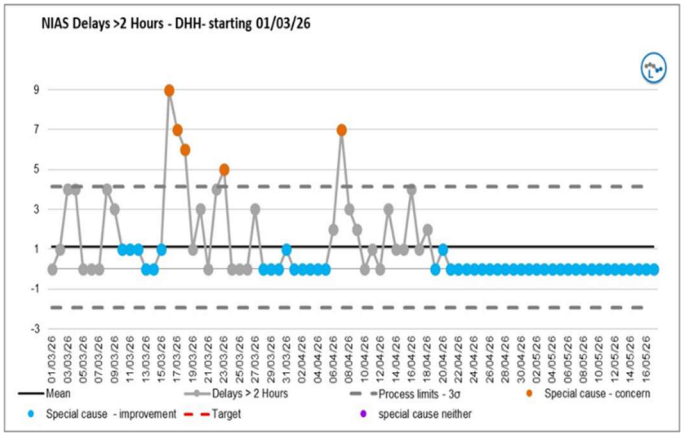
Since its introduction on 27 April 2026 both acute hospital sites are now meeting the regional 2-hour handover and turnaround target for NIAS. This improvement reflects a whole-system approach, underpinned by close operational collaboration between NIAS, ED clinicians and Patient Flow Teams, supported by Control Room oversight to optimise flow from ED to wards. This has been further strengthened by a community RESET, increasing Homecare capacity and supported by Single Discharge Teams, helping to sustain momentum on both simple and complex discharges and relieve pressure on acute hospital capacity.

SPC Charts below illustrate significant improvement achieved over both CAH and DHH sites in the numbers of patients waiting >2 hours for Ambulance Handover in the period from 01.03.26 to 17.05.26. (Daily Ambulance handover performance for CAH and DHH since 27.04.26 is detailed in Appendix 2).

