Bundle Emergency Ambulance Services Joint Committee 10 September 2019

Tackling the Challenge of Handover Delays

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Executive Director of Quality, Innovation and Improvement

THE NHS CONSTITUTION

The patient will be at the heart of everything the NHS does

The NHS aspires to the highest standards of excellence and professionalism

A Decade of Policy Direction…

NHS Confederation, 2012

Department of Health, 2012
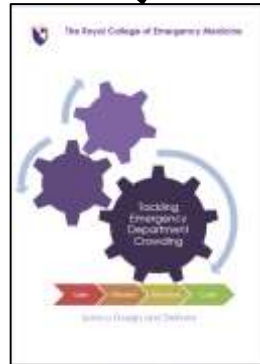
Royal College of Emergency Medicine, 2015

Carter Review, Acute Trusts, 2015

Keith Willett, NHS England, 2017
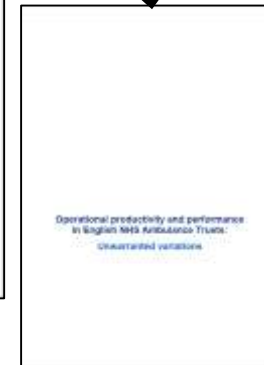
Carter Review, Ambulance, 2018

NHS England, 2019

2012   2013   2014   2015   2016   2017   2018   2019

…and Decay
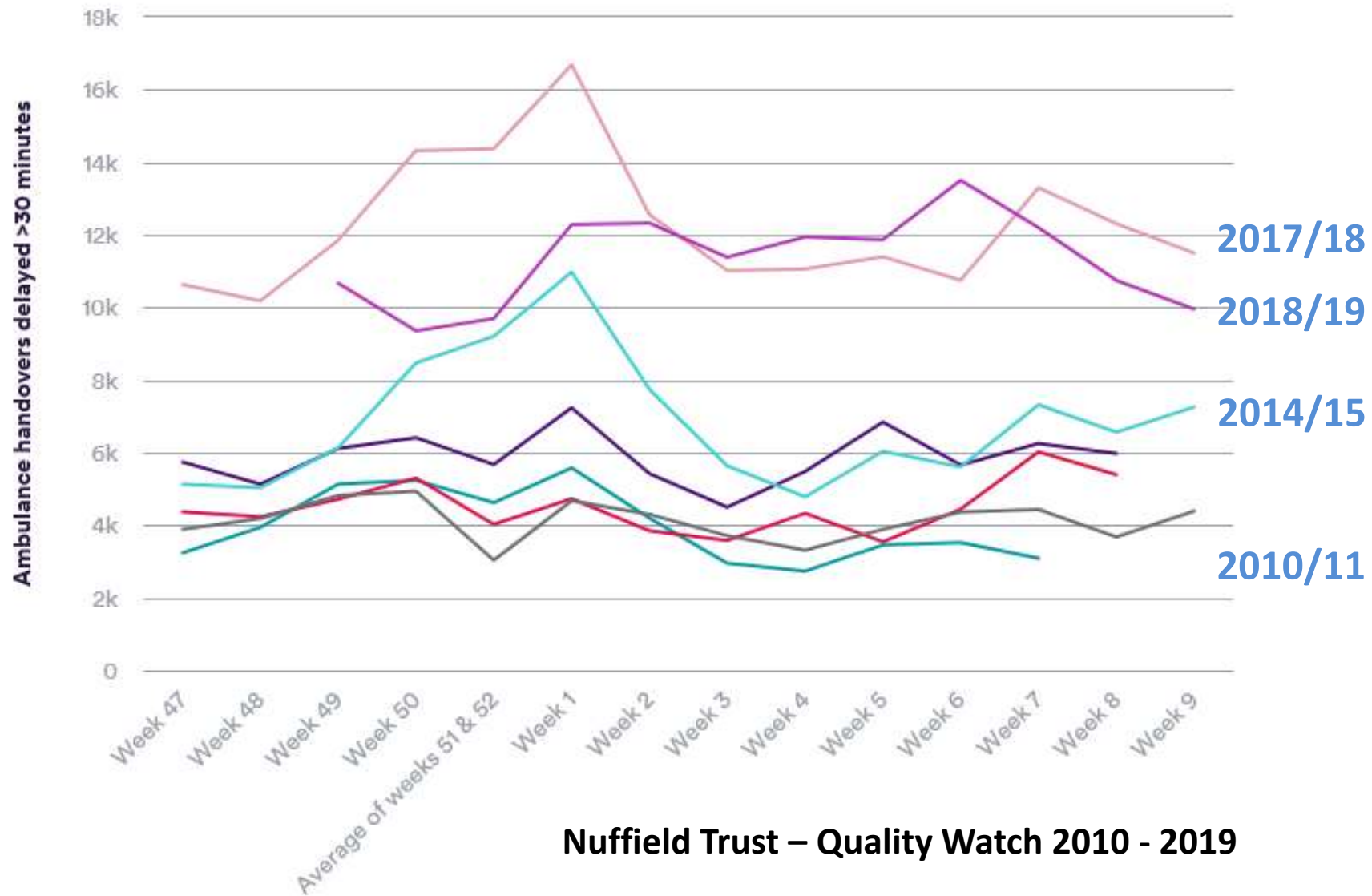
Nuffield Trust – Quality Watch 2010 - 2019

Where to start?

Lost Ambulance Hours
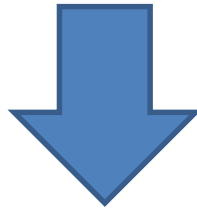
Lost hours over 30 minute standard x activity
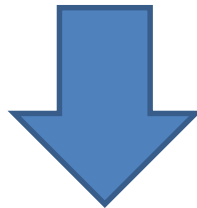
Super Six

Arrival to Handover: Longest delays ranked by lost hours

MONDAY 2nd April - SUNDAY 28th October 2018

Row Labels	Hospital Attendances	Lost time during handover past 15 mins (hh:mm)	Average Handover Time	RAG_H
Ormskirk General	963	12:09	00:11:33	1
Alder Hey Childrens	3586	22:37	00:08:22	2
Airedale General	1428	60:17	00:14:30	3
Chorley District	3085	181:46	00:16:09	4
Macclesfield District General	7272	533:29	00:19:02	5
West Cumberland	6751	558:36	00:19:00	6
Furness General	6220	733:57	00:21:39	7
Fairfield General	13201	858:50	00:17:49	8
Leighton	13776	915:40	00:18:24	9
North Manchester General	13748	1255:06	00:19:10	10
Manchester Royal Infirmary	18828	1381:15	00:18:02	11
Countess of Chester	11438	1446:25	00:23:18	12
Tameside General	14798	1456:45	00:20:19	13
Royal Liverpool University	20017	1462:09	00:18:01	14
Whiston	19671	1502:41	00:17:17	15
Warrington General	14101	1560:06	00:20:51	16
Stepping Hill	14897	1592:52	00:21:28	17
Cumberland Infirmary	12056	1596:41	00:23:34	18
Aintree University	18185	1655:23	00:19:28	19
Royal Bolton	17423	1734:40	00:18:56	20
Royal Lancaster Infirmary	11831	1791:05	00:24:36	21
Salford Royal	16800	1799:16	00:21:04	22
Wythenshawe	16868	1818:59	00:21:37	23
Royal Oldham	17281	1827:13	00:21:20	24
Southport District General	10476	1911:21	00:27:11	25
Royal Preston	17176	2301:20	00:22:19	26
Wigan Infirmary	15093	2318:52	00:23:24	27
Blackpool Victoria	21130	2488:18	00:21:35	28
Arrowe Park	17485	2732:57	00:23:37	29
Royal Blackburn	26480	4575:22	00:25:46	30
Grand Total	402064	44086:23	00:21:01	

MONDAY 1st October 2018 - SUNDAY 28th October 2018

| Row Labels	Hospital Attendances	Lost time during handover past 15 mins (hh:mm)	Average Handover Time	RAG_H
Alder Hey Childrens	566	3:42	00:09:19	1
Ormskirk General	166	5:15	00:12:44	2
Airedale General	198	12:52	00:16:33	3
Chorley District	396	18:48	00:15:13	4
Macclesfield District General	956	81:48	00:20:03	5
West Cumberland	935	95:23	00:20:31	6
Furness General	792	96:18	00:22:26	7
Whiston	2805	119:24	00:14:43	8
Royal Bolton	2290	139:31	00:16:00	9
Fairfield General	1643	140:12	00:19:25	10
Royal Preston	2274	142:49	00:15:56	11
Leighton	1960	153:32	00:19:10	12
Manchester Royal Infirmary	2483	167:02	00:17:40	13
North Manchester General	1777	173:30	00:19:51	14
Aintree University	2431	180:46	00:18:20	15
Royal Liverpool University	2751	188:43	00:17:27	16
Countess of Chester	1555	196:52	00:22:31	17
Cumberland Infirmary	1623	215:12	00:23:11	18
Tameside General	1984	215:22	00:21:11	19
Blackpool Victoria	2687	241:00	00:19:18	20
Salford Royal	2161	262:06	00:22:05	21
Wigan Infirmary	2004	267:06	00:21:35	22
Royal Lancaster Infirmary	1670	268:32	00:25:11	23
Royal Oldham	2432	275:04	00:21:40	24
Warrington General	1979	279:33	00:23:13	25
Wythenshawe	2197	281:13	00:23:23	26
Southport District General	1358	282:47	00:30:11	27
Stepping Hill	1978	296:07	00:26:09	28
Arrowe Park	2396	389:15	00:23:57	29
Royal Blackburn	3646	609:14	00:25:13	30
Grand Total	54093	5799:14	00:20:43	

The Plan

Pre work	Workshop 1	Workshop 2	Workshop 3	Summit Event
Sept 2018	Oct 2018	Nov 2018	Jan 2019	April 2018
1. Patient & Staff Experience for Shared Purpose	2. System Agreement & Accountability	3. Re- purpose A&E Delivery Board	4. Executive Visits & Intelligence Exchange	5. CEO & Executive Sponsorship
6. Joint Improvement Team (6 people – 3 Amb & 3 ED)	7. Recruited to Participate in Collaborative Learning Events (4 days out in 90)	8. Agreed goals, Measures & Data Systems	9. Agreed Process Map & Priority Focus	10. Integrate Improvement into Daily Work
11. Adoption of Agreed Methodology	12. 30 day Evaluation (x3)	13. Improvement Coaching	14. Peer site visit	15. Executive Sponsorship

Improvement Goal = Reduce Turnaround Time to 20 minutes by March 31st 2019

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1 **Arrival** (Single pin) → **Parking** → **Patient Prep for disembark** → **Un loading** | **Secure Vehicle** → **Walk to A&E entrance** | **A&E access**

2 **HAS Screen (Notify)** (Single pin) →

- Reception Booking in (PRF)
- Clinical Triage
- Identify Waiting Area
- Find equipment (stretcher / chair)

→ **T/F Patient to hospital equipment** → **Wait**

Full Handover → **3** **HAS Screen (Handover)** (Dual Pin) →

- Clean Stretcher
- IPC (hand hygiene)
- 🔊
- ⓘ

→ **Exit A&E**

Open Vehicle | **Clean & Check stock** → **4** **MDT Screen (Clear)** (Single pin) → **Exit A&E Ramp**

Learning about variation (Lost Hours from Turnaround >30 mins by hour / day)

Row L	2017							2017 Tot	2018							2018 Tot
	Mon	Tue	Wed	Thu	Fri	Sat	Sun		Mon	Tue	Wed	Thu	Fri	Sat	Sun	
00h	13.02	15.90	12.32	11.53	9.74	14.41	12.89	12.83	9.99	14.58	10.80	8.99	8.60	11.85	11.91	10.96
01h	8.84	11.25	7.90	7.43	7.27	10.33	10.10	9.02	8.27	10.99	8.25	7.49	6.78	8.91	9.68	8.63
02h	5.95	6.17	4.60	4.33	4.70	7.09	7.42	5.76	6.11	6.65	5.23	4.19	4.47	7.30	7.52	5.92
03h	6.86	6.83	5.01	5.65	4.80	7.00	8.09	6.33	6.32	6.79	5.90	4.86	4.62	7.13	7.22	6.12
04h	6.36	7.11	5.66	4.96	4.73	6.81	8.53	6.32	5.91	5.96	5.46	4.67	4.01	6.55	7.94	5.79
05h	4.65	5.78	4.14	3.91	3.99	5.27	6.19	4.85	4.69	5.57	4.24	3.79	3.99	4.44	5.55	4.61
06h	2.63	2.49	2.10	1.64	1.34	2.21	2.47	2.13	1.77	2.00	1.60	1.55	1.48	1.75	2.42	1.79
07h	3.17	3.36	1.95	2.38	2.10	2.42	3.38	2.68	2.78	2.84	2.08	1.80	1.77	2.14	2.33	2.25
08h	6.03	6.30	4.90	4.64	4.19	4.92	5.44	5.20	5.92	6.13	4.71	4.40	3.79	4.50	5.01	4.92
09h	9.58	9.58	7.21	7.36	6.95	6.88	7.89	7.92	9.00	9.10	6.65	7.17	5.81	6.05	7.26	7.29
10h	12.98	11.49	10.18	10.41	8.27	8.77	9.58	10.24	11.35	11.55	8.77	8.09	7.86	6.80	8.14	8.94
11h	17.43	14.83	12.49	12.58	10.73	11.60	13.84	13.36	15.22	13.09	11.16	10.56	9.42	8.79	10.14	11.20
12h	22.44	18.77	15.88	15.61	13.10	14.08	16.63	16.64	18.33	15.44	14.02	13.48	10.39	10.18	11.47	13.33
13h	24.06	20.82	18.12	17.71	15.45	15.88	16.55	18.37	20.73	17.98	15.48	14.90	13.67	12.86	15.00	15.80
14h	22.20	19.11	17.17	16.74	15.78	12.86	14.11	16.84	20.20	18.21	14.70	14.18	13.59	12.42	13.39	15.24
15h	26.45	22.78	19.53	19.28	19.66	15.69	17.12	20.06	22.71	21.40	17.16	15.77	15.77	14.77	15.71	17.61
16h	29.80	22.68	19.92	18.22	20.25	16.33	18.97	20.88	24.23	19.82	17.86	17.27	15.48	15.84	15.64	18.02
17h	26.84	20.20	18.58	18.82	19.27	15.38	18.71	19.68	22.01	19.32	16.17	15.86	16.87	14.27	15.01	17.07
18h	17.56	14.31	12.05	11.59	13.24	10.41	12.07	13.03	14.31	12.92	10.90	10.25	10.95	8.73	9.02	11.01
19h	24.32	17.15	16.84	14.62	16.69	12.35	12.41	16.33	19.13	15.15	14.50	13.96	11.86	10.15	10.08	13.55
20h	29.74	23.57	22.68	21.53	22.73	16.93	19.53	22.38	26.17	23.05	20.23	17.92	18.87	14.76	14.44	19.35
21h	25.96	20.58	21.83	18.17	20.39	15.61	18.16	20.09	23.57	18.16	18.04	15.49	16.94	14.07	14.74	17.29
22h	24.75	17.84	17.54	17.21	19.87	15.85	17.95	18.71	21.49	18.15	15.87	13.12	15.76	14.37	13.88	16.09
23h	19.54	15.46	14.50	14.39	15.57	14.10	15.27	15.55	17.51	14.37	12.85	11.03	13.47	12.95	12.56	13.53
Grand To	391.15	334.39	293.09	280.71	280.81	263.20	293.30	305.20	337.70	309.25	262.62	240.79	236.24	231.60	246.05	266.32

High Impact Changes

✓ Consultant Led MDT Triage Process at Handover

✓ Handover Safety Checklist

✓ Logistics (chairs, trolleys)

✓ SBAR handover

✓ Paper Systems

✓ Auto clear

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act   Plan

Study   Do
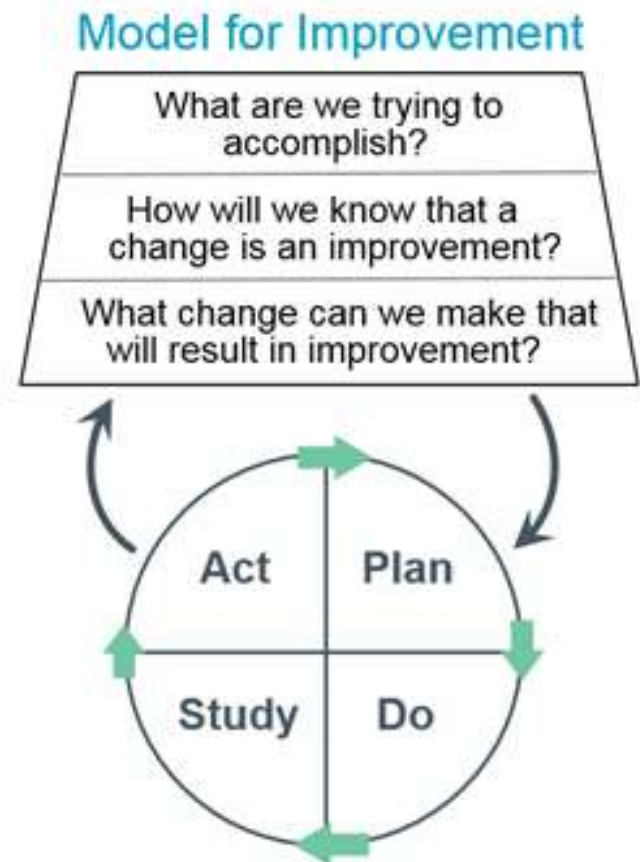
Uptake of Improvement- Site 3

Patient & Staff Experience for Shared Purpose	System Agreement & Accountability	Re- purpose A&E Delivery Board	Executive Visits & intelligence exchange	CEO & Executive Sponsorship
Joint Improvement Team (6 people – 3 Amb & 3 ED)	Recruited to participate in collaborative learning events (4 days out in 90)	Agreed goals, Measures & Data Systems	Agreed Process Map & Priority Focus	Integrate Improvement into daily work
Adoption of Agreed Methodology	30 day Evaluation (x3)	Improvement Coaching	Peer site visit	Executive Sponsorship

- Full participation with consultant led clinical triage
- ECIST in A&E
- Full capital build in progress

Uptake of Improvement - Site 4

Patient & Staff Experience for Shared Purpose	System Agreement & Accountability	Re- purpose A&E Delivery Board	Executive Visits & intelligence exchange	CEO & Executive Sponsorship
Joint Improvement Team (6 people – 3 Amb & 3 ED)	Recruited to participate in collaborative learning events (4 days out in 90)	Agreed goals, Measures & Data Systems	Agreed Process Map & Priority Focus	Integrate Improvement into daily work
Adoption of Agreed Methodology	30 day Evaluation (x3)	Improvement Coaching	Peer site visit	Executive Sponsorship

- Only 1 member of operational management attended LS2 &3
- Clinical resistance to handover safety checklist
- Culture of 15 minute handover to clear

Impact of the Collaborative by Site

Site	Pre-Collaborative Average Turnaround (mins)	Final Collaborative Average Turnaround (mins)	Post-Collaborative Average Turnaround (mins)
1	32.00	27.00 ↓	30.00 ↑
2	39.00	34.00 ↓	34.00 ↔
3	34.00	25.00 ↓	24.00 ↓
4	35.00	35.00 ↔	36.00 ↑
5	40.00	38.00 ↓	27.00 ↓
6	36.00	25.00 ↓	28.00 ↑

- ✓ 5 out of 6 sites improved turnaround times compared to pre-collab performance
- ✓ On average sites reduced turnaround by 5 minutes
- ✓ 3 sites have seen increases in average turnaround times post April 2019
- ✓ 2 have seen improvements
- ✓ 1 site has remained unchanged

Variation in Time to Respond
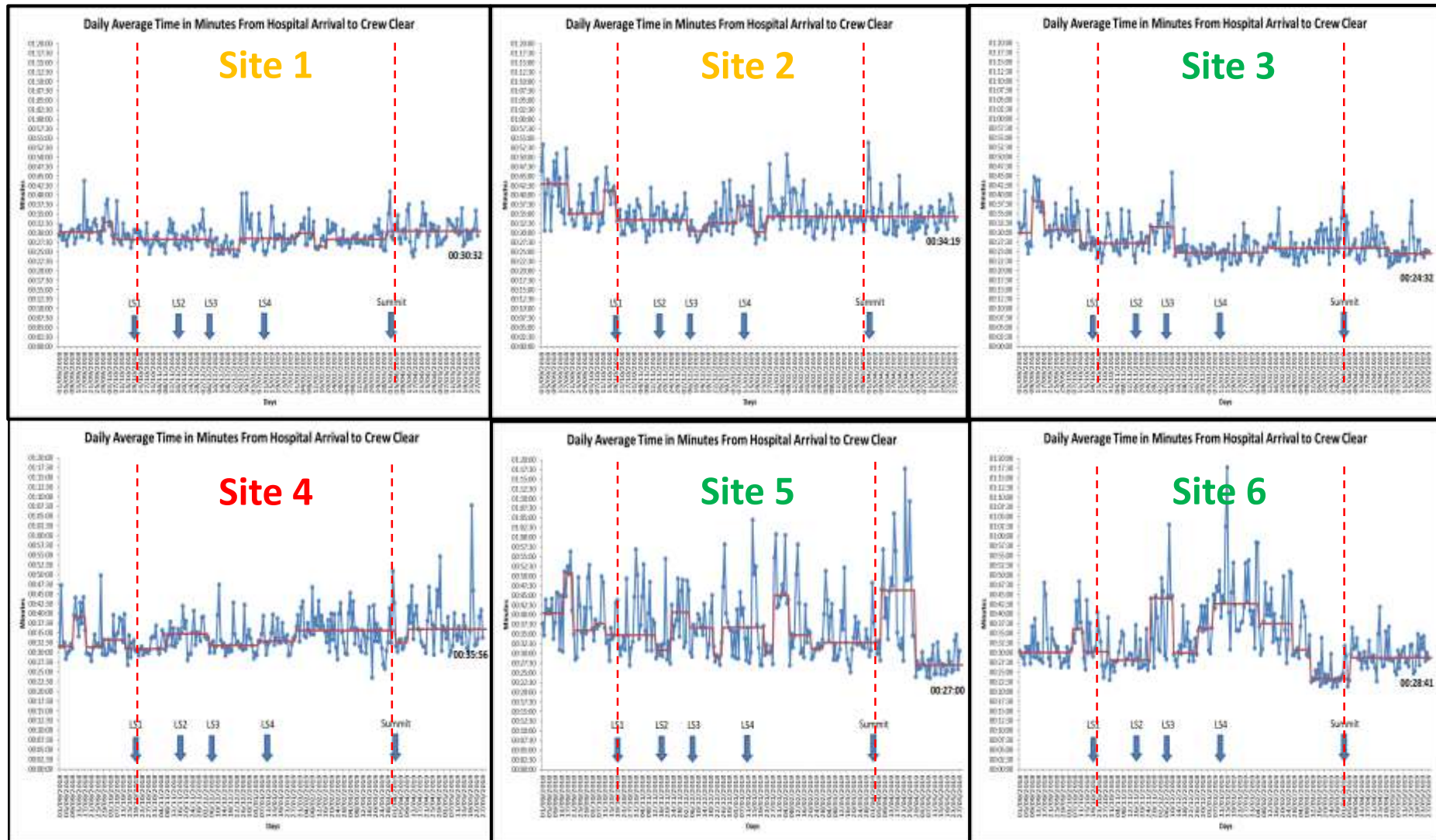
Overall Collaborative Response

Weekly Average Time in Minutes From Hospital Arrival to Crew Clear
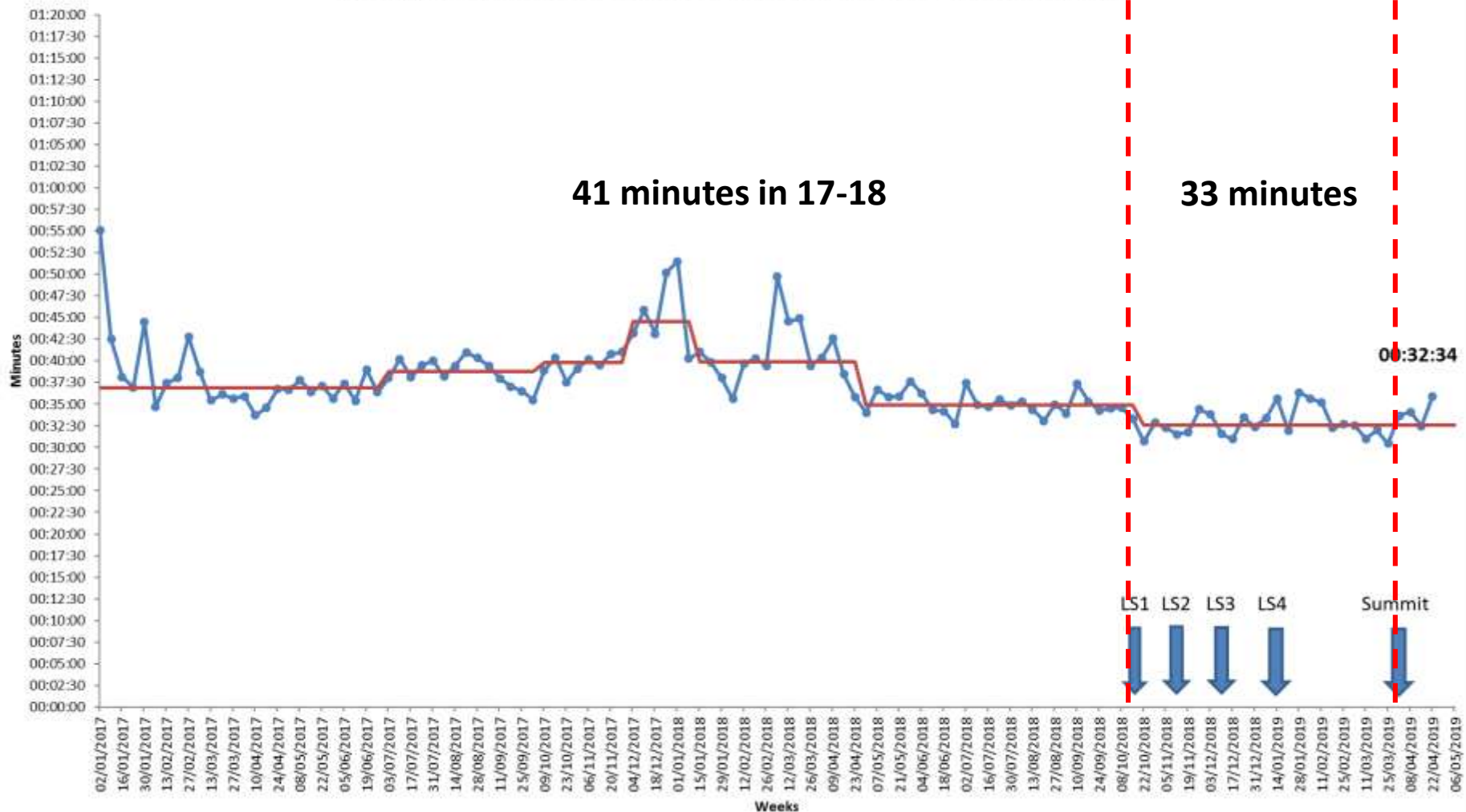
Collaborative verses Control
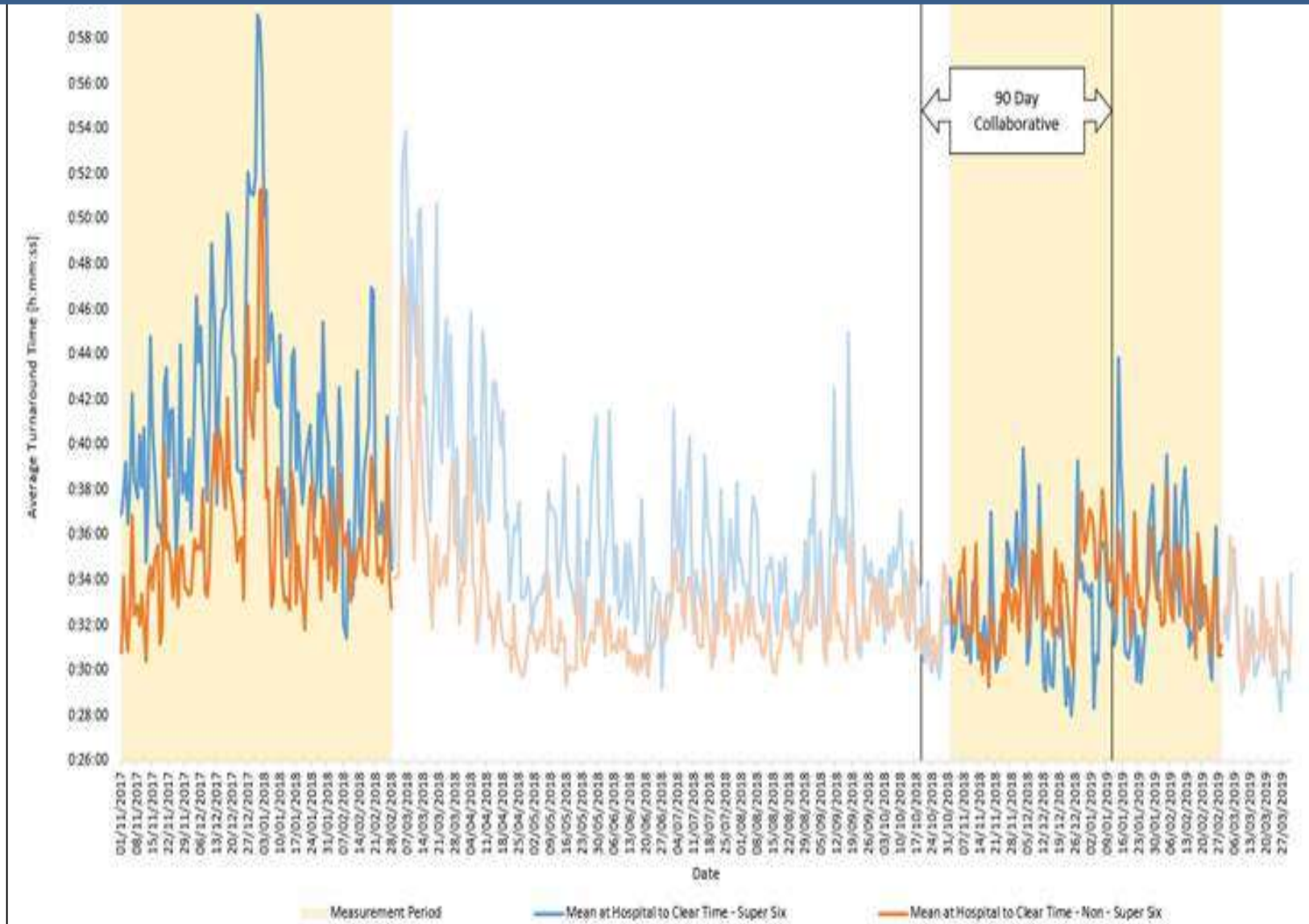
Scaling Up

Step 1
- **Super Six** Oct 2018-Apr 2019
- Method: Improvement Collaborative (BTS)

Step 2
- **Super Six plus 10 new sites**
- Sept 2019- Apr 2019
- Method: Rapid BTS & Knowledge x change

Step 3
- **All NWAS sites**
- Jan 2020 – Apr 2020
- Virtual BTS & Knowledge x change

Key Questions

- How do we get the biggest impact for our effort (and money)?

- How does any future programme fit with our strategic intent & priorities, in particular S&T?

- How does any future approach ensure our contract deliverables?

- How does any future approach align with regulatory, policy requirements or ambulance improvement priorities?

Benefits Case Focus

Serious Incidents

Improvement Skills

Patient Experience

Staff Experience

Productivity

Serious Incidents

A 40% reduction in SI's due to delays

StEIS Incidents Opened by Month
February 2016 - March 2019
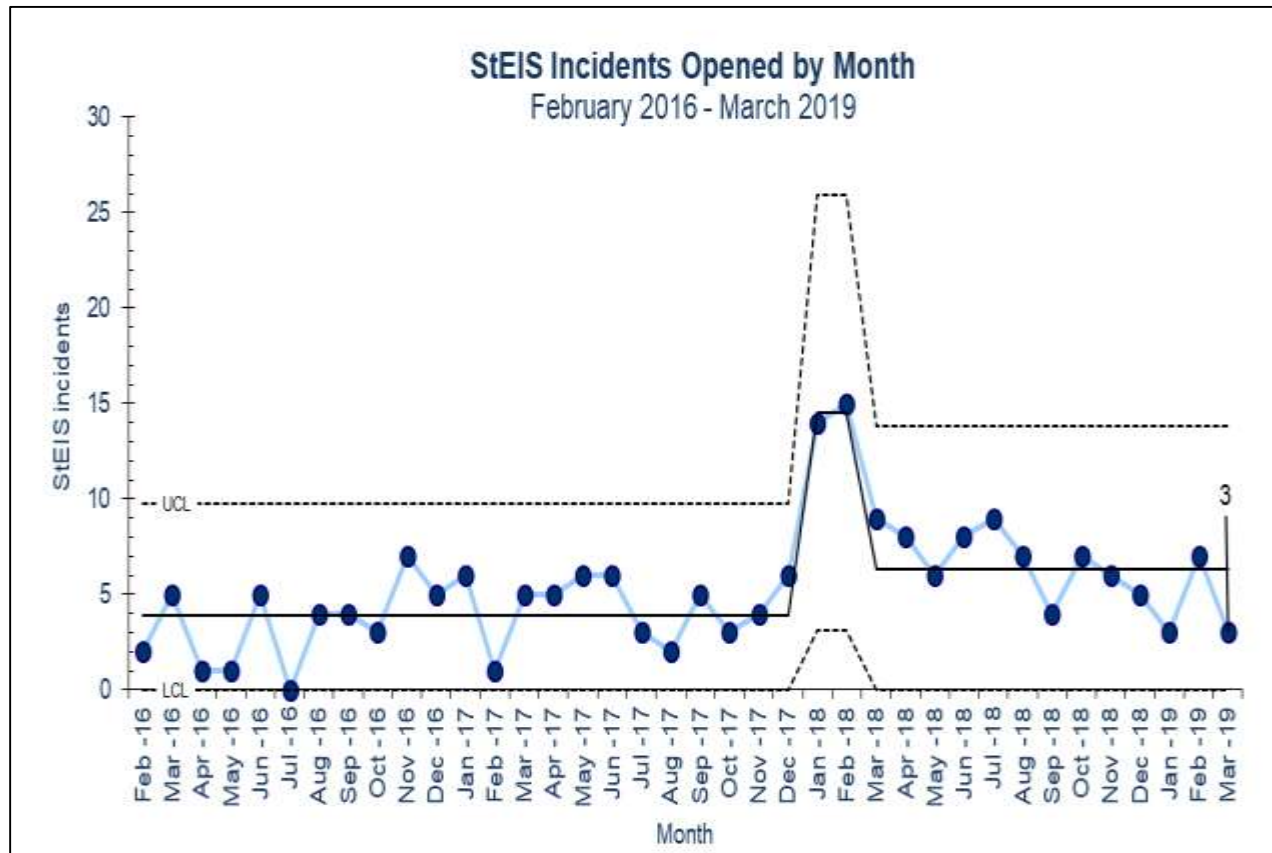
Half of reported serious incidents (SIs) are a result of delays. During the collaborative period (October 2018 - March 2019) there were **17 SI's** as a result of delays across NWAS compared to 30 in the same period in 2017/18. Converting incidents to costs is notoriously challenging, particularly in the ambulance sector. In healthcare settings it is estimated that an SI costs **£6,000** in extra care (3), but in addition there are financial implication related to increased work for staff and litigation. In 2017/18 NWAS paid **£833,032** in costs for 6 successful clinical claims (4).

3 – Patient Safety: Cost Implications of Adverse Health Events, F Gailey & P Cachia, NES Patient Safety Multidisciplinary Steering Group. 2010.

Skills: *A minimum of 1,000 staff & patients trained in basic QI*

Quality Improvement (QI) initiatives provide participating staff with a skills introduction to improvement methodology. Evidence suggests (5) that whilst this is a long term investment, improved QI capability will I mprove productivity and Safety, whilst supporting workforce satisfaction and retention. Improvement programmes also provide the potential for staff to become content experts and leaders in the field nationally and internationally. The spread of capability from any improvement programmes is in combination with organisational education and training programmes, but based on a 10 team collaborative we might expect the following:

10 Teams

60 Staff & Patients

30 ED Staff

All ED Staff (approx. 400)

30 NWAS Staff

NWAS staff (approx. 400)

Additional hospital, ambulance and commissioning staff, and patients (200)

5 – Building the foundations for improvement, B Jones, T Woodhead. Health Foundation, 2015.
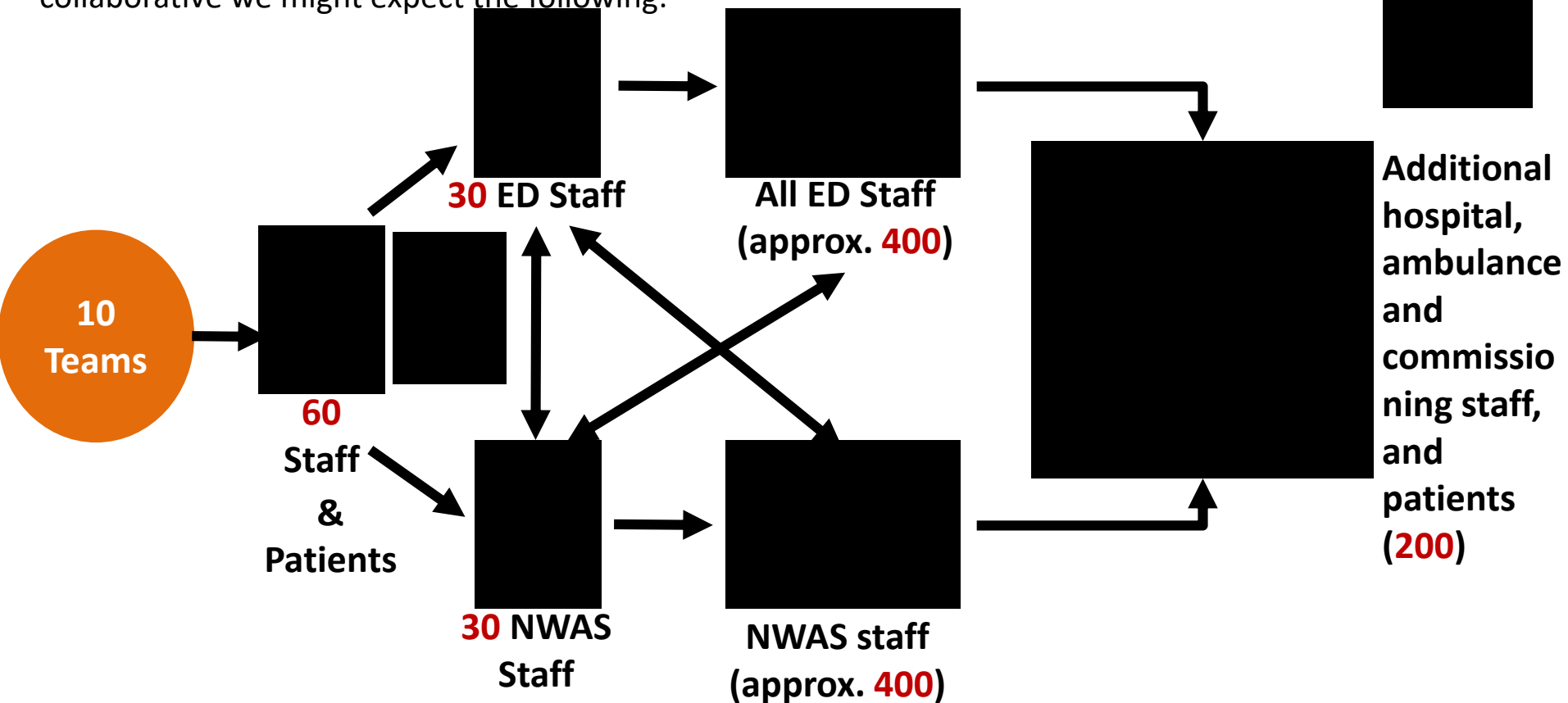
Patient, carer and family experience and outcomes:

- *A 62% reduction in the number of patients waiting longer than 60 minutes for handover*
- *Reduction in the complaints received as a result of delays*

Reducing delays in Hospital Handover and increased See & Treat along with improved workforce capability will support organisation reduction in serious incidents. This means fewer patients will be at risk of harm related to delays – potentially
17 patients during a collaborative programme period.

Fewer hospital delays will impact on patient experience at hospital, waiting less time to see a clinician and for a decision to be made about their care. There was a **62%** reduction in the number of patients waiting longer than 60 minutes for hospital handover between the collaborative period and the same time in 2017/18. In Phase 2 a similar reduction could result in more than **10,000** patients waiting less than 60 minutes for handover who previously wouldn't have. This will also mean patients will wait less time on an ambulance trolley – and reduce risk from pressure related sores. Process improvements in ED's have resulted in review of patient management and flow – along with reductions in delays this means fewer patients being treated in corridors and improved privacy and dignity.

Increased See & Treat performance will result in quicker resolution to treatment decisions and localised care. Average performance on the Friends & Family Test in 2018/19 highlights much better rated experience in See & Treat (**95%**) than See & Convey (**75%**).

Staff Experience & Organisational Benefit

Collectively waiting 80 hours less per day

Improvement in Hospital Handover have a direct impact on ambulance staff. Based on the ▮▮▮▮▮▮ in lost hours during the collaborative period, collectively staff are waiting **80 hours** less per day from handovers that take in access of 30 minutes across the 6 participating sites. This has had a positive impact on staff welfare and has the potential to improve mental wellbeing, fatigue and general staff satisfaction. During the collaborative staff satisfaction feedback included:

- As a result of working collaboratively staff from both hospital ED's and NWAS have much better insight into how each other work and have built **stronger working relationships**. There is now better communication between staff, structured verbal handovers, and a group ownership of the process of hospital handover.
- Through creating an improvement community staff have been **empowered** to improve the service they deliver and have stronger relationships with senior staff from both services to support their work. This has sped up the process of testing changes and provided a forum for **shared learning**. In turn this has improved **staff morale**.
- The collaborative has improved **staff awareness of the system** they work in, providing data to improve knowledge of performance and to give ideas on where to focus improvement.

At an organisation level large scale change programmes are not only impactful on developing staff capability and achieving quality outcomes, they are also a key ingredient in the **Care Quality Commission's 'outstanding' rating** (6). Hospital handover improvement has also built stronger relationships with stakeholders in the delivery of emergency care and has strengthened NWAS' role within A&E Delivery Boards.

6 – The improvement journey: Why organisation-wide improvement in healthcare matters, and how to get started – B Jones, T Horton, W Warburton. The Health Foundation, May 2019.

Productivity   *To reduce NWAS average turnaround time to 26 minutes by December 2020*

Collaborative Phases	Potential Start Dates	Baseline (Oct 18 – March 19)	Winter 19/20 (Nov 19 – Feb 20)	Winter 20/21 (Nov 20 – Feb 21)
Cohort 1 (6 sites, Super Six)	September 2019	**00:32:58**	**00:28:00** *Assumption 2 = 00:22:00 2 = 00:30:00 2 = 00:34:00*	**00:25:00** *Assumption 2 = 00:20:00 2 = 00:26:00 2 = 00:30:00*
Cohort 2 (10 Sites)	September 2019	**00:35:05**	**00:32:00** *Assumption 3 = 00:25:00 5 = 00:33:00 2 = 00:38:00*	**00:28:00** *Assumption 3 = 00:22:00 5 = 00:30:00 2 = 00:34:00*
Cohort 3 (10 Sites)	January 2020	00:31:04	**00:31:04** *Assumption 3 = 00:28:00 5 = 00:30:00 2 = 00:36:00*	**00:26:00** *Assumption 3 = 00:22:00 5 = 00:26:00 2 = 00:32:00*
Average		**00:33:02**	**00:30:00**	**00:26:00**

Potential Productivity Saving Phase II & III

	Baseline (2018/19)		Phase 1 (2019/20)		Phase 2 (2020/21)	
	Total	%	Total	%	Total	%
Incidents	1,131,556	100	1,150,792	100	1,170,355	100
Hear & Treat	71,337	6.3	82,857	7.2	99,480	8.5
See & Treat	283,737	25.1	322,222	28	386,217	33
See & Convey (ED)	705,145	62.3	655,951	57	573,474	49
See & Convey (Non-ED)	71,337	6.3	89,762	7.8	111,184	9.5

Estimated Cost Savings by 2021

Hospital Handover Collaborative

1,229,425
Hospital Conveyances

71,030
Hours Saved

£73.68 per hour for a DCA

£5,233,490
Saving

£5,233,490

Scaling Up NWAS & Beyond

Step 1

- **Super Six** Oct 2018-Apr 2019
- Method: Improvement Collaborative (BTS)

Step 2

- **Super Six plus 10 new sites**
- Sept 2019- Apr 2019
- Method: Rapid BTS & Knowledge x change

Step 3

- **All NWAS sites**
- Jan 2020 – Apr 2020
- Virtual BTS & Knowledge x change

Every Minute Matters

All comments gratefully received

maxine.power@nwas.nhs.uk

"It is the long history of humankind (and animal kind, too) that those who learned to collaborate and improvise most effectively have prevailed." – Charles Darwin

EMERGENCY AMBULANCE SERVICES JOINT COMMITTEE

A meeting of the Joint Committee will be held at 13:30hrs
On Tuesday 10 September 2019 at the
National Collaborative Commissioning Unit, 1 Charnwood Court, Heol Billingsley,
Treforest Industrial Estate, CF15 7QZ

Video Conference Facilities are available

AGENDA

Part 1- Preliminary Matters			
1.1	Welcome & Introductions	*Chair*	Oral
1.2	Apologies for Absence	*Chair*	Oral
1.3	Declarations of Interest *Members must declare if they have any personal or business pecuniary interests, direct or indirect, in any contract, proposed contract, or other matter that is the subject of consideration on any item on the agenda for the meeting.*	*Chair*	Oral
1.4	To receive the 'unconfirmed' minutes of the Emergency Ambulance Services Committee meeting held on 23 July 2019	*Chair*	Attachment
1.5	1.5.1 Action Log 1.5.2 Matters Arising not considered within the Action Log	*Chair*	Attachment
Part 2 – Key items for discussion			
2.1	Chair's Report	*Chair*	Attachment
2.2	Chief Ambulance Services Commissioner's Report	*CASC*	Attachments
2.3	WAST Provider Update including Demand and Capacity Review	*CEO WAST*	Attachment
2.4	WAST Relief Gap for Emergency Ambulance Services – Reference Document	*CASC*	Attachment
2.5	Alternative Pathways / Emergency Services Map (to follow)	*CEO WAST*	Attachment
2.6	EASC Finance Report	*Dir of Finance*	Attachments
2.7	Ambulance Quality Indicators	*Asst Dir Quality & Performance*	Attachments
Part 3 - For Approval / Endorsement			
3.1	Regional Escalation	*Asst Dir Quality & Performance*	Attachment
3.2	1% 'A Healthier Wales' Allocation	*Head of Commissioning*	Attachment

3.3	Establishment of the South, Mid and West Wales Trauma Network – Welsh Ambulance Services NHS Trust Business Case	*Asst Dir Quality & Performance*	Attachment
3.4	Forward Plan of Business	*CASC / Committee Secretary*	Attachment
Part 4 – Other matters			
4.1	Any other urgent business	*Chair*	Oral
Date of Next Meeting: A meeting of the Joint Committee will be held at 09:30hrs On Tuesday 12 November 2019 at WHSSC, Unit G1, The Willowford, Main Ave, Treforest Industrial Estate, Pontypridd CF37 5YL			

Future meetings

All meetings will be held in WHSSC, Unit G1, The Willowford, Main Ave, Treforest Industrial Estate, Pontypridd CF37 5YL

28 January 2020 (WHSSC AM, EASC PM)
10 March 2020 (EASC AM, WHSSC PM)
12 May 2020 (WHSSC AM, EASC PM)
14 July 2020 (EASC AM, WHSSC PM)
08 September 2020 (WHSSC AM, EASC PM)
10 November 2020 (EASC AM, WHSSC PM)
19 January 2021 (WHSSC AM, EASC PM)
16 March 2021 (EASC AM, WHSSC PM)

GIG
CYMRU
NHS
WALES

Pwyllgor Gwasanaethau
Ambiwlans Brys
Emergency Ambulance
Services Committee

**EMERGENCY AMBULANCE SERVICES
JOINT COMMITTEE MEETING**

**'UNCONFIRMED' MINUTES OF THE MEETING HELD ON
23 JULY 2019 AT THE EDUCATION CENTRE LLANDOUGH
HOSPITAL CARDIFF**

PRESENT

Members	
Chris Turner	Independent Chair
Stephen Harrhy	Chief Ambulance Services Commissioner
Gary Doherty	Chief Executive, Betsi Cadwaladr UHB
Len Richards	Chief Executive, Cardiff & Vale UHB
Sian Harrop-Griffiths	Swansea Bay UHB
Karen Miles	Hywel Dda UHB (Via VC)
Carol Shillabeer	Chief Executive, Powys THB
Glyn Jones	Director of Finance/Deputy CEO, Aneurin Bevan UHB
In Attendance:	
Jason Killens	Chief Executive Welsh Ambulance Services NHS Trust
Anthony Hayward	Corporate Director, National Collaborative Commissioning Unit
James Rodaway	Head of Commissioning, EASC
Jamie Kaijaks	Finance Graduate Trainee, Swansea Bay UHB
Ross Whitehead	Assistant Chief Ambulance Services Commissioner
Shane Mills	Director Quality and Patient Experience, National Collaborative Commissioning Unit
Stuart Davies	Director of Finance, WHSSC and EASC Joint Committees
Chris Polden	Managing Director ORH (for one item)
Gwenan Roberts	Head of Corporate Services, Cwm Taf Morgannwg UHB (Secretariat)

Part 1. PRELIMINARY MATTERS		ACTION
EASC 19/48	**WELCOME AND INTRODUCTIONS** Chris Turner (Chair), welcomed Members to the meeting of the Emergency Ambulance Services Committee and those present introduced themselves. The Chair advised that the main business would be followed by a development session involving a presentation from James Rodaway on Risk Management.	

EASC 19/49	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Judith Paget, Len Richards, Steve Moore, Tracy Myhill, Sharon Hopkins, Julian Baker, Steve Webster and Robert Williams.	
EASC 19/50	**DECLARATIONS OF INTERESTS** There were no additional interests to those already declared.	
EASC 19/51	**MINUTES OF THE MEETING HELD ON 14 MAY 2019** The minutes were **confirmed** as an accurate record of the meeting held on 14 May 2019.	
EASC 19/52	**ACTION LOG** Members **RECEIVED** the action log and **NOTED** progress as follows: **EASC17/44 & 17/73 & 19/21** **Emergency Medical Retrieval and Transfer Service (EMRTS) Gateway review** Members **NOTED** that a further update would be provided at the next meeting.	CASC
	EASC 18/06 & 18/65 & 19/21 **Integrated Performance Dashboard** Members **NOTED** that work was continuing on the development of the Dashboard which was linking data across the system. A further update would be provided at the next meeting.	CASC
	EASC 18/107 & 19/21 **Expansion of EMRTS (Emergency Medical Retrieval and Transfer Service)** Members **NOTED** that an update would be provided in the Chief Ambulance Service Commissioner's report.	CASC
	EASC 19/08 & 19/21 **Mental Health Staff Clinical Desk** Members **NOTED** that work was continuing with the Welsh Government in terms of developing a national approach. A further update would be provided to the Committee in November (**Added to the Forward Look**).	Director of Quality and Experience

	EASC 19/08 & EASC 19/21 & EASC 19/23 **Emergency Medical Retrieval and Transfer Service (EMRTS)** Members **NOTED** that information was awaited in relation to the Gateway Review, a meeting was scheduled to take place in early August and an update would be provided at the November meeting. **Ambulance Quality Indicators (AQI)** Members **NOTED** the work to link the AQIs with the performance dashboard. Members **RESOLVED** to: • **NOTE** the action log.	CASC
EASC 19/53	**MATTERS ARISING** There was none.	CASC
EASC 19/54	**CHAIR'S REPORT** The Chairs report was **received** by Members. In presenting the report Chris Turner highlighted his key meetings which had taken place since the last meeting of the Committee. Members **NOTED** that during the appraisal with the Minister, the emphasis had been on driving change across the system and ensuring that the EAS Committee was operating corporately. Other issues discussed included Amber implementation and the Red performance. Members also **NOTED** that a request has been received from the Deputy Chief Executive at NHS Wales for a discussion to take place at EASC on the regional escalation processes. Members **RESOLVED** to: • **NOTE** the Chair's Report.	Chair
EASC 19/55	**CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT** The Chief Ambulance Services Commissioners (CASC) report was **received** by the Committee. • **Update on Emergency Medical Retrieval and Transfer Service (EMRTS) Gateway Review** Members **NOTED** that the CASC was due to meet with colleagues from Swansea University at the beginning of August to receive the first draft of the Gateway Review.	CASC

	The document would be shared with Committee Members when received and discussion would take place at the next available Management Group meeting and a summary of the discussions would be provided to the Committee.	CASC

• **Update on Management Group**
Members **NOTED** that the first meeting of the Management Group took place on 12 July was well attended.

The meeting concentrated on the use of the 1% 'A Healthier Wales' allocation which allowed time to discuss in detail. The CASC explained that a good and positive start had been made at the first Management Group meeting.

Sian Harrop-Griffiths asked about the Terms of Reference and membership for the Management Group; Stephen Harrhy explained that it was similar to the approach to the Welsh Health Specialised Services Committee (WHSSC) management group and the terms of reference would be shared with the Committee at the next meeting. The aim was to ensure that the right representatives attend management group. Stephen Harrhy agreed to ensure that the meetings were scheduled and planned in advance to ensure the right staff were available to represent the health boards (**Added to the Action Log**).

CASC

• **RED performance**
Members **NOTED** that the performance in June was over 65% and was an improvement on the previous 2 months. Red performance across Wales was in excess of 70% and although was 61.9% in Hywel Dda this was slowly increasing. Members **NOTED** that the Powys and Hywel Dda areas were regularly reporting lower than 65%.

• **Mental Health**
Members **NOTED** that South Wales Police requested continuation of the funding for Mental Health clinicians in the control room. Shane Mills explained that discussions were taking place with the Police Federation lead which included Carol Shillabeer as the lead Chief Executive.

Although the report is yet to be published, the South Wales Police have shared that early findings from a review are that there has been a reduction in persons with 'MH issues' requiring a Police response. Members **NOTED** that further discussion and analysis would need to take place in order that Members understood how this all fits together with 111 and the WAST clinical desk.

	Members **NOTED** that the Mental Health Access review was due to report in the new year which would give a better understanding of demand from people with mental health distress for urgent care services. Carol Shillabeer explained that the term 'mental health' was being used in its widest form. Jason Killens also supported that there was a need for a better service but suggested a 'Once for Wales' approach was needed. Shane Mills and Carol Shillabeer agreed to develop further information for Committee Members to capture all of the work to date (**Added to the Action Log**). Members **RESOLVED** to: • **NOTE** the update and the actions agreed.	Carol Shillabeer /Shane Mills
EASC 19/56	**DEMAND AND CAPACITY REVIEW** Jason Killens provided an overview of the work on the Demand and Capacity Review at the Welsh Ambulance Services NHS Trust (WAST) to date and invited Chris Polden from ORH to give a short presentation. Members **NOTED** the intention to provide a final report to the Committee at the November meeting. Chris Polden gave an overview of the work of the ORH Management Consultancy set up in 1986 who were working globally with emergency services. Members **NOTED** the work across the UK with ambulance services who were identifying similar themes to those identified by WAST. Other issues such as the ageing population, long waits for patients in Amber category and seasonal variation were also considered as part of the review. The Review aims were clarified as: • Forecast incident demand over the next 5 years • Agree the required level of quality and time performance for each type of patient • Model the resources needed to achieve these levels of time and quality assuming current operations • Identify WAST efficiencies and the impact these will have on the staffing required • Identify unscheduled care system efficiencies and the impact these will have on the staffing required • Model the impact of planned service changes and their impact on patient flows • Model the resources required for call handling clinical staff and dispatch in the clinical contact centres.	Jason Killens

	The Review would ensure comprehensive data collection to identify issues across Wales and would also model the incident life cycle. Members discussed the impact of the work and the potential to widen across the pathway. Chris Polden confirmed that work was underway to also benchmark both within and outside of Wales and the UK.	
	Members **NOTED** that a steering group would be developed to oversee the work. It was felt that clinical service plan leads could provide the right links to get the best information for the Review and although the review would not include aspirational ideas although they would be captured as issues. Directors of Planning had also been involved in the work which included the changes planned for the major trauma service although the steering group would clarify what could be included in the work. Members discussed the information shared and suggested that the work on population segmentation may also be helpful for the Review team.	Steve Moore
	Members **NOTED** that schemes which have been evaluated were included, such as the clinical desk and advanced paramedic practitioners. Members felt that the role of the steering group would be important to test the model and analyse the choices to be made about the future provision. Steve Moore would provide the leadership for the group and the reports and minutes of meetings would be shared with Members (**Added to Action Log**).	Steve Moore
	The Chair thanked Chris Polden for the helpful presentation on the overview of the work and it was agreed to receive further information on the work, if available, at the next meeting (**Added to the Action Log).**	
	Members **RESOLVED** to • **NOTE** the presentation.	
EASC 19/57	**PROVIDER ISSUES BY EXCEPTION** The Welsh Ambulance Services NHS Trust Provider Update was received by the Committee. In presenting the report, Jason Killens highlighted some key issues: • **Serious Adverse Incidents (SAIs)** Members **NOTED** the increasing trends for SAIs in the Aneurin Bevan and Swansea Bay University Health Board areas. The Directors of Nursing were discussing the Joint Investigation Framework in July to identify the best practice on investigating incidents going forward.	Jason Killens

- **RED Performance**

Members **NOTED** that in the main Hywel Dda and Powys health board areas were dipping below the 65% target; recovery plans were in place and further actions had been added although it was recognised that there was more work to do to improve response times.

Members **NOTED** the current improvement focus areas had been identified and were being actioned including:

- Continuing to develop and utilise information on demand, capacity and efficiency to inform action planning. This includes the use of sophisticated performance analysis and modelling software (Qliksense and Optima Predict) to support Operations
- Overproducing on RRV unit hours at times when red performance is poor (twilight shifts)
- Increasing the number of Community First Responders
- Working with Trade Union Partners to understand post production hours lost and to identify actions to reduce them
- Continuing work to reduce abstraction rates, with sickness levels now on a downward trend
- Reviewing deployment points, moving them where possible to reduce response times.

The expansion of the Advanced Paramedic Practitioner (APP) was discussed and Members **NOTED** the plans for the condensed APP MSc programme.

Members **NOTED** that WAST had also been working to reduce hours lost from handover to clear. As part of this work to cleanse and refine the data, a dual pin system for handover was being rolled out in each Emergency Department and the work would be completed by the end of August.

Jason Killens explained that the service changes and the Major Trauma Network work would have an impact and WAST felt that a co-ordinating desk would be required for 16 hours. Members **NOTED** that the WAST bid covered training and how much in the current allocation or getting the ambulance teams for the major trauma centre, call handling requirements would also need to be considered.

Members **RESOLVED** to
- **NOTE** the report.

EASC 19/58	**UPDATE ON AMBER REVIEW**	Shane Mills
	Members **received** the report on the Amber Review which was presented by Shane Mills.	
	Members **NOTED** that additional work was required and an action plan had been developed; a group was in place to oversee the work working with the team at WAST to ensure progress was being made. The aim was to have a comprehensive action plan which included all health board to reduce the numbers of ambulances waiting. Members **NOTED** that patients are being informed when the service is at escalation and a script has been developed for the staff.	
	Shane Mills explained that the aim was to link the data across the whole system and to use the NHS Wales Informatics Service (NWIS) data set. The work to complete the Amber Review should be completed by the end of the year and Members may need to consider the commissioning intentions for the service. A further update would be provided at the next meeting (Added to the Action Log).	Shane Mills
	Members **RESOLVED** to: • **NOTE** the report	
EASC 19/59	**INTEGRATED MEDIUM TERM PLAN (IMTP) UPDATE**	Anthony Hayward
	Members received the IMTP Update Report which was presented by Anthony Hayward.	
	Members **NOTED** the clarity of information relating to the accountability conditions as part of the reporting proforma for 2019-2020. The EASC IMTP Quarter 4 for 2018/19 and the Quarter 1 for 2019/20 progress was discussed and **NOTED**.	
	Areas identified which had slipped from the target timescale included: • Quality assurance and improvement findings reporting for EMRTS • Quality assurance and improvement findings reporting for NEPT • EMS commissioning Intentions • NEPTS commissioning Intentions Members were assured that plans were in place to recover the position.	
	Members **RESOLVED** to: • **NOTE** the report.	

EASC 19/60	**REGIONAL ESCALATION** Members **AGREED** to discuss further in the development session.	Chair
EASC 19/61	**FINANCE REPORT** Members r**eceived** the Finance Report which was presented by Stuart Davies. Members **NOTED** that the identified risks were being managed. Members **RESOLVED** to: • **NOTE** the report.	Stuart Davies
EASC 19/62	**1% 'A HEALTHIER WALES' ALLOCATION** Members received the report on the allocation of the 1% 'A Healthier Wales' funding. The Chief Ambulance Services Commissioner gave a short overview of the work to date and James Rodaway presented the report which highlighted the important principles being adopted. Members **NOTED** that a long list would be developed for further discussion and no information would be sifted before the meeting of the Management Group to finalise the allocation, this would take place on 26 July 2019. Following discussion, Members requested that the Management Group undertake an evaluation of all the Schemes which should be shared with the Committee (**Added to Action Log**). Members **NOTED** that all of the information was being captured to ensure the principles were upheld. The evaluation panel would take place on Friday and the recommendations would be sent to Members. Stephen Harrhy explained that if there were any specific issues to be resolved a special meeting of the Committee would be convened. Following discussion Members **RESOLVED** to: • **NOTE** the report • **APPROVE** that the Management Board evaluate the bids and report back to the Committee.	James Rodaway CASC
EASC 19/63	**EASC GOVERNANCE UPDATE** The governance update report was **received** by the Committee and presented by Gwenan Roberts.	Gwenan Roberts

	Members **NOTED** that the Annual Governance Statement had been finalised and received at the Audit Committee on 30 May 2019. Members **RECEIVED** and **NOTED** the Internal Audit Report on Handover of Care at Emergency Departments Follow-up Health Board Related Recommendations which was received by the Host Body's Audit Committee on 9 July 2019. Members **NOTED** that the report received a 'Reasonable' assurance rating and four medium priority recommendations had been made. The actions required would be factored into the forward work plan for the Committee with the majority to be delivered by the next meeting. Members **RESOLVED** to: • **ENDORSE** the Annual Governance Statement • **NOTE** the report.	
EASC 19/64	**CLINICAL RISK REVIEW – CLOSURE REPORT** The closure report for the Clinical Risk Review was **received**. In presenting the report, Ross Whitehead confirmed that 24 actions had been identified and most had now been completed or now informed the work of the Management Group. Member **NOTED** the importance of the clinical records within the Ambulance service; additional clinical audits would also be carried out and access to policies and guidelines would take place. Members **RESOLVED** to: • **NOTE** the report • **ENDORSE** the closure report.	Ross Whitehead
EASC 19/65	**FORWARD PLAN OF BUSINESS** Members **received** the forward plan of business. Members **RESOLVED** to: • **NOTE** the Forward Plan • **AGREE** that the Chair and the Chief Ambulance Services Commissioner review the Forward Plan for future meeting.	*ALL*

ANY OTHER BUSINESS		
EASC 19/66	There was none.	
DATE AND TIME OF NEXT MEETING		
EASC 19/67	A meeting of the Joint Committee would be held at 13:30 hrs, on Tuesday 10 September 2019 at the National Collaborative Commissioning Unit, Treforest Industrial Estate.	Committee Secretary

Signed   ………………………………………………

                           Christopher Turner (Chair)

Date   ………………………………………………

Action Log
JOINT COMMITTEE MEETING

Update for meeting on 10 September 2019

Minute	Action	Lead	Progress
EASC 17/44 & EASC 17/73 & EASC 19/21	**Emergency Medical Retrieval and Transfer Service (EMRTS) Gateway review** Further update on the direction of travel in relation to the recommendations of the gateway review to be provided	CASC	**Agenda item 2.2 CASC Update Report**
EASC 18/06 & EASC 18/65 & EASC 19/21	**Integrated Performance Dashboard** To develop bespoke Health Board reports that will provide more HB specific data.	*Julian Baker*	**Oral update September 2019**
EASC18/107 & EASC 19/21	~~**Expansion of EMRTS** (Emergency Medical Retrieval and Transfer Service) – business case to include funding options – included in IMTP~~ ~~Business case to be received by EASC~~	~~*CASC Dir NCCU*~~	~~**Agenda item 2.2 CASC Update Report**~~
EASC 19/08 & EASC 19/21	~~CASC to raise the matter with the Director General at the Welsh Government for the potential to work across all 999 services~~	~~*CASC*~~	~~**Completed**~~
	~~Report / position statement to be developed to capture the effective areas of work~~	~~*CASC*~~	~~**Mental Health Review**~~
EASC 19/08 & EASC 19/21 & EASC 19/23	**Emergency Medical Retrieval Service (EMRTS)** Refresh of the commissioning framework	*Julian Baker*	**Was July 2019 Now November 2019**
	~~**'A Healthier Wales' Commissioning allocation**~~ ~~Report to be submitted to the next meeting on potential utilisation of the allocation~~	~~*CASC/Dir NCCU*~~	~~**Agenda item**~~
EASC 19/12	**EASC Risk Register** Review of Risks and actions	*James Rodaway*	**November 2019**
EASC 19/38	**Falls Schemes** Further evaluation to take place	*James Rodaway*	**Agenda item 2.3 September 2019**
EASC 19/41	**Red Performance** Quality Assurance process to be clarified and letter sent; discussion in relation to the use of advanced paramedic practitioners across Wales and key themes to be identified	*CASC*	**Agenda item 2.4**

Minute	Action	Lead	Progress
EASC 19/42	**Ambulance Quality Indicators** More detailed trend analysis would be undertaken on quality, performance and activity	*Ross Whitehead*	**November 2019**
EASC 19/55	**Management Group** Stephen Harrhy agreed to ensure the schedule of meetings and the terms of reference was shared with Members	*CASC*	**To be confirmed**
EASC 19/55	**Mental Health** Additional information to be developed and shared to assist Members with the work to date	*Shane Mills / Lead CEO*	**To be confirmed**
EASC 19/56	**ORH Demand and Capacity Review** Reports and minutes from the Steering group to be shared with Members	*Steve Moore*	**To be confirmed**
EASC 19/57	**Amber Review** Update on the action plan developed	*Shane Mills*	**Agenda item 2.2**
EASC 19/61	**1% 'A Healthier Wales' allocation** Following evaluation by the Management Group the meeting report to be shared with Members	*James Rodaway*	**Agenda item 2.3**

Emergency Ambulance Services Committee Report
EASC CHAIR'S REPORT

Lead: Chris Turner Chair of the Emergency Ambulance Services Committee (EASC)	
Author: Chris Turner	
Contact Details for further information: Chris.Turner2@wales.nhs.uk 01443 744946	

Purpose of the Emergency Ambulance Services Committee Report
The purpose of this report is for the Committee to receive an update on key matters related to the work of the Chair.

Governance	
Link to the Commissioning Agreement	The Committee's overarching role is to ensure its Commissioning Strategy for Emergency Ambulance Services utilising the five step patient pathway outlined within the National Collaborative Commissioning Quality and Delivery Agreement and the related outcomes for each care standard aligned with the Institute of Healthcare Improvement's (IHI) 'Quadruple Aim' are being progressed. This report focuses on all the above objectives, but specifically on **providing** strong governance and assurance.
Supporting evidence	The development of this report has where appropriate been informed by updates provided through established governance processes. A number of the issues highlighted within the report are covered in more detail within the main agenda of the Committee meeting.
Engagement – Who has been involved in this work?	

Engagement – Who has been involved in this work?
The Emergency Ambulance Services Commissioning Team has contributed to the development of information contained within this report.

Emergency Ambulance Services Committee Resolution to:						
APPROVE		**ENDORSE**		**DISCUSS**	√	**NOTE**	√
Recommendation		The Emergency Ambulance Services Committee is asked to: • **DISCUSS** and **NOTE** the report				

Summarise the Impact of the EASC Report	
Equality and diversity	There are no equality and diversity implications contained within this report.
Legal implications	There are no legal implications contained within this report.
Population Health	No impact.
Quality, Safety & Patient Experience	Ensuring the Committee and its Sub Groups make fully informed decisions is dependent on the quality and accuracy of the information presented and considered by those making decisions. Informed decisions are more likely to impact favourably on the quality, safety and experience of patients and staff.
Resources	No impact.
Risks and Assurance	Ensuring the Committee is fully sighted on key areas of its business is essential to Board Assurance processes and related risks.
Health and Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes; • Staying Healthy; Safe Care; Effective Care • Dignified Care; Timely Care; Individual Care; Staff & Resources Within an overarching Governance Framework. Welsh Government Health & Care Standards Framework 2015 This report focuses mainly on Governance & Accountability but also spans some of the 7 quality themes.
Workforce	No impact.
Freedom of information status	Open

CHAIR'S REPORT

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is for the Committee to receive an update on key matters related to the work of the Chair.

2. BACKGROUND / INTRODUCTION

Since the last Committee meeting Members should note:

External meetings

Since the last meeting I have attended one joint Chairs and Chief Executives meetings and a Ministerial meeting (5 August) and a Chairs meeting (27 August).

Key themes of these meetings have been as follows:
- Strategic Partnerships,
- the Quality Bill and
- the emerging Health Education and Improvement Wales (HE&IW) Workforce strategy.

Red performance concerns have also been raised at the ministerial meeting as has regional escalation.

On 5 September, the Chief Ambulance Services Commissioner (CASC) and I met with the Chair and Chief Executive of the Welsh Ambulance Services NHS Trust (WAST) as part of our regular round of constructive meetings.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

Chair's appraisal

I have now received feedback on my annual appraisal and this focused on the Minister's expectations around EASC helping to drive system change rather than simply supporting localised initiatives.

Assurance is also required in relation to implementation of the Amber Review – the final report is due to be submitted to the Minister in November 2019. The Minister also requires WAST and EASC to **work** together regarding initiatives to support winter preparedness.

'A Healthier Wales' allocation

On 26 July, I chaired the Evaluation Panel for the 1% 'A Healthier Wales' allocation. It was particularly helpful to have expert input from Professor Ceri Phillips of Swansea University at the meeting. There is a detailed report on the Panel outcomes on the agenda.

Establishment of an NHS Executive for Wales

Though neither the CASC nor I were copied into the Director General's letter of 14 August regarding the establishment of the NHS Executive we are aware of its contents. We have written jointly to express our concern that we were not included in the circulation.

The establishment and functions of the NHS Executive will be undertaken as a Special Health Authority (SHA), though it is clear that the Joint Committees, including EASC, "…will not be subsumed into the SHA."

However, there will be an impact on EASC in that the NHS Executive is to become a member of the Joint Committee "…in order to ensure there is a stronger national focus to decision making." It will be interesting to understand the intention with regard to the role of this individual since they will not have a stake (operational/financial) in the business being transacted at the committee, as Chief Executives do, nor will they have the independence that the Chair has.

It is not clear what the letter means when it states that "… the governance and hosting arrangements for the existing Joint Committees will be streamlined and standardised."

Visits to Health Boards

Over the next few months the CASC and I intend to visit Boards and to provide an update on key EASC issues and, importantly, to hear and respond to the views of Board members. The assistance of Chief Executives in arranging these meetings would be greatly appreciated.

4. RECOMMENDATION

The Emergency Ambulance Services Committee is asked to:

- **DISCUSS** and **NOTE** the report.

Freedom of information status	Open

	AGENDA ITEM 2.2
	10 September 2019

Emergency Ambulance Services Committee Report
CHIEF AMBULANCE SERVICES COMMISSIONER'S UPDATE REPORT

Executive Lead: Chief Ambulance Services Commissioner (CASC)
Author: Chief Ambulance Services Commissioner
Contact Details for further information: Stephen.harrhy@wales.nhs.uk 01443 744946

Purpose of the Emergency Ambulance Services Committee Report
The purpose of this report is for the Committee to receive an update on key matters related to the work of the Chief Ambulance Services Commissioner.

Governance	
Link to the Commissioning Agreement	The Committee's overarching role is to ensure its Commissioning Strategy for Emergency Ambulance Services utilising the five step patient pathway outlined within the National Collaborative Commissioning Quality and Delivery Agreement and the related outcomes for each care standard aligned with the Institute of Healthcare Improvement's (IHI) 'Quadruple Aim' are being progressed. This report focuses on all the above objectives, but specifically on **providing** strong governance and assurance.
Supporting evidence	The development of this report has where appropriate been informed by updates provided through established governance processes. A number of the issues highlighted within the report are covered in more detail within the main agenda of the Committee meeting.
Engagement – Who has been involved in this work?	
The Emergency Ambulance Services Commissioning Team has contributed to the development of information contained within this report.	

Emergency Ambulance Services Committee Resolution to:						
APPROVE		**ENDORSE**		**DISCUSS**	√	**NOTE**	√

Recommendation	The Emergency Ambulance Services Committee is asked to: • **DISCUSS** and **NOTE** the report

Summarise the Impact of the EASC Report	
Equality and diversity	There are no equality and diversity implications contained within this report.
Legal implications	There are no legal implications contained within this report.
Population Health	No impact.
Quality, Safety & Patient Experience	Ensuring the Committee and its Sub Groups make fully informed decisions is dependent on the quality and accuracy of the information presented and considered by those making decisions. Informed decisions are more likely to impact favourably on the quality, safety and experience of patients and staff.
Resources	No impact.
Risks and Assurance	Ensuring the Committee is fully sighted on key areas of its business is essential to Board Assurance processes and related risks.
Health and Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes; • Staying Healthy; Safe Care; Effective Care • Dignified Care; Timely Care; Individual Care; Staff & Resources Within an overarching Governance Framework. Welsh Government Health & Care Standards Framework 2015 This report focuses mainly on Governance & Accountability but also spans some of the 7 quality themes.
Workforce	No impact.
Freedom of information status	Open

CHIEF AMBULANCE SERVICES COMMISSIONER'S UPDATE REPORT

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is for the Committee to receive an update on key matters related to the work of the Chief Ambulance Services Commissioner (CASC).

2. BACKGROUND / INTRODUCTION

Since the last Committee meeting progress has been made against a number of key areas which for ease of reference are listed below:

- Amber
- Management Group
- Risk Register
- Stroke services
- Emergency Medical Retrieval and Transfer Service (EMRTS) Gateway review
- Non Emergency Patient Transport Service (NEPTS)

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

- **Amber Review Implementation Programme**

Work continues on the Amber Review Implementation Programme and Members should NOTE that the Minister is planning to make a statement in November. Progress continues to be made against the 9 recommendations and a more detailed report will be provided to the Committee in November.

Members will wish to note that at the regular EASC Quality and Delivery meeting with the Welsh Government held recently the progress against each individual recommendation was discussed and noted. There are no major risks to bring to the attention of the Committee. However, Members will be aware of the continuing challenges to ambulance responsiveness and lost hours in handover delays. More detail is available

- **Update on Management Group**

Members will wish to note that the Terms of Reference of the Group have been drafted and are attached as Appendix 1 for approval by the Committee. Representation at the meetings of the Group have been good and Members are thanked for their ongoing support in this matter.

- **Risk Register**

Following discussion at the last Committee Members agreed with the approach being recommended at the last development session to refresh and review the EASC Risk Management Framework. Further discussion will take place at the meeting in November.

- **Stroke Services**

Members may be aware that the Minister for Health and Social Services has announced his expectations that new measure for ambulance services (including Stroke) would be piloted this winter. Proposals are being developed and engagement is taking place with key stakeholders such as the Stroke Association and key clinical leaders. It is intended to publish these measures alongside the Ambulance Quality Indicators in January 2020.

- **Emergency Medical Retrieval and Transfer Service (EMRTS) Gateway review**

The meeting scheduled with Swansea University in August was cancelled. It is currently being rearranged and Members will receive an update at the next meeting. This will be discussed at the EMRTS Delivery Assurance Group on 19 September.

- **Non Emergency Patient Transport Service (NEPTS)**

The NEPTS Quality and Delivery Framework has been signed by the CASC & Chair of EASC and is with WAST to be signed by the WAST Chair and CEO, we are expecting this to be signed in September 19.

The transfer of NEPTS provision from health boards and trusts to WAST is progressing through the plurality model; this has seen Cardiff & Vale University Health Board (CVUHB), Velindre, Hywel Dda University Health Board (HDUHB) and Swansea Bay University Health Board (SBUHB) non-emergency transport provision transfer to WAST. The quality assurance mechanism associated with this process is being followed and good progress is being made The remaining Health Boards are working towards a transfer date of October 2019. A formal update report will be provided at the January meeting.

4. RECOMMENDATION

The Emergency Ambulance Services Committee is asked to:

- **DISCUSS** and **NOTE** the report
- **APPROVE** the Terms of Reference for the Management Group.

Freedom of information status	Open

TERMS OF REFERENCE
EMERGENCY AMBULANCE SERVICES COMMITTEE
MANAGEMENT GROUP

1. Introduction

The Emergency Ambulance Services Committee (EASC) is a joint committee of each LHB in Wales, established under the Emergency Ambulance Services Committee (Wales) Regulations 2014 (2014 No.566 (w.67)) (the EASC Directions). The Committee has proposed to have a sub group - a Management Group.

The role of the Management Group is:
- To support the Officers of EASC in the development and implementation of Emergency Ambulance, Non-Emergency Patient Transport Services and the Emergency Medical Retrieval and Transfer Services

- The governance arrangements of the Host Health Board "Cwm Taf Morgannwg" will apply and this includes the Audit Committee arrangements as approved by the EASC.

- All matters relating to specific Providers will be dealt via the respective approved commissioning frameworks

- All matters that have a service and/or financial impact will need to ensure that there is a balanced provider and commissioner view.

2. Purpose

The overall purpose of the Management Group is to make recommendations to EASC and to ensure that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance, non-emergency patient transport services and Emergency Medical Retrieval & Transfer Service for the purpose of jointly exercising those functions will establish the joint committee.

It will underpin the commissioning of EASC to ensure equitable access to safe, effective, sustainable and acceptable services for the people of Wales.

The Group will be responsible for undertaking the following functions:

- To agree, make recommendations and monitor the Annual Plan

- To receive recommendations from Programme Teams and to make recommendations to the EASC regarding service improvements including investments, disinvestments and other service change

- To co-ordinate the delivery of the productivity and efficiency delivery plans for specialised services, including signing off detailed delivery plans and monitoring implementation

- To oversee performance monitoring and management including monitoring the overall financial position, key variances and the main actions to address performance issues

- To undertake the role of Project Board / Programme for specific work streams and projects / programmes as approved by EASC and its Members and monitor their implementation

- To consider consultation outcomes and recommended pathway or services changes / developments before consideration by EASC members

- To ensure the development and maintenance of the needs assessment across Wales for Ambulance Services

- To agree and recommend commissioning/service issues to the EASC Committee which are to be considered as part of the Integrated Plan. This will include issues which will have an impact on the plan raised by other sub groups/advisory groups, including the WAST IMTP

3. Delegated Powers and Authority

The Group is authorised to:

- Investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of The UHBs. It can seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Management Group

- Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the EASC budgetary and other requirements

- By giving reasonable notice, require the attendance of any of the officers or employees at any meeting of the Group

- Establish Task & Finish Groups to support its work, such as investigating, reporting upon and proposing corrective action for local performance issues.

4. Sub Group

The Group may establish sub-groups or task and finish groups to carry out on its behalf specific aspects of the business within its remit.

5. Membership

The Membership of the Group will be determined locally but should as a minimum to consist of LHB planning / commissioning representation and/or operations representative. The 7 LHBs will be required as a minimum to nominate a Member and a nominated Deputy to sit on the Group. Clinical representation will be encouraged.

Other members may be appointed as deemed appropriate by the Group.

Members from the NHS Trusts in Wales and/or the provider arm of the Local Health Boards will be invited to attend meetings as required.

Group will be chaired by Stephen Harrhy, Chief Ambulance Services Commissioner.

In the absence of the Chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

Other staff may be invited to attend when the Group as Agenda Item required.

6. Member Appointments

The membership of the Management Group shall be determined by the EASC, based on the recommendation of the EASC Chair and Chief Ambulance Services Commissioner (CASC) – taking account of the balance of skills and expertise necessary to deliver the Management Group's remit and subject to any specific requirements or directions made by the Welsh Government.

Membership will be reviewed every three years.

7. Support to Members

The CASC, on behalf of the Chair of the EASC, shall:

• Arrange the provision of advice and support to the Group members on any aspect related to the conduct of their role

8. Meetings

- **Quorum**

At least six Members, of which at least 4 of the LHBs must be represented to allow any formal business to take place at the Management Group.

- **Frequency of Meetings**

Meetings shall be held bi-monthly.

- **Dealing with Members' interests during meetings**

The Chair, must ensure that the decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual members must demonstrate, through their actions, that their contribution to the decision making is based upon the best interests of the NHS in Wales.

- **Responsibilities of Members and Attendees**

Members have a responsibility to:

a) Attend at least 75% of meetings (or ensure a nominated deputy attends), having read all the papers beforehand

b) Disseminate information throughout their respective organisation and through the appropriate Peer Groups and other networks

c) Brief the Chief Executive of their respective LHBs/Trusts prior to the meeting of the EASC Committee

d) Identify any agenda items to the **Debra Fry: Administrator – Quality & Delivery Frameworks, NCCU,** 10 working days before the meeting; and

e) Prepare and submit the papers for the meeting 8 days before the meeting

- **Withdrawal of Individuals in Attendance**

The Management Group may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

- **Circulation of Papers**

Debra Fry: Administrator – Quality & Delivery Frameworks, NCCU will ensure that all papers are distributed at least 7 days prior to the meeting.

Debra Fry: Administrator – Quality & Delivery Frameworks, NCCU will ensure that a briefing is circulated to Members following the meeting so this can be used as part of the local briefing mechanisms.

The confirmed Minutes of the Committee will be sent to Management Group for information.

9. Relationship with the EASC and its Management Group

The Emergency Ambulance Services Committee (EASC) through the Management Group NHS Wales for its performance in exercising the functions set out in these terms of reference.

The Group through its Chair and Members shall work closely with the Management Groups other sub groups, to provide advice and assurance to EASC through the:

• Joint planning and co-ordination

• Ensuring that any issues which have an impact on the IMTP are considered by the Management Group; and

• Sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Management overall risk and assurance framework.

The Group shall embed the Management Groups' standards, priorities and requirements e.g. equality and human rights, through the conduct of its business.

10. Reporting and Assurance Arrangements

The Chair of the Group shall:

• Report formally to the EASC on the Group's activities. This includes verbal updates on activity, the submission of the minutes and written reports

• Bring to the Management Groups' specific attention any significant matters under consideration by the EASC; and

• Include in matters for decision, the formal views of the group, for consideration by the Management Group

• Ensure appropriate escalation arrangements are in place to alert the EASC Chair, Chief Executive or Chairs of other LHBs and relevant sub grups of any urgent/critical matters that may affect the operation and/or reputation of the LHBs

The Management Group may also require the Chair of the Management Group to report upon the group's activities at public meetings or to partners and other stakeholders including NHS Wales Health Boards where this is considered appropriate.

The Chair, Stephen Harrhy, Chief Ambulance Services Commissioner on behalf of the Joint Committee, shall oversee a process of regular and rigorous self-assessment and evaluation of the group's performance and operation including that of any sub-groups established.

11. Applicability of Standing Orders to Committee Business

The requirements for the conduct of business as set out in the Joint Committee's Standing Orders are equally applicable to the operation of the Group.

12. Review

These Terms of Reference shall be adopted by the Management Group at its first meeting and subject to review at least on an annual basis thereafter.

FOR ANNUAL REVIEW

Date of approval by the EAS Committee: September 2019

Next review due: September 2020

EMERGENCY AMBULANCE SERVICES COMMITTEE (EASC)

**WELSH AMBULANCE SERVICES NHS TRUST (WAST)
PROVIDER UPDATE**

Executive Lead: Jason Killens, Chief Executive Officer (WAST)	
Author: Kerri Hitchings, Commissioning and Performance Manager (WAST); Hugh Bennett, Assistant Director of Commissioning and Performance (WAST)	
Contact Details for further information: hugh.bennett2@wales.nhs.uk	

Purpose of the EASC Report
The purpose of this report is to provide EASC with an update on key issues affecting quality and performance for Emergency Medical Services (EMS) and Non-Emergency Patient Transport Services (NEPTS) and also to provide an update on strategy and planning for EMS and NEPTS respectively.

Governance	
Link to the Commissioning Agreement	The Committee's overarching role is to ensure its Commissioning Strategy for EMS and NEPTS utilising the respective five step patient pathway outlined within the National Collaborative Commissioning Quality and Delivery Agreements and the related outcomes for each care standard aligned with the Institute of Healthcare Improvement's (IHI) 'Quadruple Aim' are being progressed. This report focuses on the above objectives, but specifically on providing an update on quality, performance, strategy and planning in WAST on these steps.
Supporting evidence	The Collaborative Commissioning Quality and Delivery Frameworks: EMS and NEPTS.
Engagement – Who has been involved in this work?	
WAST, Chief Ambulance Services Commissioner (CASC)	

Emergency Ambulance Services Committee Resolution to:					
APPROVE		**ENDORSE**		**DISCUSS**	√	**NOTE**	√

Recommendation	The Emergency Ambulance Services Committee is asked to: • **DISCUSS** the contents of the report. • **NOTE** the work being undertaken.
Summarise the Impact of the Emergency Ambulance Services Committee Report	

Equality and diversity	There are no implications arising directly from this report.
Legal implications	There are no legal implications arising directly from this report, but Coroner's activity in relation to EMS is identified in the report.
Population Health	EMS ambulance response times are a key determinant of population health, particularly, for Red – immediately life threatening calls – the report provides information on Red and Amber performance.
Quality, Safety & Patient Experience	The report details the level of serious adverse incidents (SAIs) for EMS and root cause of these.
Resources	The report provides information on the deployment of ambulance resources and on the funding of key initiatives, in particular, Advanced Paramedic Practitioners (APPs) and Healthier Wales funding.
Risks and Assurance	WAST has a Risk Management Framework and Corporate Risk Register. The two key risks relevant to this report are: - 1) Unable to attend to patients in the community who require see and treat services 2) Patients unable to access secondary care assessment and treatment (Patients being delayed in ambulances prior to clinical handover at Accident & Emergency departments).
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf The work reported in this summary and related annexes take into account many of the related quality themes.
Workforce	The report identifies active workforce planning by WAST and over recruiting against future predicted vacancies.
Freedom of information status	Open

WELSH AMBULANCE SERVICES NHS TRUST (WAST)
PROVIDER UPDATE

1. SITUATION

The purpose of this report is to provide EASC with an update on key issues relating to quality, performance, resources and strategy across the Emergency Medical Services (EMS) and Non-Emergency Patient Transport Services (NEPTS).

2. BACKGROUND

The EASC meets on a bi-monthly basis, and previously, the WAST Chief Executive has provided a verbal update on key issues by exception. It has been agreed that it would be helpful for EASC members to receive a written report. This report is the second of such written briefings, designed to enable a more comprehensive update to be received and improve understanding of the issues being managed by the Trust in relation to quality, performance, resources and strategy.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

Quality, Safety & Patient Experience

Serious Adverse Incidents (SAI)
The Trust continues to review and discuss high volumes of potential Serious Adverse Incidents (SAIs) at its Serious Case Incident Forum. The themes and trends from those cases reported as SAI's are long handover and response delays, call categorisation, missed allocation and clinical practice issues.

The following table shows the total numbers of SAIs reported to Welsh Government by the Trust, by Health Board area. It is evidenced below that there has been a reduction in the total number of SAIs reported to Welsh Government in the current year to date.

SAIs Reported to WG								
	ABHB	SBHB	BCUHB	CVHB	CTMHB	HDHB	POHB	Total
2017/18	17	10	12	6	2	1	0	48
2018/19	11	7	13	15	1	4	0	51
2019/20 to date	6	6	0	0	1	2	0	15

The data shows that 80% of the reported SAIs year to date are divided equally across the Aneurin Bevan and Swansea Bay University Health Board areas. There are two further cases identified as SAIs and reported to Welsh Government.

At the time of compiling this report they have not been issued a Welsh Government identification number so are not reflected in the total above. These incidents occur with the Aneurin Bevan University Health Board area.

Following a Patient Safety event held in October 2018 with Welsh Government and the Delivery Unit, it was agreed to develop a Joint Investigation Framework. Since ratification this has clarified the process to be followed where a potential SAI relates to a delayed ambulance response as a consequence of identified hospital notification to handover delays. This was agreed at the Directors of Nursing forum, and outlines which organisation will be responsible for the investigation and reporting of the SAI.

The Trust has already started working with Health Boards in this way, and in addition to the numbers reported above, a further 8 incidents have been passed to Health Boards for investigation.

Coroners Activity
The Trust is also continuing to receive large numbers of requests for information from coroners. The impact of the numbers received through the winter of 2017/18 is still being felt. Since January 2019, a further 161 requests have been received. Again, the majority of these cases relate to incidents where there was a delayed ambulance response to a patient in the community.

Safeguarding Referrals
The Trust has experienced a small number of duty to report referrals through the safeguarding referral process, relating to delayed responses to patients in nursing homes in the Aneurin Bevan area. The Trust and Health Board and commissioner are working with nursing homes in the area.

Longest Waits
The Patient Safety team are now undertaking regular reviews of the longest responses to patients, even where no complaint or concern has been received or raised, this is to provide assurance around the quality of the care that they received.

Number of Patient Waits over 12 hours

Patient Waits in Hours																									
Month	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	41	45	Grand Total
Apr-18	23	18	10	7	15	12	7	7	2	2			1	1	1		1								107
May-18	17	32	20	13	13	11	5	12	5	2	1	1				1	1								134
Jun-18	36	24	16	7	11	3	5	5	2	4	1	1	3						1					1	120
Jul-18	36	20	24	13	8	5	11		2		1	1	1	1		1									124
Aug-18	22	14	16	12	18	4	6	4	2	2	1							1							102
Sep-18	20	13	9	10	12	3	8	5		1	1								1	1					84
Oct-18	19	14	10	12	7	5	9	1	1	1					1										80
Nov-18	25	16	15	10	13	10	8	2	3	4	1			3						1					111
Dec-18	36	26	21	21	20	13	11	7	3	3	4	1	2		1							1			170
Jan-19	36	23	22	19	17	19	18	8	4	4	2	2	1	1		1		2	1			2	1		183
Feb-19	17	21	16	13	9	8	5	9	1	1	4														104
Mar-19	17	27	16	8	12	7	4	2	4	1															98
Apr-19	28	29	20	10	9	11	4	5	2	2															120
May-19	30	25	18	16	10	13	2	7		1															122
Jun-19	26	16	10	13	5	10	8	8		1				1											98
Jul-19	45	28	22	14	9	14	5	4	4	1		2	1	1	2	1	1								154
Grand Total	433	346	265	198	188	148	116	86	35	30	16	8	9	4	5	7	4	2	4	1	1	3	1	1	1911

> **EASC is asked to note the continuing risks and number of SAIs and coroners requests that are being dealt with by the Trust, which relate in the main to incidents where there was a delayed ambulance response to patients in the community.**

PERFORMANCE

Red Performance

Red performance has been consistently above 70% for the last 12 months, with the exception of July 2019 achieving 69.3%. Despite consistently achieving the 65% target, as the graph below shows, there has been a gradual decline in the monthly performance, linked in part to increasing red incident demand (up 6.9% from 2017/18 to 2018/19) and to a reduction in the number of running calls recorded (through increased consistency in the application of the standard / guidance). Changes to the treatment and recording of running calls to provide the most accurate presentation of true response performance have been notified to the Chief Ambulance Service Commissioner in correspondence dated 16 April 2019 and 13 August 2019.

Red 8 Performance and Contribution from Running Calls
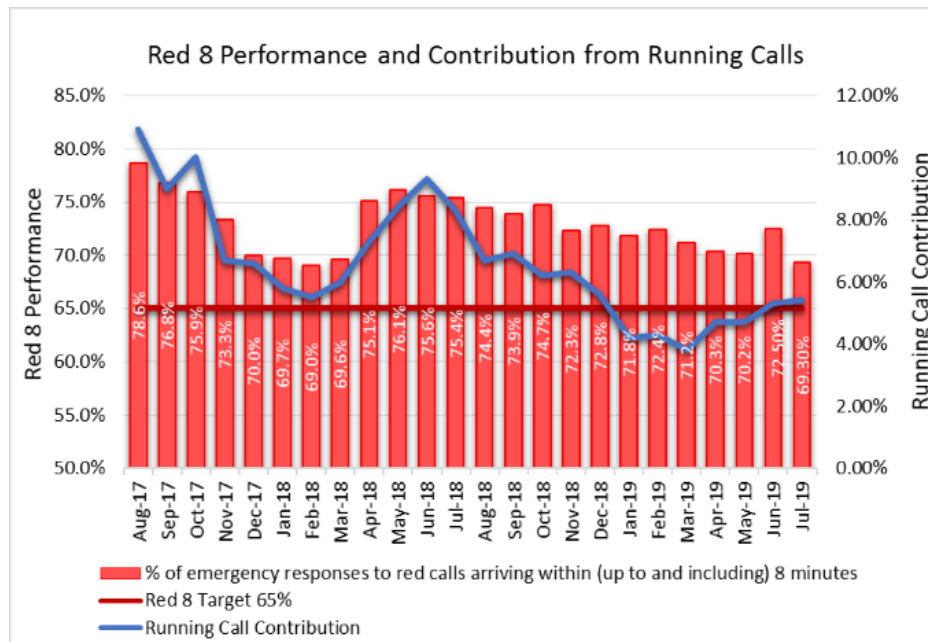
The Trust acknowledges that there is scope to improve performance, particularly in respect of reducing variation between Health Board areas, with the graph below highlighting the difference between the highest and lowest performing Health Boards each month. The variation has reduced month on month since April 2019, reaching the lowest level in July 2019 at 10.7% variation between the best and worst performing Health Boards.

Reduction in the variation in RED call response time performance between the best and worst HB performance
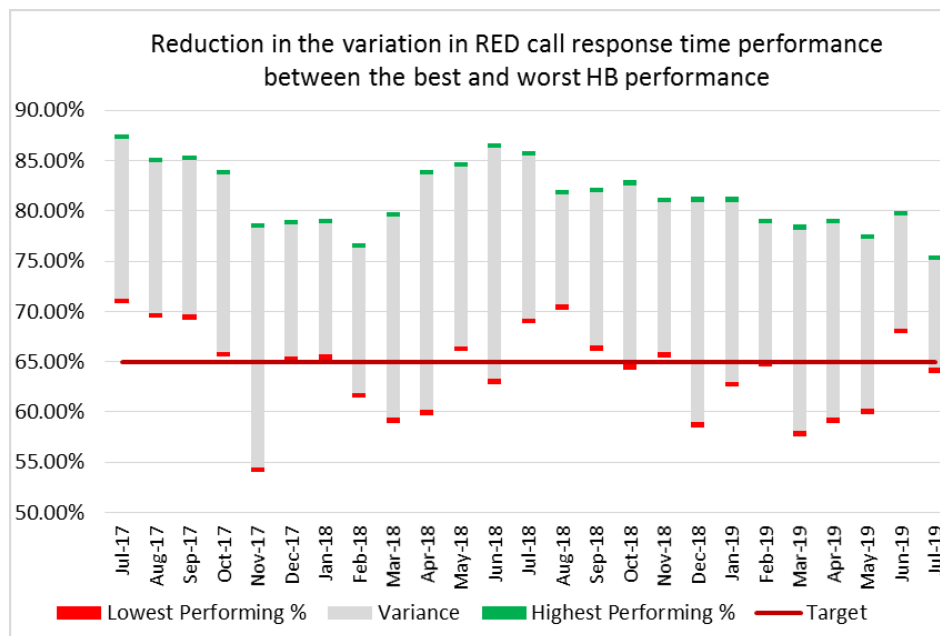
Historically, Powys and Hywel Dda have consistently been the lowest performing Health Boards for the last 12 months. In July, there was one Health Board under 65%, Hywel Dda. Significant improvements have been evident in Powys in particular, April and May failed to reach the 65% target achieving 58.9% and 59.8% respectively, shifting to improvements in June and July achieving 74.7% and 71.3% respectively.

However, the Hywel Dda position has not yet seen the same level of improvement missing the 65% target in May at 59.9% and in July at 63.9%. Work will continue in terms of monitoring and refining action plans.

The Trust is complying with a requirement from the Commissioner for enhanced monitoring and reporting. Data is currently being provided on a daily and weekly basis, action plans are being developed, shared and monitored, and progress is discussed in a weekly teleconference call. A Red Performance Dashboard is also now shared on a weekly basis with key stakeholders.

WAST has a comprehensive Red Improvement Plan in place (with 25 key actions and rising), which is being reviewed weekly by the Director of Operations. Key highlights from the Red Improvement Plan include:
- Continuing to develop and utilise information on demand, capacity and efficiency to inform action planning. This includes the use of sophisticated performance analysis and modelling software (QlikSense and Optima Predict) to support Operations. One of the actions for Optima Predict will be to start producing a forward prediction of Red performance (weekly, monthly, seasonal e.g. winter);
- A Clinical Review of the Clinical Contact Centre;
- A proposed system leadership approach for the 11-00 Gold Call (see separate paper);
- A review of station estate/highway access to improve mobilisation times;
- Overproducing on RRV unit hours at times when Red performance is poor (twilight shifts);
- Increasing the number of Community First Responders (CFRs), in particular, in Hywel Dda with an additional 36 CFRs currently being trained and coming on stream in September 2019;
- Continuing work to reduce abstraction rates, with sickness levels now on a downward trend;
- Reviewing deployment points, moving them where possible to reduce response times (this work has been completed for AB, CTB, HD and P, with some adjustments being made, but the extent of adjustment is limited by the relief gap).