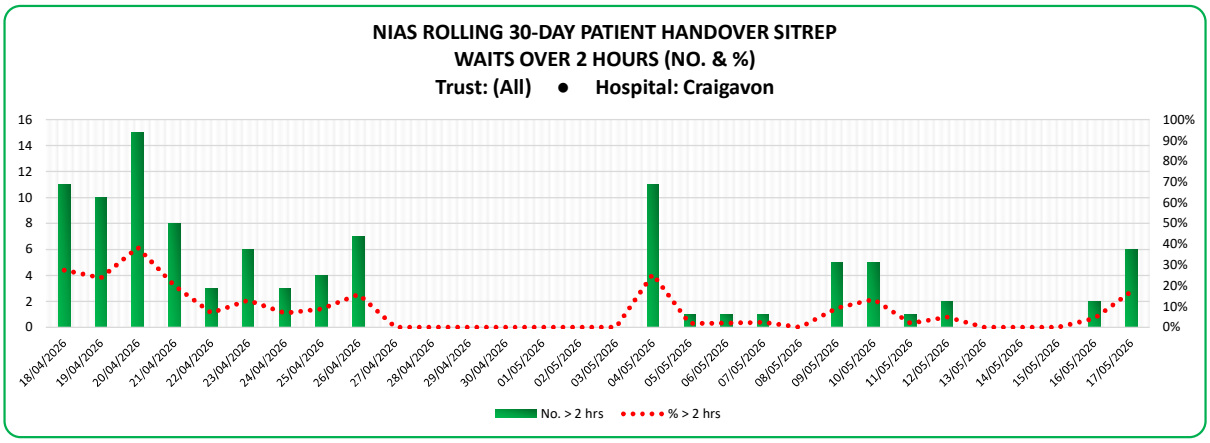
CAH – Long-term Trend 2 hrs waits

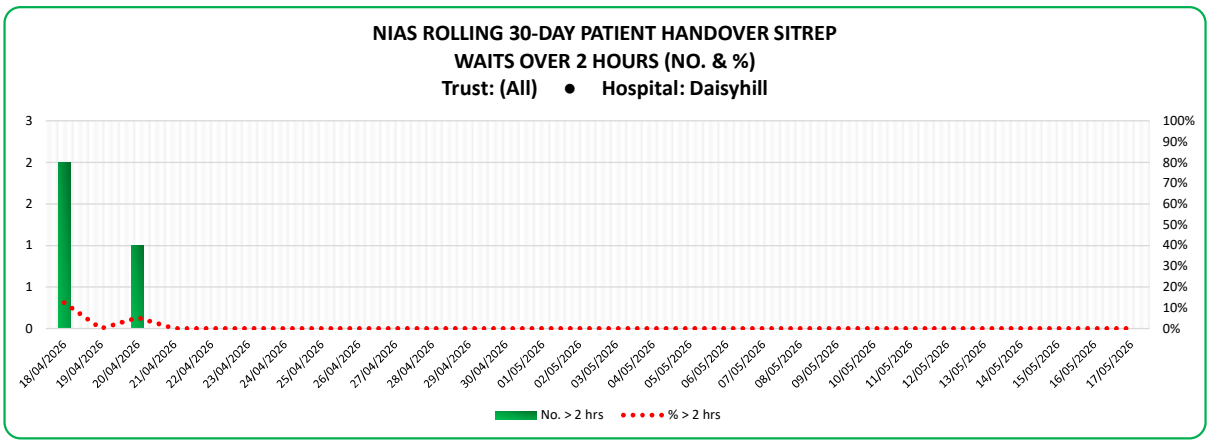


DHH – Long-term Trend in 2 hr waits



The Figures below show the 30 day 2 hour ambulance wait numbers in CAH and DHH showing a substantial reduction in the number of 2 hour breaches. It should be notes that the majority of breaches are within 15 minutes of the 2 hour target and the NIAS has now agreed to allow a 15 minute window before a breach is declared. This would reduce the majority of these days to zero breaches.





This is a significant improvement on previous reported 30 day rolling periods:

- 17th Jan to 15th Feb – 34% of patients (343 patients) waited >2 hours in CAH and 10%waited >2 hours in DHH (57 patients).
- 9th March to 7th April - 29% of patients (317 patients) waited > 2 hours in CAH and 10% waited >2 hours in DHH (55 patients).
- 18th April to 17th May – 7% of patients (102 patients) waited >2 hours in CAH and 1% waited >2 hours in DHH (3 patients).

Prior to the 27th April and implementation of R2R, for the months of January, February and March, the average wait times in CAH and DHH were as follows;

(Source: PSSI NIAS Long Term Trends Report 6th May 26)

Hospital	Ambulance Patient Handover Times (Hr:Min:Sec)					
	Jan-26		Feb-26		Mar-26	
	Average	Longest	Average	Longest	Average	Longest
CAH	02:49:38	19:15:00	01:44:07	15:10:16	1:49:11	10:35:05
DHH	01:24:20	08:22:00	00:52:46	07:04:28	1:00:05	04:54:21
All (Region)	01:22:42	21:50:44	01:00:56	19:35:22	00:58:39	12:58:57

The PSSI NIAS Long Term Trends information for the month of April is not yet available however, for comparison, information contained in the NIAS Daily Patient SITREP for

the period from 18th April to 17th May indicates that the average wait time for CAH during that period was 00:49:37 (Hr:Min:Sec) and in DHH 00:38:54 (Hr:Min:Sec) – a reduction across both sites with the longest wait in CAH of 2 hrs 43 minutes and DHH 1hr 50 minutes, a huge reduction from the figures outlined in the table above.

Changes Implemented – A whole systems approach

In support of the implementation of R2R the Emergency Department in the CAH site has reconfigured the RED area making it into an Extended Emergency Medicine Ambulatory Care (EEMAC) area in order to reducing patient time Spent in ED, this new approach aims to provide a protected non-escalation ambulatory pathway for patients and enable the ED to work towards the four hour target of being assessed and onward pathway of care completed. It is expected that separating ambulatory patients from higher acuity cases, EEMAC will improve flow, and directly support the sustainability of R2R performance.