In addition, the Trust has recently revised its process for Managing Immediate Release Requests. At peak times the level of emergency pressures across any region can mean that ambulances are either engaged in calls or waiting to handover patients at Accident and Emergency Departments. This may limit the Trust from providing a response to life threating 999 calls within the community. The immediate release process has been agreed with NHS Wales Medical Directors, in regard to the release of delayed ambulance resources where life threatening calls are held awaiting a response with no resource available to assign.

The request must be made from the Allocator/Dispatcher direct to the A&E Department. It is only applicable where ambulance resources are delayed more than 15 minutes handing over patient care and where, on receipt of a RED or Amber 1 call, there are no ambulances available to respond in the local area. The revised process has allowed improved accuracy of reporting with effect from 30th July 2019. The graph below shows the number of requests split by those declined, accepted and not responded to.
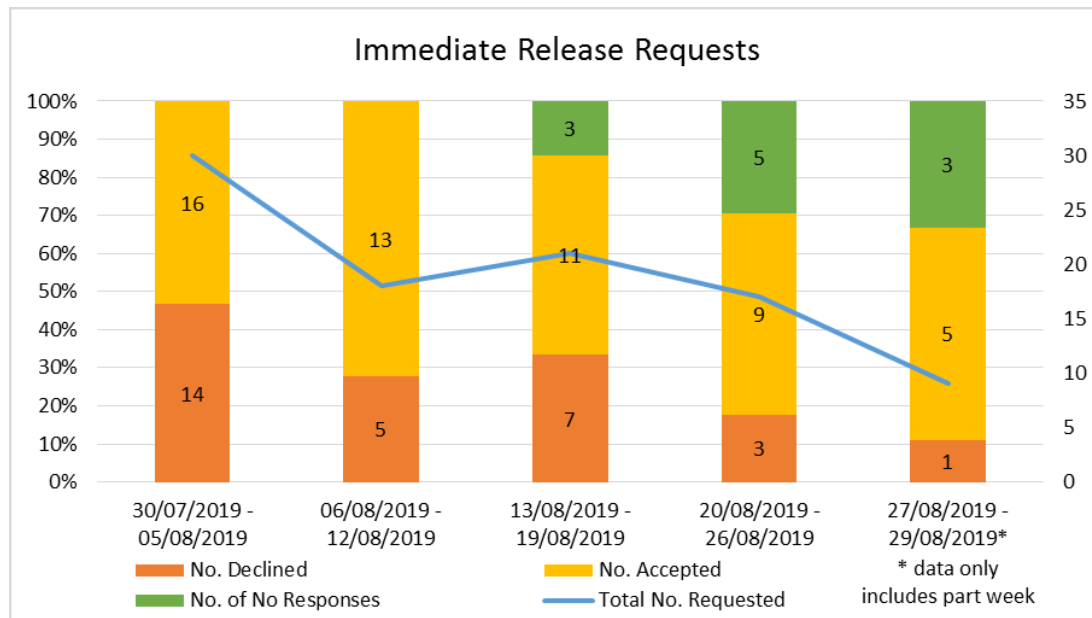
EASC to note the ongoing work to improve red performance through a national Red Improvement Plan which is being actively managed and monitored, with a particular focus on Hywel Dda and Powys.

Amber Performance / Amber Review

Amber performance remains an area of concern with Amber median, 65th centile and 95th centile times on a slight upward trend, although performance remains significantly better than that seen in the winter of 2017/18.

Amber Median, 95th & 65th percentile
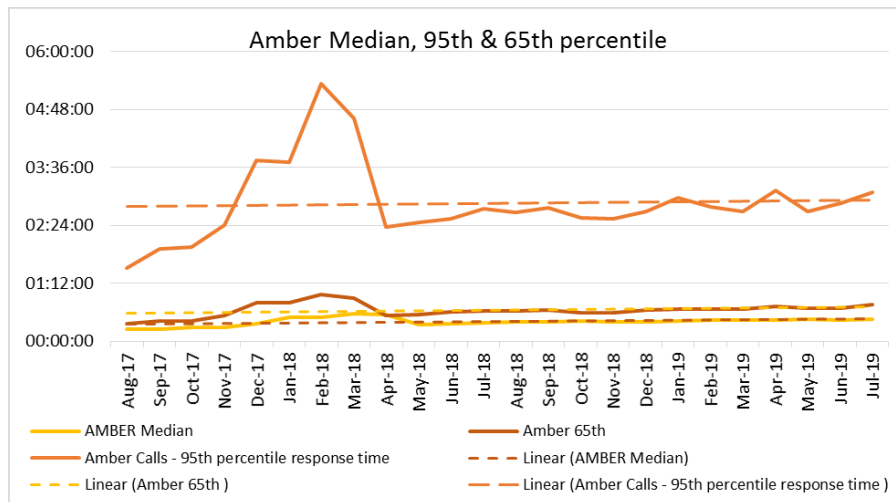
WAST has established an internal Amber Delivery Group and is making good progress on delivering the required recommendations where these are within its purview. Some key elements of the programme and other areas of work designed to improve overall response times and the quality of services provided to patients are summarised in the paragraphs below.

The key action in the Amber Review Implementation Programme is the EMS **Demand & Capacity Review** (final report due to be presented to EASC in November 2019) which will enable EASC to consider options for improving the response to amber patients (and other categories). WAST expects these to include stretching internal efficiencies, wider unscheduled care system efficiencies and, in all likelihood, additional resources being required to respond through hear and treat or see and treat. The slide deck from the 29 August 2019 Demand & Capacity Steering Group is attached at **Appendix 1**. Key highlights from the Review so far are as follows:-

Activity is forecast to grow at a rate of 2.3% per annum over the five year horizon of the review.

Areas of operational delivery where WAST benchmarks favourably across the UK that have been highlighted from the review thus far include:
- Overall job cycle benchmarks favourably with other UK ambulance services (with the exception of arrival to handover;
- Handover to clear benchmarks favourably
- Hear & Treat rate compares favourably and the ambulance stopped ratio of c. one out of two calls is good (and the quality of data supplied is good);
- Introduction of the new Computer Aided Dispatch (CAD) has produced a performance gain of c.5% (more than the estimated 3%);
- Post Production Lost Hours compare favourably, with the exception of return to base meal breaks; and

- Clinical Contact Centre (CCC) rosters are aligned to the demand pattern.

Known areas for Improvement highlighted from the review so far include:
- Roster abstraction rates are high (sickness being the major issue, but there are other abstractions that need to reduce);
- Return to base meal breaks account for 75% of Post Production Lost Hours;
- Hours lost to handover are high.

At the recent Steering Group a range of assumptions, efficiency parameters and performance parameters were agreed, these include:
- Reducing the abstraction rates to the benchmark average;
- Reducing call durations;
- Changes to CCC boundaries;
- Increased alignment of Response rosters to demand patterns;
- Modelling of an expanded hear & treat code set; and
- A range of performance parameters.

The assumptions, efficiencies and performance parameters were collaboratively agreed with the Chief Ambulance Services Commissioner (CASC) and WAST CEO respectively.

The Review has also identified that there is scope to improve the meal break policy and the APP code set, but these are more complex and will not be modelled at this stage.

Finally, a range of known or planned system wide reconfigurations will be modelled e.g. commissioning of the new Grange Hospital in Aneurin Bevan.

Communications around the Review need to be managed collaboratively and with care. WAST has a communications plan, which has been approved by the D&C Steering Group and WAST will liaise closely with the CASC and Welsh Government over the coming months to ensure communications (external and internal) are appropriately co-ordinated and that the health care system is given sufficient opportunity to consider the emerging findings and final report. **Appendix 2** contains an extract from the communications plan, which details key actions over the coming months.

Other key actions in the Amber Review Implementation Programme that are being progressed include:-
- A review of Amber high volume pathways including a database, the identification of good practice and its dissemination (see separate report to EASC);
- Changes to the Ambulance Quality Indicators from quarter 3 onwards, as per the Minister's expectation;
- The development of more sophisticated reports on handover; and

- The further development of longest waits reporting, including breech reports for the very longest waits.

The Amber Implementation Programme is expected to deliver to its agreed timetable.

Amber performance is also adversely impacted by pressures in the wider unscheduled care system, including hours lost through hospital handover delays. WAST lost 79,150 hours to **notification to handover** in the last 12 months, compared to 73,106 in the previous 12 months. The overall upward trend masks variations across Health Boards with some Health Board areas seeing reducing trends, and others seeing increasing trends as demonstrated in the below graph.
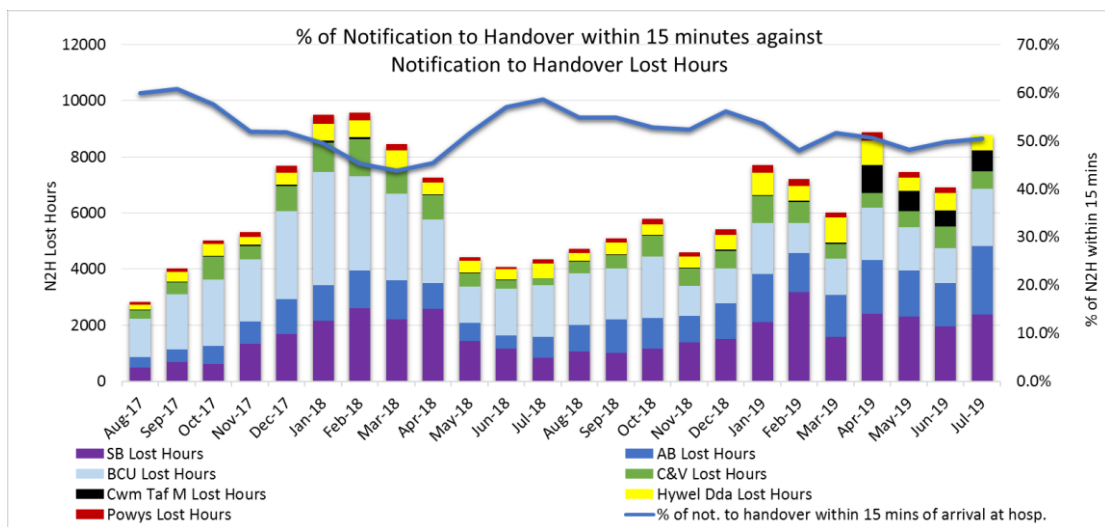
The Trust have also been working to reduce hours lost from **handover to clear.** As part of this work to cleanse and refine the data, a **dual pin system** for handover was rolled out in each ED with all hospitals live in August 2019. The below graph demonstrates the direct impact the system has had on handover to clear rates with significant improvements in lost hours, reducing to 342 hours in July 2019 compared to 909 in July 2018.

% of Handover to Clear within 15 Minutes against Lost Hours to Handover to Clear
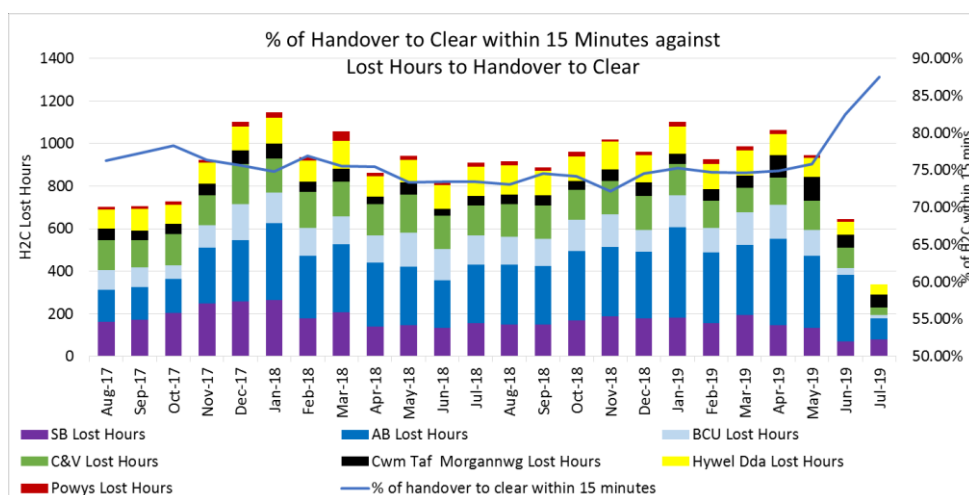
> **EASC to note the actions that are being taken in response to the enhanced performance management of Red and the Amber Review.**

RESOURCES

The NCCU is currently running a process with Health Boards and WAST to identify suitable initiatives to invest the recurring £1.7m which the Minister has made available to progress the implementation of the Healthier Wales Strategy. WAST have put forward seven bids, all of which were highlighted as key deliverables in its IMTP. This process will be considered in a separate paper to the Committee. WAST are keen to see deployment of this resource as soon as possible.

> **EASC to note the bids that have been submitted in relation to the 1% Healthier Wales funding with approval remaining outstanding for some schemes**.

DEVELOPMENTS/PLANNING

Health Board Service Changes

The most imminent strategic service change which is of material importance to WAST relates to the launch of a South Wales and South Powys Major Trauma network on the 01 April 2020. The WAST business case has been through various iterations and at every step tested with key stakeholders including the network board, the CASC and EMRTS. In addition, the business case was the subject of an external peer review lead by the medical Director of the South West Ambulance Service NHS Trust.

The final business case for consideration by EASC forms part of a separate agenda item.

The other key system wide service change relates to the development of the Grange hospital. The proposed clinical model will fundamentally alter flows in the area and significantly increase demand on transfer and discharge activity. The expectation is that the proposed all Wales transfer and discharge model will provide a solution.

All currently known changes to NHS services and configurations are being modelled through the EMS Demand & Capacity Review. The key criteria for service changes to form part of the D&C review include;
- A definitive service model being known
- Service changes which are not internal to a single health board
- Impact is known to be on EMS services i.e. not NEPTs

WAST is currently working with ORH on which NHS services and configurations can be modelled through the EMS Demand & Capacity Review. These should be agreed with ORH this week (w/c 02 Sep-19) and will be signed off with the CASC.

ePCR

Following submission of the Trust's ePCR Outline Business Case V1.1 to Welsh Government, the Trust has been asked to include a fifth option for consideration within the case. This option is to extend the Welsh Clinical Portal (WCP) System to include a dedicated WAST front end to WCP without the requirement for a self-contained ambulance ePCR solution. The Trust does not have the expertise to determine the feasibility of this option and will therefore require external specialist support to undertake a feasibility study. It is likely that this feasibility work will exceed the value permissible for direct award and the work will therefore be tendered through the appropriate procurement process. Trust Executives and CEO are in discussions with WG regarding the funding and scope of this work so that it can proceed as soon as possible.

All Wales Transfer and Discharge Service

Both the WAST and EASC Integrated Medium Terms Plans (IMTP) articulate a commitment to develop a single "All Wales" transfer and discharge service. A further commitment was made to be able to articulate what this service *could* look like by the end of quarter two.

A workshop was held on the 09 July 2019, with all health boards invited. An invitation was also extended to the Critical Illness Implementation Group in light of recent investment from the Minister and the NCCU was represented.

Internally, work is now being progressed to develop a model 'in principle' using both health board feedback and data from the forthcoming D&C Review.

Non-Emergency Patient Transport Services (NEPTS)

NEPTS has developed an innovative proposal on managing the transport requirements of patients who do not have an eligible medical need for transport. The proposal, which will need support from the Healthier Wales funding allocation to ensure its delivery, will introduce a system whereby non-eligible patients are supported to find and book alternative transport arrangements to help them access their treatment. This proposal will also ensure the service is operating fully within the guidelines set out by WHC 2007(005). A briefing paper and engagement plan to support the delivery of the proposal and this has been shared with Welsh Government. WAST is expecting to undertake a separate demand & capacity review of NEPTS in the second half of 2019/20.

Integrated Medium Term Plan (IMTP) 2020/23

WAST's 2020/21 internal planning cycle will support the refresh of the organisation's current IMTP. WAST's refreshed IMTP has to be submitted by the 31 January 2019. WAST will need earlier engagement with the NCCU, in particular, on the 2020/21 commissioning intentions in order to meet the required deadline, and time will need to be built into the EASC agenda to consider and approve the plan.

Winter Planning

WAST's National Winter Plan will be presented to our Trust Board on 26 September Board for approval. The tactical plan covers actions across the EMS and NEPTS five step pathways (and in the case of EMS will be underpinned by Health Board level plans).

WAST will be undertaking a desk top winter management scenario exercise in mid-October to stress test arrangements. A key lesson from last winter was that the Silver Cell that operated over the festive period needed to be extended into January (and other periods).

WAST is working with Cardiff University Business School on forecasting and the plan will be supported by a tactical demand forecast over the period of the plan, which will be linked to Optima Predict to provide a performance prediction, in advance of winter.

The Plan also includes a range of service initiatives, should winter monies become available, which include:

- Enhanced NEPTs discharge & transfer capacity;
- Remote working for Clinical Support Desk staff (internal discretionary capital, rather than winter monies);
- Increased capacity for concerns and serious incident responses and investigation;
- Staff Welfare Plan (welfare vehicles and welfare packs);
- A number of small pilot schemes.

Whilst not winter planning initiatives, WAST has also focused other key parts of the organisation to support winter resilience, in particular, workforce planning over recruiting to off-set predicted vacancies, St John Falls Assistants, the further expansion of the APP rotational model (another 26 APPs from September 2019) and the continuation and further improvement of the Clinical Support Desk.

The Director of Operations has also identified three additional quick to implement actions that WAST could undertake to support the unscheduled care system 1) the expansion of the existing partnership with St John Cymru Wales to contract additional fixed term Urgent Care Service (UCS) skilled resource 2) improved access for patient facing staff to clinical records and senior decision making through the linkage of clinical records and the Clinical Support Desk 3) to utilise alternate providers to be an interface at acute hospital sites (where handover delays are prominent) to take a handover of WAST patients and provide care under WAST supervision to the point of handover; thereby freeing up WAST staff to respond to patients in the community, whilst improving staff welfare and morale.

> **EASC to note the range of service developments and planning ongoing and the need for further detailed papers to come back to EASC in due course for consideration.**

4. RECOMMENDATIONS:

The Emergency Ambulance Services Committee is asked to:

- **DISCUSS** and **NOTE** the content of the report

Freedom of information status	Open

Welsh Ambulance Services NHS Trust

Demand and Capacity Review

Chris Polden and James Batchelor

29 August 2019

ORH

PLAN. PREPARE. PERFORM.

Contents

- Project Update

- Updated Ops Analysis

- Ops Relief Requirement

- APP Potential

- Dispatch Analysis

- CCC Relief Requirement

- CTA Potential

- CCC Modelling Assumptions

- CCC Modelling

- Ops Modelling Assumptions

- Ops Modelling

- Optimal Location Modelling

- Next Steps

Project Update

Project Update

Final analysis items have been undertaken.

Operational simulation models have been set up and validated.

Operational models have been used to show the impact of achieving planned rosters and of increased demand.

Initial location optimisation modelling has been undertaken.

Ops and CCC modelling assumptions have been confirmed.

CCC model set-up progressing.

Review Timetable

Week No	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Week Commencing	17-Jun	24-Jun	01-Jul	08-Jul	15-Jul	22-Jul	29-Jul	05-Aug	12-Aug	19-Aug	26-Aug	02-Sep	09-Sep	16-Sep	23-Sep	30-Sep
a) Data Collection	■	■														
b) Data Analysis		Model Set-up and Current Service Profile														
c) Benchmarking					■	■										
d) Demand Projections			■	■			■	■								
e) Model Setup and Validation					■	■	■	■								
f) Operational Scenario Modelling						■	■	■	■	■	■	■	■	■	■	
g) Control Scenario Modelling						■	■	■	■	■	■	■	■	■	■	
h) Stakeholder Engagement		■		■			■				■			■		■
Reporting			Progress Report 1			Progress Report 2				Interim Report			Draft Results Report		Final Report	
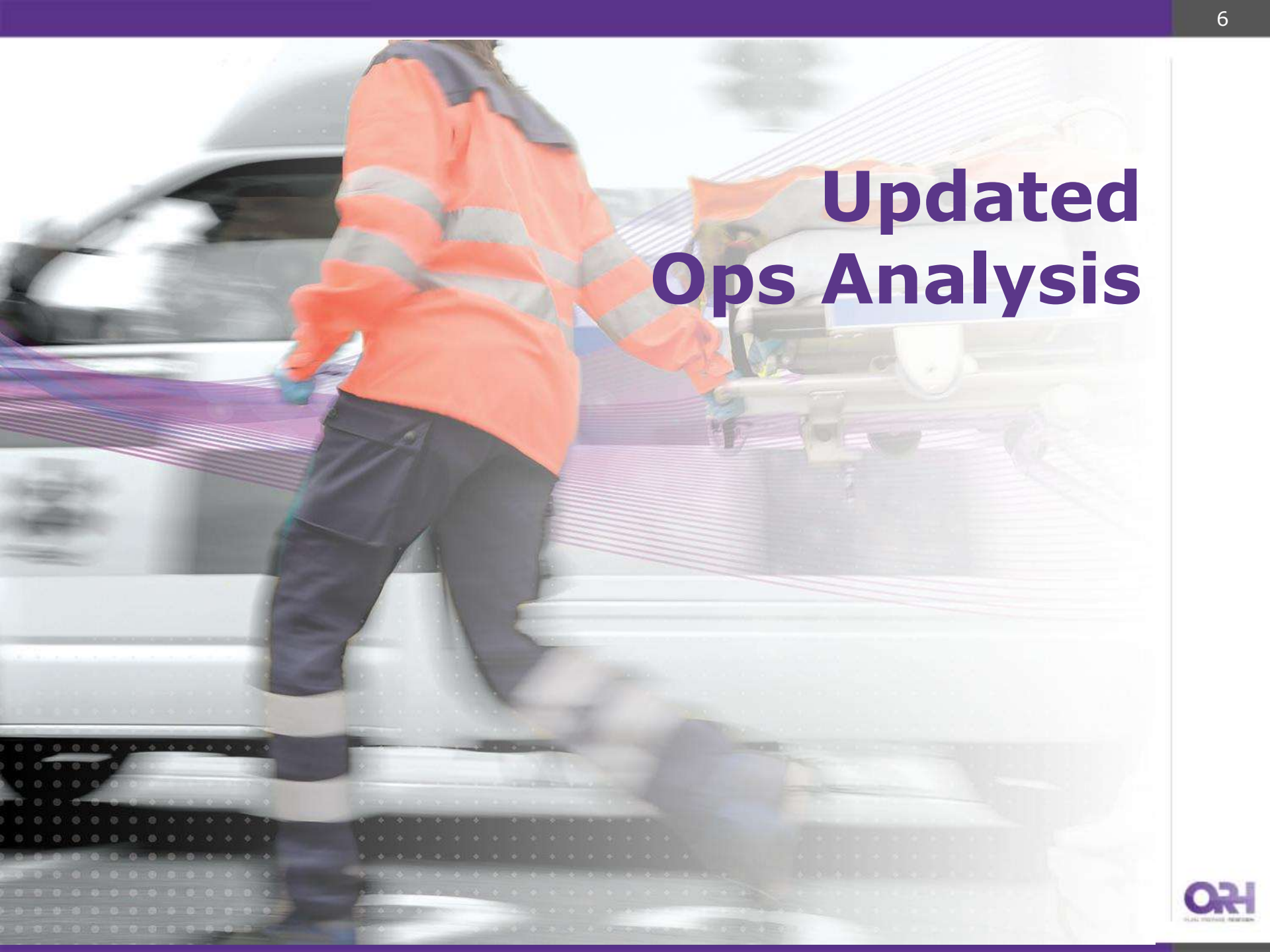
Updated Ops Analysis

Utilisation by LHB

Emergency Ambulance

Local Health Board	Weekly Vehicle Hours	Avg Weekly Occupied Time	Utilisation
Aneurin Bevan	2,240.8	1,635.7	73.0%
Cardiff & Vale	1,461.6	1,086.9	74.4%
Cwm Taf	1,204.2	727.8	60.4%
Betsi Cadwaladr	4,283.5	2,579.9	60.2%
Abertawe Bro Morgannwg	2,288.5	1,519.9	66.4%
Hywel Dda	3,010.9	1,374.3	45.6%
Powys	1,549.3	576.7	37.2%
Trust Wide	16,038.7	9,501.1	59.2%

RRV

Local Health Board	Weekly Vehicle Hours	Avg Weekly Occupied Time	Utilisation
Aneurin Bevan	1,565.3	582.8	37.2%
Cardiff & Vale	822.6	283.7	34.5%
Cwm Taf	816.6	243.7	29.8%
Betsi Cadwaladr	1,081.1	378.1	35.0%
Abertawe Bro Morgannwg	991.8	397.1	40.0%
Hywel Dda	442.3	166.0	37.5%
Powys	315.7	60.8	19.3%
Trust Wide	6,035.5	2,112.2	35.0%

UCS

Local Health Board	Weekly Vehicle Hours	Avg Weekly Occupied Time	Utilisation
Aneurin Bevan	442.6	301.9	68.2%
Cardiff & Vale	420.9	222.2	52.8%
Cwm Taf	409.7	226.2	55.2%
Betsi Cadwaladr	635.4	389.1	61.2%
Abertawe Bro Morgannwg	442.5	271.4	61.3%
Hywel Dda	354.3	192.4	54.3%
Powys	202.7	82.9	40.9%
Trust Wide	2,908.2	1,686.0	58.0%

APP

Local Health Board	Weekly Vehicle Hours	Avg Weekly Occupied Time	Utilisation
Aneurin Bevan	25.1	18.3	73.0%
Cardiff & Vale	-	0.4	-
Cwm Taf	14.0	9.7	69.1%
Betsi Cadwaladr	94.1	55.1	58.6%
Abertawe Bro Morgannwg	67.2	42.7	63.6%
Hywel Dda	44.5	15.4	34.5%
Powys	10.3	1.4	13.4%
Trust Wide	255.2	143.0	56.0%

Note: 84 APP weekly hours per control have been removed from the actual vehicle hours in this analysis to represent the APPs planned to work in the control room. This has been proportioned to LHB level.

Red 8 by Contributing Vehicle

Vehicle Type Description	LHB							Overall
	Aneurin Bevan LHB	Betsi Cadwaladr University LHB	Cardiff & Vale University LHB	Cwm Taf LHB	Abertawe Bro Morgannwg University LHB	Hywel Dda LHB	Powys LHB	
Emergency Ambulance	33.9%	44.4%	44.6%	37.6%	39.9%	45.5%	38.9%	40.9%
Rapid Response Vehicle	30.0%	16.9%	28.9%	25.6%	27.2%	10.7%	12.2%	23.2%
UCS/St John UCS	2.6%	3.0%	3.3%	4.7%	1.7%	2.3%	3.3%	2.8%
Advanced Paramedic Practitioner	0.5%	1.2%	0.0%	0.4%	1.7%	0.6%	0.1%	0.8%
DEFIB(MEDIC)	4.0%	4.2%	2.8%	3.5%	3.8%	3.7%	4.8%	3.7%
Community First Responder	1.7%	1.8%	0.9%	0.4%	1.0%	1.1%	2.3%	1.3%
All other vehicles	0.3%	0.8%	0.8%	0.3%	1.2%	1.6%	4.3%	1.0%
Overall	**73.0%**	**72.4%**	**81.3%**	**72.5%**	**76.4%**	**65.6%**	**65.9%**	**73.7%**
Core Vehicles	67.1%	65.5%	76.9%	68.4%	70.4%	59.1%	54.5%	67.7%
Other Vehicles	5.9%	6.9%	4.4%	4.2%	6.0%	6.5%	11.3%	6.0%

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Dropped Shifts

Actual - sample period

Model Area	EA	RRV	UCS	APP	Overall
Central & West	6,849	1,750	1,000	204	9,802
North	4,284	1,081	635	178	6,178
South East	4,852	3,204	1,273	123	9,453
Overall	**15,984**	**6,036**	**2,908**	**505**	**25,433**

Planned

Model Area	EA	RRV	UCS	APP	Overall
Central & West	7,144	1,954	998	288	10,383
North	4,758	1,373	652	168	6,950
South East	5,395	3,998	1,233	229	10,855
Overall	**17,296**	**7,324**	**2,882**	**685**	**28,187**

Difference

Model Area	EA	RRV	UCS	APP	Overall
Central & West	-295	-204	2	-84	-581
North	-474	-291	-16	10	-771
South East	-543	-793	40	-106	-1,402
Overall	**-1,312**	**-1,288**	**26**	**-180**	**-2,754**

Dropped Shift Rate

Model Area	EA	RRV	UCS	APP	Overall
Central & West	4.1%	10.4%	-0.2%	29.3%	5.6%
North	10.0%	21.2%	2.5%	-6.0%	11.1%
South East	10.1%	19.8%	-3.3%	46.3%	12.9%
Overall	**7.6%**	**17.6%**	**-0.9%**	**26.3%**	**9.8%**

Ops Relief Requirement

Deriving an Abstraction Rate

ORH analysed WAST abstraction rates for the financial year 2018/19.

Current abstraction rates are some of the highest ORH has analysed in any UK ambulance service.

WAST has put forward a suggestion for new abstraction rates based on industry best practices, to be achieved through internal efficiencies.

Abstraction Rate Calculation

WAST proposed abstraction rates are:

Abstraction Reason	Rate
Annual Leave	12.66%
Bank Holidays	3.07%
Sickness	5.99%
Alternative Duties	3.00%
Training	3.00%
Maternity	1.20%
Other	1.00%
Total	29.91%

This gives a relief rate requirement of 42.67%. ORH has benchmarked this against other services in the UK:

Trust	Frontline Relief Rate
A	37.0%
B	38.5%
C	38.9%
WAST	42.7%
D	43.3%
E	46.2%
F	47.4%

Planned Vehicle Hours

Current planned rosters across frontline resourcing in WAST provide (when fully staffed) the following weekly vehicle hours:

Vehicle Type	BCU	ABM	HD	CT	CV	AB	Powys	Total
EA	4,758	2,450	3,033	1,292	1,528	2,576	1,660	17,296
RRV	869	680	268	650	578	1,618	97	4,759
UCS	652	438	332	421	301	512	305	2,959
Total	**6,278**	**3,568**	**3,634**	**2,363**	**2,406**	**4,705**	**2,062**	**25,015**

This is equivalent to the following weekly staff hours:

Vehicle Type	BCU	ABM	HD	CT	CV	AB	Powys	Total
EA	9,515	4,901	6,067	2,584	3,055	5,152	3,320	34,593
RRV	869	680	268	650	578	1,618	97	4,759
UCS	1,303	876	665	842	601	1,023	609	5,919
Total	**11,687**	**6,456**	**6,999**	**4,076**	**4,234**	**7,793**	**4,026**	**45,270**

Required Staff

Taking account of the 30 minute unpaid break per shift and assuming a 36.5 hour working week, the following staff are required (excluding relief) to run the roster:

Vehicle Type	BCU	ABM	HD	CT	CV	AB	Powys	Total
EA	249.6	128.6	159.2	67.7	79.9	135.0	86.9	907.0
RRV	22.7	17.3	6.8	17.0	15.1	42.4	2.2	123.5
UCS	33.6	22.9	17.3	22.1	15.7	26.8	15.8	154.3
Total	**306.0**	**168.9**	**183.3**	**106.8**	**110.6**	**204.2**	**105.0**	**1,184.8**

Adding in the 42.67% relief rate gives a requirement of:

Vehicle Type	BCU	ABM	HD	CT	CV	AB	Powys	Total
EA	356.1	183.5	227.1	96.6	113.9	192.7	124.0	1,294.0
RRV	32.4	24.7	9.7	24.3	21.5	60.4	3.2	176.1
UCS	48.0	32.7	24.7	31.5	22.4	38.2	22.6	220.1
Total	**436.5**	**240.9**	**261.6**	**152.4**	**157.8**	**291.3**	**149.8**	**1,690.3**

Required Staff by Grade

The staff are then converted from vehicles to staff by grade by assuming the following staffing on a vehicle:

- EA: Para and Tech

- RRV: Para

- UCS: UCA and UCA

Staff Grade	BCU	ABM	HD	CT	CV	AB	Powys	Total
Para	228.3	125.6	134.7	77.4	84.2	166.4	71.4	887.8
Tech	160.3	82.6	102.2	43.5	51.3	86.7	55.8	582.3
UCA	48.0	32.7	24.7	31.5	22.4	38.2	22.6	220.1
Total	**436.5**	**240.9**	**261.6**	**152.4**	**157.8**	**291.3**	**149.8**	**1,690.3**

A 55/45 split between Para and Tech has been assumed on the EA roster to reduce the likelihood of double technician crews.

Funded Staffing and Requirement

WAST is currently funded for the following staff by grade:

Staff Grade	BCU	ABM	HD	CT	CV	AB	Powys	Total
Para	195.4	129.3	138.0	69.0	84.5	139.0	60.5	815.7
Tech	118.8	51.0	61.0	26.0	45.9	67.0	44.5	414.2
UCA	49.0	33.0	23.0	29.0	18.9	31.0	14.0	198.0
Total	**363.2**	**213.3**	**222.0**	**124.0**	**149.3**	**237.0**	**119.0**	**,1427.8**

This gives the following shortfall compared to the requirement:

Vehicle Type	BCU	ABM	HD	CT	CV	AB	Powys	Total
Para	-32.8	3.7	3.3	-8.4	0.4	-27.4	-10.9	-72.1
Tech	-41.5	-31.6	-41.2	-17.5	-5.4	-19.7	-11.3	-168.2
UCA	1.0	0.3	-1.7	-2.5	-3.5	-7.2	-8.6	-22.2
Total	**-73.3**	**-27.6**	**-39.6**	**-28.4**	**-8.5**	**-54.3**	**-30.8**	**-262.5**

APP Potential

APP Potential

An APP suitable code set has been taken from the pre determined attendance list from the DCR table.

Responded Demand per day (2018/19)

LHB	All	APP Suitable			% APP Suitable		
		APP Only	APP and/or Other	Total	APP Only	APP and/or Other	Total
Abertawe Bro Morgannwg Uni.	157.2	5.2	21.0	26.2	3.3%	13.4%	16.6%
Aneurin Bevan	171.7	5.6	22.8	28.4	3.3%	13.3%	16.5%
Betsi Cadwaladr University	255.4	10.2	39.1	49.3	4.0%	15.3%	19.3%
Cardiff & Vale University	130.2	3.7	16.6	20.3	2.8%	12.7%	15.6%
Cwm Taf	95.2	3.6	13.5	17.1	3.8%	14.2%	18.0%
Hywel Dda	131.7	5.0	18.4	23.4	3.8%	14.0%	17.7%
Powys	46.4	1.7	6.2	8.0	3.7%	13.5%	17.2%
Out of Area	0.7	0.0	0.0	0.0	0.0%	1.7%	1.7%
Trust-wide	**988.4**	**34.9**	**137.6**	**172.5**	**3.5%**	**13.9%**	**17.5%**

APP Potential

- Potential to increase APP workload to 172.5 incidents per day, or **17.5%** of total incident volumes.

- In 2018/19 APPs responded to 14.3 incidents per day, only 4 of which were considered APP suitable.

- To those suitable incidents, APPs had an average conveyance rate of 25.5%, compared to 59.1% if an APP didn't attend.

- Pilots have suggested that as the APP codeset is expanded, an average conveyance rate of 33% is achievable.

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Dispatch Analysis

Dispatch

- Use vehicle deployments required to meet targets in 2025 to appraise the dispatch desk areas.

- Agree preferred dispatch desk structure.

- Identify dispatch desk boundaries that:

    - Minimise variation in the number of vehicles per desk

    - Minimise variation in workload (assignments) per desk

    - Respect the patient-hospital vehicle flows as much as possible

- Potential for merging some desks during the night.

Dispatch Desk Workload (2018/19)

Vehicle Workload

Dispatch Desk	Average Planned Vehicles		
	Day (07:00-19:00)	**Evening (19:00-02:00)**	**Night (02:00-07:00)**
Anglesey & Gwynedd	15.4	15.4	10.5
Conwy & Denbighshire	13.2	10.8	9.0
Flintshire & Wrexham	13.2	12.3	8.3
Carmarthenshire & Pembrokeshire	16.8	16.0	13.5
Neath Port Talbot & Bridgend	14.1	14.2	9.7
Powys & Ceredigion	20.4	18.2	12.9
Swansea	9.4	9.9	7.5
Cardiff & Vale	15.8	17.9	10.3
North & West Aneurin Bevan	17.5	17.8	11.9
Rhondda Cynon Taf	16.5	15.9	8.3
South Aneurin Bevan	13.5	13.3	7.8

HCP North	8.5	-	-
HCP Central & West	9.4	-	-
HCP South East	9.2	-	-

APP North	2.0	2.0	-
APP Central & West	1.8	1.4	1.0
APP South East	1.7	1.4	1.1

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Dispatch Desk Workload (2018/19)

Incident Workload (Assignments)

| Dispatch Desk	Average Hourly Incidents		
	Day (07:00-19:00)	Evening (19:00-02:00)	Night (02:00-07:00)
Anglesey & Gwynedd	3.3	2.8	1.5
Conwy & Denbighshire	3.9	3.3	2.1
Flintshire & Wrexham	4.2	3.6	2.1
Carmarthenshire & Pembrokeshire	4.9	4.2	2.3
Neath Port Talbot & Bridgend	3.6	3.4	1.9
Powys & Ceredigion	3.2	2.6	1.4
Swansea	3.0	3.0	1.7
Cardiff & Vale	5.2	5.1	2.7
North & West Aneurin Bevan	3.8	3.5	1.9
Rhondda Cynon Taf	4.1	3.7	2.0
South Aneurin Bevan	3.6	3.2	1.8
HCP North	3.1	-	-
HCP Central & West	3.4	-	-
HCP South East	4.3	-	-
APP North	0.6	0.3	-
APP Central & West	0.4	0.3	0.1
APP South East	0.2	0.1	0.0

Hospital Flows

Patient flows to major hospitals across Wales are mapped.
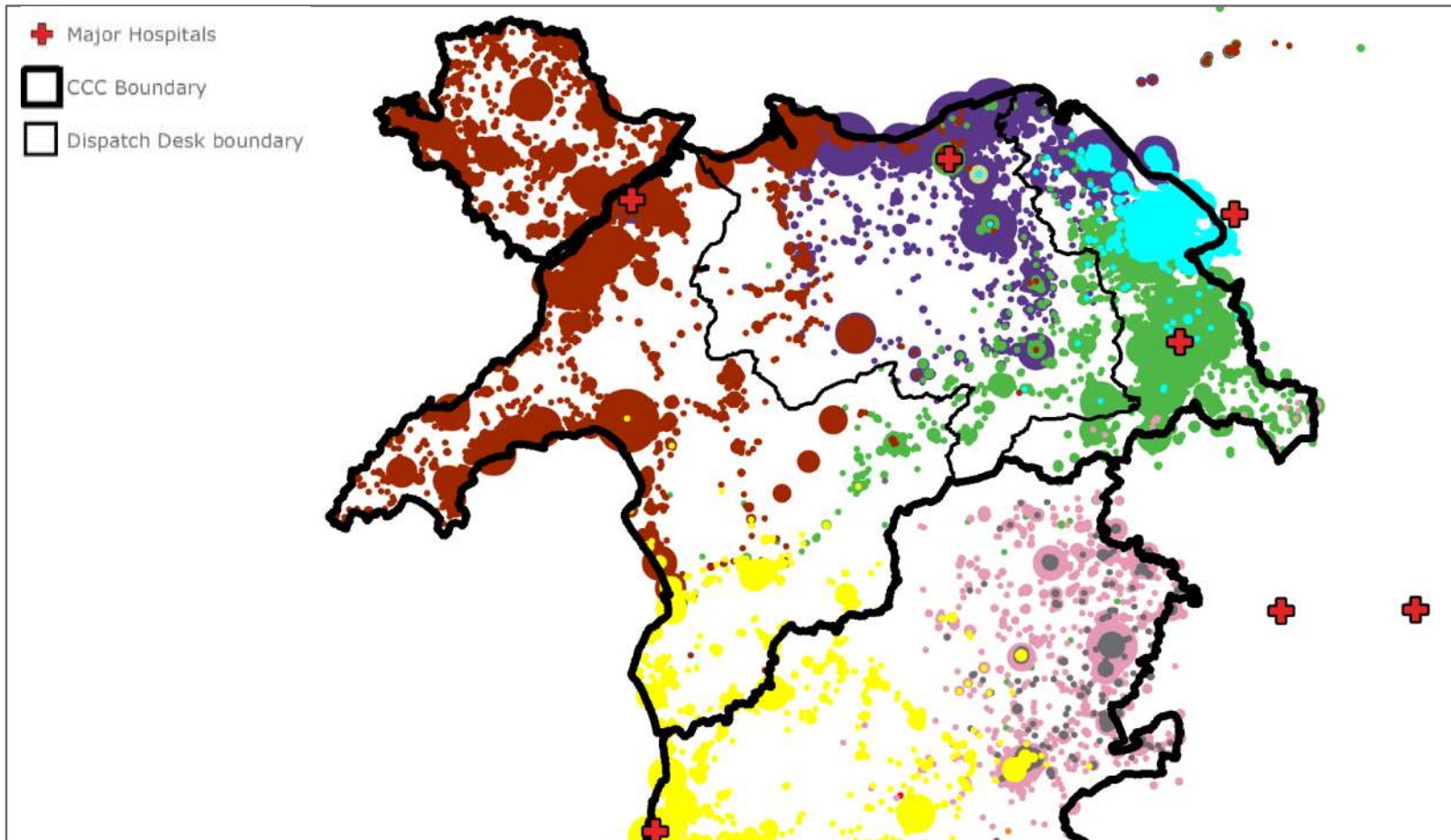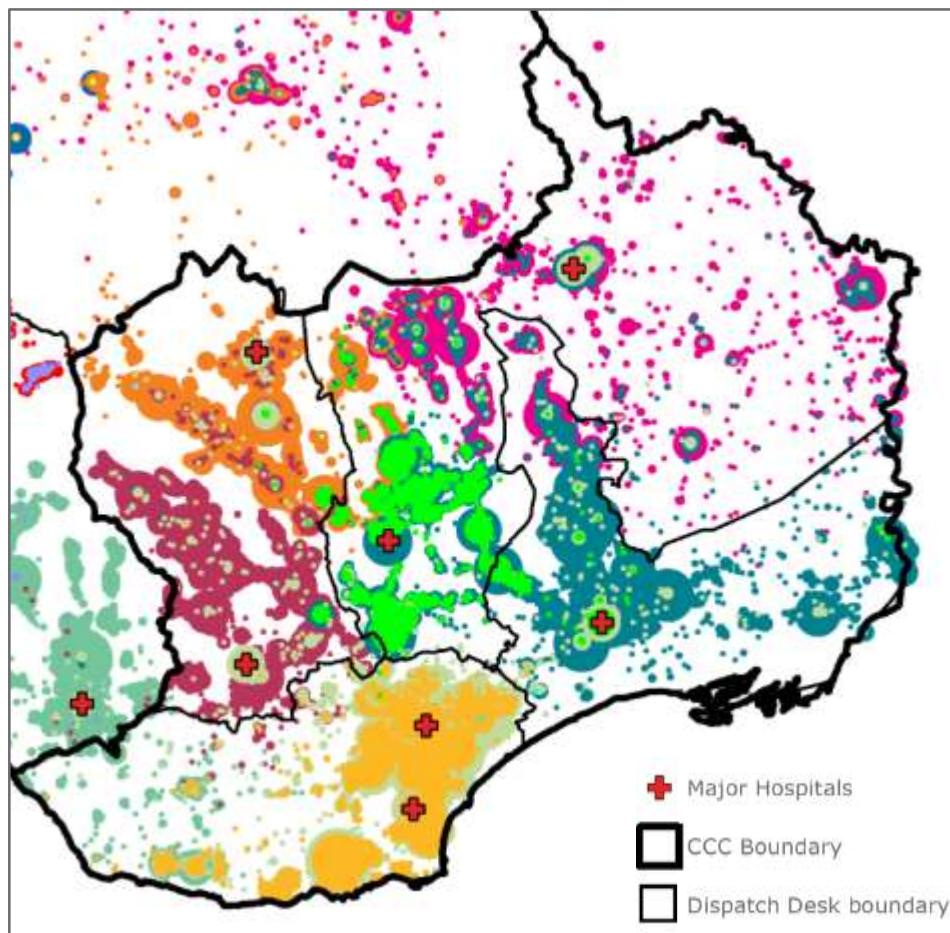
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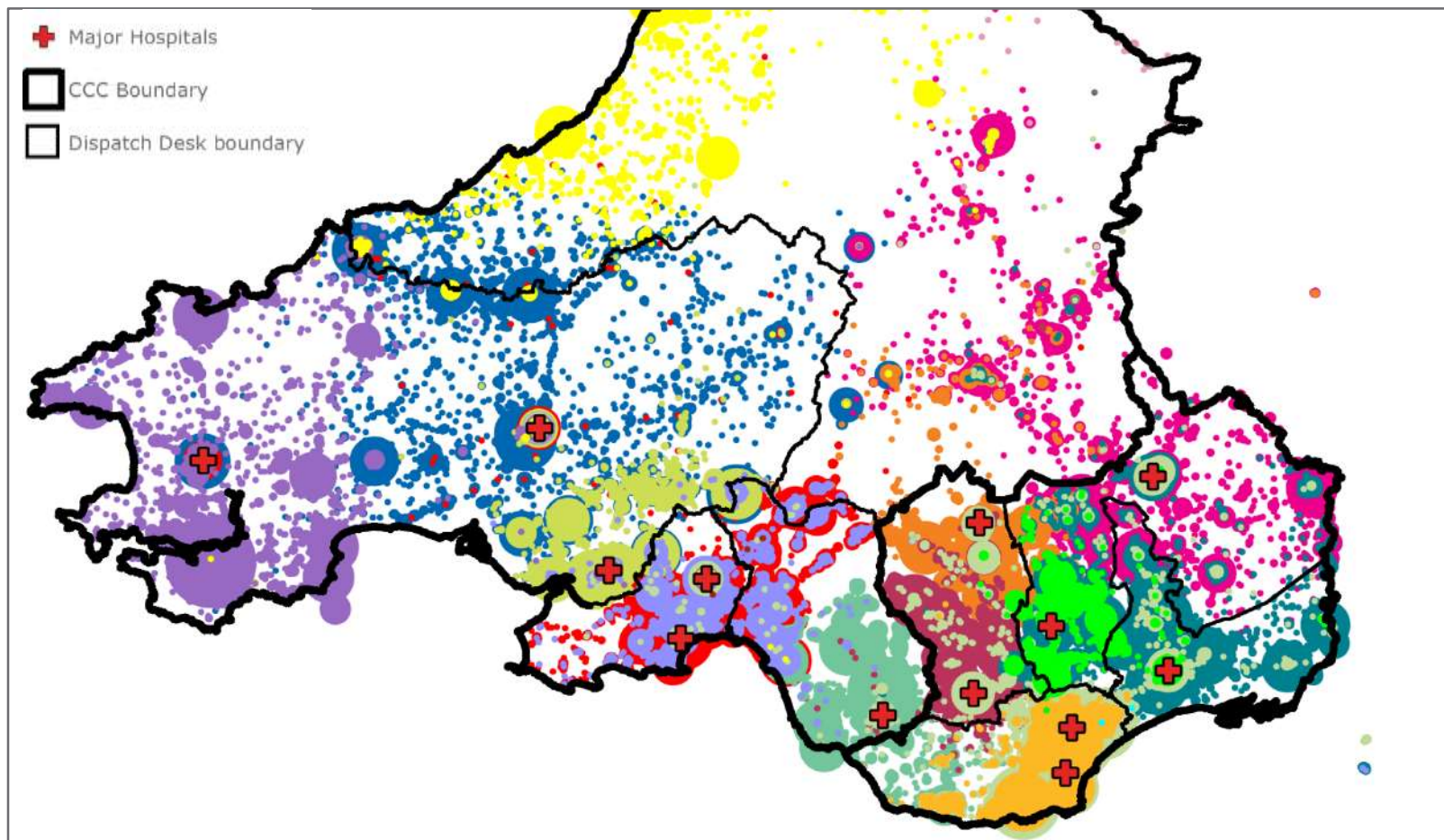
Hospital Flows

Patient flows to major hospitals across Wales are mapped.

CCC Relief Requirement

Relief Rate

WAST have identified abstraction efficiencies to be made.

Absence Reason	2018/19	WAST Proposed	Difference
Annual Leave*	14.0%	15.7%	1.8%
Sickness	9.7%	6.0%	-3.7%
Alternative Duties	2.2%	3.0%	0.8%
Training	5.4%	3.0%	-2.4%
Maternity	2.2%	2.0%	-0.2%
Other	1.5%	1.0%	-0.5%
Abstraction Rate	**35.1%**	**30.7%**	**-4.3%**

Relief Rate	**54.0%**	**44.3%**	**-9.6%**

Trust	CCC Relief Rate
J	37.8%
K	43.7%
L	44.1%
WAST	44.3%
M	47.7%

*Based on maximum 33 days and 8 bank holidays.