Also supporting the R2R is work commenced in the Control Room to define the ideal flow state across the 24 hour period to allow the Trust to forecast daily downstream capacity requirements. This should allow the Trust to identify the number of discharges, transfers and internal bed moves required to ensure that the inpatient capacity is released in a consistent and continuous process throughout the day. The aim is to support steady movement of ED bed waits, minimise accumulation of delay and reduce overcrowding within the ED department.

As part of the Trust's ongoing Timely Care programme and its wider focus on improving ambulance hand over and reducing time spent in the Emergency Department (ED), a programme of specialty service reviews is being undertaken. This work is intended to address the underlying drivers of ED pressure, including demand, capacity, flow and length of stay.

The reviews will provide a clear assessment of both elective and unscheduled demand across specialty services, alongside an evaluation of current, funded and required capacity—including workforce, bed allocation, systems and processes—to meet this demand safely and sustainably. Emphasis will be placed on identifying opportunities to reduce reliance on acute inpatient beds through alternative clinical pathways, ambulatory models and more effective use of non-acute settings.

The programme will also examine average length of stay, benchmarking performance against comparable hospitals, and identify actions to support timely progression to medically fit status and discharge. In parallel, existing medical models of care across the Trust will be reviewed to identify the most efficient and effective approaches for both patient outcomes and workforce sustainability.

Four dedicated working groups have been established to progress this work:

- Elective demand, capacity, workforce and bed allocation
- Unscheduled demand, capacity, bed utilisation, length of stay and clinical pathway development
- Medical models of care across acute sites
- Alternatives to hospital admission, including virtual and community-based models

Closing Summary

In conclusion, the Trust's response to Release to Rescue demonstrates a coordinated, whole-system approach that is beginning to deliver measurable improvements in ambulance handover performance and patient flow. The successful achievement of the 2-hour handover standard across both acute sites reflects the collective impact of strengthened operational collaboration, enhanced patient flow oversight, and increased community capacity.

The range of initiatives implemented directly supports the sustainability of R2R. Emergency Department reconfiguration, including the introduction of the Extended Emergency Medicine Ambulatory Care (EEMAC) model, is improving patient streaming and reducing avoidable delays within ED. Control Room developments are enabling better prediction and management of downstream capacity, supporting a more consistent and proactive approach to discharges and bed utilisation

In parallel, the expansion of community services, including increased homecare capacity and strengthened discharge arrangements, is helping to relieve pressure on acute services and maintain flow across the system. The ongoing specialty reviews and Timely Care programme further underpin this work by addressing the root causes of demand, capacity constraints and length of stay, while promoting alternative pathways to hospital admission.

Collectively, these initiatives align with the core principles of R2R by prioritising patient safety, improving flow, and ensuring that ambulance crews can return promptly to the community. Continued focus on system-wide collaboration, early escalation, and sustained flow will be essential to embed these improvements and progress towards the longer-term ambition of a 45-minute ambulance handover standard

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Appendix 2: Ambulance Daily Handovers CAH and DHH

(Source: NIAS Daily Patient Handover Report – Note data subject to change following data cleansing)