Planned Staff Hours - CCCs

Current planned rosters across CCC resourcing in WAST provide (when fully staffed) the following weekly staff hours:

Position	CCC			Total
	North	**Central & West**	**South East**	
Allocator	554	736	840	**2,130**
Call Handler	793	982	1,103	**2,879**
Clinician	-	-	-	**656**
DCM	168	168	168	**504**
Dispatcher	336	672	840	**1,848**
DSM	-	-	-	**119**
Senior Clinician	-	-	-	**169**
Supervisor	154	168	168	**490**
Total	**2,005**	**2,727**	**3,119**	**8,796**

Note: Plan as of July 2019. Allocator includes the HCP desk.

Required Staff (excluding Relief)

Taking account of the 30 minute unpaid break per shift and assuming a 37.5 hour working week, the following staff are required (excluding relief) to run the roster:

Position	CCC			Total
	North	Central & West	South East	
Allocator	14.1	18.8	21.5	**54.4**
Call Handler	20.2	25.0	28.1	**73.3**
Clinician	-	-	-	**16.7**
DCM	4.3	4.3	4.3	**12.9**
Dispatcher	8.6	17.2	21.5	**47.2**
DSM	-	-	-	**3.0**
Senior Clinician	-	-	-	**4.3**
Supervisor	3.9	4.3	4.3	**12.5**
Total	**51.1**	**69.6**	**79.6**	**224.4**

Required Staff (including Relief)

Adding in the 44.34% relief rate increases the staff requirement to:

Position	CCC			Total
	North	Central & West	South East	
Allocator	20.4	27.1	31.0	**78.6**
Call Handler	29.1	36.1	40.5	**105.7**
Clinician	-	-	-	**24.2**
DCM	6.2	6.2	6.2	**18.6**
Dispatcher	12.4	24.8	31.0	**68.2**
DSM	-	-	-	**4.3**
Senior Clinician	-	-	-	**6.3**
Supervisor	5.7	6.2	6.2	**18.1**
Total	**73.8**	**100.4**	**114.9**	**323.8**

Funded Staffing

WAST is currently funded for the following staff across the three CCCs:

Position	CCC			Total
	North	Central & West	South East	
Allocator	20.0	26.0	30.0	**76.0**
Call Handler	30.1	28.6	38.2	**96.9**
Clinician	-	-	-	**41.0**
DCM	6.0	6.0	6.0	**18.0**
Dispatcher	12.6	24.2	30.0	**66.8**
DSM	-	-	-	**3.0**
Senior Clinician	-	-	-	**7.0**
Supervisor	1.0	1.0	1.0	**3.0**
Total	**69.8**	**85.7**	**105.2**	**311.6**

Note: Funded establishment as on 24th June 2019.

Staffing Shortfall (Relief Rate Gap)

Comparing the staffing requirement (including relief) with the funded staffing gives the following shortfall:

Position	CCC			Total
	North	Central & West	South East	
Allocator	-0.4	-1.1	-1.0	**-2.6**
Call Handler	1.0	-7.5	-2.4	**-8.9**
Clinician	-	-	-	**16.8**
DCM	-0.2	-0.2	-0.2	**-0.6**
Dispatcher	0.2	-0.6	-1.0	**-1.4**
DSM	-	-	-	**-1.3**
Senior Clinician	-	-	-	**0.7**
Supervisor	-4.7	-5.2	-5.2	**-15.1**
Total	**-4.1**	**-14.7**	**-9.7**	**-12.2**

Clinical Triage Assessment (CTA) Potential

CSD Suitable Calls

- Three quarters of Hear & Treat not coming from CSD codeset.

- Triage not attempted on 38% of CSD suitable calls.

Average Daily Calls

CSD Outcome	Hear & Treat Reason	CSD Suitable		Total	% Verified Calls
		Yes	No		
Hear & Treat	Alternative Transport	5.0	14.4	19.4	1.5%
	Hear and Treat Discharge	4.5	11.2	15.7	1.2%
	Taxi Suitable	3.7	11.7	15.3	1.2%
	Hear and Treat Referral	2.9	6.9	9.8	0.8%
	Hear & Treat Total	**16.1**	**44.2**	**60.3**	**4.8%**
Upgrade		11.7	63.5	75.2	5.9%
CSD Aborted/Unable to Complete		13.8	24.3	38.1	3.0%
Response Appropriate (No Change)		8.2	27.0	35.2	2.8%
Downgrade		0.1	2.9	3.0	0.2%
Other		0.7	0.7	1.4	0.1%
CSD Total		**50.7**	**162.5**	**213.2**	**16.8%**

Not Dealt with by CSD	31.2	-	-	2.5%

CTA Potential (Current Codeset)

- In 2018/19 WAST had a Hear & Treat rate of 7.9%
  - 4.8% CSD (1.3% from CSD codeset)
  - 3.1% NHSD

- Maximising the current CSD and NHSD codesets would give a total Hear & Treat rate of **8.0%**.
  - 2.1% CSD
  - 5.9% NHSD

- Assumes current CSD and NHSD "success" rates.

- Assumes no contribution from non-CSD suitable calls.

CTA Potential (Expanded Codeset)

WAST's CSD codeset benchmarked against three UK Trusts.

Average Daily CSD Suitable Calls

Initial Category	WAST Codeset			Trust A Codeset	Trust B Codeset	Trust C Codeset			
	NHSD	CSD	Total			Clinician	Pharm	MH	Total
RED	0.1	0.1	0.2	0.1	0.1	0.2	0.1	0.2	0.5
AMBER1	0.1	0.0	0.1	2.2	2.2	2.2	0.1	0.0	2.2
AMBER2	0.0	29.7	29.7	7.0	13.6	51.1	0.0	50.0	101.1
GREEN2	0.0	42.1	42.1	20.6	21.4	36.7	2.2	4.4	43.3
GREEN3	133.4	10.1	143.5	125.8	111.2	108.7	23.8	7.3	139.9
GREEN(HCP)	0.1	0.0	0.1	0.1	0.1	0.1	0.0	0.0	0.1
ROUTINE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	133.7	81.9	215.6	155.8	148.7	199.0	26.1	62.0	287.1
% of Calls	10.5%	6.5%	17.0%	12.3%	11.7%	15.7%	2.1%	4.9%	22.6%

WAST compare favourably when CSD and NHSD codesets are combined.

CTA Potential (Expanded Codeset)

CSD potential when combined with WAST's codeset.

CSD Suitable Calls	WAST Codeset			WAST + Trust C Codeset			
	NHSD	CSD	Total	Clinician	Pharm	MH	Total
Average Daily Calls	133.7	81.9	215.6	282.5	216.1	237.4	304.8
% of Verified Calls	10.5%	6.5%	17.0%	22.3%	17.0%	18.7%	24.0%

Potential to increase the volume of CSD suitable calls from 17% to 24% of calls, with assistance from MH professionals.

Note: Codeset changes are subject to clinical governance processes, so are used for modelling purposes only at this stage.

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CTA Potential (Expanded Codeset)

- Potential to more than double the CSD codeset (excluding NHSD) from 81.9 to 171.1 calls per day.

- Almost a quarter (24%) of all calls would be passed to the CSD desk or NHSD.

- Maximising an expanded CSD codeset, and current NHSD codeset, would give a total Hear & Treat rate of **10.2%**, assuming current "success" rates.
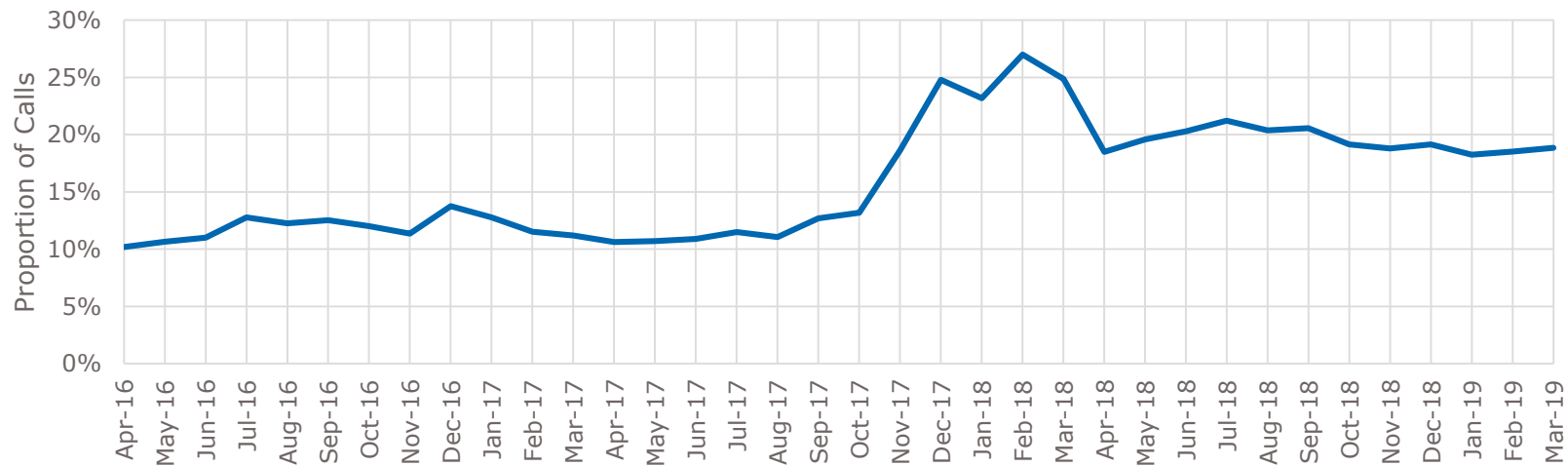
CCC Modelling Assumptions

Duplicate Calls

- 999 call volumes have increased at a faster rate than CAD calls, due in part to duplicate/repeat calls.

- Expectation that volumes will fall as response times improve.

DUP and PDET Calls

- **WAST to target 11% duplicates, a level seen in the more stable period of summer 2017.**

Calls by Line

- Use of 0845 lines varies between CCCs. No change in 19/20.

Average Daily Calls Offered (December 18 to March 19)

Line Type	Line Area			Total
	North	Central & West	South East	
Emergency Services (0845)	45.6	6.2	95.1	**146.9**
Routine (0845)	44.3	3.8	10.7	**58.8**
Primary 999	329.3	437.9	570.7	**1,337.9**
Urgent (0845)	38.9	77.5	129.5	**245.9**
Total	**458.0**	**525.4**	**806.0**	**1,789.5**

- WAST have identified 70 calls day per which Central & West receive from Police, Fire and Coastguard on direct DDIs.

- **Assume 76 calls per day on C&W Emergency Services line, if used correctly. No change to Routine lines.**

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Calls by Position

- Call logging data only shows the current staff position, taking no account of overtime and promotions.

- Many calls with unknown answerer (suspected ICCS).

Calls Answered (2018/19)

Line Type	Call Taker	Supervisor	Dispatcher	Allocator	Unknown
Emergency Services (0845)	52,146	1,921	1,408	515	4,213
HCP Urgent (0845)	71,875	3,667	2,020	791	7,663
Primary 999	435,039	19,655	16,870	4,531	9,328
Routine (0845)	18,271	243	1,310	332	13,838
Inbound-Other	6,994	381	231	316	2,660,953
Total	**584,325**	**25,867**	**21,839**	**6,485**	**2,695,995**

- **Assume 999 and 0845 calls are only ever answered by a Call Taker. Exclude all inbound other/ICCS calls.**

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Calls by Area

- WAST operates a virtual call handling model across the three CCCs, bringing with it benefits of increased efficiency and resilience by utilising capacity WAST-wide.

- The proportion of 999 calls answered by the home CCC has reduced slightly over the past year.

CCC	% Calls Answered Within Home CCC					Total
	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	
Central & West	63%	65%	68%	60%	61%	63%
North	77%	73%	73%	78%	73%	75%
South East	71%	66%	63%	63%	62%	65%
Overall	**70%**	**68%**	**67%**	**66%**	**64%**	**67%**

Calls by Area

- There is no perceivable benefit to call handling times of a call being answered by the home CCC.

Average Call Duration (Primary 999, 2018/19)

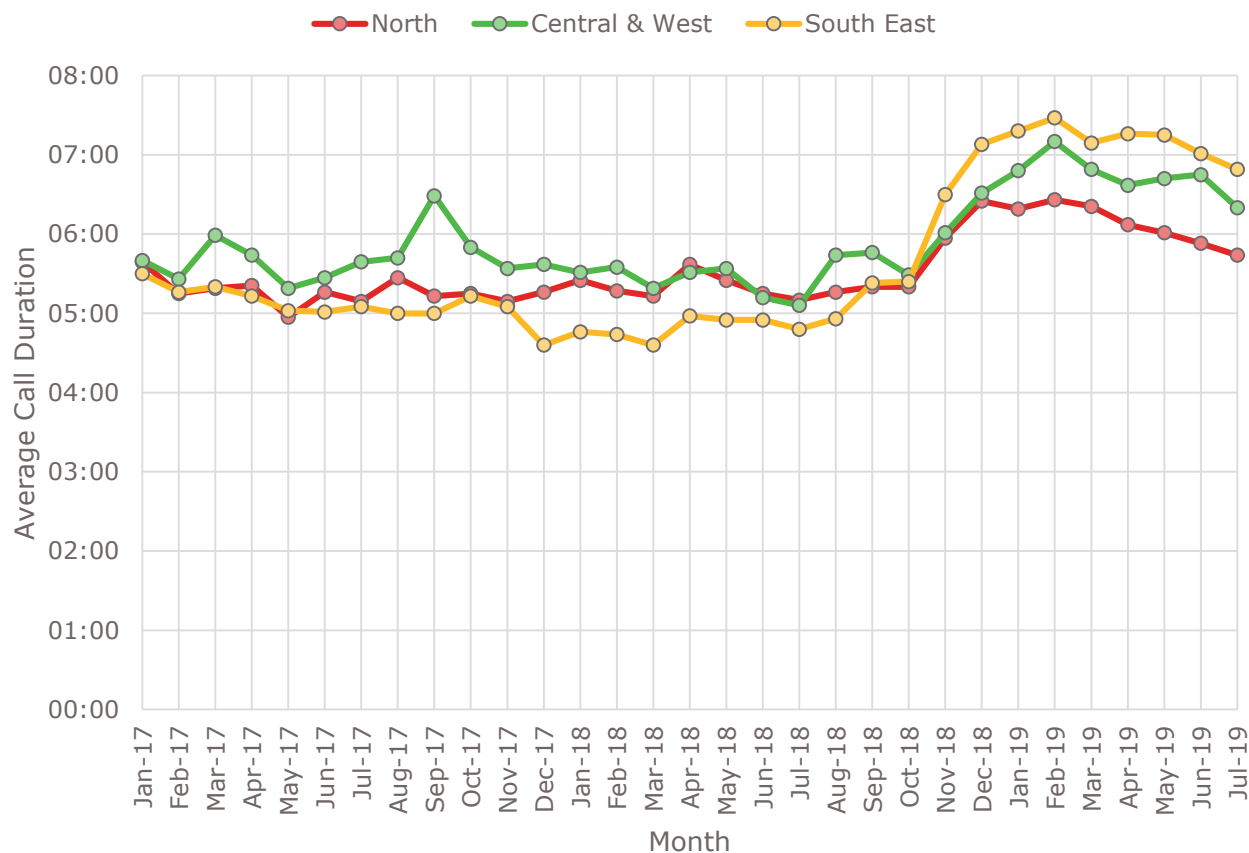| Line Area	CCC Answered		
	North	**Central & West**	**South East**
North	05:42	05:42	05:39
Central & West	05:51	06:01	05:55
South East	05:48	05:52	05:53

- **For BCP purposes, WAST to target 85% of calls being answered by the home CCC.**

Call Durations

Call durations have increased significantly since October 2018.

Average 999 Call Duration by CCC

North — Central & West — South East

Trust	999 Average Call Duration
O	04:16
Q	04:59
WAST 2018	05:11
R	05:12
S	05:27
T	05:30
WAST 2019	06:40

Call Durations

- It is felt that call durations will naturally reduce as response times improve, through:
    - less use of demand management scripts
    - less staying on the line until the ambulance arrives

- **WAST to target a return to 2018 handling times.**

- Variation between CCCs to remain for modelling.

Average 999 Call Duration

CCC Answered	2018	2019	Efficiency
Central & West	05:29	06:44	01:15
North	05:19	06:07	00:48
South East	04:52	07:10	02:18
Overall	**05:11**	**06:40**	**01:29**

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Time to Answer

- Non-999 are answered more slowly that 999 calls not only due to call prioritisation, but primarily due to IVR delays.

- **It is assumed that this behaviour will continue.**

Time to Answer Distribution
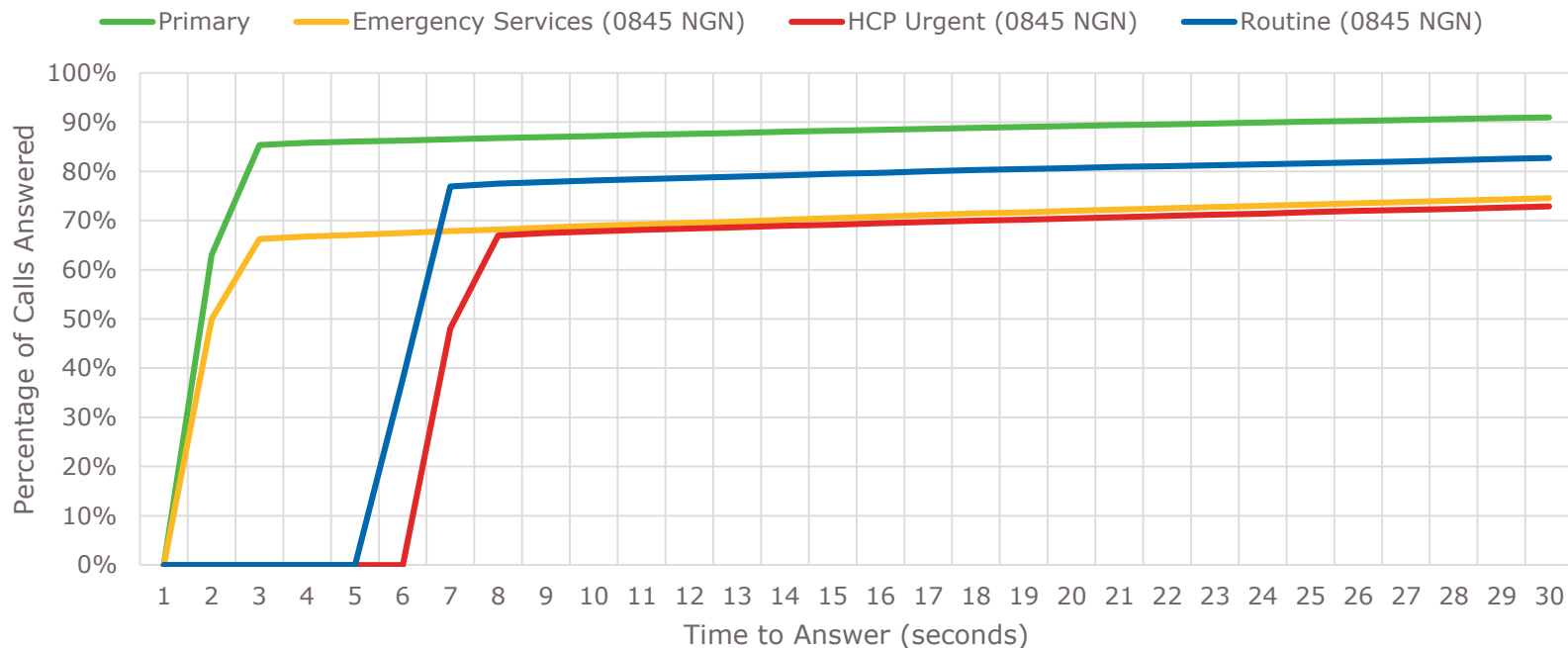
Clinical Triage Assessment (CTA)

CSD

- Average call duration: 26m 31s

- Hear & Treat "success" rate: 31.8%

- No Hear & Treat contribution from non-CSD suitable calls.

- Not modelling other CSD tasks.

NHSD

- Average call duration: 23m 24s

- Hear & Treat "success" rate: 56.0%

Other Assumptions

Targets

- Call Handing: 95% in 5 seconds call answer target.

- CSD Triage: 90% in 30 minutes call back target.

- Targets to be met in busiest month (i.e December).

General

- 2.8% annual demand growth.

- Current rest break policy.

- Minimum shift 6 hours, maximum 12 hours.

- Earliest start time 06:00, latest finish time 02:00.

CCC Modelling

CCC Modelling Plan

Simulation models are being set up. Modelling will look at:

Call Handling

1) Realign rosters to demand with current demand levels

2) Performance trajectory to 2025 with no additional staffing

3) Call taker requirement to meet call answer targets

Clinical Triage Assessment (CTA)

1) CSD staff requirement to maximise WAST codeset

2) NHSD staff requirement to maximise WAST codeset

3) CSD requirement to maximise expanded codeset (inc. Trusts C)

Ops Modelling Assumptions

Response Times

Standard	Pan Wales	By LHB	Period	Comments
Red 8 Minute	70%	65%	Monthly	With expectation of continuous improvement. Parameters are minimum.
Red 90th	15 mins	-	Monthly	As per English ARP. See what pan-Wales means at HB level. Improve distribution curve.
Amber 1 (first on scene)	18 mins	-	Monthly	As per English ARP. To mirror ARP this is a hybrid: 18 minutes if not conveyed, 18 minutes for conveying resource if conveyance required. Model first on scene as per EASC AQIs.
Amber 1 90th (first on scene)	40 mins	-	Monthly	As per English ARP. See what pan-Wales means at HB level. Improve distribution curve. Hybrid as above. Model first on scene as per EASC AQIs.
Longest Waits	-	-	-	Provide a table that shows predicted waits by hour, as per separate table attached. Review this, based on other changes proposed.

95% of Amber first responses to be modelled as ideal.

Operations Rosters

Roster review should conform to the following parameters:

- Shift lengths between 8 and 12 hours

- No shift to start before 06:00 or after 23:00 – if 23:00 start – maximum shift length to be 9 hours

- No shift to finish after 2am?

- Model assuming current meal break policy

Job Cycle Times

WAST components of JCT benchmarked favourably to other Trusts, therefore no change in JCT.

Arrival to handover times to be based on sample period – no change.

Utilisation to be seen as an output of the review, not an input.

Ops Modelling

Model Inputs

Model Parameter	Degree of Adjustability
Demand	By time, location, call category and clinical specialism (cardiac, stroke, etc)
Activation time (time of call or clock start to time assign)	By category and time
Mobilisation time	By time of day and vehicle type
Travel times	Fixed during calibration/setup but are varied by time, location, vehicle type and response priority
Time at scene	By category, vehicle type and time of week
Hear and Treat rates	By category, area and time of week, affecting responded demand levels
Conveyance rates	By time of week and type of call - can be altered by vehicle type
Hospitals	Location, opening hours and specialism accepted
Time spent at hospital	By time of day and type of patient
Response locations	Location, capacity, type (station, deployment point, etc)
Vehicle deployment	Shift times, locations, on duty vs on call variations, vehicle types and availability
Staff skill levels	Adjust staff skill be shift and input the impact by skill type on conveyance or 'See and Treat' rates
Meal breaks	Meal break length based on shift length, meal break locations and policy on interrupts
Dispatch rules	Type, number and distance of vehicles to send to each type of call. End of Shift behaviour
Reporting options	Geographical areas over which to aggregate results, response and transport time standards

Model Outputs

- Response performance against KPIs

  – By category: % within X minutes, mean response time, response time percentiles

  – Also presented by area, day and hour

- Vehicle utilisation

  – By type, day, hour and location

- Multiple attendance rate and vehicle workload

  – By category, showing influence of dispatch rules

- Hospital profiles – journeys by specialty

In the first instance, these outputs are used to validate the model against analysed performance

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Validated Performance

Local Health Board	Red	Red	Amber 1	Amber 2	Red	Amber 1	Amber 2
	8	Mean			90th Percentile		
Abertawe Bro Morgannwg University LHB	76.4%	05:37	48:22	101:45	10:59	114:14	262:34
Aneurin Bevan LHB	73.0%	06:07	49:52	104:37	12:07	110:45	258:18
Betsi Cadwaladr University LHB	72.4%	06:14	31:32	66:53	13:26	67:22	159:19
Cardiff & Vale University LHB	81.3%	05:18	43:15	113:07	09:44	95:33	281:28
Cwm Taf LHB	72.5%	06:06	38:19	70:08	11:49	82:58	163:59
Hywel Dda LHB	65.6%	06:45	32:01	54:51	15:08	70:19	124:52
Powys LHB	65.9%	07:08	30:39	48:39	17:30	65:31	109:49
Wales-wide	**73.7%**	**06:01**	**39:41**	**81:02**	**12:19**	**88:03**	**197:21**

Red performance based on first response. Amber based on hybrid response measure.

Modelling Scenarios

With the model validated, the following scenarios have been run:

- Moving to planned shifts (assumes full shift coverage)

- Moving to projected December 2024 demand (highest month in final modelled year)

Planned Shifts – Current Demand

Planned Shifts

Local Health Board	Red	Red	Amber 1	Amber 2	Red	Amber 1	Amber 2
	8	Mean			90th Percentile		
Abertawe Bro Morgannwg University LHB	81.0%	04:58	40:44	79:24	09:49	94:28	194:49
Aneurin Bevan LHB	83.9%	04:46	29:59	54:47	09:28	61:48	109:07
Betsi Cadwaladr University LHB	77.4%	05:15	23:23	40:39	10:20	50:12	84:29
Cardiff & Vale University LHB	83.7%	05:08	26:24	61:45	09:10	53:01	126:28
Cwm Taf LHB	77.6%	05:29	23:14	36:27	10:26	45:52	67:56
Hywel Dda LHB	66.3%	06:37	28:38	46:07	14:53	63:19	101:34
Powys LHB	67.9%	06:32	27:09	40:32	15:57	58:11	87:17
Wales-wide	**78.7%**	**05:19**	**28:35**	**51:22**	**10:38**	**61:24**	**110:19**

Difference from Actual Resourcing

Local Health Board	Red	Red	Amber 1	Amber 2	Red	Amber 1	Amber 2
	8	Mean			90th Percentile		
Abertawe Bro Morgannwg University LHB	4.6%	- 00:39	- 07:38	- 22:21	- 01:10	- 19:45	- 67:44
Aneurin Bevan LHB	10.9%	- 01:21	- 19:53	- 49:50	- 02:39	- 48:57	- 149:11
Betsi Cadwaladr University LHB	5.0%	- 00:59	- 08:09	- 26:14	- 03:06	- 17:10	- 74:50
Cardiff & Vale University LHB	2.4%	- 00:10	- 16:51	- 51:22	- 00:34	- 42:32	- 154:59
Cwm Taf LHB	5.1%	- 00:37	- 15:05	- 33:41	- 01:23	- 37:06	- 96:03
Hywel Dda LHB	0.7%	- 00:08	- 03:23	- 08:44	- 00:15	- 07:00	- 23:18
Powys LHB	2.0%	- 00:36	- 03:30	- 08:07	- 01:33	- 07:20	- 22:32
Wales-wide	**5.0%**	**- 00:42**	**- 11:06**	**- 29:40**	**- 01:40**	**- 26:38**	**- 87:02**

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Impact of December 2024 Demand

Planned Shifts - December 2024 Demand

Local Health Board	Red	Red	Amber 1	Amber 2	Red	Amber 1	Amber 2
	8	Mean			90th Percentile		
Abertawe Bro Morgannwg University LHB	68.5%	08:27	282:36	427:36	15:11	450:20	
Aneurin Bevan LHB	78.5%	05:35	129:40	284:28	10:53	404:27	
Betsi Cadwaladr University LHB	72.2%	06:17	61:49	199:59	13:22	150:40	
Cardiff & Vale University LHB	75.0%	06:17	133:09	313:07	12:02	392:51	
Cwm Taf LHB	71.1%	06:24	115:53	251:37	12:01	382:34	
Hywel Dda LHB	55.9%	10:11	270:14	401:26	21:32	396:01	
Powys LHB	60.2%	09:23	261:18	404:33	21:18	392:31	
Wales-wide	**70.5%**	**07:12**	**161:13**	**305:22**	**14:14**	**339:57**	**>12 hours**

Difference from Current Demand

Local Health Board	Red	Red	Amber 1	Amber 2	Red	Amber 1	Amber 2
	8	Mean			90th Percentile		
Abertawe Bro Morgannwg University LHB	-12.5%	03:29	241:52	348:12	05:22	355:51	
Aneurin Bevan LHB	-5.4%	00:49	99:41	229:42	01:25	342:39	
Betsi Cadwaladr University LHB	-5.1%	01:03	38:26	159:20	03:02	100:28	
Cardiff & Vale University LHB	-8.7%	01:09	106:46	251:22	02:52	339:50	
Cwm Taf LHB	-6.6%	00:55	92:38	215:10	01:35	336:42	
Hywel Dda LHB	-10.4%	03:34	241:36	355:19	06:39	332:42	
Powys LHB	-7.6%	02:51	234:09	364:00	05:21	334:20	
Wales-wide	**-8.2%**	**01:53**	**132:38**	**254:01**	**03:36**	**278:33**	

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Ops Modelling Plan

The next modelling steps are:

- Add staff to meet targets with current demand

- Add staff to meet targets with December 2024 demand

- Model efficiencies through increased:

    – Hear and treat

    – APP usage

    – Locations

- Model trajectory from 2019/20 to 2024/25
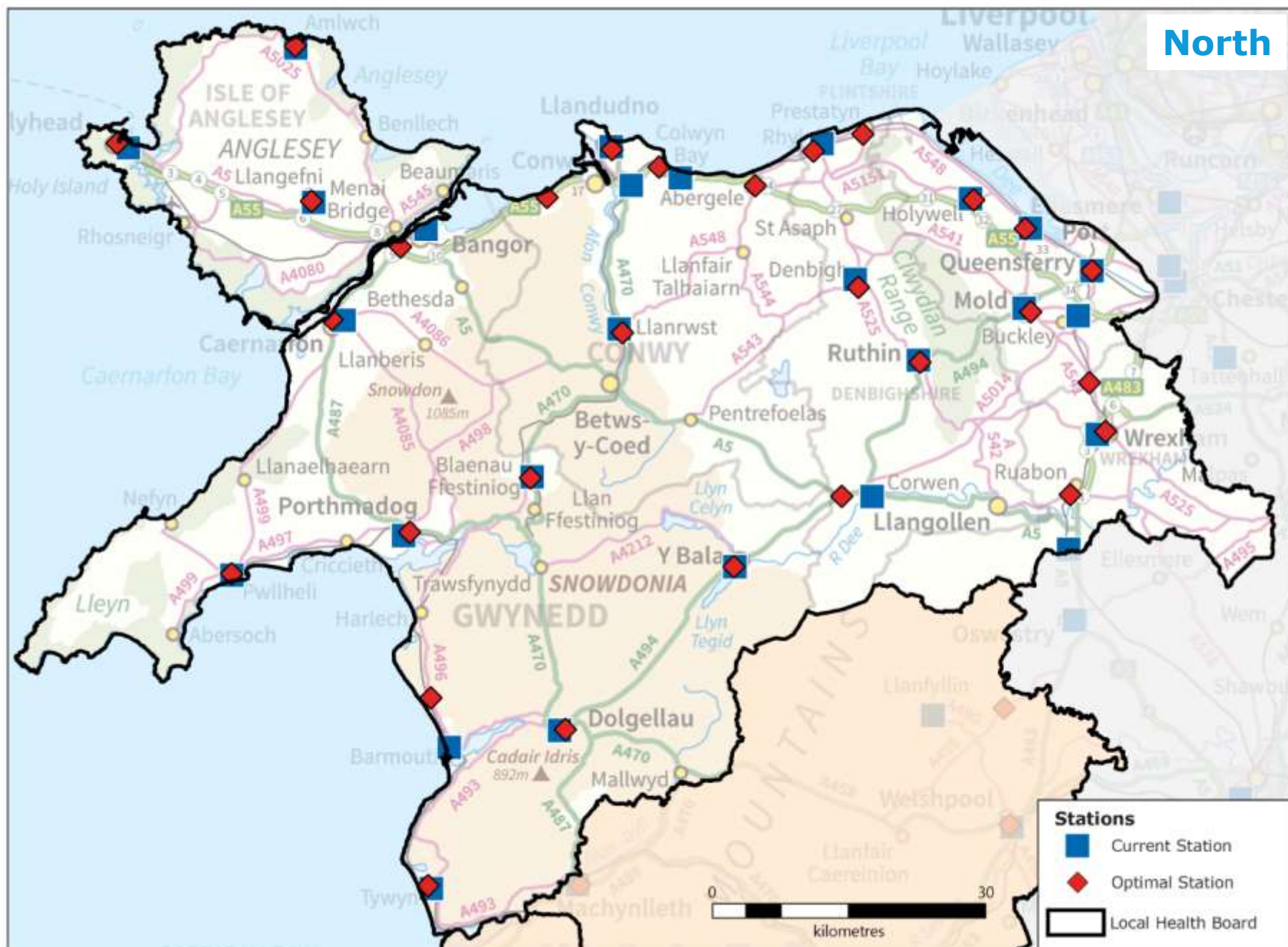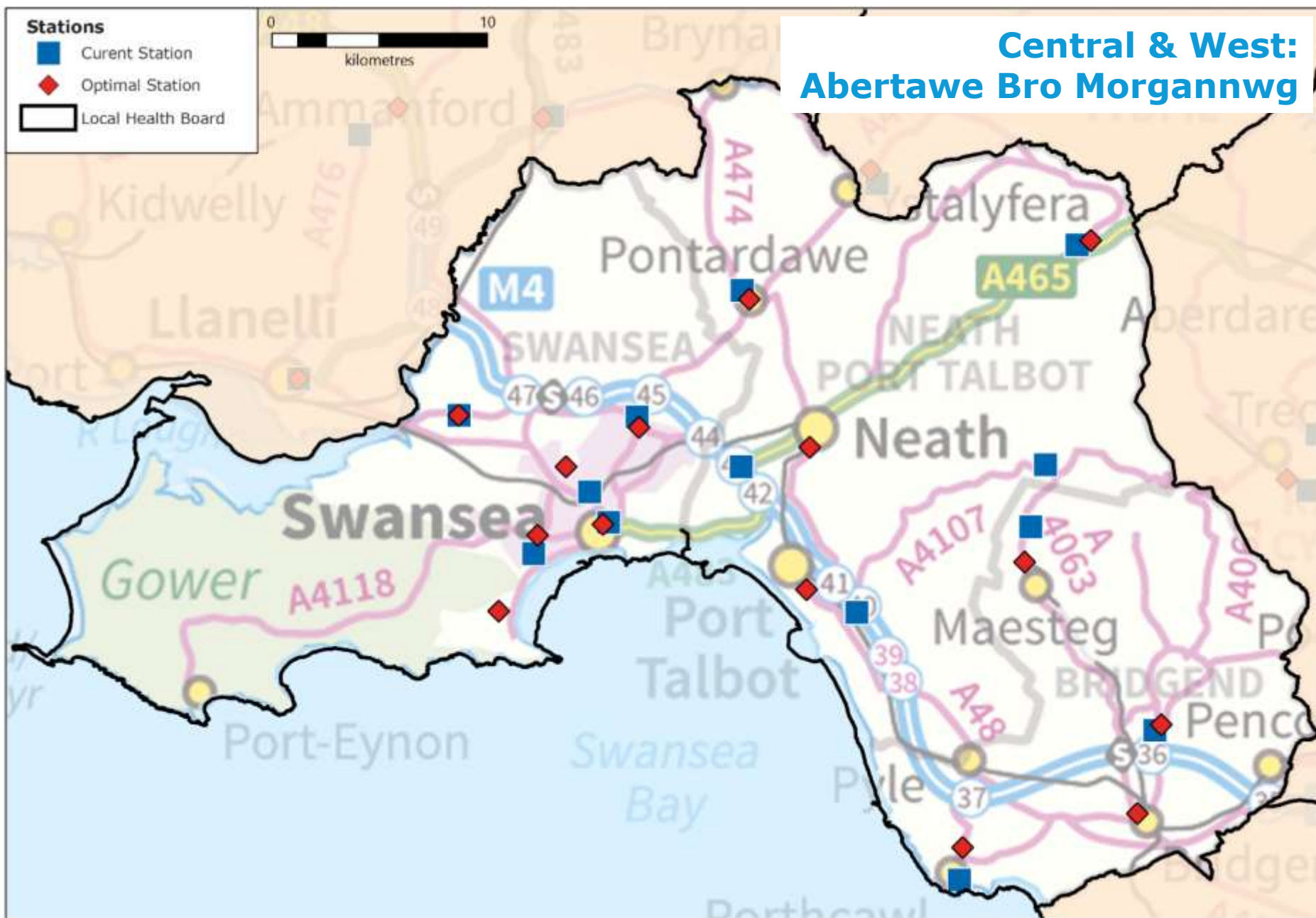
Optimal Location Modelling

Location Optimisation

- Applied 'blank canvas' location optimisation to assess current estates configuration.

  - Blank canvas modelling uses optimisation techniques to identify ideal locations with no account of current locations or other constraints.

- Majority of existing stations are aligned with optimal locations.

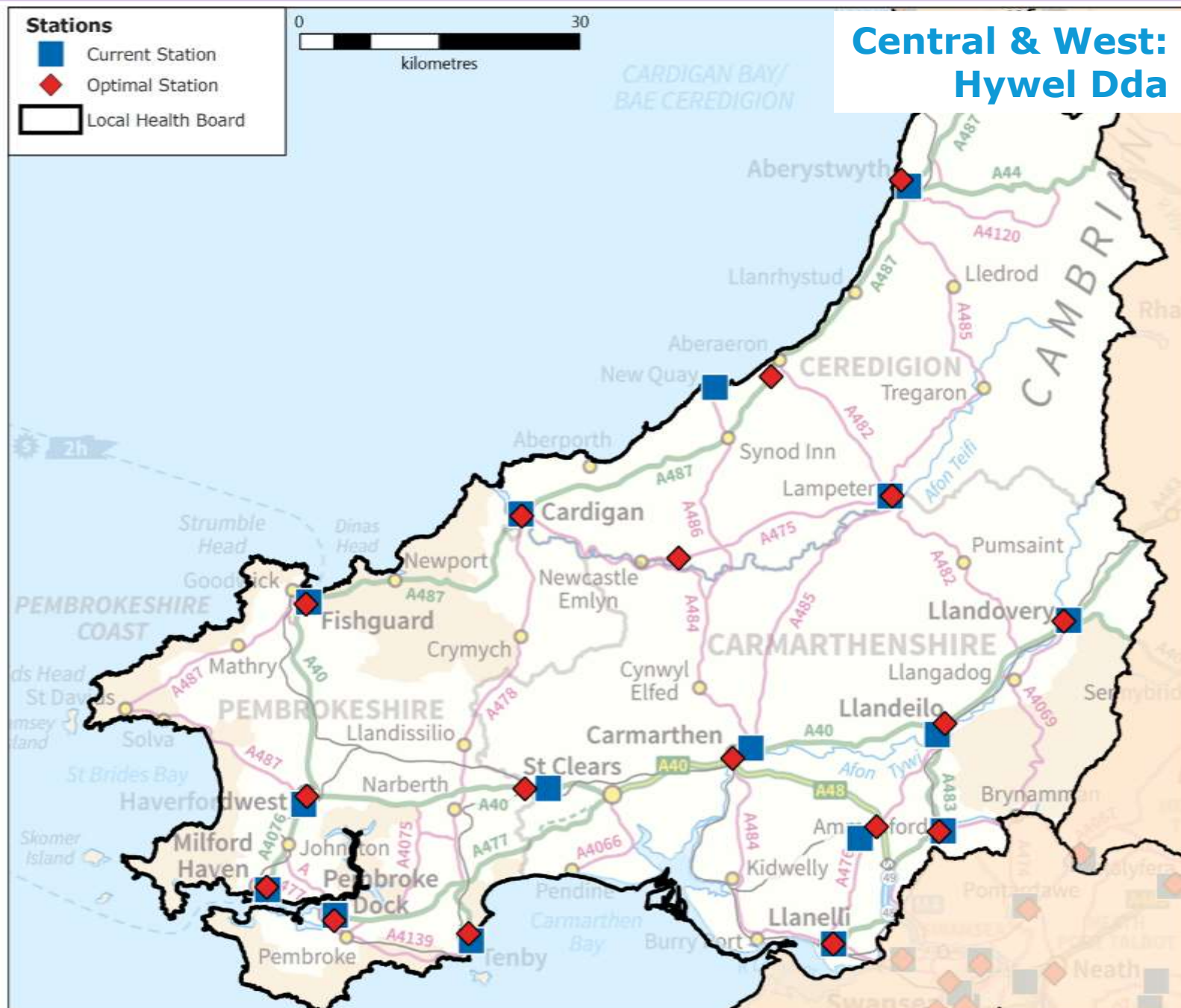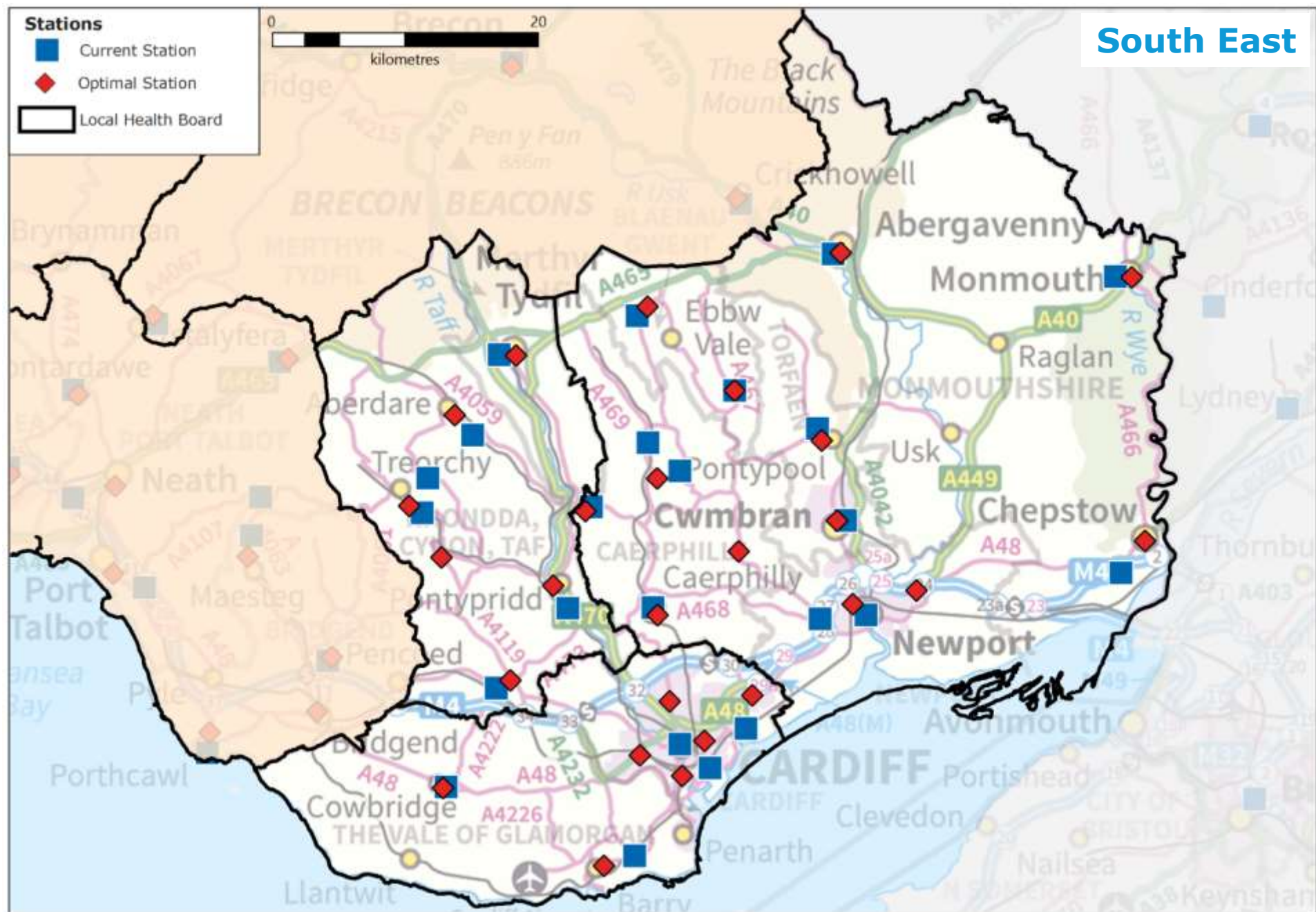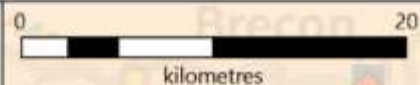- However, there may be some opportunities to improve coverage.

North

Stations

■ Current Station

◆ Optimal Station

▢ Local Health Board

0   30
kilometres

Central & West: Abertawe Bro Morgannwg

Central & West: Hywel Dda

Central & West: Powys

South East

Next Steps

Next Steps

- Ops Modelling:

  – Add staff to meet targets with current demand

  – Add staff to meet targets with December 2024 demand

  – Model efficiencies through increased H&T, APP, Locations

  – Model trajectory from 2019/20 to 2024/25

- Call Handling Modelling:

  – Realign rosters to current demand

  – Performance trajectory to 2025 (no additional staffing)

  – Call taker requirement to meet call answer targets

- CTA Modelling:

  – CSD staff requirement to maximise WAST codeset

  – NHSD staff requirement to maximise WAST codeset

  – CSD requirement to maximise expanded codeset

Discussion

Appendix 2

Extract of Demand and Capacity Review Communications and Engagement Plan

Updated: 30/08/19

1. Action plan

Phase	Date	Action	Lead	Status
1				
2	23/07/2019	Presentation to EASC	CASC/CEO	
	29/07/2019	WAST Closed Facebook Page	AD C&P	
	29/07/2019	WASPT (presentation by DPP)	DPP	
	31/07/2019	Set up generic email address and place on SIREN (and set up page on SIREN/Intranet)	AC&P	
3	26/08/2019	Steering Group only.	DPP	
4	Early 09	SIREN Update (about webinars)	AD C&P	
	Early 09	WAST Closed Facebook Page (about webinars)	AD C&P	
	25/09/09	Webinars x 1 (shift changeover evening)	CEO	
	23/09/2019	WASPT (presentation by DPP)	DPP	
5	06/09/2019	DoPs – Update on Review	AD Strategy & Planning	
	10/09/2019	EASC – Update on Review		
	11/09/2019	WAST EMT	CEO/CASC	
	26/09/2019	WAST Board – Update on Review	CEO	
	Tbc	Specific meeting with WG Senior Decision Makers	CEO	
	23/09/2019	Welsh Ambulance Service Partnership Team (WASPT)	CASC	
	10/10/2019	WG Assurance Meeting	DPP	
	?	DoPs – Update on Review	CEO	
	Tbc	EASC Management Group		
6	23/10/2019	EMT	CASC	

	08/11/2019	JET	CASC	
	?	WG Assurance Meeting	CASC	
	10/11/2019	EASC – Final Report and Implementation Plan	CASC	
	11/11/2019	Webinar x 1 (shift changeover evening)	CEO	
	?	Amber Review Ministerial Statement	CEO	
	?	Collaborative Media Release or Media Lines prepared	CEO	
	21/11/2019	Trust Board (after Ministerial Statement or closed session)	CEO	
	Tbc	SIREN (after Ministerial Statement)	DPP	
	Tbc	CEO All User Email (after Ministerial Statement)		
	Tbc	Board of Community Health Councils		

Note: DoF dates to be added (information being obtained).

2. Completed communications activity

Phase	Date		Lead	Status
1		CEO All User Email	CEO	
		SIREN Announcement	CEO	
		Establish Steering Group with key stakeholders (TUs, NCCU, HB and WG)	AD C&P	
		Webinars arranged	HofCs	
		Closed Facebook account created for project manager	Project Support	

3. Phase Descriptions and Timelines

Phase 1 – Agreement to undertake Review and appointment of supplier (25/06/2019).

Phase 2 – Data requirements, forecasting and base position (29/07/2019).

Phase 3 – Modelling and Interim Results (26/08/2019).
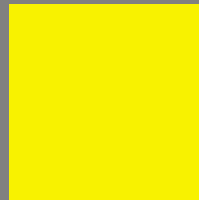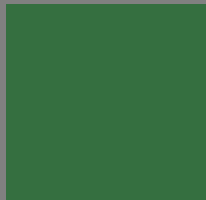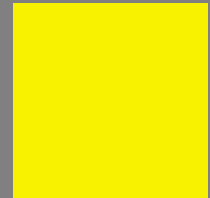
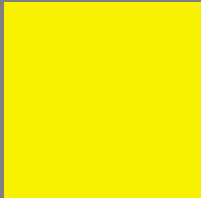Phase 4 – Draft Results (16/09/2019).

Phase 5 – Final Report (30/09/2019).

Phase 6 – Final Report and Implementation Plan (12/11/2019).
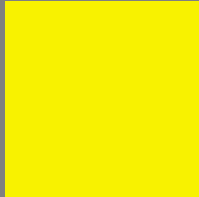
Welsh Ambulance Service NHS Trust:
Red Improvement
10th September 2019 EASC

Demand Increase

Total Verified Demand split by RED, AMBER, GREEN
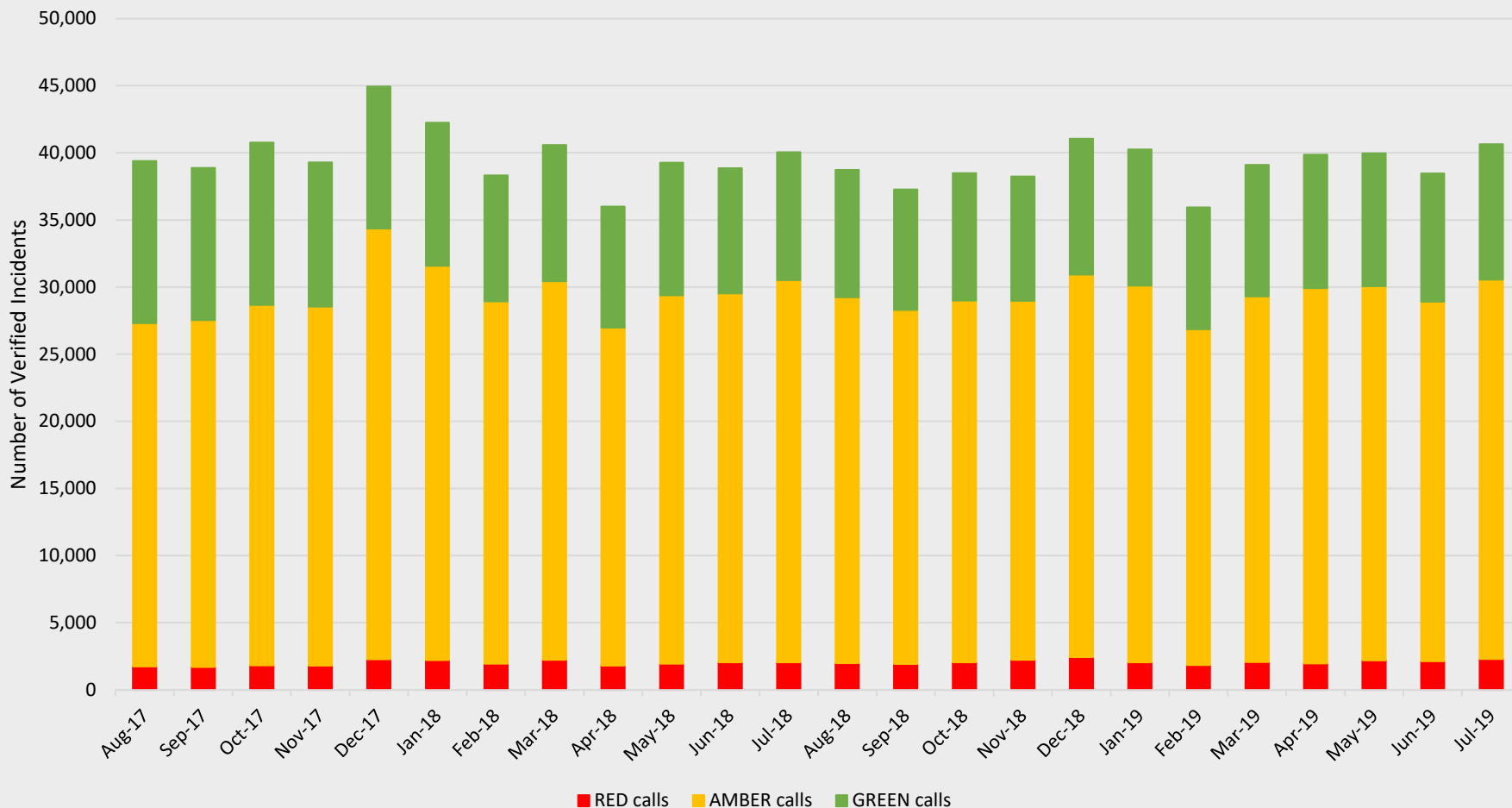
RED calls   AMBER calls   GREEN calls

Exploring Increasing Red Demand (extract from JET slides to WG)

MPDS	Code	Ranking Pan-Wales and by LHB (by volume not percentage increase)							
Summary									
		Pan Wales	ABMU	AB	BCU	C&V	CT	HD	Powys
06	BREATHING PROBLEMS	(1,822) 1	(275) 1	(430) 1	(283) 1	(328) 1	(223) 1	(200) 1	(83) 1
31	UNCONSCIOUS/FAINTING(NEAR)	410) 2	(74) 3	(73) 2	(51) 2	(106) 3	(46) 2	(37) 3	(23) 3
23	OVERDOSE/POISONING (INGESTION)	(314) 3	(85) 2	(35) 5	(25) 4	(111) 2	(23) 4		(24) 2
17	FALLS	(200) 4	(69) 4	(45)4			(22) 5	(29) 4	
24	PREGNANCY/CHILDBIRTH/MISCARRIAGE	164 (5)						(58) 2	(21) 4
32	UNKNOWN PROBLEM - COLLAPSE-3RD PTY		(48) 5		(20) 5	(36) 5	(24) 3		
09	CARDIAC/RESPIRATORY ARREST/DEATH			(65) 3		(51) 4			
12	CONVULSIONS/FITTING				(32) 3				
02	ALLERGIES(REACTIONS)/ENVENOMATIONS							(26) 5	
30	TRAUMATIC INJURIES, SPECIFIC								(7) 5

- Year on year (2017 v 2018) comparison of increase in Red demand.
- Red demand increased by 13% overall, and in every Heath Board area.
- Increased demand seen in almost every MPDS code, but biggest volume increases seen in breathing problems (up by 36%).
- Increases likely to be therefore genuine and due to increasing age / morbidity in general population.
- Increases in Pregnancy/Childbirth/Miscarriage seen in HD and Powys.
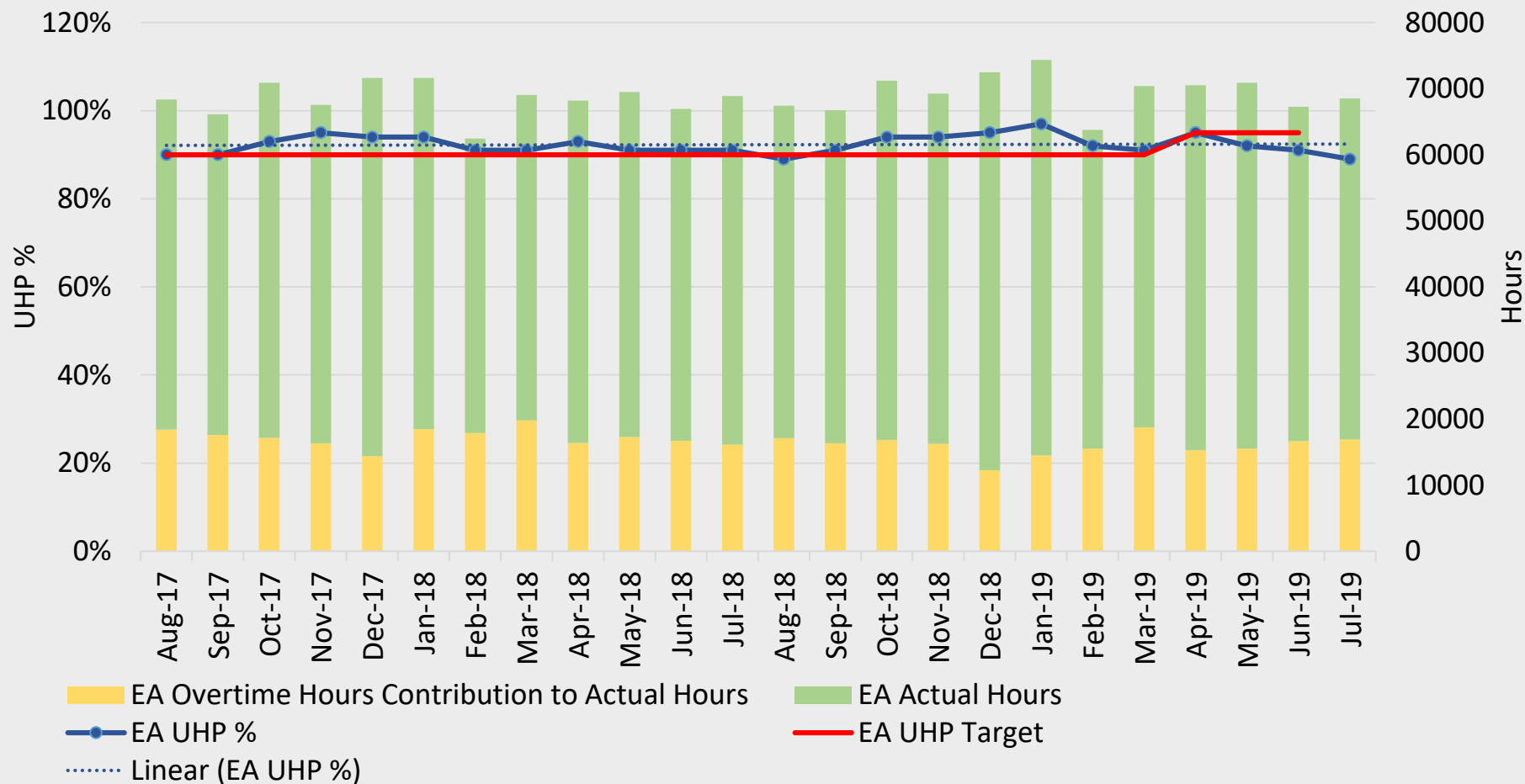
Overtime Production

All Wales Total Overtime by HB
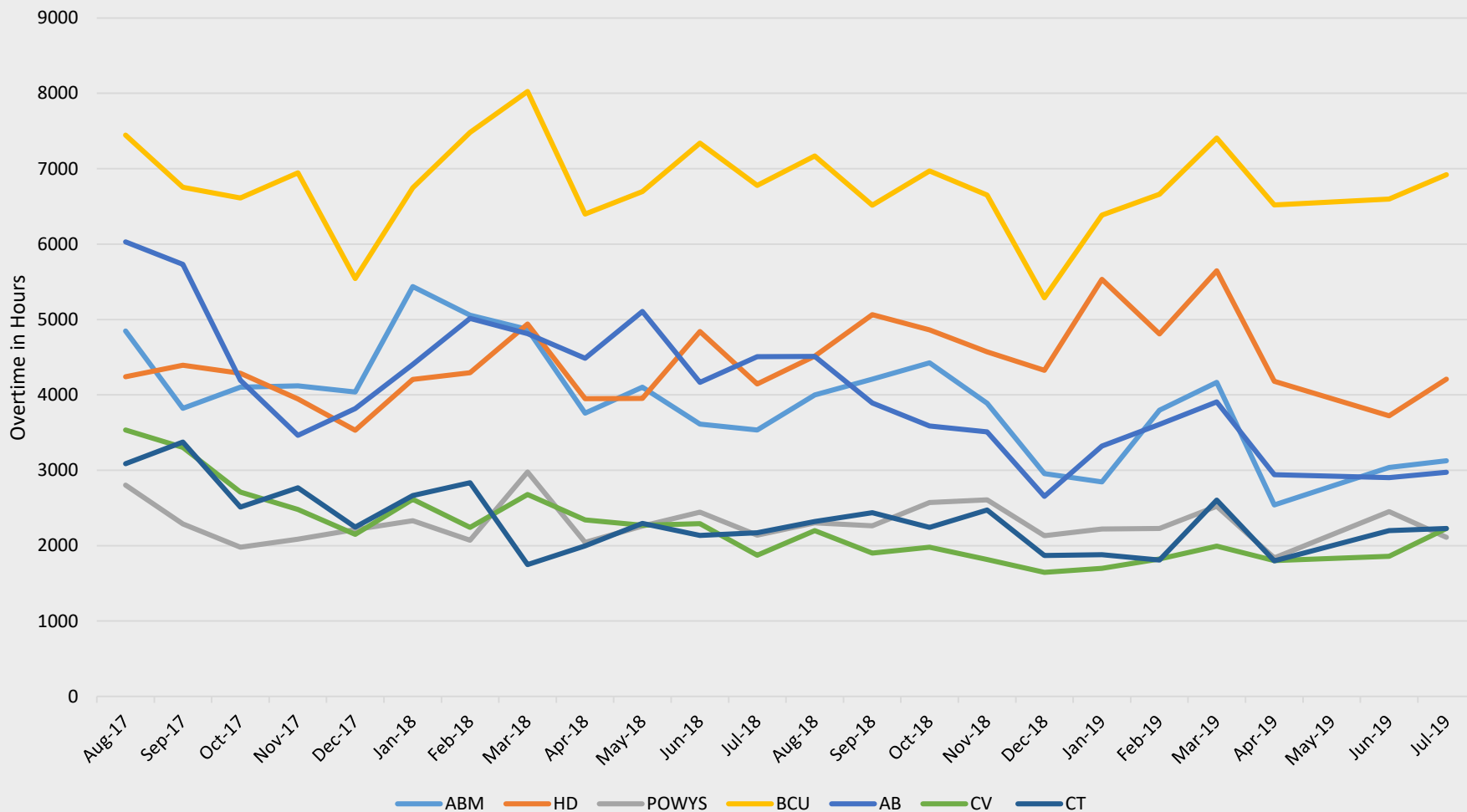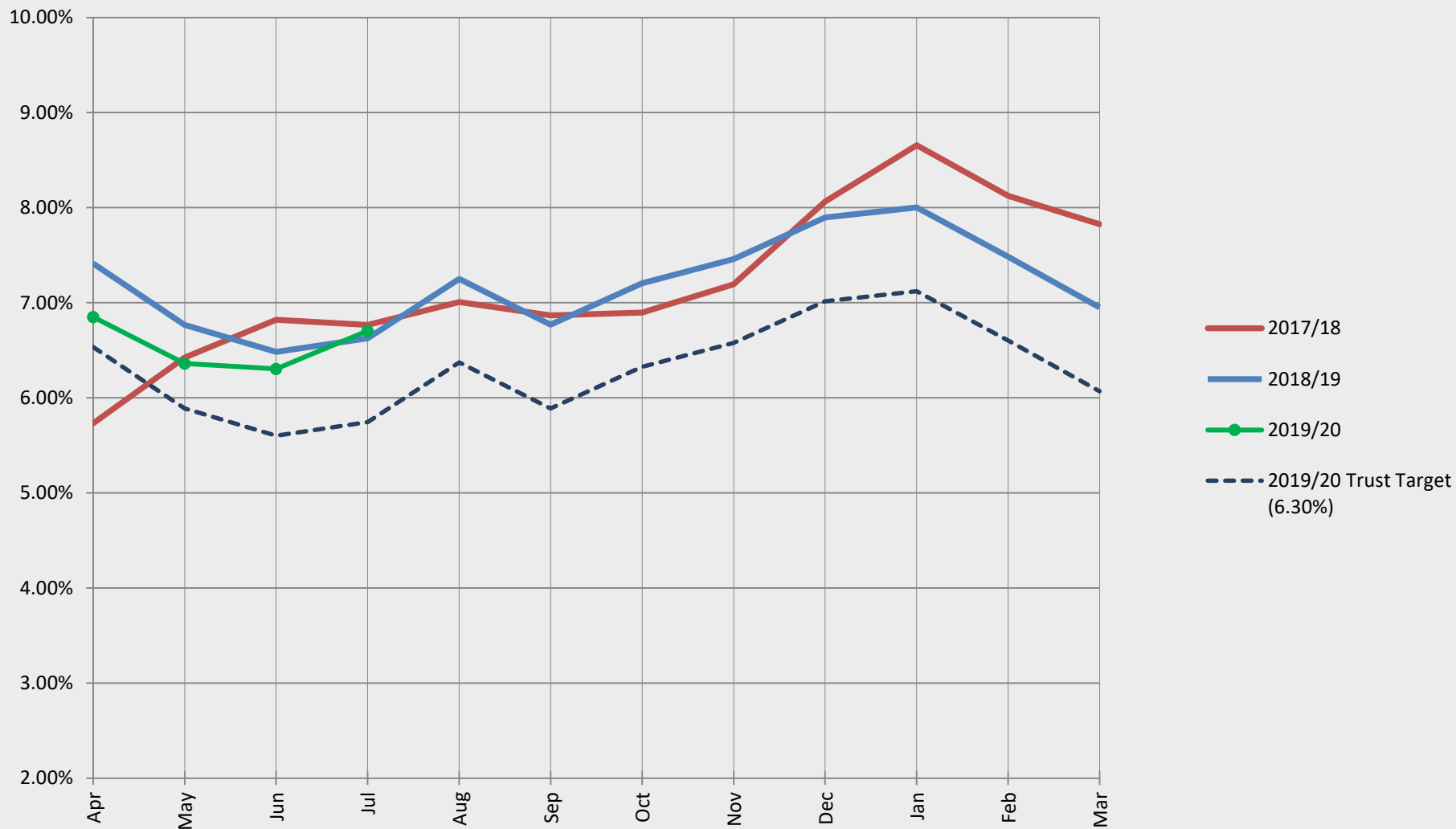
www.ambulance.wales.nhs.uk   @welshambulance   #TeamWAST

Running Calls

Red 8 Performance and Contribution from Running Calls

EA Red Contribution

EA* Contribution to Red Performance
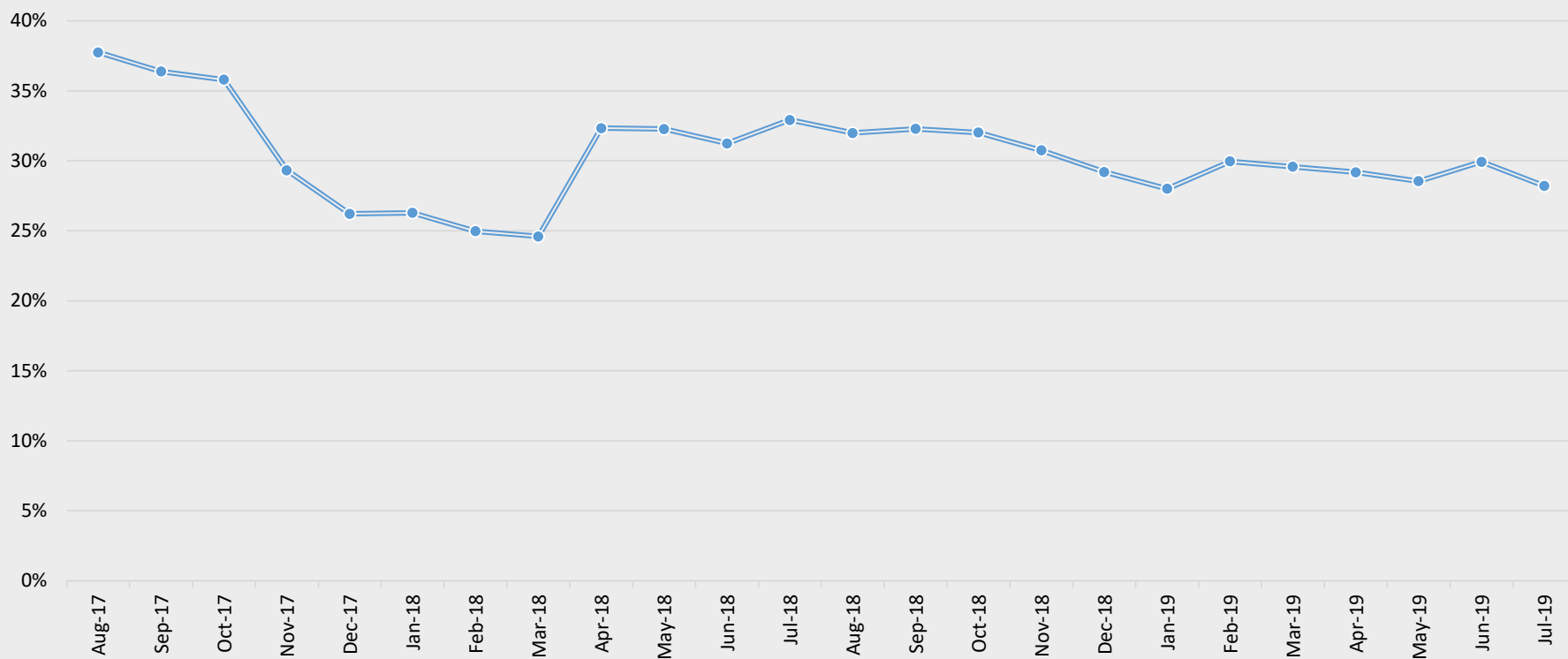
* includes all vehicle types with an "EA" prefix

Response Times against Lost Hours to Notification to Handover Delays
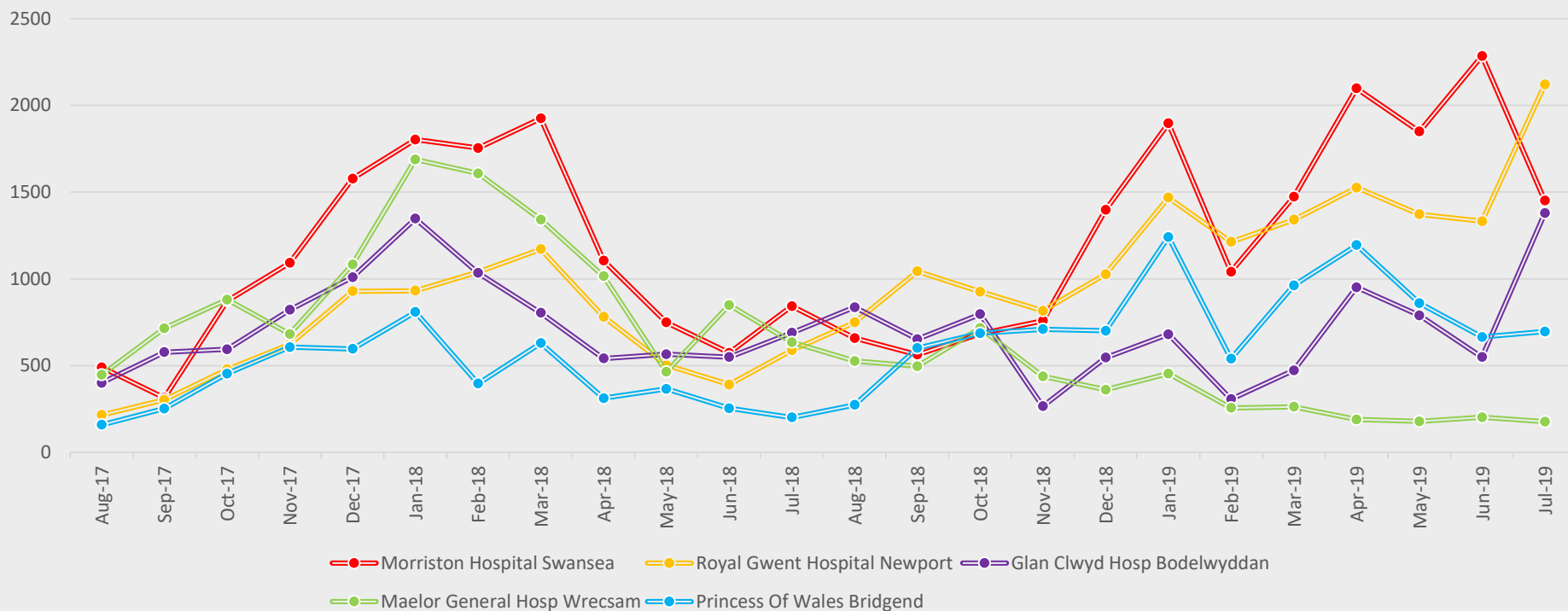
The abstraction rate is the percentage of hours a staff member is absent from planned duties.

For example, a paramedic who is rostered to work 2,000 hours a year, but is absent for 500 hours a year.

The abstraction rate is $\frac{500}{2000}$ = 25%.

The relief rate is the percentage that needs to be applied to cover all abstractions.

For example, imagine a paramedic who is rostered to work 2,000 hours a year, but is absent for 500 hours a year.

The relief rate is $\frac{500}{2000 - 500}$ = $\frac{500}{1500}$ = 33%.

The relief rate is higher than the abstraction rate because relief staff have abstractions too.

EMS Response Relief

Item	Description	ORH Previous (1) Hours	Percent
Contractual Hours	**37.5 hr contract (37.5 hours x 52.14 weeks per year)**	**1955.25**	
Abstractions	*Lost shift hours*	**ORH Previous**	*(1)*
Item	**Description**	**Hours**	**Percent**
Annual Leave	*Based on maximum 33 days*	247.50	12.66%
Bank Holidays	*Based on Hours (8 days)*	60.00	3.07%
Sickness	*Based on 5.99% of contract hours*	117.15	5.99%
Alternative Duties	*Secondments, pre-maternity leave alternative duties, acting up and alternative duties (asbsence management).*	58.60	3.00%
KSF (52 hours)	*1 hour per week but extracted at source not requiring abstraction*	-	0.00%
Training	*Non CPD (EMT - Para, Induction, Conversion, MSC, TLDP, SORT)*	58.60	3.00%
Maternity	*Based on 1.2% of contract Hours*	23.40	1.20%
Other	*Based on 1.0% of contract hours (Special leave, TU, Toil e.g. overruns, other etc.)*	19.50	1.00%
	Total abstractions (as percentage of hours available for shift cover)	**584.75**	**29.91%**
Available Shift Hours	*Balance available for shift cover (after abstractions / ksf not removed based on ORH view)*	1,370.50	
Relief rate	*Total abstractions / available shift hours (rostered hours)*		42.67%

EMS Relief Gap FTEs

WAST has a difference between its funded establishment and the FTEs required to cover the core EMS rosters (RRV/EA and UCS) at the required re-based abstraction rate (and subsequent relief rate) of 29.21% and 42.67% respectively.

Funded

Staff Grade	BCU	ABM	HD	CT	CV	AB	Powys	Total
Para	195.4	129.3	138.0	69.0	84.5	139.0	60.5	815.7
Tech	118.8	51.0	61.0	26.0	45.9	67.0	44.5	414.2
UCA	49.0	33.0	23.0	29.0	18.9	31.0	14.0	198.0
Total	363.2	213.3	222.0	124.0	149.3	237.0	119.0	1427.8

Required

Staff Grade	BCU	ABM	HD	CT	CV	AB	Powys	Total
Para	228.3	125.6	134.7	77.4	84.2	166.4	71.4	887.8
Tech	160.3	82.6	102.2	43.5	51.3	86.7	55.8	582.3
UCA	48.0	32.7	24.7	31.5	22.4	38.2	22.6	220.1
Total	436.5	240.9	261.6	152.4	157.8	291.3	149.8	1690.3

Difference

Vehicle Type	BCU	ABM	HD	CT	CV	AB	Powys	Total
Para	-32.8	3.7	3.3	-8.4	0.4	-27.4	-10.9	-72.1
Tech	-41.5	-31.6	-41.2	-17.5	-5.4	-19.7	-11.3	-168.2
UCA	1.0	0.3	-1.7	-2.5	-3.5	-7.2	-8.6	
Total	-73.3	-27.6	-39.6	-28.4	-8.5	-54.3	-30.8	-262.5

NQP Pipeline

Qliksense "Hackathon"

- The Red Improvement Plan includes using more advanced performance software (Qliksense and Optima Predict). In Jun-19 WAST held a "hackathon", using Qliksense.

- The "hackathon" looked for trends over time which were close to the RED decline or followed similar patterns.

- The "hackathon" identified Red incident re-categorisation as an issue a) a decline in Red downgrades and b) an increase in Red upgrades. As a result a new process was implemented in the CCC which allows the response to be faster without changing the category of the call or not downgrading.

- The "hackathon" also identified RRV standby points (currently being reviewed: completed in AB, CT, HD and P) and overnight RRVs.

- WAST's Health Informatics are continuing to roll out Qliksense and as part of this adding in more information about ambulance availability (the key issue identified in the Amber Review), in particular, post production lost hours and resource information (planned ambulance hours and actual ambulance hours). This should provide a much more powerful causal analysis than we are able to provide currently.

Red Improvement Plan contains is comprehensive, containing 25 main actions (with supporting sub-actions). Key points from Plan as follows:-

Community First Responders
- 36 additional responders being trained by St John for HD and P, due to go live in Sep-19.
- Further work via Optima Predict on identifying gaps in Community First Responder schemes (quarter 4, see other priorities for Optima Predict below).

Public/HCPs
- PAD sites and GoodSAM information loaded into CAD to maximise contribution.
- An extra 476 additional AEDs will be in circulation by 30 Sep-19.
- Support from HBs on HCPs carrying AEDs would have impact.

RRVs/Status Management Plan i.e. location of RRVs to maximise speed of response
- Optima Predict currently being used to review each HB.
- Ability to deliver on findings significantly hindered by relief gap.
- Overproducing on RRVs in HD and P to boost performance (has had impact, but difficult to sustain, particularly, during summer annual leave period.

CCC Clinical Review
- Review of the CCC process and sub-processes (redesign where appropriate), the performance metrics underneath these and performance reporting to empower managers (to reduce time lost in CCC and reduce response times) (to complete Oct-19).

Station Mobilisation
- Review of estate and highways by stations to reduce mobilisation times

Improving Resource Availability Programme (separate programme, linked to Red)
- Improving attendance.
- Improving recruitment timescales.
- Modernising bank arrangements.
- Transforming Resource Policy.
- Handover to Clear (dual pin technology).

Optima Predict/Qliksense
- Improved reporting, in particular, predictive reporting (week, month, season i.e. winter)

Red Improvement Plan

Dynamic Reporting
- Development of triggers to give automatic notification to managers.

Management Focus
- Weekly corporate meeting on Red, led by Director of Operations.
- Specific recovery plans for HD & P.
- Increased focus on twice weekly UHP/planning meeting with AOMs and AD Response.
- Design and implementation of on-duty management role to improve resolution of tactical issues (silver cell)
- Improved daily performance briefing framework.

Handover
- Availability of Patient Flow Co-ordinators for major ED sites.
- Modelling via Optima Predict of impact of handover.
- WAST support to NCCU on hospital handover work (linked to Amber Review).
- Paper from NCCU, with WAST input, on gold call systems leadership.
- Immediate Release Protocol.
- Fast track opportunities to support patient handover.
- Support to Delivery Unit and NCCU on gold command training / hospital capacity.

Conclusions

- Red performance has previously been maintained above 70% and the 65% monthly requirement is achieved, however the pattern is inconsistent with the commissioning intention.

- WAST has been reducing "running calls" from Red performance within the context of rising demand. Removing "running calls" does more accurately reflect WAST's response performance.

- There are three fundamentals affecting Red: increased demand, the relief gap and handover lost hours.

- The difference between A8 and A9 indicates that if WAST can make marginal gains it can impact on Red performance, within the limits of these fundamentals.

- WAST has a comprehensive Red Improvement Plan that is being delivered at pace.

- As we move into winter, there needs to be a realism about the levels of performance that can be delivered, given the fundamentals and potential flu and broader winter impacts.

WAST Relief Gap for Emergency Ambulance Services Reference Document

August 2019

Purpose

This reference document has been put together as a response to the request directly to Welsh Government from the Welsh Ambulance Service NHS Trust (WAST) on the stated relief gap within the provision for Emergency Ambulance Services.

Introduction

This reference document is framed within the timescales 2009/10 – 2019-20. The primary focus and available data relates to the formation of EASC 2014/15 and the enactment of the EMS Collaborative Commissioning Quality & Delivery Framework 2015/16.

This reference document presents factual information from a number of sources; namely:

- WAST IMTP 2019/22.
- EASC IMTP 2019/22.
- EMS Collaborative Commissioning Quality & Delivery Framework.
  - Quarterly WAST resource Returns.
  - EMS 2019/20 Commissioning Intentions.
- WAST Governance Committees.
- Lightfoot (2009) and OHR Demand and Capacity Reviews 2017 and 2019 (in progress).
- WAO Structured Assessments (2016, 2017, 2018).

A visual timeline is included from 2009/10 – 2019/20 showing investments through EASC, WAST expenditure; and a corresponding chronology events pertinent to this response. (Figure 1).

Strategic context
A Strategic Review of Welsh Ambulance Services

The Strategic Review of Welsh Ambulance Services 2013 found:

"*Generally it was felt that the Trust receives sufficient funding to deliver effective unscheduled care services*"

With regards to the period prior to the 2013 Strategic Review of Welsh Ambulance Services the review reported:

It has also been difficult to establish the extent to which the recommendations from previous reviews have been fully enacted and is, therefore, imperative that the cycle of review upon review is broken to allow the future model for the delivery of ambulance services to mature.

Ultimately, any future recommendations need to be accompanied by a clearly measurable work programme.

For the purposes of this reference document in line with the findings of the Strategic Review of Welsh Ambulance Services we are focused on enactment of actions directly relating to EASC Investment and the recommendations of external reviews post the establishment of EASC.

Emergency Ambulance Services Committee (EASC)

It is not the role of EASC or the CASC through the commissioning arrangements to direct internal financial resource within WAST. EASC provide an annual resource envelope for the delivery of commissioned services across Wales in line with IMTP's. EASC do not recognise funded and unfunded positions as detailed in the request. As a statutory body the WAST board have freedom to allocate resource internally within the agreed resource envelope.

IMTP & Commissioning Intentions

WAST 2019/22 IMTP was approved by WAST Board, EASC and Welsh Government.

The WAST 2019/22 IMTP included a commitment to deliver the 2019/20 Commissioning Intentions as well as the recommendations detailed in the Amber Review.

Commissioning Intentions are issued on an annual basis in line with the Welsh Government Planning Framework to support the development of IMTP's

The 2019/20 Commissioning Intentions for EMS were issued in December 2018. These were accepted by WAST and were included in the approved WAST & EASC IMTP's 2019/22.

EASC's ambition is to move towards a smaller number of strategic Commissioning Intentions through the development of strategic commissioning plan. However; a number of the 2018/19 and 2019/20 Commissioning Intentions were rolled from 2018/19 due to lack of progress.

For ease of reference the Commissioning Intentions related to this issue have been listed below:

Resource Envelope

- Existing WAST resources to be fully utilised and evidenced as providing value for money.
- Proportion of spend will shift from Steps 5 & 4 to Steps 3 & 2.
- Reduced spend on operating expenses.
- Sickness rates reduced for all direct staff across each of the steps.
- Overtime use to reduce.
- Rosters aligned to demand (across days and time of day) for direct staff across each step.

Review of Performance

- Red performance to be maintained and the 95th percentile to reduce.
- Amber 95th percentile times to reduce across each health board area.

There were no additional financial assumptions included within WAST or EASC IMTP for the delivery of these Commissioning Intentions.

Amber Review

The Amber Review (completed November 2018) made a number of recommendations as a result of its findings. The recommendations related to this issue are listed below:

- There must be sufficient numbers of clinicians in the contact centers to ensure patients receive the most appropriate level of care.
- The ambulance service must ensure that planned resources are sufficient to meet expected demand.
- The ambulance service must deliver against its planned resource.

Demand & Capacity Review Chronology

In the time period quoted a number of reviews have been undertaken, these are documented below:

Lightfoot 2009

This review took place long before the establishment of the current commissioning arrangements but highlighted a potential gap of up to 344 WTE (99 WTE vacancies, 163 WTE to reduce overtime use, 82 WTE to increase relief to 35%). It is not clear what specific actions were taken to address this.

OHR Review of Control 2012

Referenced within the McClelland review; Documented as being supported in the minutes of the closed session of the former Strategic Planning Committee sub-group of the WAST board in February 2013. We could find no further detail on the implementation if the review.

OHR Operational Capacity Review 2012.

Referenced within the McClelland review; Documented as being supported in the minutes of the closed session of the former Strategic Planning Committee sub-group of the WAST board in February 2013. We could find no further detail on the implementation if the review.

ORH Demand and Capacity 2017

The ORH 2017 demand and capacity review was commissioned in isolation by WAST, it focused solely on response resource and did not consider the CCC element of WAST. The review indicated a shortfall of 299.5 WTE (205.5 WTE to fill current rosters, 76.6 WTE for Red performance ambitions, 17.5 WTE for Amber 1 performance improvement). The report was not received by EASC.

ORH Demand and Capacity 2019

The 2019 review has been commissioned jointly (EASC/WAST) It is in the early stages and so only initial observations have been produced.

WAO structured Assessment

Each year from 2016/17 to present WAO have provided structured assessment. WAST have given assurance that they are drawing on the findings from the OHR reviews and addressing the gap in their resources internally. WAST have also provided assurance to their Finance & Resources Committee with regards to this issue.
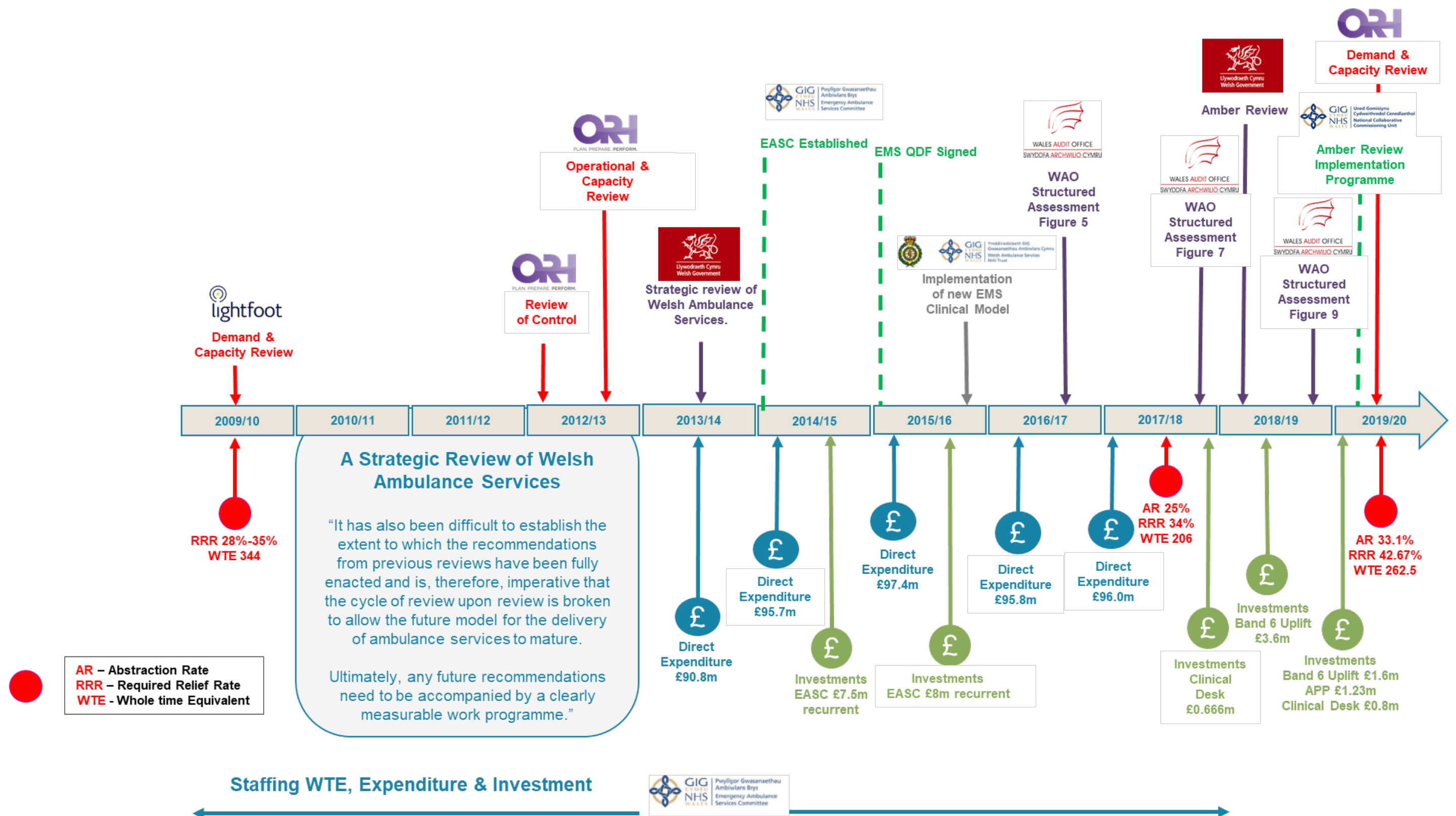
Figure 1: Strategic Context (Interventions, Staffing WTE, Expenditure & EASC Investment)

Analysis

The following sections provide analysis on the facts and data as a reference point in relation to the request by the Welsh Ambulance Service.

EASC Investments

EASC Investments 2014/15

Upon the establishment of EASC in 2014/15 a recurrent £7.5m was made available to WAST for the recruitment of additional front line staff.

A collaborative commissioning methodology was adopted allowing WAST the freedom to utilise their total available financial resource as required to deliver the requirements of the commissioning framework

EASC Investments 2015/16

In 2015/16 EASC committed a further £8m recurrent to be focused on the following areas:

- Improving A8 (tier 1) performance (£4.1m);
- Delivery of the New Clinical Model (£1.0m);
- Delivery of service change initiatives across the 5 Step Ambulance Care Pathway ;
- Transformation of the CCC's) (£0.8m);
- Improving the corporate infrastructure in line with the Commissioning; Quality and Delivery Framework (CQDF) Core requirements (£1.4m).

EASC investments 2017-2019

In addition EASC have provided targeted funding to enhance front line service delivery in response to developments within WAST:

	17/18 (£000)	18/19 (£000)	19/20 (£000)
Clinical Desk	666	-44	
Band 6 Uplift		3,577	1,573
APP			1,163
Clinical Desk Enhancement			824

Table 1: 2017-2019 EASC specific funding

Finance and Resource Utilisation

The submission of quarterly resource returns is a requirement under the EMS Collaborative Commissioning Quality & Delivery Framework. The following graphs have been drawn from these returns.

The EMS Collaborative Commissioning Quality & Delivery Framework focuses on WAST delivery across the 5 step model. As such assurance can be given to direct expenditure across the steps.

WAST have committed through their 2019/22 IMTP to deliver the 2019/20 Commissioning Intentions including a reduction in spend on operating expenses.

Assurance has also been given to WAO and the WAST Finance & Resources Committee that the recommendations of reviews are being implemented.

EASC Funding & Direct spend on 5 Step Model

EASC funding for WAST has increased by 4.3% on average annually from 2013/14 to present. WAST direct expenditure across the 5 step model on frontline services has increased by 1.4% average over the same period. However, it should be noted that the average for this period masks the fact that in actual terms the direct spend was less in both financial years 2016/17 and 2017/18 than in 2015/16.
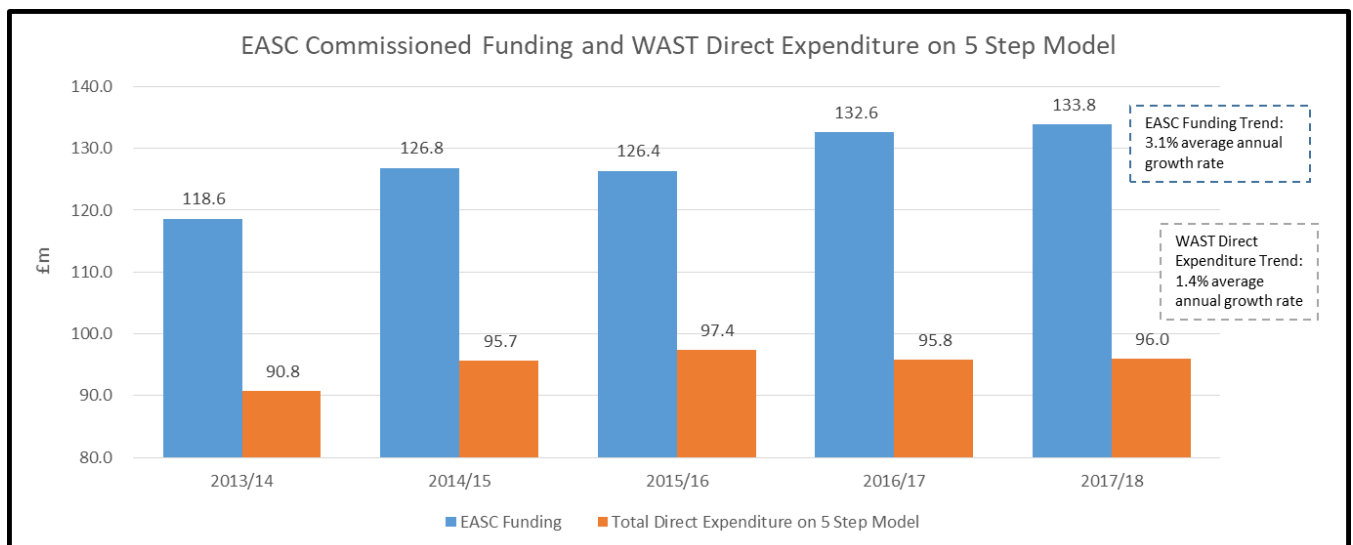
Graph 1: EASC Commissioned Funding and WAST Direct Expenditure on 5 Step Model

Note: Adjustments have been made to ensure like for like comparisons across financial years. The direct expenditure excludes investments for specific initiatives e.g. paramedic re-banding, clinicians in control. Source of data
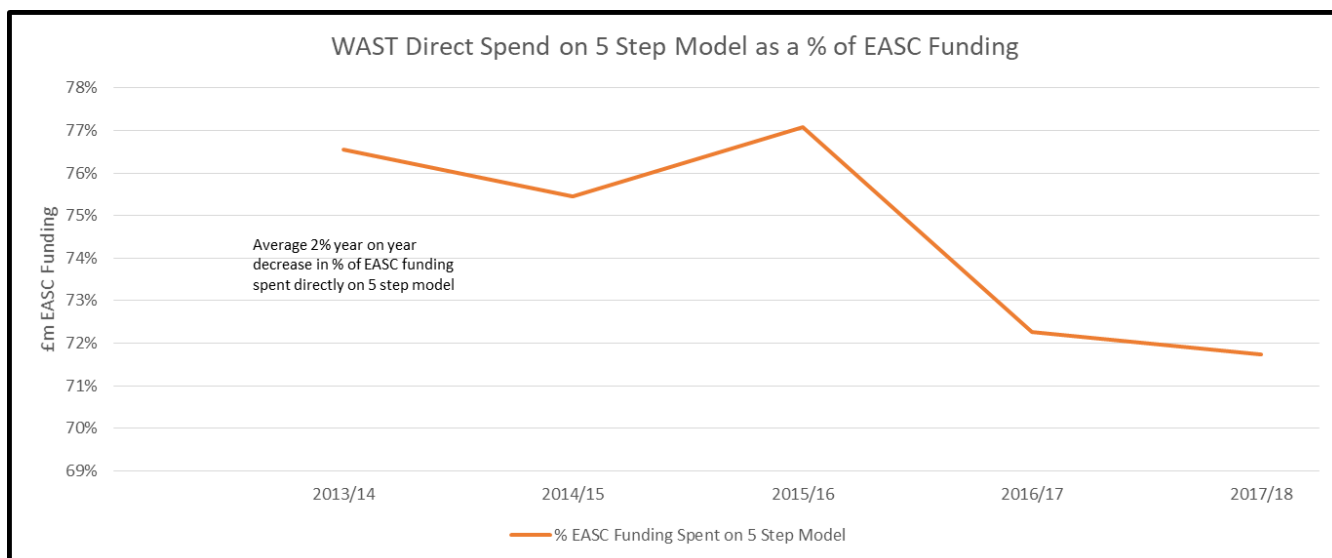
Graph 2: WAST Direct Spend on 5 Step Model as a % of EASC Funding

There has been a decrease spend on average of 2% per year across the 5 step model as a % of EASC funding over the same period.

Aligning Capacity to meet demand

WAST as a statutory organisation have the autonomy through their Board to address gaps and prioritise expenditure in line with demand.

The table below provides a comparison of the abstraction rate, required relief rate & WTE required for reviews conducted between 2009 – 2019. (Information from the 2012 reviews was not available.)

	2009 Lightfoot	2017 OHR	2019 OHR
Abstraction Rate	N/A	25%	33.1%
Required Relief Rate	28-35%	34%	42.67%
WTE Required	344	299.5	262.5

Table 2: Comparison OHR 2017 & 2019 reports.

Governance chronology
The following section provides relevant extracts from WAO assessments and minutes of WAST sub-committees.

2016

WAST commitment through a WAO Structured Assessment to implement the details of the demand & capacity review.

Figure 1: WAO Structured Assessment 2016

Wales Audit Office -Structured Assessment 2016
Welsh Ambulance Service NHS Trust
"A demand and capacity review commissioned by the Trust has also been completed in 2016. This work, which examined use of the organisations' resources (workforce, estates and assets), population trends and service demands, is being used by the Trust to inform and strengthen its future planning and delivery of services."

"Going forward, the demand and capacity review and full implementation of the clinical response model will help support more detailed and improved financial planning."

"A demand and capacity review has been undertaken by external consultants, the findings of which are currently being considered by the Trust. The review will assist the Trust in developing strategic resource plans for its workforce and fleet to support the new clinical response model. Financial planning is expected to develop further through application of this work and the implementation of zero based budgeting."

"The introduction of a business partner model will provide more planning support for operational and corporate teams and the 2017 iteration of the Trust's IMTP will also be informed by the recent demand and capacity review."

"The Trust is currently reviewing its training, incorporating learning from the demand and capacity review and identification of the skills needed to face future service demands."