Craigavon	<15 mins	15-30 mins	30-45 A	45-60 mins	1-2 hrs	2-3 hrs	>3 hrs	Total	Daily Average hh:mm:ss	Daily Maximum hh:mm:ss
27.04.26	10	18	11	4	3	0	0	**46**	00:30:27	01:41:34
28.04.26	13	27	11	4	2	0	0	**57**	00:26:55	01:23:36
29.04.26	8	23	12	1	6	0	0	**50**	00:29:58	01:26:35
30.04.36	18	27	9	3	2	0	0	**59**	00:24:48	01:31:53
01.05.26	14	21	13	3	1	0	0	**52**	00:24:27	01:03:12
02.05.26	7	16	5	2	9	0	0	**39**	00:38:53	01:56:50
03.05.26	5	17	7	3	4	0	0	**36**	00:33:00	01:52:10
04.05.26	3	12	4	5	8	11	0	**43**	01:10:19	02:21:30
05.05.26	17	13	7	7	9	1	0	**54**	00:37:51	02:03:07
06.06.25	9	15	8	7	9	1	0	**49**	00:37:26	02:00:31
07.05.26	7	19	6	4	4	1	0	**41**	00:36:17	02:10:09
08.05.26	5	20	11	5	5	0	0	**46**	00:34:33	01:37:56
09.05.26	5	9	14	6	15	5	0	**54**	00:57:07	02:24:26
10.05.26	5	8	7	3	9	5	0	**37**	00:57:12	02:18:47
11.05.26	8	15	8	4	14	1	0	**50**	00:48:19	02:02:51
12.05.26	11	11	8	2	7	2	0	**41**	00:43:09	02:21:06
13.05.26	4	16	9	6	5	0	0	**40**	00:36:17	01:58:48
14.05.26	8	10	6	5	14	0	0	**43**	00:41:22	01:31:10
15.05.26	6	21	16	4	12	0	0	**59**	00:40:47	01:59:52
16.05.26	4	16	4	11	10	2	0	**47**	00:48:20	02:13:56
17.05.26	6	12	5	3	3	6	0	**35**	00:50:55	02:39:00
18.05.26	6	6	8	6	14	9	0	**49**	01:09:11	02:43:17

DHH	<15 mins	15-30 mins	30-45 A	45-60 mins	1-2 hrs	2-3 hrs	>3 hrs	Total	Daily Average hh:mm:ss	Daily Maximum hh:mm:ss
27.04.26	2	7	5	4	8	0	0	**26**	00:49:04	01:52:00
28.04.26	0	4	4	3	1	0	0	**12**	00:37:54	01:01:32
29.04.26	4	6	8	2	1	0	0	**21**	00:30:02	01:31:00
30.04.36	1	6	8	6	4	0	0	**25**	00:43:47	01:23:05
01.05.26	1	7	9	3	2	0	0	**22**	00:36:57	01:36:10
02.05.26	1	8	3	2	2	0	0	**16**	00:38:28	01:22:29
03.05.26	3	5	6	1	3	0	0	**18**	00:41:12	01:42:07
04.05.26	0	2	8	3	3	0	0	**16**	00:46:38	01:41:21
05.05.26	1	8	7	0	0	0	0	**16**	00:29:06	00:41:26
06.06.25	1	4	8	4	3	0	0	**20**	00:39:27	01:41:29
07.05.26	1	5	5	3	0	0	0	**14**	00:31:25	00:59:35
08.05.26	2	10	8	2	0	0	0	**22**	00:29:35	00:52:15
09.05.26	1	5	7	2	2	0	0	**17**	00:37:11	01:21:00
10.05.26	2	8	6	2	4	0	0	**22**	00:35:19	01:38:08
11.05.26	4	9	6	2	4	0	0	**25**	00:36:00	01:41:35
12.05.26	4	7	3	1	1	0	0	**16**	00:27:02	01:00:40
13.05.26	4	7	5	2	2	0	0	**20**	00:35:18	01:50:37
14.05.26	0	4	6	1	3	0	0	**14**	00:42:46	01:26:13
15.05.26	4	8	4	4	4	0	0	**24**	00:38:03	01:08:11
16.05.26	2	9	2	2	0	0	0	**15**	00:25:10	00:47:28
17.05.26	0	5	3	3	1	0	0	**12**	00:36:00	01:11:22
18.05.26	3	6	5	1	1	1	0	**17**	00:34:46	02:20:38