2017

The 2017 OHR demand and capacity review highlighted a known gap of 299.5 WTE.

WAST Executive have reported to WAST Finance committee a commitment to align their resource with demand.

" Last rota review had been conducted in 2013/14 and had looked at rostering staff to the best fit for demand and capacity. The new demand analysis allowed the Trust to look at more detail and therefore the ability to plot for the best demand requirements "
Meeting of the WAST Finance & Resource Committee, 26th October 2017

Figure 2: WAST Minutes Finance & Resources Committee Oct 17.

This following excerpt is from WAO Structured Assessment 2017:

Wales Audit Office -Structured Assessment 2017
Welsh Ambulance Service NHS Trust

"The Trust has increased its focus on amber performance during 2017 and agreed a plan to improve amber performance through a number of actions, including:
• realigning resource deployment as per the demand and capacity review;
• increasing the consistency of relief cover into staff rotas; and
• increasing the deployment of emergency ambulances and reducing Rapid Response Vehicles (RRV's) to improve efficiency."

Figure 3: WAO Structured Assessment2017

WAST Executive have reported progress to its Finance & Resources Committee in May 2018. We have been unable to find any follow up of this in any subsequent WAST Finance & Resource Committee published notes or minutes.

CONFIRMED MINUTES OF THE CLOSED SESSION OF THE MEETING OF THE FINANCE AND RESOURCES COMMITTEE HELD ON 10 MAY 2018
WORKFORCE PLANNING – BRIDGING THE RELIEF CAPACITY GAP
The Director of Workforce and OD CV, outlined several proposals being implemented by the Executive Management Team in order to close the relief capacity gap which had been identified following an independent report regarding the existing funded EMS establishment and the requirement needed to run at 34% relief capacity.
The Committee were informed by CV of the next steps being undertaken in order to implement the proposals going forward.
Members discussed the proposals in further detail recognising the challenges and the risks involved; and notwithstanding these, supported the Executive Management Team in taking them forward.
RESOLVED: That
(1) the work undertaken to identify opportunities to bridge the relief capacity gap internally, from within existing resources was noted; and
(2) the recommendations of the Executive Management Team were support

Figure 4: WAST Minutes Finance & Resources Committee May 18.

The WAO Structured Assessment 2018 noted:

Wales Audit Office -Structured Assessment 2018 – Welsh Ambulance Service NHS Trust

"The Trust continues to draw upon the findings of the demand and capacity review undertaken in 2017.18 The review examined the use of the Trust's resources (workforce, estates and assets), population trends and service demands. The review identified several future challenges for the Trust in relation to operational capacity, demand projection, performance and the impact of system wide pressures. According to the IMTP 2018-21, during 2017-18 the Trust further refined the Operational Research in Health (ORH) projections and used them to inform its workforce planning. The Trust has plans to keep its data up-to-date by developing an in-house demand and capacity modelling capability through software called Optima Predict"

"During 2018, the Trust continued to engage prospective staff by holding Big Bang recruitment events. A Big Bang event held in Swansea during summer 2018 led to the offer of Newly Qualified Paramedic posts at locations across the Trust to 84 candidates. As of August 2018, the Trust had 15 FTE paramedic vacancies, with a total of 53 FTE vacancies across its Emergency Medical Service (EMS) service. Successful paramedic recruitment has enabled the Trust to over-recruit and negate the impact of recruitment and turnover curves in advance of the 2018 seasonal pressures. The Trust is also investing in future paramedics by commissioning between 50 and 55 three-year paramedic courses. In addition to its recruitment success, the Trust is beginning to use data from the demand and capacity review to improve rosters and address the relief gap in its EMS. These steps should further support the Trust in matching its resource to demand. "

Figure 5: WAO Structured Assessment 2018

EASC Position March 2019

In the March 2019 EASC meeting the committee encouraged WAST to present a proposal at a future meeting on the numbers of Paramedics that they would be able to over-recruit early in 2019/20 with a view to not only cover its internal turnover, but also to provide additionality to support the wider unscheduled care system this winter. The committee gave assurance that they would underwrite any financial risk associated with this regardless of the number recruited.

WAST Response to EASC May 2019

At the May 19 EASC meeting WAST presented their preferred option to recruit an additional 31 WTE core paramedic staff, who would provide the backfill to allow for 36 staff to commence Advanced Paramedic Practitioner (APP) training (also filling 5 existing vacancies). This was supported by EASC.

Resource Utilisation

Given the assurances made to WAO and the WAST Finance & Resources Committee, rising demand as well as the Commissioning Intentions committed to in the IMTP there has been a consistent decline in WTE paramedics across steps 4&5.
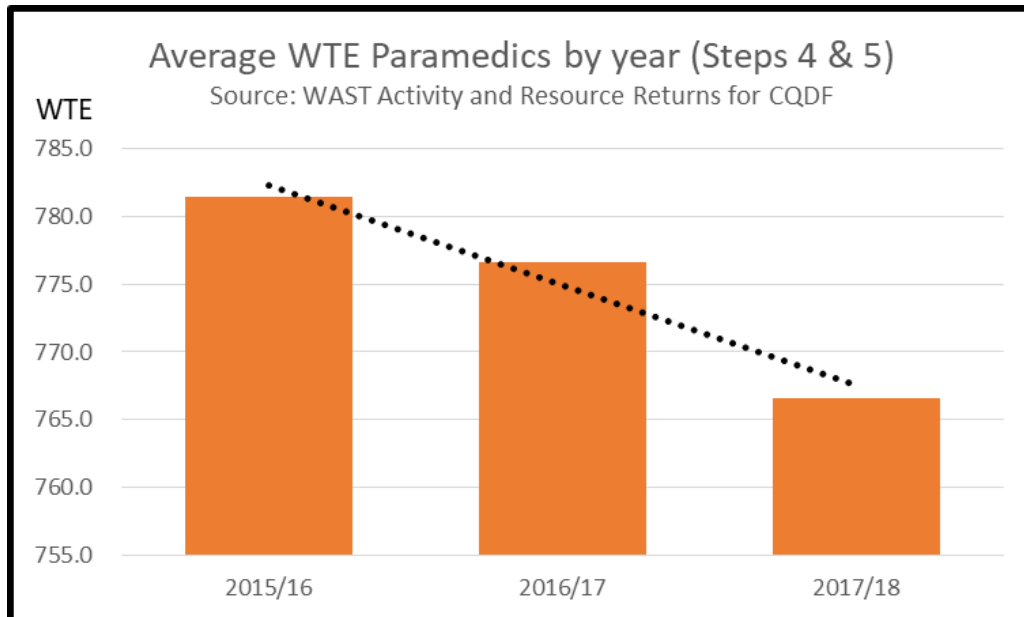
Graph 3: Average WTE Paramedics by year (Steps 4 & %)

There has been a corresponding increase in WTE Clinical Services across steps 4&5. Clinical services resource is in addition to WTE paramedic resource. Clinical Services are defined as:
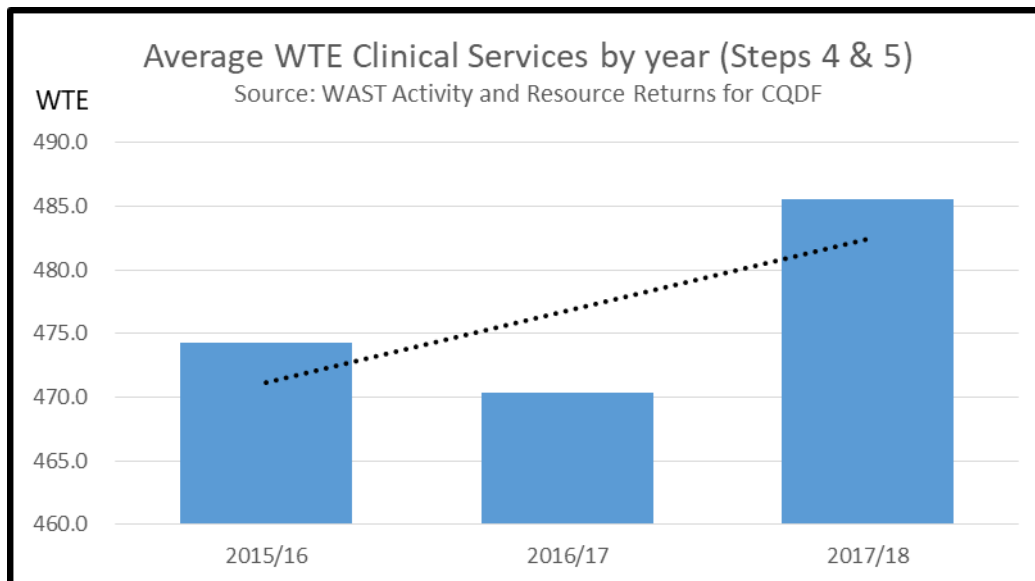
Graph 4: Average WTE Clinical Services by year (steps 4 & 5)

Early findings from the 2019 OHR Demand & Capacity review also indicate a reduction in the available average weekly deployed vehicle hours for EA, RRV & CTL between the periods Oct-15-Apr16 and Apr 18-Mar19.

	EA	RRV + CTL	USC & St John
October 15 - April 16	16150.1	6670.6	2891.6
April 18 - Mar 19	15979.2	6540.9	2892.9
Difference	-170.9	-129.7	1.3
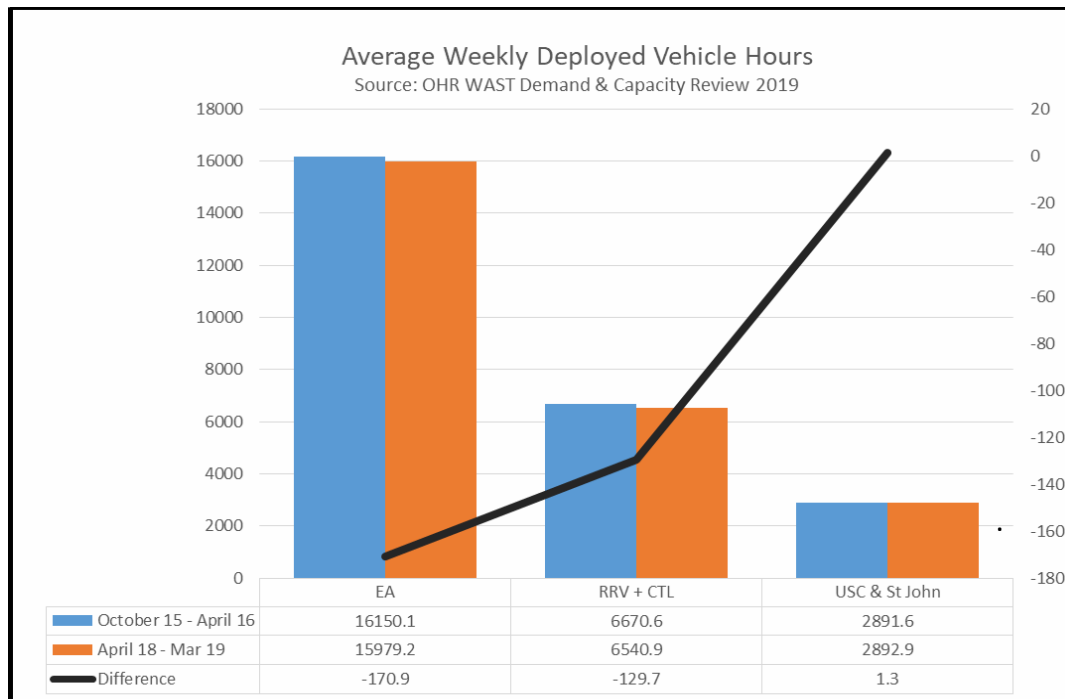
Graph 5: Average weekly deployed vehicle hours comparison (OHR 2019)

WAST have successfully delivered the commissioning intention to reduce overtime spend. Delivering a downward trend consistently between 2015/16 and 2017/18.
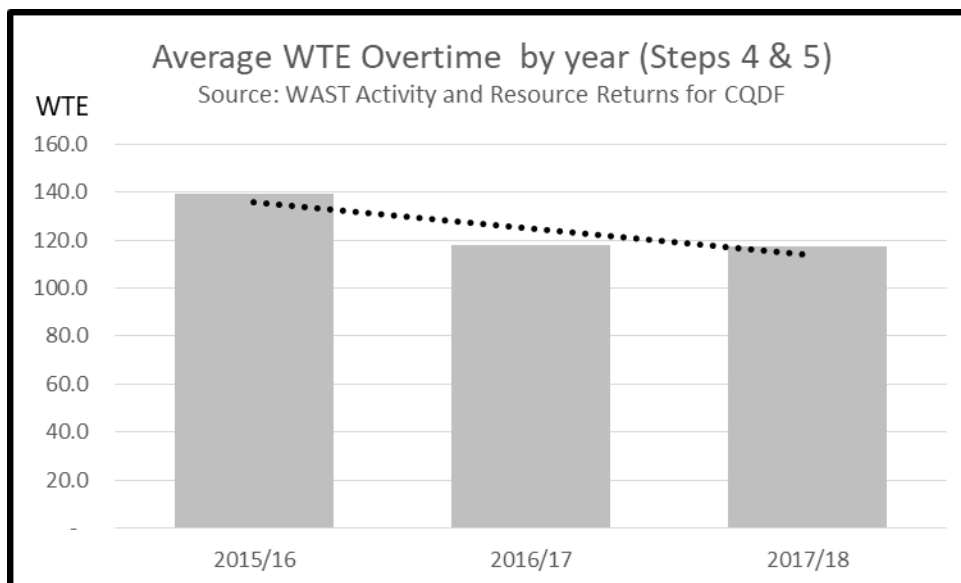
Graph 6: Average WTE Overtime by year (Steps 4&5)

Addressing Sickness Absence

The Amber Review 2018 highlighted that WAST had the highest sickness rates of any NHS Wales organisation. Within the parameters of the review (Apr 16 – Mar 18); 88,095 hours were lost to frontline sickness.

WAST have committed within their 2019/22 IMTP to improve the levels of sickness absence.

Analysis of the returns provided quarterly by WAST in Figure 5 has shown that sickness for EMS remains consistently above target and an outlier within NHS Wales.

WAST EMS Sickness Levels %

Source: WAST Activity and Resource Returns for CQDF

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sickness EMS Services	8.1%	7.4%	7.4%	7.0%	7.6%	7.4%	7.3%	7.5%	8.8%	8.6%	8.2%	7.2%
Target	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
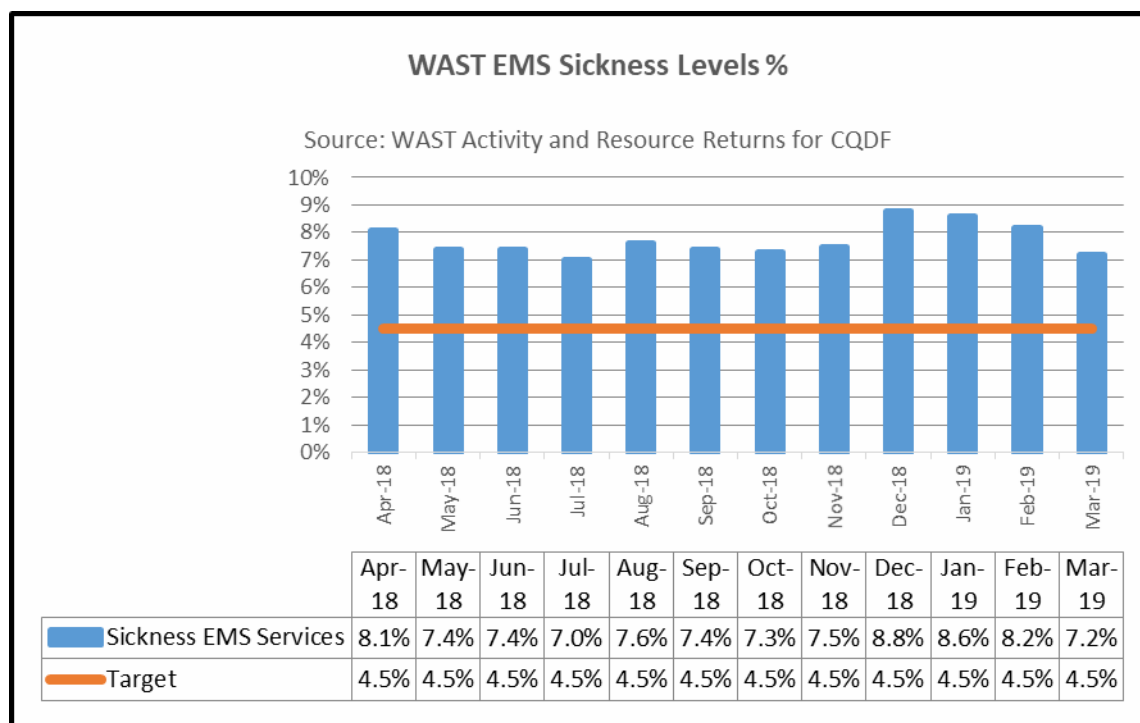
Graph 7: WAST EMS Sickness levels Apr18-Mar 19

This table shows a comparison of sickness rates by health board areas for EMS Services between April 18 – Mar 19.

Sickness - EMS Services												
	%	%	%	%	%	%	%	%	%	%	%	%
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
ABUHB	8.89	8.17	7..83	7.29	7.70	7.38	8.49	8.20	9.47	9.58	8.70	6.15
CTMUHB	9.55	8.42	7.06	5.9	6.40	8.07	6.08	7.50	10.83	9.76	8.73	8.81
HDUHB	6.21	7.19	9.25	8.27	6.11	5.1	6.65	6.35	7.83	8.68	7.75	6.18
SBUHB	9.39	7.32	7.08	7.55	9.66	8.96	6.84	6.79	6.69	6.54	8.71	8.40
BCUHB	8.73	7.50	7.13	6.58	8.27	6.79	6.63	6.88	7.30	7.85	8.08	7.25
CVUHB	9.37	9.00	8.28	7.77	8.22	8.58	8.25	7.56	9.24	8.57	10.55	8.41
PTHB	4.40	4.06	5.35	5.93	6.73	6.81	8.00	8.93	10.47	9.43	5.19	5.05
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Average Sickness	8.1%	7.4%	7.4%	7.0%	7.6%	7.4%	7.3%	7.5%	8.8%	8.6%	8.2%	7.2%
Target	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%

Table 3: Comparison of sickness rates by heath board areas

		AGENDA ITEM
		10 September 2019

Emergency Ambulance Services Committee (EASC)
WELSH AMBULANCE SERVICES NHS TRUST (WAST) – SERVICE TRANSFORMATION PROPOSALS

Executive Lead: Jason Killens, Chief Executive Officer (WAST)
Author: James Houston (Planning & Performance Business Partner)
Contact Details for further information: James.houston@wales.nhs.uk

Purpose of the EASC Report
To provide EASC with an overview of the key discussion points to be raised at the meeting with the Minister for Health & Social Services and NHS Chairs on 23 September regarding a range of scalable service transformation opportunities and pre-hospital care pathways proposal for pan-wales implementation.

Governance	
Link to the Commissioning Agreement	The development of pan Wales service transformation initiatives supports delivery against the EMS Commissioning Intentions to improve patient care the delivery of an effective and efficient clinical service.
Supporting evidence	Supporting evidence is included in the appendix for information
Engagement – Who has been involved in this work?	

This paper has been shared and discussed with WAST Executive Management Team (28 August) and with Directors of Planning (6 September).

Emergency Ambulance Services Committee Resolution to:					
APPROVE		**ENDORSE**		**DISCUSS**	√	**NOTE**	√

Recommendation	EASC is asked to:
	• Endorse proposed three service transformation initiatives suitable for scale up.
	• Endorse the ongoing work regarding alternative care pathways and.
	• Endorse that the agreed output of the pathway work (and any identified resource implication for Heath Boards) should be included within 2020/21 Health Board IMTPs

Summarise the Impact of the Emergency Ambulance Services Committee Report	
Equality and diversity	There are no implications arising directly from this report.
Legal implications	There are no legal implications arising directly from this report.
Population Health	EMS ambulance response times are a key determinant of population health, particularly, for Red – immediately life threatening calls – the report provides proposals for service transformation initiatives focussed upon improving ambulance response and enable wider improvement across the unscheduled care system
Quality, Safety & Patient Experience	There are no specific references to SAIs or Quality concerns.
Resources	The report provides information on proposed service transformation initiatives with reference to possible resource implications.
Risks and Assurance	WAST has a Risk Management Framework and Corporate Risk Register. No corporate risks are directly flagged in this paper.
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf The work reported in this summary and related annexes take into account many of the related quality themes.
Workforce	The report indicates possible workforce implications to enable the proposed service transformation initiatives.
Freedom of information status	Open

WELSH AMBULANCE SERVICES NHS TRUST (WAST) – SERVICE TRANSFORMATION PROPOSALS

1. SITUATION

The purpose of this paper is to:
- Seek endorsement from EASC to share three service transformation initiatives suitable for national scale up with the Minister at the Chairs meeting with the Minister at the end of September, in line with his expectations;
- Seek endorsement from EASC that these three service transformation initiatives will be included in 2020/23 IMTPs, noting that further work will be undertaken in the coming months to determine the financial implications;
- Seek endorsement from EASC to support the ongoing work regarding alternative care and referral pathways from WAST to Health Board services.

2. BACKGROUND

At the NHS Wales Chairs' Peer Group meeting in December 2018 the outcome and recommendations of the Amber Review, which had been published in November 2018, were considered. This led to a discussion around some of the ways in which the Welsh Ambulance Service NHS Trust (WAST) and Health Boards (HBs) could work together to develop pathways and services which avoided Emergency Department attendances or hospital admissions and reduced demand for such, which in turn would free up WAST resources to respond more appropriately to the amber category calls.

A paper was requested from WAST for the Chairs and Chief Executives on these issues.

A paper was presented at the 7 February 2019 meeting which outlined a range of service improvement initiatives being delivered by WAST in collaboration with Health Board partners to improve patient care and reduce pressures across the wider unscheduled care system through collaboration and joint working.

A further paper was subsequently requested for the Chairs and Ministerial meeting in September 2019 to put forward;
  a) An approach to standardising and rolling out All Wales Pathways.
  b) A refined list of initiatives from those initially identified in February as being 'scalable' across Wales and which initial evaluation is suggesting there are system wide benefits to scale up.

3. ASSESSMENT / GOVERNANCE AND RISKS

Nationally Scalable Service Transformation Initiatives

Building on the paper presented on the 7 February a longlist of service transformation initiatives were considered for scaling up pan Wales (table 1).

Table 1:

Area	Scheme
National	Roll Out of National 111 service
	Clinical Desk – Expansion of Hear and Treat
	Roll out of Advanced Paramedic Practitioners
	Level 1 Falls Response - Falls Assistant Trial
	Managing Non-Injury Falls Patients in Nursing / Residential Homes
	Management of Frequent Callers
SBHB	Paramedics Supporting Out of Hours Service
	Joint Working with Acute Clinical Team
ABUHB	Level 2 response to Possible Injury Falls
	Joint Response Unit
BCU	Pacesetter – APPs in primary care
	Single Integrated Clinical Assessment and Triage (SICAT) Service
Cwm Taf Morgannwg	Community Paramedic St John medical practice
Cardiff and Vale	Joint working with Care Home Integrated Support Team
	Falls Response Team
Hywel Dda	Provision of APP Support to Primary Care Services
	Provision of APP support to GP Out of Hours Services
Powys	Clinical Support in Welshpool MIU
	Community Admission Avoidance Pathway

Further detailed information on many of these schemes can be found in annex 1.

This long list was subsequently reduced and refined into three opportunities that are suitable for scaling up at pace across Wales, with early/emerging evaluations showing very positive outcomes and benefits to the wider health system.

A brief summary of these opportunities is shown below with Annex 2 providing a more detailed proposal on a page for each.

WAST has long since championed the increased role it could play in supporting the wider unscheduled care system in Wales, and these are set out it its Long Term Strategy. As such, these three opportunities do not represent the full extent of the potential transformation that could be taken forward. However in recognising that any organisation and/or system has a finite capacity for the amount of change it can progress at one time, these opportunities represent a pragmatic first step, with further system changes to be proposed and put forward in due course once these initiatives are bedded in.

Scheme 1 - Falls Response Model

WAST has developed a Framework for falls which encompasses five elements;
- **Prevention:** Recognizing the opportunities within WAST to contribute to the prevention of falls
- **Supporting Community Resilience:** Working with Nursing and Residential Homes so that they are able and equipped to assist people who fall
- **Assessment (Hear and Treat):** Ensuring we make the right assessment of the fall (uninjured, possibly injured, injured) so that we deploy the right level of resource
- **Response (See and Treat):** A falls Response model
- **Avoiding Further Harm:** Falls Referral pathways/ awareness of the development of pressure ulcers.

In addition the framework advocates three levels of falls response;

Level 1- Non injury faller attended by a falls assistant
Level 2 – Possible injury as a result of a fall needing assessment
Level 3- Injury fall requiring emergency response

A comprehensive Level 1 response service, currently provided by St John Ambulance, is now in place across South Wales funded on a non-recurrent basis. A bid has been put forward to expand this to the whole of Wales on a recurrent basis, through the EASC Healthier Wales funding, to be considered under separate agenda item. There is therefore the potential to have scaled this service up nationally by the end of this financial year.

Early evaluations of a level two pilot within Aneurin Bevan Health Board suggest significant benefits exist to moving towards the scale up of Level two falls. EASC are asked to support further work to evaluate and develop proposals further for a scale up of Level 2 response across Wales, to be included in Integrated Medium Term Plans (IMTPs) next year.

Scheme 2- Advanced Paramedic Practitioners

An Advanced Paramedic Practitioner (APP) is a paramedic with additional clinical and diagnostic skills to manage complex and frail patients in a community setting. WAST has developed an innovative rotational model with which sees these paramedics rotate across three areas;

(i) Working within the community on an Ambulance Rapid Response Vehicle (RRV)
(ii) Working within Clinical Control Centres (CCCs)
(iii) Working within Primary Care / out of hours (OOH)

This full APP rotational model is in place within parts of a number of Health Boards including Hywel Dda, Betsi Cadwaladr and Aneurin Bevan, although the primary care component varies in each Health Board.

Additional resources have been agreed on shared funding basis between WAST and Health Boards for an additional **26 APPs** to move this model forward across Wales, and these will commence their APP training in September 2019.

A significant amount of work has been undertaken on the evaluation of the RRV element of the rotation model, which shows a major impact in being able to treat patients at home or refer to alternative pathways, avoiding conveyance to hospital in around 65% of cases (Band 6 paramedics typically convey around 65% of the same call codes). However, it is recognised that further evaluation is required on the CCC and primary care aspects of this model, and a formal evaluation will now be completed in Quarter 3 of this financial year.

Having received the results of the evaluation, and also having received the outcome of the D&C review which will model the maximum impact of the APPs in the RRV element of the rotation, it will then be possible to determine the most beneficial model for APP expansion within each Health Board area, for inclusion in IMTPs.

Scheme 3- WAST as a Call Handler of Choice (this represents a 'blend' of SICAT in BCU and AGPU in SBHB)

Building on the excellent collaborative relationships which exist between local WAST and Health Boards clinicians and managers a series of local initiatives have been piloted that, whilst all slightly different in their approach and/or composition, have a common theme of providing integrated clinical assessment & triage of calls coming into WASTs clinical contact centres, with the aim of reducing unnecessary ambulance dispatches and ultimately demand on A&E departments.

Local evaluations are showing significant benefits and positive outcomes for patients and the system to the extent that an opportunity exists for WAST to develop a 'blended' model which can be standardised and rolled out across Wales. A model which starts to see WAST being described as a call handler of choice.

This model should include consideration of mental health practitioners to support the assessment and triage, as a large number of calls on the 'stack' require this specialist input, and a conveyance to an ED is typically far from the ideal response.

It is proposed that the scale up of these models across Wales should be funded from winter pressures funding, so that benefits can be felt at pace and to improve system performance this winter. Any recurrent funding requirements would then be factored into IMTPs.

Pre-hospital Clinical Pathways / Wider system referral pathways

In 2012/13 WAST led a joint work stream with all Health Boards across Wales to develop and implement three national ACPs for non-injury falls patients and patients with a resolved hypoglycaemic or resolved epileptic episode.

Over an 18 month period the three clinical pathways were implemented within each of the seven Health Boards across Wales. The success of the project was predicated on the principle of implementing a standardised pathway process with clear clinical guidelines and robust referral process.

Since then WAST has continued to implement new ACPs, however this has focused upon establishing more local pathways at a Health Board or locality level. Whilst this has increased the number of ACPs in place, covering a wide range of different clinical conditions, this has meant that there is variation in the type of pathways available across Health Board boundaries with different clinical criteria and underpinning referral processes.

As a result of this variation it can mean that frontline clinicians are unclear of the local pathways available and how to access them, especially if they are responding to a 999 call outside of their Health Board boundary. This can result in patients being unnecessarily conveyed to hospital when they were clinically suitable to be safely referred to an ACP.

To address these challenges and in response to deliver against the EMS Commissioning Intention 'Step 5 – Fewer conveyances and more conveyance to other locations i.e. non Major Emergency Departments' the Trust has formalised a programme of work to take this work forward.

A Pathways Development Group has been established to oversee and set out a clear vision for the future development of ACPs. The founding principle of this work stream is to identify and implement a range of standardised ACPs for the high volume / high activity patient groups, which can implemented on an all-Wales basis.

To progress this work stream a workshop with Operational and Clinical leads has been arranged for the 9 September to review the activity data and identify a range of national ACPs for consideration and discussion with wider system partners.

Whilst this work is ongoing the table below provides an indication of the condition specific pathways and wider system referral pathways that may be identified as part of this work.

Possible condition specific pathways
- Chest Pain   - Respiratory   - Falls   - End of Life   - Mental Health.
Proposed standardised access pan Wales to system wide clinical services
- Standardised access to Minor Injury Units   - Standardised access to refer into Primary Care services (GPs)   - Standardised referral pathway into social services (e.g. frailty)   - Standardised referral pathway to Community / District Nursing teams for an agreed set of patient conditions (e.g. blocked catheter).   - Standardised access to secondary assessment pathways, avoiding ED and allowing for the treatment of higher risk patients in a non-ED setting.

In order for progress to be made across these areas and opportunities to be realised it is vital that a collaborative approach between WAST and Health Boards is taken. As such Health Boards are asked to signal not only their commitment to this work in their 2020/21 IMTPs but also to take the opportunity to identify the resources which they may require to subsequently implement those pathways which have been developed.

It is anticipated that a number of these referral pathways will be implemented within this financial year.

4. RECOMMENDATIONS

The Emergency Ambulance Services Committee is asked to:

- **ENDORSE** the proposal to share three service transformation initiatives suitable for national scale up with the Minister at the Chairs meeting with the Minister at the end of September, in line with his expectations;
- **ENDORSE** the requirement to include these three service transformation initiatives in 2020/23 IMTPs, noting that further work will be undertaken in the coming months to determine the financial implications;
- **ENDORSE** and support the ongoing work regarding alternative care and referral pathways from WAST to Health Board services.

Freedom of information status	Open

WAST Service Transformation
Proposals

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Emergency Ambulance Services
Committee Meeting
10 September 2019

NATIONAL INNOVATIONS

1. Roll out of the National 111 Service

Status: Live – Phased roll out

Steps: Step 1 - Help Me Choose & Step 2 - Answer My Call

The 111 service is a free-to-call single number non-emergency medical helpline, available 24 hours a day, seven days a week. Patients can access 111 for health information, advice and access to urgent care.

The 111 service is currently live in 4 of the 7 health boards across Wales. Work is underway in readiness to roll out the 111 service to Aneurin Bevan Health Board in April 2019 and Cwm Taf Health Board in September 2019.

The following table provides the 111 implementation timetable:

Health Board	Go Live Date
Abertawe Bro Morgannwg UHB	October 2016
Hywel Dda UHB (Carmarthen Only)	May 2017
Hywel Dda UHB (Pembs & Ceredigion)	October 2018
Powys THB	October 2018
Aneurin Bevan UHB	April 2019
Cwm Taf UHB	Proposed September 2019/20
Betsi Cadwaladr UHB	Planned for 2020/21 onwards
Cardiff & Vale UHB	Planned for 2020/21 onwards

The benefits of 111 include:

- Access to 24/7 health information and urgent clinical advice;

- Helping patients choose the right care and reducing hospital admission where appropriate;

- Improved ability to stream activity between emergency and urgent handling and response.

It is anticipated that WAST's provider role in this service will be recognised formally in the near future.

2. Clinical Desk: Increasing Hear and Treat

Status: Live – recruitment ongoing

Steps: Step 2 – Answer my call

There are a number of patients who dial 999 and do not require an ambulance response. Some of these patients are suitable for a clinical assessment over the phone from a clinician based in one of the contact centres on the 'clinical desk' (known as Hear & Treat). The clinician will assess the patient and, based on the patients' needs, will determine the most appropriate ongoing care, which could include referral to a local community based service.

The clinical desk plays an important role in assessing patients over the phone and, in recognition of this, funding has been agreed by EASC and Health Boards to recurrently expand the clinical desk capacity through recruiting an additional 11 clinicians. The monthly combined hear and treat rate (proportion of calls that do not require an ambulance response) is currently around 8% and, following the investment, the Trust's target is to reach 12%.

Recruitment to these additional posts is currently on-going and all are expected to be filled by Spring 2019.

The benefits of the clinical desk include:

- Increasing the number of calls resolved through hear and treat;
- Reducing unnecessary ambulance dispatch;
- Increasing ambulance resource availability.

3. Roll out of Advanced Paramedic Practitioners

Status: Live – recruitment ongoing

Step 3 Come to See Me & Step 4 Give Me Treatment)

An Advanced Paramedic Practitioner (APP) is a paramedic with additional clinical and diagnostic skills to manage complex and frail patients in a community setting. APPs are trained to a Master's degree level following the completion of a two-three year academic and clinical education programme.

The APP role is becoming increasingly important in providing care for patients with complex chronic conditions in a community setting.

In 2017 WAST piloted a new framework in Betsi Cadwaladr which tested the effectiveness of utilising Advanced Practice resources in a rotational model with the aim of safely reducing conveyance to Emergency departments, and allowing more patients to be cared for in the community, closer to home. A team of APPs were in place 12 hours a day, rotating between the Clinical Contact Centre and two operational Rapid Response Vehicles (RRV), and they dealt with 1045 incidents over the five month pilot period.

- Of the patients the APPs attended, 307 conveyances to ED were prevented, compared with the conveyance rates of conventional paramedics.

- This represented a 70% reduction in A&E attendance.
- Only 13% of patients seen by an APP required an Emergency Ambulance vehicle.
- 98% of patient survey responses showed a high level of satisfaction with the service that they had received.

The net effect for patients was that they had access to the right care from the right clinician at a much earlier point than they may have done otherwise.

Through discussion and collaboration with Health Boards, WAST have added a further rotation into the model, with placement into the Primary Care or Out of Hours settings. These highly educated clinicians can work effectively to support the wider health community, whilst also further developing their proficiency in managing complex patients with multiple comorbidities. The model as now planned is set out below.
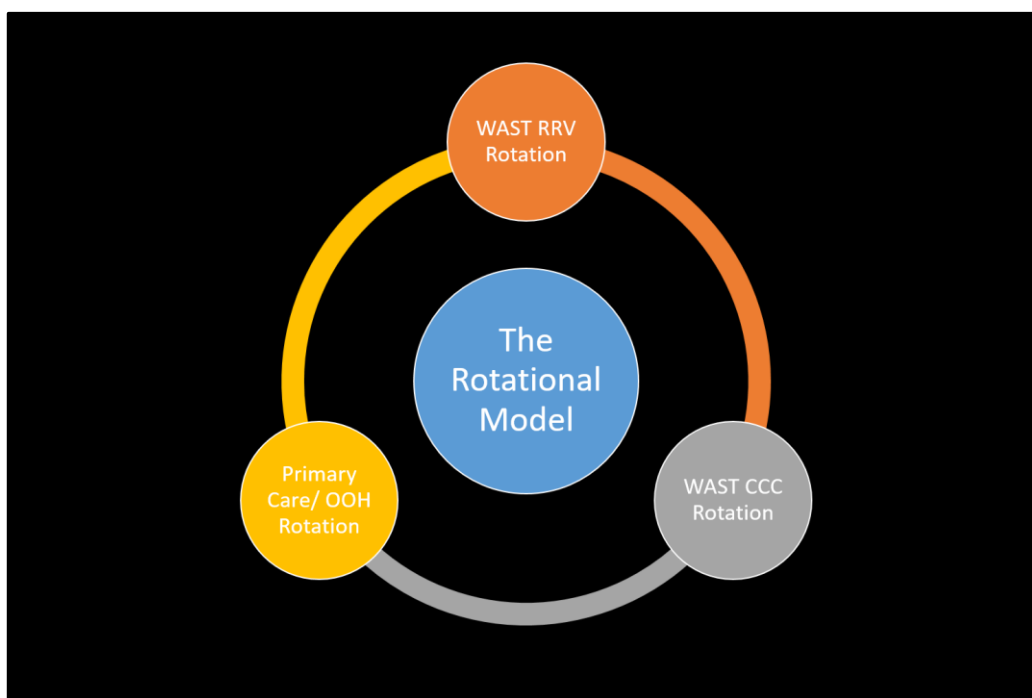
A Business Case was submitted to EASC in autumn 2018 (embedded below), which set out a plan to substantially increase APP service delivery year upon year until 2023 in order that these benefits could be extended across Wales. Recurrent funding has been confirmed by Health Boards for a first phase of expansion, with recruitment to an initial cohort of 20 APPs. These will start to be operational from February 2019, with the full cohort expected to be in place by Spring 2019.

As well as making the North Wales APP team permanent, the new investment will allow for the formation of a new team in South East Wales and expanding the existing APP team in ABM and HD Health Board areas. This will create a consistent and reliable APP presence across each area for a minimum of 12 hours each day.

WAST will be closely monitoring and evaluating the impact that this change has across Wales, in order to ensure that the patient and system benefits are established. If additional benefits continue to be demonstrated, discussions will continue with EASC and Health Boards in terms of any further expansion.

There are a range of different APP initiatives that have been trialled and developed at a Health Board level.

BCU APP Fi

These scheme have illustrated not only a dramatic increase in the number of patients being managed within a community setting but also supporting the wider unscheduled care system in providing highly skilled and competent clinicians, increasing the capacity within primary care provision, in and out-of-hours.

Upscaling this initiative will require support in respect of increased throughput on the requisite educational pathway and support for WAST in ensuring that existing service provision is maintained during the expansion. The addition of non-medical prescribing for these clinicians, further develops the potential for this role by adding greater autonomy to their practice and reducing hand offs between clinicians.

Significant interest in the role exists within the WAST paramedic workforce and as such, with the correct support, increasing the number of APPs to substantiate this system wide working could be undertaken over the medium to long term.

4. Management of Falls Patients

Status: Live

Steps: Step 3 - Come to See Me, Step 4- Give Me Treatment and Step 5 -Take me to Hospital

Falls account for a high demand on WAST services, second only to breathing problems and in 2017/18 WAST received over 62,000 calls relating to falls, of which 50% resulted in attendance at a hospital.

In response to this, WAST has developed a Falls Response Framework to provide a holistic approach to falls, from prevention to avoiding further harm as set out in the diagram below.
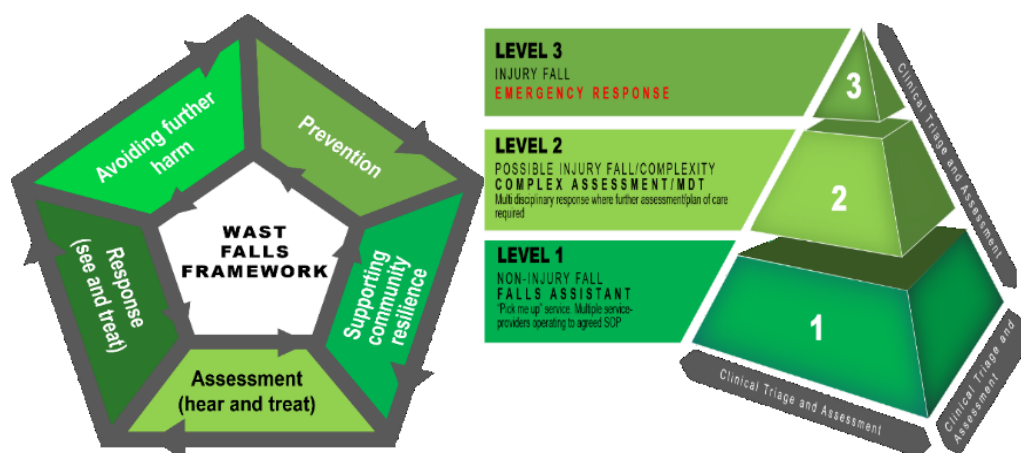
Level 1 Falls Response - Falls Assistant Trial

In relation to the Falls Response Model, WAST have received additional non-recurrent funding in Winter 2018 which has allowed the Level 1 Falls Assistant Model to be expanded across most of Wales. The Falls Assessment Trial is a collaborative initiative with St John Ambulance, Wales providing a response to clinically suitable low acuity falls patients. An evaluation report for this pilot is appended below.

The Falls Assistant is a non-clinical role that attends the patient (who has been determined to be a non/minor injury fall) to pick them up safely from the floor and undertake a further assessment of the situation at scene, supported by the Clinical Support Desk where a Paramedic or Nurse provides clinical advice and direction.

There are now seven vehicles across South Wales covering five Health Boards. These are based from Llanelli to Chepstow. In North Wales, there has been a Falls Assistant Model in place for some time, provided by WAST Community First Responders. A full evaluation is underway using a set of measures focusing on patient outcomes, process measures and balancing measures, and some data will be available in February, once 2 full months of data is available.

Data to date, notwithstanding the limited amount, appears to show a relatively low conveyance rate to hospital and a quicker response time than would have been achieved otherwise. Continuing these Level 1 services on a recurrent basis will be one of WAST's priorities for 2019/20, and this will be discussed further with the Commissioner as part of the discussions on the allocation of the 'A Healthier Wales' funding.

Welsh Ambu

Managing Non-Injury Falls Patients in Nursing / Residential Homes

It was recognised that high volumes of 999 calls from nursing and care homes were for patients who had fallen and requested an ambulance response. Following a clinical assessment it was identified that many of the patients did not sustain any injuries, but did require picking up off the floor.

To better manage patients who have fallen, WAST have rolled out training and education to care and nursing home staff across Wales. This has included the ISTUMBLE falls assessment tool. ISTUMBLE is a supportive decision making tool to help identify the right care for a falls patient and determine if an ambulance response is required. An example of the impact of this initiative is demonstrated in ABHB whereby the pilot achieved a 41% reduction in calls to 999 and has led to greater staff confidence within care homes and better outcomes for patients.

The main benefits include:

- Patients receive the right care to meet their needs;
- Reduction in 999 calls for an ambulance response;
- Improved ambulance availability.

Moving forward, funding has been identified to procure lifting equipment to enable staff to safely lift non-injured falls patients off the floor and therefore not require an ambulance response.

EASC have procured assisted lifting aids for use by care and nursing homes. The Trust is working with the Chief Ambulance Services Commission to provide training for care and nursing home staff to use the assisted lifting aids and therefore reduce ambulance responses to low acuity falls patients and subsequent conveyance to ED.

5. Management of Frequent Callers

Status: Live – Business As Usual

Steps: Step 3- Come to See Me & Step 4- Give Me Treatment

A pan-Wales initiative has been taken forward to improve the management of frequent callers. This initiative has been developed in collaboration with each Health Board whereby WAST, Health Board and other service leads have developed a multi-disciplinary approach to identify, review and put into place robust care plans for frequent service users.

The benefits of this initiative include:

- Improved care and support for service users with previously unmet needs;

- Collaborative approach to better manage high frequency service users;

- Reduction in 999 calls and ED attendances.

SERVICE INNOVATIONS BY HEALTH BOARD AREA

1. ABERTAWE BRO MORGANNWG UNIVERSITY HEALTH BOARD

Paramedics Supporting Out of Hours Service

Status: Live

Steps: Step 3- Come to See Me & Step 4 -Give Me Treatment

This initiative was developed in partnership with ABMU in response to the capacity challenges facing the Out of Hours Services. The initiative involves paramedics providing clinical support to the GPOOHs, undertaking routine home visits on their behalf during the out of hour's period.

A trial was undertaken in November 2018 that demonstrated a range of patient and system benefits including:

- More timely patient responses requiring an out of hours face to face assessment;

- Additional clinical capacity thus freeing up capacity of the OOH GPs to meet incoming demand.

Arrangements are in place to formalise the trial to provide permanent support to the OOHs, 7 days a week. Abertawe Bro Morgannwg University Health Board have also funded 2.8 WTE Band 6 Paramedic equivalent positions to rotate through GP out of hours at night to undertake home visits. This is currently run as a Rapid Response Vehicle (RRV) model which includes red call response.

There is scope to replicate this model in other areas to strengthen and enhance fragile OOH services, particularly as we expand Advanced Paramedic Practitioners and pilot paramedic prescribing later this year.

Joint Working with Acute Clinical Team

Status: Live

Steps: Step 3 -Come to See Me & Step 4- Give Me Treatment

The Acute Clinical Team (ACT) is an acute intervention service designed to prevent admission from hospital or to support/facilitate early discharge from hospital. Arrangements are in place with the Acute Clinical Team in Bridgend to access and respond to clinically appropriate 999 calls. This pathway enables patients to be cared for in the community and helps to free up ambulance capacity to respond to incoming 999 calls that require an ambulance response.

This model has been successfully embedded within the Bridgend locality. The main benefits include:

- Patients receive the right care to meet their needs;
- More patients treated and cared for in the community;
- Reduction in 999 calls requiring an ambulance response;
- Supports a reduction in the number of patients conveyed to ED.

Opportunities have been explored to roll out this model across Swansea and Neath Port Talbot localities. At present, due to capacity constraints experienced by the Acute Clinical Teams in Swansea & Neath Port Talbot, it is not possible to roll out the initiative in these areas.

2. ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Level 2 response to Possible Injury Falls

Status: Live

Steps: Step 3 - Come to See Me & Step 4 - Give Me Treatment

A Level 2 falls response is required where it is unclear if there is an injury or where the patient has co-morbidities or complex needs. In this initiative, a multi-disciplinary team is used to undertake a comprehensive assessment of the person in their own home and implement an appropriate care plan according to their individual need. Within the ABUHB area, a Falls Response Service (FRS) has been operating since October 2016 and consists of a Paramedic and Physiotherapist operating daily between 8.00am and 8.00pm. This has been supported by the Welsh Government Integrated Care Fund.

The Falls Response Service has had involvement with 1,961 falls incidents received via the 999 system from October 2016 to 31st December 2018. 1,475 people (75%) have remained at home following assessment and/or treatment by the team with the appropriate care being provided by community based services. Only 486 individuals (25%) required further treatment and/or treatment at hospital, and only 17% of individuals required treatment within an Emergency Department.

The benefits of this model include:

- Improved response to falls patients;

- Increased number of falls patients care for at home or referred to community services;

- Reduced number of patients conveyed to ED.

Joint Response Unit

Status: Live

Steps: Step 3 -Come to See Me, Step 4- Give Me Treatment and Step 5- Take me to Hospital

WAST receives around 24,000 emergency calls per annum from the Police, equating to 80 calls per day. Analysis has shown that the majority of these calls (78%) are for low acuity problems.

Within ABUHB, WAST works alongside Gwent Police using the Joint Response Unit (JRU). The JRU is an initiative to provide a single joined-up response to instances where both organisations need to attend an incident (e.g. RTC's, assaults, mental health patients at risk of harm) with the key objective being to improve patient outcomes, experience and improve efficiencies between the two organisations. Variations on the Gwent JRU exist in other Health Board areas including Pembrokeshire, Cwm Taf and ABM.

The JRU commenced in July 2016 and, following a joint activity analysis, operates between 16:00 and 02:00 hours every Friday, Saturday and Sunday. The JRU has an experienced Paramedic and Police Officer on a WAST Rapid Response Vehicle and covers the Gwent West area.

The JRU can be dispatched by either control rooms or can self-task; Police will process requests for WAST assistance as normal although the JRU may be dispatched simultaneously. The JRU will only deploy to incidents that require a joint response to an incident unless they are nearest to a Red call then the JRU can be dispatched.

JRU activity from 01/08/17 – 31/07/18 is outlined below:

JRU Activity (662 Incidents)
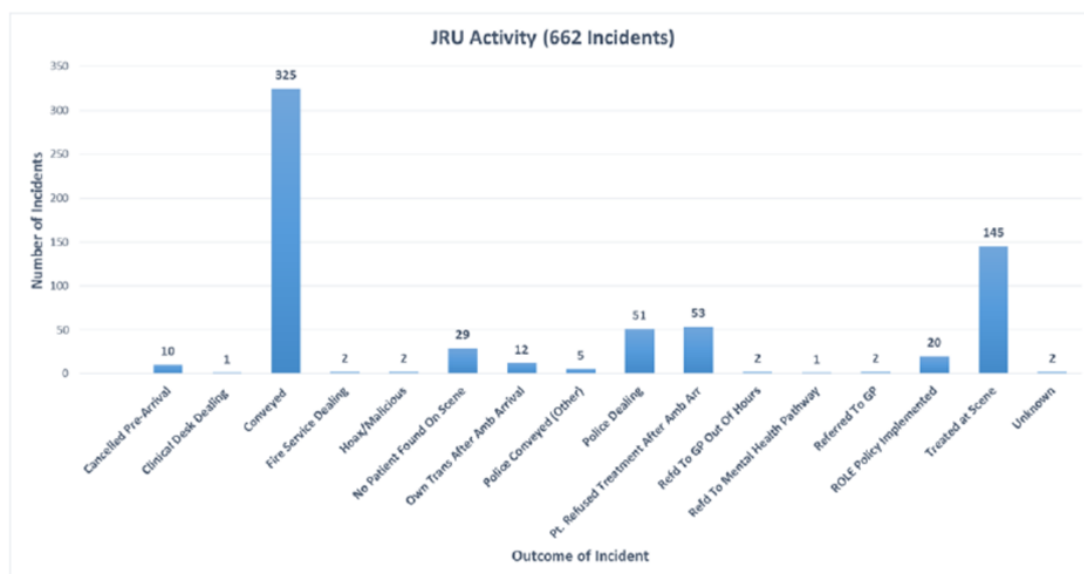
Continuing and expanding JRU schemes on a recurrent basis will be one of WAST's priorities for 2019/20, and this will be discussed further with our Commissioner as part of the discussions on the allocation of the 'Healthier Wales' funding.

BETSI CADWALADR UNIVERSITY HEALTH BOARD

Pacesetter

Status: Implementation stage

Steps: Step 3 Come to See Me & Step 4 Give Me Treatment

Welsh Government have provided funding for a 'Pacesetter' trial. The Project involves placing APPs into primary care as part of the full rotational model. The Project Board is established and working towards establishing the initial wave of APPs into the primary care rotation by 1 April 2019. The intention is to offer 8 APPs at 0.5WTE for a 2 year period, supported with a bespoke education framework developed by GP educators. The APPs will be offered to North Gwynedd, South Gwynedd, and Central and Eastern Clusters. The proposal has to be presented to and ratified by the Project Board.

Single Integrated Clinical Assessment and Triage (SICAT) Service

Status: Implementation stage

Steps: Step 2 – Answer my call

WAST is supporting the implementation of the SICAT service into the Llanfairfechan Clinical Contact Centre. This project forms part of the Betsi Cadwaladr University Health Board 90 day plan with the funding for the GPs coming from them.

CARDIFF AND THE VALUE UNIVERSITY HEALTH BOARD

Joint working with Care Home Integrated Support Team

Status: Live

Step 3 Come to See Me & Step 4 Give Me Treatment

To improve the management of low acuity fallers in care homes, WAST & C&V Health Board have worked collaboratively to better manage and reduce this demand. The scheme involves an integrated approach between WAST and the CHIST and the aim of the initiative is to provide collaborative education and support to Care Homes across Cardiff and increase the confidence of Care Home staff to self-manage residents in the home environment. This initiative was piloted in 8 care homes within C&V Health Board.

The benefits of this initiative include:

- Improved care for patients in care homes;

- Reduction in 999 calls to care homes;

- Reduction in the number of patients conveyed to ED.

Building on a successful pilot the UHB are planning to expand from 8 care homes to 11 care homes. Further development of the CHIST team is linked to C&Vs bid for Transformation Funding.

Falls Response Team

Step 3 Come to See Me, Step 4 Give Me Treatment and Step 5 Take me to Hospital

To support the management of falls patient, a Falls Response Team has been developed jointly between WAST & the Health Board.

The Falls Response team consists of a Paramedic and a therapist from the Community Response Team providing a same day urgent response and home based clinical assessment. The service is in place and operating weekdays (08:30 – 16:30).The assessment looks to provide confirmation of physical injury and provide advice and signposting to community based services as appropriate.

The benefits of this initiative include:

- Improved response to falls patients;
- Increased number of falls patients care for at home or referred to community services;
- Reduced number of patients conveyed to ED.

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD
Community Paramedic St John medical practice

Status: Pilot Finished

Step 3 Come to See Me, Step 4 Give Me Treatment and Step 5 Take me to Hospital

The pilot was a joint initiative developed in partnership with St Johns General Practice and CTUHB. The purpose of the pilot was to explore the potential to reduce conveyance, A&E attendance, hospital admissions and to increase GP capacity.

It was a 12 month pilot where Advanced Paramedics supported the multi-disciplinary team model. The model used a 'virtual ward' with reference to their frailty, multiple complex health and social care needs. Individual care plans were developed using an MDT approach and advanced paramedics undertook home visits to develop packages of care on behalf of the medical practice. The pilot was a Bevan exemplar project and founded on the principles of prudent healthcare.

The pilot indicated a number of benefits:

- Increased GP capacity:

- Reduced attendances at A&E:

- Potential for reduction in admissions to secondary care.

HYWEL DDA UNIVERSITY HEALTH BOARD

Provision of APP Support to Primary Care Services

Status: Live – ad hoc

Step 3 Come to See Me, Step 4 Give Me Treatment and Step 5 Take me to Hospital

Arrangements were put into place for WAST APPs to support the delivery of Primary Care (GP) services in Hywel Dda. Under this initiative, the HD Primary Care Support Team would contact WAST to request APPs to support GP surgeries during periods of peak demand or provide additional clinical capacity when required. The scope of the APP was to undertake appropriately triaged home visits, and also to undertake pre-triaged consultations in the surgery on behalf of the GP in line with the daily patient schedule. The APP would carry out a comprehensive patient assessment in-line with their scope of practice and determine the best treatment options for the patient. A detailed SOP was developed with the Health Board setting out the operational arrangements. APP / Primary Care Support initiatives have been in place in Hywel Dda since 2014, however APP support to in-hours services has been recently diverted to Out of Hours (OOH) services to provide additional capacity (see initiative below). Ad hoc arrangements remain in place to provide APP support to GP services as and when required, and any ad-hoc support is recharged directly to the Primary Care Services within the Health Board.

The benefits of this model include:

- Increased GP capacity to care for patients in a primary care setting (in hours);
- Collaborative approach to managing patients in the community and avoid conveyance to hospital where clinically appropriate.

Provision of APP support to GP Out of Hours Services

Status: Live

Step 3 Come to See Me, Step 4 Give Me Treatment and Step 5 Take me to Hospital

Arrangements are in place for Advanced Paramedic Practitioners (APPs) to provide rostered hours supporting the delivery of the Out of Hours (OOH) service in Hywel Dda. The scope of the APP is to undertake patient consultations and home visits as identified by the OOHs GP. The core rostered hours are Monday – Friday 19:00 – 06:00 and Saturday & Sunday 09:00 – 21:00.

The benefits of this model include:

- Increased GP capacity to care for patients in a primary care setting (out of hours);
- Collaborative approach to managing patients in the community and avoid conveyance to hospital where clinically appropriate

This initiative is currently live and a detailed MOU has been developed with the Health Board setting out the operational arrangements. This initiative is funded directly by the Health Board and request for additional support are recharged and invoiced separately.

Minor Injury Unit Admission Criteria Development

Status: Initiative Underway

Step 3 Come to See Me, Step 4 Give Me Treatment and Step 5 Take me to Hospital

Work is ongoing to improve access and increase the number of clinically appropriate patients being conveyed to a Minor Injury Unit (MIU) across Hywel Dda. As part of this work stream the admission criterias for a number of the MIUs were reviewed to understand the access criteria for conveying ambulance patients directly to the unit. To date, the admission criteria has been reviewed and approved for Tenby MIU, and work is ongoing to communicate this and increase the number of clinically appropriate patients conveyed there. Work is also ongoing to establish a similar admissions criteria for Cardigan MIU.

The benefits of this initiative are:

- Clear admission criteria in place for Paramedics to convey appropriate patients to the MIU;
- Increase in the number of patients conveyed to an MIU;
- Reduction in the number of patients conveyed to ED who would have been suitable for treatment at an MIU.

POWYS TEACHING HEALTH BOARD

Clinical Support in Welshpool MIU

Status – Trial completed

Step 3 Come to See Me & Step 4 Give Me Treatment

A trial was undertaken in April to June 2018 whereby an Advanced Practitioner Paramedic provided clinical support in Welshpool Minor Injury Unit. The scope of the trial was twofold in terms of the APP providing clinical support caring for 'walk in' patients and secondly reviewing the 999 stack to identify ambulance patients suitable to be treated in the MIU.

The trial proved successful in terms of increasing the range of patients who were clinically appropriate and could be safely treated in the MIU in line with the APPs clinical scope of practice. This therefore enabled more patients to be treated in the MIU and avoided the need for treatment in ED. It also meant that more ambulance patients could be treated locally, not requiring a long journey to the nearest ED. One example of this initiative working in practice was the APP diverting a patient from Shrewsbury ED to be treated in the MIU closer to the patient's home.

The benefits of this initiative include:

- Increased scope of practice for patients to be treated in the MIU;
- Reduced ambulance job cycle and journey times;
- Increase the number of patients treated in an MIU;
- Reduced the number of patients conveyed to ED.

This trial was undertaken to test the concept and the APP was on a bank contract. Currently there are no APPs in Powys, however if funding is identified as part of the wider APP initiative, this initiative could be fully embedded.

Community Admission Avoidance Pathway

Status – Live

Step 3 Come to See Me & Step 4 Give Me Treatment

A Community Admission Avoidance pathway has been developed for WAST clinical staff to refer clinically appropriate patients directly to the local district nursing teams.

The purpose of the pathway is to provide care closer to home by accessing and referring patients directly to the district nursing team who arrange to visit the patient at home. This pathway helps to avoid patients being conveyed to ED through accessing community based services.

The pathway was introduced into North & Mid Powys in summer 2018. To date circa 5-6 patients are referred via this pathway to the district nursing team per month. Work is ongoing to embed this pathway in South Powys and work is continuing to increase the number of patients referred using this pathway.

The benefits of this initiative include:

- More patients cared for in their own home / community setting;
- Reduction in the number of patients conveyed to ED;
- Improves ambulance availability to respond to incoming 999 calls.

The Call Handler of Choice

Purpose and Objectives:

To provide a Single 'once for Wales' Integrated Clinical Assessment & Triage Service for a range of disciplines

Background:

A National Single Integrated Clinical Assessment & Triage Service (SICAT) exists in BCU which is a GP led service centred on a GP co-located with a WAST APP working within Llanfairfechan Clinical Contact Centre, providing in hours clinical assessment and triage for 999 patients.

A similar service in Swansea Bay Health Board (AGPU) where an acute GP led service based in Singleton hospital provides additional clinical assessment and triage to safely manage patients away from requiring hospital admission.

Current status:

Both SICAT and the AGPU continuer to operate on funding arrangements put in place by the respective Health Boards however there is wider system support for an overarching clinical service model and the Chief Ambulance Service Commissioner (CASC) was supportive of undertaking a review into the feasibility of developing a pan-Wales model, which could include a wider range of clinicians such as mental health and crisis care.

The recent Amber Review of ambulance services in Wales found that *"operational staff felt they had a lack of training to be able to deal with calls from persons experiencing mental distress"*

Expected Outcomes:

Existing pilots in BCU (the SICAT model) and similar schemes in HDHB have shown clear benefits around;

Reduction in the number of 999 patients requiring a hospital admission (circa 70% of calls managed away from an ED).

Increase in the number of patients accessing community based services (e.g. referred to GP / APP / Self Care)

Reduction in the number of ambulance attended incidents

Enhanced multi-disciplinary clinical working and management of clinical risks between GP and APP.

Mobilisation time:

The development of such a strategic development for the wider system will require careful planning and implementation. Realising such an opportunity would be a 18+ months away but the process could be immediately expedited with dedicated planning / project support

Risks and Issues:

The proliferation of 'local' solutions is creating variability and equity issues for the people in Wales.

WAST through becoming the call handler of choice has the opportunity to become a system wider navigator.

Indicative Costs:

Senior planning and project lead and associated support-

Band 8A £63,949 + on costs (per annum).
Band 4: £29,266 + on costs (per annum).

Subsequent GP and/or other clinician appointments

Expansion of the Advanced Paramedic Practitioner (APP) Rotational Model

Purpose and Objectives:

To provide care for patients with often complex chronic conditions in a community setting who may otherwise have been conveyed to a hospital setting.

Background:

An APP is a paramedic with additional clinical and diagnostic skills to manage complex and frail patients in a community setting.

APPs are trained to a Master's degree level following the completion of a two year academic and clinical education programme.

In 2017 WAST piloted a new framework in Betsi Cadwaladr which tested the effectiveness of utilising Advanced Practice resources in a rotational model with the aim of safely reducing conveyance to ED, and allowing more patients to be cared for in the community, closer to home. This has developed into a rotational model with three core elements:
(i)   WAST RRV rotation
(ii)   WAST CC Centre rotation
(iii)   Primary Care / OOH rotation

Current status:

The APP model is a proven and successful clinical model that continues to be expanded across Wales. A first phase expansion of an additional 20 APPs are fully operational and funding has been agreed for further cohort of 26 APPs who will be commencing education from September this year. This expansion will mean that there is a foundation of APPs responding to 999 calls across each region of Wales. In addition, the full APP rotational model is in place within a number of Health Boards including Hywel Dda, Betsi Cadwaladr and Swansea Bay. This includes the APPs providing clinical support within the primary care (working with GP clusters) and also in the out of hours setting.

Expected Outcomes:

The pilot in BCU clearly evidenced that the presence of APPs;

Meant 70% of patients attended by an APP are managed at home or in the community

Meant there was a significant reduction in the number of patients conveyed to ED (Only 13% required conveyance with only a proportion of these patients requiring an Emergency Ambulance).

Produced 98% of patient survey response of high levels of satisfaction with the service that they had received.

A full APP business case has been produced to articulate the benefits of this scheme.

Mobilisation time:

Training and recruitment timescales mean it is highly unlikely the further rollout out of this scheme within 2019/20 will be possible. However further expansion through 20/21 is possible.

Opportunities exist to procure additional vehicles and equipment with the current year to even further improve the effectiveness of existing APPs.

Risks and Issues:
» Recruitment of sufficient paramedics into APPs
» Educational programmes require level 6 education to enrol, so there is a requirement to increase the number of WAST paramedics with this base level of education
» Need to plan the provision on an all Wales basis to ensure programme is developed in a coordinated and cohesive manner

Indicative Costs - Creating a team of 8 Apps:

Year 1 - £372k
Year 2 - £568k
Year 3 - £557k

Costs reduce in year 3 due to completion of the education programmes

Expansion of the Level 2 Falls Response (WAST Falls Framework)

Purpose and Objectives:
To provide an holistic approach to falls, from prevention to avoiding further harm. Level 2 focuses on providing a timely response to patients who have a possible injury or patients who have complex presentations following a Fall to prevent unnecessary hospital attendances/admissions

Background:
WAST has developed a Falls Framework and a Falls Response Model which are intended not only to provide clarity within the organisation but to inform our partners when developing local services. This consists of five core elements:

Prevention: Recognizing the opportunities within WAST to contribute to the prevention of Falls

Supporting Community Resilience: Working with Nursing and Residential Homes so that they are able and equipped to assist people who fall. Developing the role of our Community First Responders

Assessment (Hear and Treat): Ensuring we make the right assessment of the fall (uninjured, possibly injured, injured) so that we deploy the right level of resource

Response (See and Treat): A falls Response model focuses on three levels of response. Level 1 (Non Injury/Minor Injury). Level 2 (Complex, Possible Injury), Level 3 (Emergency Response)

Avoiding Further Harm: Falls Referral pathways/ awareness of the development of pressure ulcers.

Current status:
Level 1 falls response – In partnership with St John Cymru Wales a Falls Assistant (FA) model exists across five Health Boards.

A robust evaluation of the scheme has taken place and WAST is awaiting the outcome of a bid to the Chief Ambulance Services Commissioner for Welsh Government Healthier Wales monies which have been ring-fenced for WAST. Results demonstrated an improved timeliness of response.

A Level 2 Falls Response (L2) has subsequently been trialed and operated in Aneurin Bevan Health Board since 2016 under the Integrated Care Fund. The L2 ABUHB has demonstrated a range of patient, operational and wider system benefits. During the period of 2018/19, 77% of patients were safely assessed and managed at home and/or referred to community based services. Only 17% of patients required further assessment in the Emergency Department. Referrals by the multi-disciplinary team and equipment provided assisted in reducing the likelihood of future falls as a result of putting into place bespoke care

Expected Outcomes:
Previous full service evaluation of the period Oct 16- March 17 indicates that the decision making by the FRS team differed significantly from that of the core, non-FRS service .It has been possible to estimate that the FRS team succeeded in keeping a significantly greater proportion of patients at home and, even following 30 days of initial intervention, 63% of patients were cared for outside of hospital.

The evaluation estimated that the FRS team succeeded in keeping a significantly greater proportion of patients at home and, even following 30 days of their initial intervention, 63% of people continued to be cared for outside of hospital. Through tracking patient's journey through hospital, it was also possible to estimate the number of bed days typically incurred by patients conveyed to hospital. Due to the reduced conveyance rate to hospital by the FRS team, the system benefitted from 210 fewer conveyances to hospital, 190 fewer ED attendances, 106 fewer hospital admissions and 1,685 occupied bed days (the equivalent of 10 beds). * Assumes no re contact

Outcomes: Reduction in Conveyance to ED, Reduction in Bed Days occupied, Improved access to Community Services

Mobilisation time:
» Recruitment and Training would have to commence within the Community Resource Teams and Integrated Care Teams. Introduction of Level 2 teams would be possible during 2019/20 and 2020/21

Risks and Issues:
» Staffing concerns within community teams and release of Therapy Staff
» Increase in workload within the Clinical Contact Centre required to identify suitable incidents

Indicative Costs:
2.7 WTE- Band 6 Physio's at £41,000 (inc 20 % Unsocial hours –estimated- £133,000
2.7 WTE- Band 6 Paramedics- £123,493 including Unsocial Hours). **Total cost £256,493 (per HB area)**

		Agenda Item	2.6
Meeting Title	**Joint Committee**	Meeting Date	10 Sept 2019
Report Title	**EASC Financial Performance Report – Month 4 2019/20**		
Author (Job title)	**Author:** Finance Manager – Contracting		
Executive Lead (Job title)	Director of Finance	Public / In Committee	**Public**

Purpose	The purpose of this report is to set out the estimated financial position for EASC for the 4th month of 2019/20. The financial position is reported against the 2019/20 baselines following approval of the 2019/20 EASC IMTP by the Emergency Ambulance Services Committee in January 2019.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

Sub Group /Committee	Not Applicable	Meeting Date	Click here to enter a date.
	Management Group	Meeting Date	Click here to enter a date.

Recommendation(s)	Members are asked to: • **NOTE** the current financial position and forecast year-end position.

Considerations within the report (tick as appropriate)

	YES	NO		YES	NO		YES	NO
Strategic Objective(s)	✓		Link to Integrated Commissioning Plan	✓		Health and Care Standards		✓
Principles of Prudent Healthcare		✓	Institute for HealthCare Improvement Triple Aim		✓	Quality, Safety & Patient Experience		✓
Resources Implications	✓		Risk and Assurance	✓		Evidence Base		✓
Equality and Diversity		✓	Population Health		✓	Legal Implications		✓

Finance Performance Report – Month 4

1. Situation / Purpose of Report

The purpose of this report is to set out the estimated financial position for EASC for the 4th month of 2019/20 together with any corrective action required.

Table 1 - financial summary

	Annual Budget	Budgeted to Date	Actual to Date	Variance to Date	Movement	Current EOYF	Movement in EOYF
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
WAST (commissioned service)	157,663	52,554	52,554	0	0	0	0
Renal NEPTS	1,144	381	381	0	0	0	0
EASC - EMRTS	3,893	1,298	1,298	0	0	0	0
NCCU	1,345	448	448	0	0	0	0
Sub-total WAST / EASC / QAT	**164,045**	**54,682**	**54,682**	**0**	**0**	**0**	**0**

2. Background / Introduction

The financial position is reported against the 2019/20 baselines following approval of the 2019/20 IMTP by the EASC Joint Committee in January 2019. There are no corrective actions to report at this point.

The budget at this point does not include the APP Expansion Plan, unscheduled care allocation nor the National Pay Issues of pension rate increase and holiday pay on voluntary overtime.

Please note that as LHB's cover any EASC variances, any over/under spends are adjusted back out to LHB's. Therefore, although this document reports on the effective position to date, this value is actually reported through the LHB monthly positions, and the EASC position as reported to WG is a nil variance.

3. Assessment / Governance & Contracting

All budgets have been updated to reflect the 2019/20 approved IMTP. The IMTP sets the baseline for all the 2019/20 contract values.

3.1 EMS Contract

The current reported financial position of WAST is a break even at year end.

The WAST budget is currently reported as the total of the following service lines:

Welsh Ambulance Service NHS Trust Provider

Service	
	Annual Budget £'000
Emergency Services - Revenue	117,206
Emergency Services - Capital Charges	16,044
ARRP (18/19 value)	210
NHS Direct	10,881
Paramedic Banding Funding	5,258
Clinical Desk enhancements	1,465
ESMCP project	1,902
Neonatal Transport	215
APP (full year impact of 18/19 development)	1,163
18/19 & 19/20 Pay Award Through Commissioners	3,320
Total WAST	**157,663**

Renal NEPTS

Service	
	Annual Budget £'000
Renal NEPTS - Hub	459
Renal NEPTS - Increased Capacity	398
Renal NEPTS - Twilight (North East & South East)	287
Total Renal NEPTS	**1,144**

The funding for Renal Transport has been separated from WAST and will be reported separately. Air Ambulance (EMRTS) has been transferred from WAST and now sits within EASC – EMRTS and will be paid directly to Swansea Bay UHB.

3.2 EMRTS

There is a breakeven position reported against the EMRTS baseline funding of £3.893m.

3.3 Core running costs budget

Costs are reported against two separate lines to reflect the original investment by LHB's. Please note that these have not yet been amalgamated in risk-sharing lines due to the different purposes of the two sources of funding at this point.

The total funding for costs running through the WHSSC ledger is £1,345k. This is made up of £763k for the original QAIT element, £503k for EASC and £79k for EASC clinical leads and Committee Chair.

4. Summary of Key Movements and Issues

There are no movements to report in the planned position in month. The overall forecast remains at breakeven.

5. Actual Year To Date and Forecast Over/Underspend (Provider positions)

5.1 WAST:
- Position reported to budget level

5.2 Direct Running Costs (Staffing and non-pay):
- Team costs are based on expected staffing levels, including filling vacancies. The unscheduled care allocation is yet to be received.

6. Actual Year to Date Over/(under)spend 2019/20 (Commissioner positions)

Table 2 – Year to Date position by LHB

	Allocation of Variance							
	Total £'000	Cardiff and Vale £'000	SB £'000	Cwm Taf Morgannwg £'000	Aneurin Bevan £'000	Hywel Dda £'000	Powys £'000	Betsi Cadwaladr £'000
Variance M4	0	0	0	0	0	0	0	0
Variance M3	0	0	0	0	0	0	0	0
Movement	0	0	0	0	0	0	0	0

Table 3 – End of Year Forecast by LHB

	Allocation of Variance							
	Total £'000	Cardiff and Vale £'000	SB £'000	Cwm Taf Morgannwg £'000	Aneurin Bevan £'000	Hywel Dda £'000	Powys £'000	Betsi Cadwaladr £'000
EOY forecast M4	0	0	0	0	0	0	0	0
EOY forecast M3	0	0	0	0	0	0	0	0
EOY movement	0	0	0	0	0	0	0	0

7. Income / Expenditure Assumptions

7.1 Income from LHB's

Income for Month 4 was mostly in line with expectations for the EASC element; future months will include a table by LHB.

8. Overview of Key Risks / Opportunities

The key risks remain consistent with those identified in the annual plan process to date.

The additional risk and opportunities highlighted in this report are:
- APP Expansion Plan
- Continuity risks re 2018/19 winter management initiatives
- Pension Rate Increase – Employers Contributions
- Holiday Pay on Voluntary Return

9. Public Sector Payment Compliance

The WHSSC/EASC payment compliance target is consolidated and reported through the Cwm Taf monitoring process.

10. Confirmation of position report by the MD and DOF:

Stuart Davies,
Director of Finance, EASC and WHSSC

Stephen Harrhy,
Chief Ambulance Commissioner, EASC

	AGENDA ITEM 2.7
GIG CYMRU NHS WALES — Pwyllgor Gwasanaethau Ambiwlans Brys / Emergency Ambulance Services Committee	**10 September 2019**

Emergency Ambulance Services Committee Report
AMBULANCE QUALITY INDICATORS **01 April 2019 – 30 June 2019**

Executive Lead: Stephen Harrhy – Chief Ambulance Services Commissioner
Author: Ross Whitehead – Assistant Ambulance Services Commissioner
Contact Details for further information: ross.whitehead@wales.nhs.uk

Purpose of the Emergency Ambulance Services Committee Report
The purpose of the report is to provide the committee with the most recent Ambulance Quality Indicators published on Wednesday 31 July 2019.

Governance	
Link to the Commissioning Agreement	The Committee's overarching role is to ensure its Commissioning Strategy for Emergency Ambulance Services utilising the five step patient pathway outlined within the National Collaborative Commissioning Quality and Delivery Agreement and the related outcomes for each care standard aligned with the Institute of Healthcare Improvement's (IHI) 'Quadruple Aim' are being progressed. This report focuses on all the above objectives, but specifically on **providing** strong governance and assurance.
Supporting evidence	The Collaborative Commissioning Quality and Delivery Framework for Emergency Medical Services
Engagement – Who has been involved in this work?	
WAST; EASC; Health Boards	
Emergency Ambulance Services Committee Resolution to:	

APPROVE		**ENDORSE**		**DISCUSS**		**NOTE**	√
Recommendation		The Emergency Ambulance Services Committee is asked to: • **NOTE** the overview of the last quarter AQI's					

Summarise the Impact of the Emergency Ambulance Services Committee Report	
Equality and diversity	There are no implications arising directly from this report.
Legal implications	There are no implications arising directly from this report.
Population Health	The aim of the AQI's is to improve the population health
Quality, Safety & Patient Experience	The aim of the AQI's is to improve quality, safety and patient experience
Resources	All resource implications are contained within the Framework
Risks and Assurance	The aim of the AQIs is to increase assurance
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf The work reported in this summary and related annexes take into account many of the related quality themes in particular timely care.
Workforce	All workforce implications are contained within the Framework
Freedom of information status	Open

Ambulance Quality Indicators
1 April 2019 – 30 June 2019
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Emergency Ambulance Services
Committee Meeting
10 September 2019

AMBULANCE QUALITY INDICATORS
01 April 2019 – 30 June 2019

1. SITUATION / PURPOSE OF REPORT

The purpose of the report is to provide an overview of the most recent quarter data which was published on Wednesday 31 July 2019.

This report should be read in conjunction with the public release of the Ambulance Quality Indicators attached as **Appendix 1**. These Indicators are for the period: 01 April 2019 to 30 June 2019 and the narrative below describes performance across the 5 Step Ambulance Care Pathway

2. BACKGROUND / INTRODUCTION

Members of the Committee will be aware that the Ambulance Quality Indicators were developed to monitor and improve performance across the 5 Step Ambulance Care Pathway.

The Ambulance Care Pathway is designed to ensure that ambulances are dispatched to calls where there is an immediate need to save life or provide treatment which requires an ambulance. For other less serious cases, alternative treatments such as referrals to other parts of the NHS or telephone advice will be provided. The pathway is intended to ensure the ambulance service is providing the right response for a patient dependent on their clinical need.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

Step One – Help Me Choose

- The Welsh Ambulance Services NHS Trust (WAST) organised 71 community engagement meetings across Wales between 01 April 2019 and 30 June 2019.
- Community engagement events help WAST listen to the concerns and ideas of people in Wales and communicate information with people in Wales about self-care, choice and appropriate use of the Welsh Ambulance Service and the wider NHS.
- In the period 01 April 2019 and 30 June 2019 there were 954,451 visits to the NHS Direct Wales website.
- Measuring the number of visits to the NHS Direct Wales website helps identify periods of high demand and examine links to call volumes to both NHS Direct Wales and the Clinical Contact Centres.
- Dental problems are the top reason for the public to call NHS Direct Wales. There were 11,457 calls to NHS Direct Wales about dental problems between 01 April 2019 and 30 June 2019.

- Identifying the top 10 reasons for calling NHS Direct Wales helps identify the topics for advice that NHS Direct Wales needs to be able to provide. It also allows Local Health Boards to develop services where there is an unmet need.
- Frequent callers are defined as people who call WAST via the 999 system five times or more in a month. 7,022 incidents were generated by frequent callers in the period 01 April 2019 and 30 June 2019.
- Identifying frequent callers helps WAST manage the needs of this group of callers, many of whom are vulnerable adults who have an unmet need. Simply sending ambulances to these patients does not necessarily mean they get the help they need. Frequent caller patient needs are managed via multi-disciplinary teams including primary, secondary care and clinical managers in the Local Health Boards and WAST. This may involve WAST referring a patient to a GP service or a specialist team such as a mental health service.

Step Two – Answer My Call

- There were 19,896 calls for an urgent (1-4 hour) admission from health care professionals between 01 April 2019 and 30 June 2019.
- A health care professional is defined as: a Doctor usually a General Practitioner, Paramedic, Nurse, Midwife, Dentist or Approved Social Worker. Measuring the number of calls from healthcare professionals helps WAST plan and develop strategies to manage the needs of these patients.
- 122,457 - 999 calls were answered between 01 April 2019 and 30 June 2019.
- 118,151 calls were taken through the medical priority dispatch system, a system that WAST uses to assess the severity of 999 calls.
- 13,506 of these calls were regarding falls and 12,956 were regarding chest pains between 01 April 2019 and 30 June 2019.
- 10,026 calls were ended following WAST telephone assessment; 'Hear and Treat'.
- 'Hear and Treat' is the telephone clinical advice that callers who do not have serious or life threatening conditions receive from WAST. This may mean an ambulance response will not necessarily be sent immediately. Instead, patients may be given more appropriate healthcare advice based on what they tell the clinician over the phone. They may receive advice on how to care for themselves or where they might go to receive appropriate assistance, for example a GP or a Pharmacy. They may also be advised to make their own way to hospital where this is safe or be provided with alternative transport rather than an ambulance.
- Re-contact rates measure the number of patients who dial 999 after receiving telephone advice ('hear and treat') services or after being treated at the scene ('see and treat'); this may be for an unexpected or new problem within the following 24 hours. To ensure WAST is providing safe and effective care, first time, this indicator measures how many patients call WAST back within 24 hours of the initial call being made.

- Of the 10,026 calls ended following 'hear and treat' there were 722 re-contacts within 24 hours between 01 April 2019 and 30 June 2019.
- Of the 8,666 treated at scene ('see and treat') there were 65 re-contacts within 24 hours.

Step Three – Come to See Me

- There were 6,277 RED calls between 01 April 2019 and 30 June 2019.
- The Wales national target for a response arriving to RED calls in 8 minutes is 65%. At an all Wales level this target was met for each month this quarter. The target for each Health Board area is 60% and this was also met across each month this quarter, with the exception of April when Powys' performance was 58.9% and May when Hywel Dda's performance was 59.9% and Powys' performance was 59.8%.
- RED calls are immediately life threatening so it is important to measure not just how WAST performs against the Wales national target, but the distribution of performance.
- The median RED response time in June 2019 was 5 minutes and 23 seconds. 65% of Red calls were responded to within 6 minutes and 55 seconds and 95% of calls were responded to within 16 minutes and 4 seconds.
- There were 66,741 AMBER calls between 01 April 2019 and 30 June 2019.
- AMBER calls are serious, but not immediately life threatening. AMBER calls are measured by the standard of care provided by WAST.
- There were 6,649 GREEN calls between 01 April 2019 and 30 June 2019.
- GREEN calls are 999 calls received that are considered neither serious or life threatening.
- It is important to make the best use of available ambulance resources and to measure the number of resources that are allocated to an incident. There are occasions when it is appropriate for more than one ambulance to be allocated, for example, a multiple response to a very serious call where there is an immediate threat to life (categorised as RED) or multi-casualty incidents such as road traffic collisions.
- In June 2019 for incidents that would normally only require one resource; one resource was allocated to 82.9% of incidents, two resources to 15.5% of incidents, 3 resources to 1.3% of incidents and 4 resources to 0.3% of incidents.
- Community First Responders are volunteers trained by WAST who are sent to certain incidents to provide immediate care before the arrival of an ambulance. These volunteers are vital to saving lives across Wales.
- Community First Responders attended 4,558 incidents between 01 April 2019 and 30 June 2019. They were first on scene in 3,955 of these incidents (86.8%).

Step Four – Give Me Treatment

- Treatment given by ambulance clinicians before a patient reaches hospital is a major factor in their chances of survival and recovery. Ambulance clinicians use packages of care, assessment and treatment known as care bundles for certain conditions.

Care bundles are a series of assessments, treatments and actions that are clinically recognised to improve a patient's outcome and experience. This information is gained from clinical patient records completed by staff using their digital pens. In this release we have highlighted the performance against seven key clinical indicators for Cardiac Arrests, Strokes, Heart Attacks (called STEMI), fractured hips (known as neck of femur injuries), febrile convulsion, sepsis and hypoglycaemia.

- Cardiac arrest (no pulse and not breathing): this indicator measures how many patients who are in cardiac arrest, but are successfully resuscitated at the scene by WAST and have a pulse/ heartbeat on arrival at hospital. It is recognised that providing resuscitation as early as possible to those in cardiac arrest is key to improving the chances of recovery.
- Stroke: a stroke happens when the supply of blood to the brain is suddenly interrupted. This indicator measures the number and percentage of suspected stroke patients assessed face to face who received all of the elements of the stroke care bundle. The measures include a F.A.S.T (Face Arm Speech Test) assessment, the recording of blood glucose and blood pressure readings.
- Fractured hips (known as neck of femur injuries): fractured hips cause significant pain which can be exacerbated by movement. Pain control for patients with a fractured neck of femur in the immediate post-trauma period is paramount to promoting recovery and patient experience. This reduces suffering and the detrimental effects uncontrolled pain may have. This indicator measures the recording of initial and subsequent verbal pain scores and administration of appropriate pain medicines before arrival at hospital.
- STEMI: STEMI is a type of heart attack caused by a blood clot in the heart which is diagnosed by an electrocardiogram taken by the ambulance crew. The care bundle includes taking verbal pain scores from the patient, administering aspirin to reduce blood clotting, Glyceryl Trinitrate to relax and widen blood vessels and the provision of pain relief.
- Sepsis: Sepsis, also referred to as blood poisoning or septicaemia, is a potentially life-threatening condition, triggered by an infection. This indicator records patients with a suspected diagnosis of sepsis or septic shock who have been reviewed using a screening tool (NEWS) and have a documented score. This promotes early recognition of suspected sepsis and enhances handover in hospital.
- Febrile convulsion: is a seizure that can happen when a child has a fever. This indicator measures patients under 5 with suspected febrile convulsion who are documented as receiving the appropriate care bundle comprising of the measurement of heart rate, respiratory rate, oxygen saturation, temperature and blood glucose.
- Hypoglycaemia: is an abnormally low level of glucose (sugar) in the blood. This indicator measures patients who are documented as receiving the appropriate care bundle, which comprises of blood glucose measurement before treatment, treatment and blood glucose measurement after treatment.
- Between 01 April 2019 and 30 June 2019 15,083 incidents did not result in a conveyance to a hospital or another destination.

The reasons for non-conveyance is that 8,666 of these incidents were treated at scene and 6,417 were referred to an alternative provider.

- WAST has different types of ambulance resource that can be dispatched to incidents. It is important for patient care and the most effective use of resource that the ideal resource is dispatched and arrives on scene first. Between 01 April 2019 and 30 June 2019 the ideal resource arrived on scene first for Amber incidents 68.3% of the time.
- There is no ideal resource for Red incidents, which are immediately life threatening and time critical. For these incidents the nearest available resource will be dispatched with further resources dispatched as back up.

Step Five – Take Me to Hospital

- 45,979 patients who called 999 were conveyed to a hospital or another destination between 01 April 2019 and 30 June 2019.
- NHS Wales guidance is that the handover of care of patients from an ambulance crew to hospital staff should be within 15 minutes. Across Wales, between 01 April 2019 and 30 June 2019 this occurred in 49.4% of cases.
- Once an ambulance crew has handed over the care of a patient to a hospital or other destination NHS Wales guidance is that ambulances clear and be ready for the next call within 15 minutes or less.
- Between 01 April 2019 and 30 June 2019, 77.7% of ambulances cleared within 15 minutes or less.
- The handover to clear is an important efficiency measure. Between 01 April 2019 and 30 June 2019, 2,652 hours were lost to delayed handovers to clear.

4. RECOMMENDATION

Members of the Emergency Ambulance Services Committee are asked to:

- **NOTE** the contents of the report.

Freedom of information status	Open

Welsh Ambulance Services NHS Trust
National Collaborative Commissioning: Quality and Delivery Framework
Ambulance Quality Indicators: April 2019 - June 2019

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The information contained in this document is not restricted and is classified for general release

Produced by the Welsh Ambulance Services NHS Trust Health Informatics Department commissioned by the Emergency Ambulance Services Committee in accordance with the National Collaborative Commissioning: Quality and Delivery Framework

EASC Ambulance Quality Indicator Definition Table

No.	AQI Ref.	AQI Description	AQI Detailed Description
1	AQI1	Number of Welsh Ambulance Services NHS Trust community engagement events	How often are the Welsh Ambulance Services NHS Trust engaging with the communities it serves and spreading health messages about self-care, choice and appropriate use of ambulance/health services?
3	AQI3	Number of attendances at key stakeholder events	How often is the Welsh Ambulance Services NHS Trust meeting with stakeholders to discuss, agree and design services to meet clinical and service user expectation needs?
4	AQI4i	Number of NHS Direct Wales unique website visits	How often is the NHS Direct Wales website being used? This allows us to examine links between website use and 999 and 0845 call volumes. It also allows for the identification of high demand periods.
5	AQI4ii	NHS Direct Wales number of calls by reason (top 10)	What are people calling NHS Direct Wales about? How does this demand compare to website visits? What are the gaps in service that NHS Direct Wales are identifying?
6	AQI5	Number and Percentage of frequent callers	How many frequent callers are there and how often are they calling? What is the number of calls from frequent callers in the overall call volume?
8	AQI6	Number of Healthcare Professional Calls Answered	How many Healthcare professional calls for assistance does the Welsh Ambulance Services NHS Trust receive?
9	AQI7i	Number of 999 Calls Answered	How many 999 calls do the Welsh Ambulance Services NHS Trust receive?
10	AQI7ii	Median, 65th and 95th percentile of Time Taken To Answer 999 Calls	This AQI looks at how quickly 999 calls received by the Welsh Ambulance Services NHS Trust are answered.
11	AQI8	Number of 999 calls taken through the Medical Priority Dispatch System (MPDS)	How many 999 calls are assessed using the MPDS system? MPDS is the system that WAST call takers use to assess the severity of 999 calls.
12	AQI9i	Number of calls ended following WAST telephone assessment (Hear & Treat)	Number of NHSDW & Clinical Desk telephone assessments that were resolved with an ambulance not required as the outcome (Hear & Treat).
13	AQI9ii	Number and Percentage of calls transferred to NHS Direct Wales	How many 999 calls are, after assessment, being transferred to NHS Direct Wales?
14	AQI9iii	Number of calls returned from NHS Direct Wales	How often does NHS Direct Wales then return a call to the Welsh Ambulance Services NHS Trust?
15	AQI9iv	Number of calls ended through transfer to alternative care advice	How often does NHS Direct Wales and the Welsh Ambulance Services NHS Trust pass a call to another part of the NHS rather than sending an ambulance?
16	AQI10i	Number and Percentage of incidents received within 24 hours following WAST telephone assessment (Hear and Treat)	Unplanned re-contact with the Welsh Ambulance Services NHS Trust within 24 hours of discharge of care (by clinical telephone advice).
17	AQI10ii	Number and Percentage of incidents within 24 hours following an attendance at scene that were not transported to hospital (See and Treat)	Unplanned re-contact with the Welsh Ambulance Services NHS Truste within 24 hours of discharge of care (following treatment at the scene).
18	AQI11	Number of RED coded calls including median, 65th and 95th percentile	How many 999 calls received are coded as a RED verified incident resulting in an emergency response within 8 minutes.

19	AQI12	Number of AMBER coded calls including median, 65th and 95th percentile	How many 999 calls received are coded as an AMBER verified incident resulting in an emergency response?
20	AQI13	Number of GREEN coded calls including median, 65th and 95th percentile	How many 999 calls received are coded as a GREEN verified incident resulting in a response?
21	AQI14	Number of responded Incidents where at least 1 resource arrived at scene	How effective is the Welsh Ambulance Services NHS Trust at sending the right resource first time to an incident.
22	AQI15	Number of Community First Responders attendances at scene, including by call category and percentage	How often is a Community First Responder sent to a 999 call?
23	AQI16i	Number and percentage of patients with attempted resuscitation following cardiac arrest, documented as having a return of spontaneous circulation (ROSC) at hospital door	Outcome from out-of-hospital cardiac arrest with attempted resuscitation, measured by documented return of spontaneous circulation (ROSC) at time of arrival of the patient to hospital. Recording of ROSC at hospital is the international Utstein standard and indicates the outcome of the pre-hospital response and intervention.
24	AQI16ii	Number and percentage of suspected stroke patients who are documented as receiving appropriate stroke care bundle	Patients with suspected stroke (including unresolved transient ischaemic attack) who are documented as receiving the appropriate care bundle. The stroke care bundle comprises measurement of blood pressure, consciousness level, blood glucose and FAST test.
25	AQI16iii	Number and percentage of older patients with suspected hip fracture who are documented as receiving analgesia and appropriate care bundle	Fractured hips (known as neck of femur injuries): fractured hips cause significant pain which can be exacerbated by movement. Pain control for patients with a fractured neck of femur in the immediate post-trauma period is paramount to promoting recovery and patient experience. This reduces suffering and the detrimental effects uncontrolled pain may have. The care bundle measures the recording of initial and subsequent verbal pain scores and administration of appropriate pain medicines before arrival at hospital, also included is the total number of patients with a suspected fractured hip who received analgesia.
26	AQI16iv	Number and percentage of ST segment elevation myocardial infarction (STEMI) patients who are documented as receiving appropriate STEMI care bundle	Patients with STEMI diagnosis (ST-elevation myocardial infarction) who are documented as receiving the appropriate care bundle. The STEMI care bundle comprises of four elements including pain assessment and administration of three medicines including analgesia.
27	AQI16v	Number and percentage of suspected sepsis patients who have had a documented NEWS score	Patients with a suspected diagnosis of sepsis or septic shock who have a documented NEWS score. This promotes early recognition of suspected sepsis and enhances handover in hospital.
28	AQI16vi	Number and percentage of patients with a suspected febrile convulsion aged 5 years and under who are documented as receiving the appropriate care bundle	Patients aged 5 years and under with suspected febrile convulsion who are documented as receiving the appropriate care bundle. The febrile convulsion care bundle comprises measurement of heart rate, respiratory rate, oxygen saturation, temperature and blood glucose.
29	AQI16vii	Number and percentage of hypoglycaemic patients who are documented as receiving the appropriate care bundle	Patients with low blood sugar (hypoglycaemia) who are documented as receiving the appropriate care bundle, which comprises blood glucose measurement before treatment, treatment and blood glucose measurement after treatment.
30	AQI17	Number of incidents that resulted in a non conveyance to hospital	How effective are the Welsh Ambulance Services NHS Trust in closing incidents at scene?
31	AQI18	Number and percentage of incidents where a resource was the ideal response as per the clinical response model	How often are Welsh Ambulance Services NHS Trust sending the ideal resource to scene?
32	AQI19i	Percentage of patients conveyed to hospital following a face to face assessment	What percentage of patients from 999 calls are conveyed to hospital.
33	AQI19ii	Number of patients conveyed to hospital by type	Where do Welsh Ambulance Services NHS Trust convey patients? What are opportunities to convey elsewhere?

34	AQI20i	Number and percentage of notification to handover within 15 minutes of arrival at hospital	This AQI measures handover performance at hospital.
35	AQI20ii	Number and percentage of notification to handover within 15 minutes of arrival at hospital by hospital type.	This AQI looks at handover performance by site. This allows good practice to be identified and spread.
36	AQI21	Number of lost hours following notification to handover over 15 minutes	This AQI measures the amount of lost hours following notification to handover over 15 minutes.
37	AQI22i	Number and percentage of handover to clear within 15 minutes of transfer of patient care to hospital staff	This AQI measures the number of times where a WAST crew are available again within 15 minutes of handing over their patient.
38	AQI22ii	Number and percentage of handover to clear within 15 minutes of transfer of patient care to hospital staff by hospital type	This AQI looks at handover to clear performance by site. This allows good practice to be identified and spread.
39	AQI23	Conveyance to other LHB locations	This AQI records the number of occasions where a patient is taken to a destination in a different Health Board area than the location of the call.
40	AQI24	Number of lost hours following handover to clear over 15 minutes	This AQI shows the amount of time lost where ambulance crews are not available within 15 minutes of handing over their patient.

Clinical Response Model

Call Type	EASC Definition	Example	Quality Indicator
RED	Immediately life threatening calls such as cardiac arrest or choking. These calls will be subject to both clinical indicators such as Return of Spontaneous Circulation (ROSC) rates and a time based standard requiring a minimum attendance at 65% of these calls within 8 minutes.	Respiratory / cardiac arrest	8 minute response time within 65%. National target
AMBER	Serious but not immediately life threatening. These calls will include most medical and trauma cases such as chest pain and fractures. Amber calls will receive an emergency response. A response profile has been created to ensure that the most suitable clinical resource is dispatched to each amber call. This will include management via "hear & treat" services over the telephone. Patient experience and clinical indicator data will be used to evaluate the effectiveness of the ambulance response to amber calls.	Cardiac chest pains / stroke	Compliance with care bundles for cardiac stroke and fractured neck of femur patients.
GREEN	999 calls received and categorised as green are neither serious or life threatening. Conditions such as ear ache or minor injuries are coded as green calls. Green calls are ideally suited to management via secondary telephone triage. Health Care Professionals (HCP) such as doctors, midwives or community hospitals often require an urgent transfer of a patient from low acuity care to a higher acuity facility. These transfers are coded as green calls and undertaken within a timeframe agreed with the requesting HCP.	Fainting - recovered and alert	Clinical outcomes and patient satisfaction for 999. Compliance with healthcare professional agreed admission timescales for HCP calls.

Step 1 Help Me Choose LHB Review: April 2019 - June 2019

Step 1: Help Me Choose

AQI Ref	AQI Description	Apr-19								May-19								Jun-19								All Wales Total
		All Wales	AB	BCU	C&V	CTM	HD	P	SB	All Wales	AB	BCU	C&V	CTM	HD	P	SB	All Wales	AB	BCU	C&V	CTM	HD	P	SB	
AQI1	Number of Welsh Ambulance Services NHS Trust (WAST) community engagement events	11	2	1	1	3	1	-	3	29	9	1	9	4	1	1	4	31	6	-	4	7	2	2	10	71
AQI3	Number of attendances at key stakeholder events	39								41								18								98
AQI4 i	Number of NHS Direct Wales unique website visits	296,222	-	-	-	-	-	-	-	293,461	-	-	-	-	-	-	-	364,768	-	-	-	-	-	-	-	954,451
AQI4 ii	NHS Direct Wales number of calls by reason (top 10)																									
	Dental Problems	3,806	64	1,271	24	328	841	261	1,017	3,924	63	1,274	21	360	923	313	970	3,727	59	1,231	21	315	847	309	945	11,457
	Abdominal Pain	1,227	183	164	162	169	219	90	240	1,340	168	212	151	186	228	105	290	1,243	183	181	148	169	205	74	283	3,810
	Other Symptoms	633	109	98	75	89	119	40	103	700	119	125	97	80	119	43	117	620	95	93	68	96	136	36	96	1,953
	Chest Pain	689	89	73	85	93	124	46	179	607	60	89	69	80	119	37	153	567	60	62	58	70	122	38	157	1,863
	Fever	691	98	83	71	96	161	47	135	570	100	76	65	87	109	27	106	540	82	78	59	75	100	35	111	1,801
	Rash	641	92	59	71	92	126	37	164	557	90	56	54	89	94	39	135	585	71	59	75	105	114	36	125	1,783
	Sore Throat	554	43	35	32	99	131	38	176	466	36	22	30	63	122	38	155	438	27	27	32	69	108	24	151	1,458
	Back Pain	462	67	70	55	52	93	33	92	459	64	59	49	70	89	37	91	476	63	72	51	67	94	29	100	1,397
	Vomiting	376	58	49	34	68	84	26	57	394	59	55	41	46	89	25	79	322	53	41	42	45	44	25	72	1,092
	Cough	461	43	29	24	81	126	32	126	306	25	19	20	45	72	23	102	259	29	26	22	35	58	14	75	1,026
AQI5	Number of Frequent Callers	275	34	93	30	29	38	11	40	273	36	97	36	29	33	5	37	267	47	74	31	33	33	6	43	815
	Number of Incidents generated by Frequent Callers	2,278	264	754	250	216	372	79	343	2,257	295	804	265	232	343	44	274	2,487	377	691	290	361	310	68	390	7,022
	Total Number of Incidents	39,876	6,969	10,297	5,274	5,676	5,041	1,761	4,858	39,785	7,085	10,593	5,480	5,314	4,886	1,747	4,680	38,490	6,797	10,185	5,256	5,116	4,692	1,762	4,682	118,151
	Percentage of Frequent Callers Incidents against overall number of Incidents	5.7%	3.8%	7.3%	4.7%	3.8%	7.4%	4.5%	7.1%	5.7%	4.2%	7.6%	4.8%	4.4%	7.0%	2.5%	5.9%	6.5%	5.5%	6.8%	5.5%	7.1%	6.6%	3.9%	8.3%	5.9%

Step 2 Answer My Call LHB Review: April 2019 - June 2019

Step 2: Answer My Call

AQI Ref	AQI Description	Apr-19 All Wales	AB	BCU	C&V	CTM	HD	P	SB	May-19 All Wales	AB	BCU	C&V	CTM	HD	P	SB	Jun-19 All Wales	AB	BCU	C&V	CTM	HD	P	SB	All Wales Total
AQI6	Number of Healthcare Professional (HCP) Calls answered	6,701	-	-	-	-	-	-	-	6,915	-	-	-	-	-	-	-	6,280	-	-	-	-	-	-	-	19,896
AQI7i	Number of 999 calls answered	41,531	-	-	-	-	-	-	-	40,793	-	-	-	-	-	-	-	40,133	-	-	-	-	-	-	-	122,457
AQI7ii	999 Calls: Time to Answer - Median Response (mm:ss)	00:02	-	-	-	-	-	-	-	00:02	-	-	-	-	-	-	-	00:02	-	-	-	-	-	-	-	
	999 Calls: Time to Answer - 65th Percentile (mm:ss)	00:03	-	-	-	-	-	-	-	00:03	-	-	-	-	-	-	-	00:03	-	-	-	-	-	-	-	
	999 Calls: Time to Answer - 95th Percentile (mm:ss)	01:03	-	-	-	-	-	-	-	00:56	-	-	-	-	-	-	-	01:06	-	-	-	-	-	-	-	
AQI8	Number of 999 calls taken through the Medical Priority Dispatch System (MPDS)	39,876	6,969	10,297	5,274	5,676	5,041	1,761	4,858	39,785	7,085	10,593	5,480	5,314	4,886	1,747	4,680	38,490	6,797	10,185	5,256	5,116	4,692	1,762	4,682	118,151
	Protocol 17: FALLS	4,544	808	1,294	576	590	579	201	496	4,522	756	1,401	564	591	571	178	461	4,437	756	1,335	557	560	556	191	482	13,503
	Protocol 10: CHEST PAIN	4,435	794	1,065	543	643	613	207	570	4,311	786	1,090	545	590	554	208	538	4,210	736	1,055	512	585	574	229	519	12,956
	Protocol 35: HEALTH CARE PROFESSIONAL	4,113	706	1,059	509	535	634	269	401	4,201	838	996	560	539	576	257	435	3,944	714	1,032	534	498	549	237	380	12,258
	Protocol 06: BREATHING PROBLEMS	4,319	789	1,078	555	676	533	172	516	3,904	689	997	509	561	499	156	493	3,691	736	950	465	490	420	160	470	11,914
	Protocol 26: SICK PERSON - SPECIFIC DIAGNOSIS	2,998	475	853	389	429	380	137	335	3,001	506	894	368	392	395	124	322	2,828	460	837	349	394	352	102	334	8,827
	Protocol 31: UNCONSCIOUS/FAINTING(NEAR)	2,419	422	618	369	339	313	78	280	2,371	427	612	361	325	296	104	246	2,390	419	582	392	306	302	96	293	7,180
	Protocol 21: HAEMORRHAGE/LACERATIONS	1,505	278	408	188	211	193	85	142	1,516	289	425	214	187	186	56	159	1,423	289	416	175	187	154	57	145	4,444
	Protocol 28: STROKE - CVA	1,438	226	381	163	209	203	75	181	1,347	245	341	161	164	179	88	169	1,305	206	367	157	151	162	76	186	4,090
	Protocol UGA2: UPGRADE TO AMBER 2	1,245	244	296	143	171	174	43	174	1,463	272	386	176	178	215	58	178	1,308	249	339	130	151	180	64	195	4,016
	Protocol 12: CONVULSIONS/FITTING	1,303	210	319	199	217	153	36	169	1,327	226	342	215	196	152	46	150	1,272	211	305	212	168	166	50	160	3,902
AQI9 i	Number of calls ended following WAST telephone assessment (Hear and Treat)	3,412	670	648	565	560	311	98	560	3,280	650	661	622	456	291	86	514	3,334	694	602	568	485	314	106	565	10,026
	Number of NHSDW telephone assessments that were resolved with an 'ambulance not required' outcome	1,393	223	386	215	190	168	65	146	1,430	244	405	243	174	176	43	145	1,423	266	359	201	199	181	70	147	4,246
	Number of Clinical Desk telephone assessments that were resolved with an 'ambulance not required' outcome	2,019	447	262	350	370	143	33	414	1,850	406	256	379	282	115	43	369	1,911	428	243	367	286	133	36	418	5,780
	Percentage of calls ended following WAST telephone assessment	8.6%	9.6%	6.3%	10.7%	9.9%	6.2%	5.6%	11.5%	8.2%	9.2%	6.2%	11.4%	8.6%	6.0%	4.9%	11.0%	8.7%	10.2%	5.9%	10.8%	9.5%	6.7%	6.0%	12.1%	8.5%
AQI9 ii	Number of calls transferred to NHS Direct Wales	2,660	446	732	386	372	318	104	302	2,670	448	776	404	330	332	111	269	2,681	481	720	374	376	321	118	291	8,011
	Number of 999 calls taken through the Medical Priority Dispatch System (MPDS)	39,876	6,969	10,297	5,274	5,676	5,041	1,761	4,858	39,785	7,085	10,593	5,480	5,314	4,886	1,747	4,680	38,490	6,797	10,185	5,256	5,116	4,692	1,762	4,682	118,151
	Percentage of calls transferred to NHS Direct Wales	6.7%	6.4%	7.1%	7.3%	6.6%	6.3%	5.9%	6.2%	6.7%	6.3%	7.3%	7.4%	6.2%	6.8%	6.4%	5.7%	7.0%	7.1%	7.1%	7.1%	7.3%	6.8%	6.7%	6.2%	6.8%
AQI9 iii	Number of calls returned from NHS Direct Wales with an outcome of 'ambulance required'	959	175	257	115	141	129	34	108	959	168	289	120	123	117	50	92	948	168	291	131	114	112	34	98	2,866
	Total Number of Calls Triaged by a Nurse Advisor	2,352	398	643	330	331	297	99	254	2,389	412	694	363	297	293	93	237	2,371	434	650	332	313	293	104	245	7,112
	Percentage of calls returned from NHS Direct Wales	40.8%	44.0%	40.0%	34.8%	42.6%	43.4%	34.3%	42.5%	40.1%	40.8%	41.6%	33.1%	41.4%	39.9%	53.8%	38.8%	40.0%	38.7%	44.8%	39.5%	36.4%	38.2%	32.7%	40.0%	40.3%
AQI9 iv	Number of calls ended through transfer to alternative care advice services	1,393	223	386	215	190	168	65	146	1,430	244	405	243	174	176	43	145	1,423	266	359	201	199	181	70	147	4,246
	Total Number of Calls Triaged by a Nurse Advisor	2,352	398	643	330	331	297	99	254	2,389	412	694	363	297	293	93	237	2,371	434	650	332	313	293	104	245	7,112
	Percentage of calls ended through transfer to alternative care advice services	59.2%	56.0%	60.0%	65.2%	57.4%	56.6%	65.7%	57.5%	59.9%	59.2%	58.4%	66.9%	58.6%	60.1%	46.2%	61.2%	60.0%	61.3%	55.2%	60.5%	63.6%	61.8%	67.3%	60.0%	59.7%
AQI10 i	Re-Contact rates - Telephone																									
	Number of incidents received within 24 hours following WAST telephone assessment (Hear and Treat)	211	38	42	17	54	17	8	35	212	36	41	23	27	17	2	66	299	52	61	14	56	30	13	73	722
	Number of calls ended following WAST telephone assessment (Hear and Treat)	3,412	670	648	565	560	311	98	560	3,280	650	661	622	456	291	86	514	3,334	694	602	568	485	314	106	565	10,026
	Re-contact percentage within 24hrs of telephone triage (Hear and Treat)	6.2%	5.7%	6.5%	3.0%	9.6%	5.5%	8.2%	6.3%	6.5%	5.5%	6.2%	3.7%	5.9%	5.8%	2.3%	12.8%	9.0%	7.5%	10.1%	2.5%	11.5%	9.6%	12.3%	12.9%	7.2%
AQI10 ii	Re-Contact rates - Attendance at Scene																									
	Number of incidents within 24 hours following See and Treat	18	6	9	-	-	2	-	1	21	-	14	2	1	4	-	-	26	7	6	2	3	6	1	1	65
	Number of Attendances at Scene that were not transported to hospital (See and Treat)	2,854	485	987	317	279	366	165	255	3,007	488	1,091	305	266	397	144	316	2,805	520	938	333	258	338	158	260	8,666
	Re-contact percentage within 24hrs of See and Treat	0.6%	1.2%	0.9%	0.0%	0.0%	0.5%	0.0%	0.4%	0.7%	0.0%	1.3%	0.7%	0.4%	1.0%	0.0%	0.0%	0.9%	1.3%	0.6%	0.6%	1.2%	1.8%	0.6%	0.4%	0.8%

Step 3 Come to See Me LHB Review: April 2019 - June 2019

Step 3: Come to See Me

AQI Ref	AQI Description	Apr-19								May-19								Jun-19								All Wales Total
		All Wales	AB	BCU	C&V	CTM	HD	P	SB	All Wales	AB	BCU	C&V	CTM	HD	P	SB	All Wales	AB	BCU	C&V	CTM	HD	P	SB	
AQI11	Number of RED category incidents resulting in an emergency response	1,967	372	404	285	281	237	73	315	2,172	398	456	322	323	274	82	317	2,138	409	423	343	300	242	95	326	6,277
	Number of RED category incidents with first response arriving on scene within 8 minutes	1,382	265	283	223	199	161	43	208	1,525	284	320	247	228	164	49	233	1,549	298	292	271	210	164	71	243	4,456
	Percentage of RED category incidents with first response arriving on scene within 8 minutes, 65% of the time	70.3%	71.2%	70.0%	78.2%	70.8%	67.9%	58.9%	66.0%	70.2%	71.4%	70.2%	76.7%	70.6%	59.9%	59.8%	73.5%	72.5%	72.9%	69.0%	79.0%	70.0%	67.8%	74.7%	74.5%	71.0%
	RED Category - Median Response	00:05:30	00:05:38	00:05:33	00:04:56	00:05:35	00:05:19	00:04:29	00:06:02	00:05:26	00:05:06	00:05:32	00:05:08	00:05:20	00:06:03	00:06:20	00:05:50	00:05:23	00:05:40	00:05:34	00:05:25	00:05:24	00:04:44	00:03:26	00:05:36	
	RED Category - 65th Percentile	00:07:12	00:07:09	00:07:04	00:06:35	00:07:16	00:07:23	00:08:48	00:07:54	00:07:16	00:06:53	00:07:04	00:06:28	00:07:23	00:08:52	00:10:08	00:07:16	00:06:55	00:06:54	00:07:17	00:06:33	00:07:18	00:07:15	00:05:36	00:06:46	
	RED Category - 95th Percentile	00:16:32	00:14:48	00:16:50	00:13:06	00:14:47	00:17:21	00:20:17	00:16:57	00:16:03	00:15:28	00:17:05	00:12:23	00:14:47	00:19:31	00:21:23	00:14:27	00:16:04	00:15:00	00:19:09	00:13:31	00:15:52	00:18:52	00:20:03	00:13:15	
AQI12	Number of AMBER category incidents resulting in an emergency response	22,551	4,021	6,041	2,884	3,182	3,005	1,060	2,358	22,688	4,034	6,267	2,853	3,031	2,940	1,066	2,497	21,502	3,805	5,855	2,782	2,833	2,795	1,063	2,369	66,741
	AMBER Category - Median Response	00:27:53	00:30:50	00:22:25	00:27:35	00:32:00	00:24:27	00:21:09	01:03:24	00:26:42	00:29:30	00:21:57	00:32:35	00:27:52	00:24:27	00:21:35	00:42:12	00:26:53	00:29:41	00:22:48	00:30:41	00:25:40	00:23:59	00:22:04	00:47:12	
	AMBER Category - 65th Percentile	00:42:45	00:47:32	00:32:19	00:45:18	00:48:23	00:36:15	00:29:31	01:40:55	00:40:32	00:48:38	00:31:29	00:49:20	00:41:50	00:34:27	00:31:03	01:08:59	00:41:04	00:47:13	00:32:41	00:49:27	00:38:46	00:35:21	00:32:00	01:19:59	
	AMBER Category - 95th Percentile	03:06:52	03:22:49	01:54:47	02:59:08	03:21:46	02:24:32	01:32:16	05:14:26	02:41:39	03:12:26	01:49:58	03:08:48	02:35:24	01:55:27	01:37:22	04:21:19	02:51:56	03:17:40	02:06:50	03:17:46	02:34:39	02:05:54	01:28:36	04:23:15	
AQI13	Number of GREEN category incidents resulting in a response	2,237	361	684	215	268	339	146	224	2,243	311	698	215	293	326	138	262	2,169	330	653	181	314	329	120	242	6,649
	GREEN Category - Median Response	00:45:49	01:04:43	00:40:10	00:48:01	00:42:00	00:45:38	00:37:34	00:51:18	00:44:44	00:46:38	00:39:39	00:47:50	00:48:15	00:44:08	00:42:19	00:50:46	00:44:17	00:57:58	00:37:51	00:46:14	00:44:56	00:45:43	00:37:08	00:44:10	
	GREEN Category - 65th Percentile	01:11:24	01:34:16	01:01:29	01:14:27	01:12:18	01:05:38	01:00:53	01:23:21	01:06:06	01:13:17	00:55:34	01:10:16	01:11:50	01:09:27	00:55:05	01:17:28	01:04:36	01:23:45	00:53:38	01:18:49	01:05:29	01:08:07	00:50:54	01:11:52	
	GREEN Category - 95th Percentile	04:39:20	05:58:35	03:12:23	04:37:58	04:48:53	04:07:37	03:29:58	07:37:32	05:00:18	07:17:48	03:09:23	05:44:49	05:00:45	05:08:58	02:23:22	06:47:06	04:30:06	05:49:57	03:50:33	05:14:48	04:35:14	03:41:56	02:39:37	07:05:10	
AQI14	Number of responded Incidents where at least 1 resource arrived at scene (excluding incidents where multiple dispatches are appropriate)	21,757	3,818	5,820	2,823	3,041	2,911	1,011	2,333	22,321	3,887	6,047	2,928	3,068	2,901	1,002	2,488	20,999	3,726	5,640	2,782	2,889	2,706	934	2,322	65,077
	Percentage of Incidents where 1 Vehicle Arrived at Scene	82.5%	76.3%	86.3%	82.3%	79.7%	87.7%	86.0%	78.6%	83.0%	76.9%	86.6%	80.8%	80.1%	90.6%	87.5%	79.1%	82.9%	76.5%	87.7%	80.7%	81.0%	88.7%	86.8%	78.0%	82.8%
	Percentage of Incidents where 2 Vehicles Arrived at Scene	16.0%	21.5%	12.8%	16.2%	18.3%	11.3%	12.8%	19.3%	15.5%	20.6%	12.6%	17.5%	17.6%	8.9%	12.0%	18.6%	15.5%	21.4%	11.1%	17.6%	16.8%	10.8%	12.2%	19.4%	15.7%
	Percentage of Incidents where 3 Vehicles Arrived at Scene	1.2%	1.8%	0.8%	1.3%	1.4%	0.7%	1.1%	1.5%	1.3%	2.3%	0.8%	1.4%	1.8%	0.4%	0.4%	1.8%	1.3%	1.8%	0.9%	1.3%	1.9%	0.4%	1.0%	2.1%	1.3%
	Percentage of Incidents where 4 or More Vehicles Arrived at Scene	0.3%	0.4%	0.1%	0.2%	0.6%	0.2%	0.2%	0.6%	0.2%	0.2%	0.1%	0.3%	0.4%	0.2%	0.1%	0.5%	0.3%	0.3%	0.2%	0.4%	0.3%	0.1%	0.0%	0.5%	0.3%
AQI15	Number of Community First Responders (CFRs) attendances at scene	1,521	354	441	193	137	207	86	103	1,453	344	416	152	117	215	90	119	1,584	338	430	214	141	232	99	130	4,558
	RED	1,193	294	346	150	103	160	64	76	287	54	63	44	23	57	20	26	306	67	57	43	29	55	28	27	1,786
	AMBER	61	6	42	3	3	2	4	1	1,108	281	315	105	94	157	64	92	1,216	263	332	163	110	176	69	103	2,385
	GREEN	267	54	53	40	31	45	18	26	58	9	38	3	-	1	6	1	62	8	41	8	2	1	2	-	387
	Number of Community First Responders (CFRs) attendances at scene where first response arriving on scene	1,316	313	394	148	121	176	76	88	1,278	304	384	126	107	179	73	105	1,361	290	393	169	121	189	84	115	3,955
	Percentage of Community First Responder (CFR) attendances at scene where they were the first response arriving at scene	86.5%	88.4%	89.3%	76.7%	88.3%	85.0%	88.4%	85.4%	88.0%	88.4%	92.3%	82.9%	91.5%	83.3%	81.1%	88.2%	85.9%	85.8%	91.4%	79.0%	85.8%	81.5%	84.8%	88.5%	86.8%

Step 4 Give Me Treatment LHB Review: April 2019 - June 2019

Step 4: Give Me Treatment

AQI Ref	AQI Description	Apr-19 All Wales	AB	BCU	C&V	CTM	HD	P	SB	May-19 All Wales	AB	BCU	C&V	CTM	HD	P	SB	Jun-19 All Wales	AB	BCU	C&V	CTM	HD	P	SB	All Wales Total
AQI16 i	Percentage of patients with attempted resuscitation following cardiac arrest, documented as having a return of spontaneous circulation (ROSC) at hospital door	17.2%			All Wales Indicator Only					20.0%			All Wales Indicator Only					11.0%			All Wales Indicator Only					16.5%
	Number of patients with attempted resuscitation following cardiac arrest, documented as having a return of spontaneous circulation (ROSC) at hospital door	41	-	-	-	-	-	-	-	45	-	-	-	-	-	-	-	19	-	-	-	-	-	-	-	105
	Total Number of patients with attempted resuscitation following cardiac arrest	238	-	-	-	-	-	-	-	225	-	-	-	-	-	-	-	172	-	-	-	-	-	-	-	635
AQI16 ii	Percentage of suspected stroke patients who are documented as receiving appropriate stroke care bundle	94.6%			All Wales Indicator Only					95.9%			All Wales Indicator Only					96.6%			All Wales Indicator Only					95.7%
	Number of suspected stroke patients who are documented as receiving appropriate stroke care bundle	351	-	-	-	-	-	-	-	352	-	-	-	-	-	-	-	365	-	-	-	-	-	-	-	1068
	Total Number of suspected stroke patients	371	-	-	-	-	-	-	-	367	-	-	-	-	-	-	-	378	-	-	-	-	-	-	-	1116
AQI16 iii	Percentage of older patients with suspected hip fracture who are documented as receiving appropriate care bundle [including analgesia]	83.9%			All Wales Indicator Only					81.7%			All Wales Indicator Only					83.9%			All Wales Indicator Only					83.2%
	Number of older patients with suspected hip fracture who are documented as receiving appropriate care bundle	214	-	-	-	-	-	-	-	205	-	-	-	-	-	-	-	214	-	-	-	-	-	-	-	633
	Total Number of older patients with suspected hip fracture	255	-	-	-	-	-	-	-	251	-	-	-	-	-	-	-	255	-	-	-	-	-	-	-	761
	Percentage of older patients with suspected hip fracture who are documented as receiving analgesia	93.3%			All Wales Indicator Only					91.6%			All Wales Indicator Only					93.7%			All Wales Indicator Only					92.9%
	Number of older patients with suspected hip fracture who are documented as receiving analgesia	238	-	-	-	-	-	-	-	230	-	-	-	-	-	-	-	239	-	-	-	-	-	-	-	707
	Total Number of older patients with suspected hip fracture	255	-	-	-	-	-	-	-	251	-	-	-	-	-	-	-	255	-	-	-	-	-	-	-	761
AQI16 iv	Percentage of ST segment elevation myocardial infarction (STEMI) patients who are documented as receiving appropriate STEMI care bundle	70.3%			All Wales Indicator Only					64.4%			All Wales Indicator Only					82.9%			All Wales Indicator Only					71.9%
	Number ST segment elevation myocardial infarction (STEMI) patients who are documented as receiving appropriate STEMI care bundle	45	-	-	-	-	-	-	-	58	-	-	-	-	-	-	-	58	-	-	-	-	-	-	-	161
	Total Number of ST segment elevation myocardial infarction (STEMI) patients	64	-	-	-	-	-	-	-	90	-	-	-	-	-	-	-	70	-	-	-	-	-	-	-	224
AQI16 v	Percentage of suspected sepsis patients who have had a documented NEWS score	98.6%			All Wales Indicator Only					97.3%			All Wales Indicator Only					100.0%			All Wales Indicator Only					98.5%
	Number of suspected sepsis patients who have had a documented NEWS score	70	-	-	-	-	-	-	-	73	-	-	-	-	-	-	-	53	-	-	-	-	-	-	-	196
	Total Number of suspected sepsis patients	71	-	-	-	-	-	-	-	75	-	-	-	-	-	-	-	53	-	-	-	-	-	-	-	199
AQI16 vi	Percentage of patients with a suspected febrile convulsion aged 5 years and under who are documented as receiving the appropriate care bundle	100.0%			All Wales Indicator Only					100.0%			All Wales Indicator Only					100.0%			All Wales Indicator Only					100.0%
	Number of patients with a suspected febrile convulsion aged 5 years and under who are documented as receiving the appropriate care bundle	37	-	-	-	-	-	-	-	22	-	-	-	-	-	-	-	39	-	-	-	-	-	-	-	98
	Total Number of patients with a suspected febrile convulsion aged 5 years and under	37	-	-	-	-	-	-	-	22	-	-	-	-	-	-	-	39	-	-	-	-	-	-	-	98
AQI16 vii	Percentage of hypoglycaemic patients who are documented as receiving the appropriate care bundle	87.6%			All Wales Indicator Only					83.2%			All Wales Indicator Only					89.2%			All Wales Indicator Only					86.5%
	Number of hypoglycaemic patients who are documented as receiving the appropriate care bundle	261	-	-	-	-	-	-	-	253	-	-	-	-	-	-	-	215	-	-	-	-	-	-	-	729
	Total Number of hypoglycaemic patients	298	-	-	-	-	-	-	-	304	-	-	-	-	-	-	-	241	-	-	-	-	-	-	-	843
AQI17	Number of Incidents that resulted in non conveyance to hospital	5,102	893	1,526	629	474	737	293	550	5,159	866	1,617	639	473	703	263	598	4,822	876	1,406	655	432	633	254	566	15,083
	Treated At Scene	2,854	485	987	317	279	366	165	255	3,007	488	1,091	305	266	397	144	316	2,805	520	938	333	258	338	158	260	8,666
	Referred To Alternate Provider	2,248	408	539	312	195	371	128	295	2,152	378	526	334	207	306	119	282	2,017	356	468	322	174	295	96	306	6,417

AQI Ref	AQI Description	Apr-19								May-19								Jun-19								All Wales Total
		All Wales	AB	BCU	C&V	CTM	HD	P	SB	All Wales	AB	BCU	C&V	CTM	HD	P	SB	All Wales	AB	BCU	C&V	CTM	HD	P	SB	
	AMBER																									
	Total Number of AMBER Incidents with a Response	20,174	3,585	5,480	2,606	2,817	2,716	976	1,994	19,978	3,536	5,586	2,506	2,694	2,585	958	2,113	19,058	3,366	5,250	2,483	2,523	2,485	957	1,994	59,210
	Number of AMBER Incidents where Ideal Resource First on Scene	13,744	2,251	3,899	1,803	1,802	2,003	720	1,266	13,782	2,283	3,985	1,710	1,799	1,949	715	1,341	12,938	2,092	3,720	1,685	1,655	1,839	702	1,245	40,464
	Percentage of AMBER Incidents where Ideal Resource First on Scene	68.1%	62.8%	71.1%	69.2%	64.0%	73.7%	73.8%	63.5%	69.0%	64.6%	71.3%	68.2%	66.8%	75.4%	74.6%	63.5%	67.9%	62.2%	70.9%	67.9%	65.6%	74.0%	73.4%	62.4%	68.3%
	Number of AMBER Incidents where Ideal Resource Arrived Subsequently	1,275	297	218	193	233	151	41	142	1,100	301	187	151	178	110	34	139	1,122	326	163	177	167	119	42	128	3,497
AQI18	Percentage of AMBER Incidents where Ideal Resource Arrived Subsequently	6.3%	8.3%	4.0%	7.4%	8.3%	5.6%	4.2%	7.1%	5.5%	8.5%	3.3%	6.0%	6.6%	4.3%	3.5%	6.6%	5.9%	9.7%	3.1%	7.1%	6.6%	4.8%	4.4%	6.4%	5.9%
	GREEN2																									
	Total Number of GREEN2 Incidents with a Response	882	139	231	101	111	131	66	103	930	133	258	118	134	110	54	123	899	134	258	87	135	121	60	104	2,711
	Number of GREEN2 Incidents where Ideal Resource First on Scene	503	74	138	48	56	90	40	57	544	69	163	44	78	78	35	77	534	63	167	45	82	74	46	57	1,581
	Percentage of GREEN2 Incidents where Ideal Resource First on Scene	57.0%	53.2%	59.7%	47.5%	50.5%	68.7%	60.6%	55.3%	58.5%	51.9%	63.2%	37.3%	58.2%	70.9%	64.8%	62.6%	59.4%	47.0%	64.7%	51.7%	60.7%	61.2%	76.7%	54.8%	58.3%
	Number of GREEN2 Incidents where Ideal Resource Arrived Subsequently	36	3	9	6	7	6	2	3	44	6	8	9	7	4	1	9	30	4	8	3	5	2	2	6	110
	Percentage of GREEN2 Incidents where Ideal Resource Arrived Subsequently	4.1%	2.2%	3.9%	5.9%	6.3%	4.6%	3.0%	2.9%	4.7%	4.5%	3.1%	7.6%	5.2%	3.6%	1.9%	7.3%	3.3%	3.0%	3.1%	3.4%	3.7%	1.7%	3.3%	5.8%	4.1%
	GREEN3 (Non HCP Incidents)																									
	Total Number of GREEN3 Incidents with a Response	1,088	149	394	86	118	177	76	88	1,104	138	387	82	130	178	73	116	1,024	150	346	72	135	178	48	95	3,216
	Number of GREEN3 Incidents where Ideal Resource First on Scene	700	68	299	34	69	134	64	32	734	68	287	36	68	146	59	70	647	69	254	27	69	141	41	46	2,081
	Percentage of GREEN3 Incidents where Ideal Resource First on Scene	64.3%	45.6%	75.9%	39.5%	58.5%	75.7%	84.2%	36.4%	66.5%	49.3%	74.2%	43.9%	52.3%	82.0%	80.8%	60.3%	63.2%	46.0%	73.4%	37.5%	51.1%	79.2%	85.4%	48.4%	64.7%
	Number of GREEN3 Incidents where Ideal Resource Arrived Subsequently	59	9	7	4	10	11	2	16	58	14	12	7	11	6	1	7	68	12	10	7	13	9	1	16	185
	Percentage of GREEN3 Incidents where Ideal Resource Arrived Subsequently	5.4%	6.0%	1.8%	4.7%	8.5%	6.2%	2.6%	18.2%	5.3%	10.1%	3.1%	8.5%	8.5%	3.4%	1.4%	6.0%	6.6%	8.0%	2.9%	9.7%	9.6%	5.1%	2.1%	16.8%	5.8%
	GREEN3 (HCP Incidents)																									
	Total Number of GREEN3 Incidents with a Response	2,755	471	763	387	355	389	166	224	2,882	569	728	425	371	378	174	237	2,738	514	738	404	356	371	153	202	8,375
	Number of GREEN3 Incidents where Ideal Resource First on Scene	1,791	320	538	264	250	201	109	109	1,877	370	520	284	256	216	102	129	1,845	358	521	294	256	214	80	122	5,513
	Percentage of GREEN3 Incidents where Ideal Resource First on Scene	65.0%	67.9%	70.5%	68.2%	70.4%	51.7%	65.7%	48.7%	65.1%	65.0%	71.4%	66.8%	69.0%	57.1%	58.6%	54.4%	67.4%	69.6%	70.6%	72.8%	71.9%	57.7%	52.3%	60.4%	65.8%
	Number of GREEN3 Incidents where Ideal Resource Arrived Subsequently	8	1	3	-	1	1	-	2	10	3	3	-	-	-	2	2	9	3	1	-	-	2	-	3	27
	Percentage of GREEN3 Incidents where Ideal Resource Arrived Subsequently	0.3%	0.2%	0.4%	0.0%	0.3%	0.3%	0.0%	0.9%	0.3%	0.5%	0.4%	0.0%	0.0%	0.0%	1.1%	0.8%	0.3%	0.6%	0.1%	0.0%	0.0%	0.5%	0.0%	1.5%	0.3%

Step 5 Take Me To Hospital LHB Review: April 2019 - June 2019

Step 5: Take Me To Hospital

AQI Ref	AQI Description	Apr-19 All Wales	AB	BCU	C&V	CTM	HD	P	SB	May-19 All Wales	AB	BCU	C&V	CTM	HD	P	SB	Jun-19 All Wales	AB	BCU	C&V	CTM	HD	P	SB	All Wales Total
AQI19 i	Number of 999 Patients conveyed to Hospital	15,480	2,686	4,076	2,026	2,336	2,121	710	1,525	15,687	2,751	4,202	1,971	2,329	2,067	711	1,656	14,812	2,636	3,907	1,881	2,194	1,975	713	1,506	45,979
	Total Number of Incidents where an Ambulance Resource Attended Scene	23,295	4,100	6,355	3,004	3,215	3,105	1,119	2,397	23,352	4,058	6,545	2,934	3,166	3,016	1,097	2,536	22,276	3,925	6,107	2,890	2,983	2,888	1,090	2,393	68,923
	Percentage of patients conveyed to hospital following a face to face assessment	66.5%	65.5%	64.1%	67.4%	72.7%	68.3%	63.4%	63.6%	67.2%	67.8%	64.2%	67.2%	73.6%	68.5%	64.8%	65.3%	66.5%	67.2%	64.0%	65.1%	73.6%	68.4%	65.4%	62.9%	66.7%
AQI19 ii	Total number of patients conveyed to hospital by type	20,485	3,627	5,325	2,668	3,059	2,825	969	2,012	20,928	3,782	5,463	2,688	3,020	2,785	995	2,195	19,753	3,536	5,129	2,549	2,857	2,667	979	2,036	61,166
	Tier 1 Major A&E Units	18,622	3,442	5,171	2,093	3,032	2,289	887	1,708	19,089	3,581	5,294	2,119	2,997	2,321	899	1,878	18,008	3,342	4,966	2,041	2,838	2,217	894	1,710	55,719
	Tier 2 (Minor A&E Units) - Minor Injuries Unit or Local Accident Centre	516	154	43	1	9	14	14	281	521	169	36	2	7	13	10	284	540	166	48	-	6	8	10	302	1,577
	Tier 3 (Major Acute) - Medical Admissions Unit	1,047	3	-	524	3	515	1	1	977	1	-	533	-	435	-	8	912	-	-	472	1	432	1	6	2,936
	Other (all other units such as Maternity or Mental Health Units)	300	28	111	50	15	7	67	22	341	31	133	34	16	16	86	25	293	28	115	36	12	10	74	18	934
AQI20 i	Number and Percentage of notification to handover within 15 minutes of arrival at hospital	48.6%	43.8%	39.0%	51.3%	72.8%	57.5%	42.1%	31.5%	50.2%	44.9%	40.9%	49.2%	72.4%	64.0%	48.7%	34.3%	50.6%	48.5%	41.9%	44.0%	73.7%	63.6%	54.4%	32.0%	49.8%
	Number of Notification to Handover within 15 minutes	9,551	1,418	2,025	1,262	2,187	1,647	382	630	9,970	1,483	2,158	1,204	2,164	1,775	439	747	9,577	1,511	2,079	1,038	2,096	1,703	496	654	29,098
	Total Number of Handovers	19,661	3,235	5,192	2,459	3,006	2,864	907	1,998	19,862	3,301	5,270	2,447	2,990	2,772	902	2,180	18,912	3,118	4,961	2,358	2,843	2,679	912	2,041	58,435
AQI20 ii	TIER 1 (Major A&E Units) - Percentage of Notification to handover within 15 minutes	48.1%	43.9%	39.0%	54.1%	72.9%	51.1%	42.6%	32.1%	49.8%	44.9%	40.9%	53.1%	72.4%	59.0%	48.3%	33.5%	50.5%	48.5%	41.9%	46.2%	73.7%	59.4%	54.6%	31.7%	49.4%
	TIER 1 (Major A&E Units) - Notification to handover within 15 minutes	8,816	1,418	2,025	1,068	2,184	1,188	380	553	9,275	1,483	2,158	1,044	2,161	1,361	431	637	8,950	1,511	2,079	896	2,092	1,326	492	554	27,041
	TIER 1 (Major A&E Units) - Total Number of Handovers	18,333	3,232	5,192	1,975	2,996	2,324	892	1,722	18,627	3,300	5,270	1,967	2,985	2,308	893	1,904	17,735	3,118	4,961	1,940	2,837	2,233	901	1,745	54,695
	TIER 2 (Minor A&E Units) - Percentage of Notification to handover within 15 minutes	28.0%	-	-	0.0%	28.6%	50.0%	7.1%	28.0%	40.1%	-	-	0.0%	60.0%	38.5%	88.9%	38.3%	34.3%	-	-	-	60.0%	71.4%	40.0%	32.8%	34.0%
	TIER 2 (Minor A&E Units) - Notification to handover within 15 minutes	87	-	-	-	2	7	1	77	119	-	-	-	3	5	8	103	107	-	-	3	5	4	-	95	313
	TIER 2 (Minor A&E Units) - Total Number of Handovers	311	-	-	1	7	14	14	275	297	-	-	1	5	13	9	269	312	-	-	5	7	10	-	290	920
	TIER 3 (Major Acute) - Percentage of Notification to handover within 15 minutes	63.7%	0.0%	-	40.2%	33.3%	85.9%	100.0%	0.0%	61.4%	0.0%	-	33.4%	-	90.7%	-	100.0%	60.1%	-	-	34.0%	100.0%	84.7%	0.0%	83.3%	61.8%
	TIER 3 (Major Acute) - Notification to handover within 15 minutes	648	-	-	194	1	452	1	-	576	-	-	160	-	409	-	7	520	-	-	142	1	372	-	5	1,744
	TIER 3 (Major Acute) - Total Number of Handovers	1,017	3	-	483	3	526	1	1	938	1	-	479	-	451	-	7	865	-	-	418	1	439	1	6	2,820
	Other - Percentage of Notification to handover within 15 minutes	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Other - Notification to handover within 15 minutes	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Other - Total Number of Handovers	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
AQI21	Number of lost hours following notification to handover over 15 minutes	8,766	1915	1871	512	1005	856	302	2306	7,100	1,631	1,561	559	742	469	181	1,958	7,324	1,534	1,262	758	580	619	200	2,372	23,191
	Tier 1 Major A&E Units	8,494	1,911	1,871	426	1,003	832	291	2,160	6,924	1,630	1,561	457	741	460	181	1,894	7,097	1,534	1,262	657	579	599	195	2,271	22,515
	Tier 2 (Minor A&E Units) - Minor Injuries Unit or Local Accident Centre	159	-	-	1	1	1	11	145	66	-	-	0	1	2	0	63	106	-	-	-	0	1	4	101	331
	Tier 3 (Major Acute) - Medical Admissions Unit	113	4	-	86	0	23	-	0	110	1	-	102	-	7	-	-	121	-	-	101	-	19	0	0	344
	Other (all other units such as Maternity or Mental Health Units)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
AQI22 i	Number and Percentage of handover to clear within 15 minutes of transfer of patient care to hospital staff	74.9%	62.0%	80.9%	73.0%	75.7%	76.9%	90.2%	71.1%	75.8%	63.0%	83.9%	73.3%	75.7%	77.7%	89.4%	70.7%	82.5%	63.4%	93.7%	79.7%	82.3%	80.9%	92.2%	85.6%	77.7%
	Number of Handover to Clear within 15 minutes	14,721	2,007	4,202	1,794	2,276	2,203	818	1,421	15,063	2,080	4,424	1,793	2,264	2,155	806	1,541	15,603	1,977	4,648	1,880	2,341	2,168	841	1,748	45,387
	Total Number of Handovers	19,661	3,235	5,192	2,459	3,006	2,864	907	1,998	19,862	3,301	5,270	2,447	2,990	2,772	902	2,180	18,912	3,118	4,961	2,358	2,843	2,679	912	2,041	58,435
AQI22 ii	Number and Percentage of handover to clear within 15 minutes of transfer of patient care to hospital staff by hospital type																									
	TIER 1 (Major A&E Units) - Percentage of Handover to Clear within 15 minutes	74.3%	62.0%	80.9%	68.7%	75.7%	76.5%	90.4%	69.7%	75.2%	63.0%	83.9%	68.9%	75.7%	77.4%	89.4%	68.8%	82.0%	63.4%	93.7%	76.6%	82.4%	79.9%	92.1%	84.8%	77.1%
	TIER 1 (Major A&E Units) - Number of Handover to Clear within 15 minutes	13,615	2,004	4,202	1,357	2,267	1,778	806	1,201	14,011	2,079	4,424	1,355	2,259	1,786	798	1,310	14,544	1,977	4,648	1,487	2,337	1,785	830	1,480	42,170
	TIER 1 (Major A&E Units) - Total Number of Handovers	18,333	3,232	5,192	1,975	2,996	2,324	892	1,722	18,627	3,300	5,270	1,967	2,985	2,308	893	1,904	17,735	3,118	4,961	1,940	2,837	2,233	901	1,745	54,695
	TIER 2 (Minor A&E Units) - Percentage of Handover to Clear within 15 minutes	80.1%	-	-	100.0%	100.0%	71.4%	85.7%	79.6%	84.5%	-	-	0.0%	100.0%	100.0%	88.9%	83.6%	90.7%	0.0%	0.0%	0.0%	60.0%	100.0%	100.0%	90.7%	85.1%
	TIER 2 (Minor A&E Units) - Number of Handover to Clear within 15 minutes	249	-	-	1	7	10	12	219	251	-	-	-	5	13	8	225	283	-	-	-	3	7	10	263	783
	TIER 2 (Minor A&E Units) - Total Number of Handovers	311	-	-	1	7	14	14	275	297	-	-	1	5	13	9	269	312	-	-	5	7	10	-	290	920
	TIER 3 (Major Acute) - Percentage of Handover to Clear within 15 minutes	84.3%	100.0%	-	90.3%	66.7%	78.9%	0.0%	100.0%	85.4%	100.0%	-	91.4%	-	78.9%	-	85.7%	89.7%	0.0%	0.0%	94.0%	100.0%	85.6%	100.0%	83.3%	86.3%
	TIER 3 (Major Acute) - Number of Handover to Clear within 15 minutes	857	3	-	436	2	415	-	1	801	1	-	438	-	356	-	6	776	-	-	393	1	376	1	5	2,434
	TIER 3 (Major Acute) - Total Number of Handovers	1,017	3	-	483	3	526	1	1	938	1	-	479	-	451	-	7	865	-	-	418	1	439	1	6	2,820
	Other - Percentage of Handover to Clear within 15 minutes	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Other - Number of Handover to Clear within 15 minutes	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Other - Total Number of Handovers	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
AQI23	Conveyance to hospital outside of Local Health Board area	1,620	453	199	162	134	123	449	100	1,774	451	202	145	142	142	508	184	1,582	429	171	118	109	129	484	142	4,976
	Number of patients conveyed to hospital	20,485	3,627	5,325	2,668	3,059	2,825	969	2,012	20,928	3,782	5,463	2,688	3,020	2,785	995	2,195	19,753	3,536	5,129	2,549	2,857	2,667	979	2,036	61,166
	Percentage of Overall Conveyance to hospital outside of Local Health Board area	7.9%	12.5%	3.7%	6.1%	4.4%	4.4%	46.3%	5.0%	8.5%	11.9%	3.7%	5.4%	4.7%	5.1%	51.1%	8.4%	8.0%	12.1%	3.3%	4.6%	3.8%	4.8%	49.4%	7.0%	8.1%
AQI24	Number of lost hours following handover to clear over 15 minutes	1,062	403	160	128	106	100	18	148	947	339	120	138	111	89	15	134	644	315	30	98	59	62	11	69	2,652
	Tier 1 Major A&E Units	1,033	403	160	123	105	91	18	135	926	339	120	131	111	81	14	129	631	315	30	94	59	56	11	66	2,591
	Tier 2 (Minor A&E Units) - Minor Injuries Unit or Local Accident Centre	13	-	-	-	-	-	-	13	5	-	-	-	0	-	-	5	2	-	-	-	-	0	-	2	21
	Tier 3 (Major Acute) - Medical Admissions Unit	16	-	-	6	1	9	-	-	15	-	-	7	-	8	-	0	10	-	-	3	-	6	-	0	41
	Other (all other units such as Maternity or Mental Health Units)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Ambulance Quality Indicator Glossary

No.	Term	Definition
1	65th Percentile	A percentile (or a centile) is a measure used in statistics indicating the value below which a given percentage of observations in a group of observations fall. For example, the 65th percentile is the value below which 65 percent of the observations may be found.
2	95th Percentile	A percentile (or a centile) is a measure used in statistics indicating the value below which a given percentage of observations in a group of observations fall. For example, the 95th percentile is the value below which 95 percent of the observations may be found.
3	999	Emergency telephone service operated by telephony providers such as BT, allowing anyone to contact the emergency services, this also applies to 112 (European) & 911 (US).
4	AMBER	Calls received and categorised as serious but not life threatening. These calls will include most medical and trauma cases such as chest pain and fractures. Amber calls will receive an emergency response. A response profile has been created to ensure that the most suitable clinical resource is dispatched to each amber call. This will include management via "hear & treat" services over the telephone. Patient experience and clinical indicator data will be used to evaluate the effectiveness of the ambulance response to amber calls.
5	Call	A telephone call received by the Welsh Ambulance Services NHS Trust via 999 or from a Health Care Professional.
6	CFR	Community First Responder trained by the Welsh Ambulance Services NHS Trust to respond to appropriately graded calls.
7	Clear	Time a Welsh Ambulance Services NHS Trust crew are clear (free for other work) from either the scene or hospital.
8	Conveyance	A 999 incident which has received an emergency response at scene and resulted in the patient being conveyed to hospital.
9	EASC	Emergency Ambulance Service Committee: ambulance commissioning in Wales is a collaborative process underpinned by a national collaborative Commissioning Quality and Delivery Framework. All seven Health Boards have signed up to the Framework. Emergency Ambulance Services in Wales are provided by a single national organisation – Welsh Ambulance Services NHS Trust (WAST).
10	Incident	A 999 call which excludes the following: calls made in error, duplicate calls, information calls, test calls and calls to other ambulance controls.
11	Response	A 999 Incident which as received an emergency response at scene.
12	Fractured Femur	Hip fractures, also called proximal femoral fractures, are cracks or breaks in the top of the thigh bone (femur) close to the hip joint.

Ambulance Quality Indicator Glossary

No.	Term	Definition
13	Frequent Caller	Frequent callers are defined where the Welsh Ambulance Services NHS Trust have received 5 or more calls from the same address in the same month, or 12 or more calls from the same address in the past 3 months.
14	GREEN	Calls received and categorised as green are neither serious or life threatening. Conditions such as ear ache or minor injuries are coded as green calls. Green calls are ideally suited to management via secondary telephone triage.
15	HB	Health Board: an HB is an administrative unit within the National Health Service in Wales. The 7 HB's in Wales are Aneurin Bevan University Health Board, Betsi Cadwaladr University Health Board, Cardiff & Vale University Health Board, Cwm Taf Morgannwg University Health Board, Hywel Dda University Health Board, Powys Teaching Health Board, Swansea Bay University Health Board.
16	Handover	Handover of care from Welsh Ambulance Services NHS Trust to LHB hospital staff.
17	Health Care Professional	Suitably qualified health professional defined as: Doctor, General Practitioner, Emergency Care Practitioner, Nurse, District Nurse, Midwife, Paramedic, Dentist, Approved Social Worker.
18	Hear & Treat	Hear and treat are callers who were deemed to have non-life-threatening conditions and received triage and advice over the phone.
19	Ideal Response	The type of clinician / resource to send, in preference for the specific category (or codes).
20	Major A&E Unit	Hospitals which provide a wide range of acute in-patient and out-patient specialist services together with the necessary support systems, which allow emergency admissions and which usually has an Accident and Emergency department.
21	Major Acute	Hospitals which provide acute services limited to a one or two specialist units.
22	Median	Median is the number separating the higher half of a data sample. The median of a finite list of numbers can be found by arranging all the observations from lowest value to highest value and picking the middle one (e.g., the median of {3, 3, 5, 9, 11} is 5).
23	Minor A&E Unit	Hospitals which provide a range of acute in-patient and out-patient services specialist services (including some surgical acute specialties) but not the wide range available in major acute hospitals.
24	MPDS	Medical Priority Dispatch System: MPDS is a unified system used to dispatch appropriate aid to medical emergencies including systematised caller interrogation and pre-arrival instructions.
25	NHSDW	NHS Direct Wales is a health advice and information service available 24 hours a day, every day and is part of the Welsh Ambulance Services NHS Trust.
26	Non-Conveyance	Patients which are not transported to hospital following assessment by clinician.
27	Non-conveyances (by reason)	Number of patients not taken to hospital split by the reason why i.e. Treated at Scene.
28	Notification	Time that the Welsh Ambulance Services NHS Trust notified LHB hospital staff of their arrival at hospital.
29	Overall % Conveyance	Percentage of patients transported to hospital following initial assessment at scene by a Welsh Ambulance Services NHS Trust clinician.

Ambulance Quality Indicator Glossary

No.	Term	Definition
30	PROQA	Professional Questioning & Answering Software: ProQA is an expert system designed to help provide the very best in service and speed. Correct dispatch levels are usually determined in less than one minute. ProQA additionally provides Dispatch Life Support (DLS) protocols which meet or exceed the international standards for emergency medical dispatching. ProQA is built on a foundation of empirical literature and medical experience relevant to medical dispatching.
31	RED	Calls deemed to be Immediately Life-Threatening.
32	ROSC	Return of spontaneous circulation refers to signs of restored circulation (more than occasional gasp, occasional fleeting pulse or arterial waveform) evidenced by breathing, a palpable pulse or a measurable blood pressure
33	STEMI	STEMI - ST segment elevation myocardial infarction - occurs when a coronary artery is totally occluded by a blood clot.
34	Stroke Care Bundle	A Care Bundle is a group of between three and five specific interventions or processes of care that have a greater effect on patient outcomes if done together in a time-limited way, rather than separately.
35	Suitable Response	The type of clinician / resource to send, if the IDEAL response is not available for the specific category (or codes).
36	WAST	Welsh Ambulance Services NHS Trust: Spread over an area of 20,640 kilometres and serving a population of 2.9 million, this diverse area encompasses tranquil rural retreats, busy seaside resorts and large urban conurbations.
37	ABM	Abertawe Bro Morgannwg University Health Board
38	AB	Aneurin Bevan University Health Board
39	BCU	Betsi Cadwaladr University Health Board
40	C&V	Cardiff and Vale University Health Board
41	CT	Cwm Taf University Health Board
42	CTM	Cwm Taf Morgannwg University Health Board
43	HD	Hywel Dda University Health Board
44	P	Powys Teaching Health Board
45	SB	Swansea Bay University Health Board

Welsh Ambulance Services NHS Trust
National Collaborative Commissioning: Quality and Delivery Framework
Ambulance Quality Indicators

Changes captured within version 2	
1	From 1st April 2019 responsibility for the locality of Bridgend moved from Abertawe Bro Morgannwg University Health Board (ABM) to Cwm Taf University Health Board (CT). Additionally the health board names have changed to reflect the new boundary arrangements: Abertawe Bro Morgannwg University Health Board has changed to Swansea Bay University Local Health Board (SB) and Cwm Taf University Local Health Board has changed to Cwm Taf Morgannwg University Local Health Board (CTM)
2	Within this AQI report the HB names are sorted alphabetically which means, from this pack onwards, Aneurin Bevan (AB) is the first HB listed, not ABM, which is now called Swansea Bay (SB) and listed last.
3	AQI 7 has become AQI 7i and 0845 numbers have been removed from the reported dataset.
4	AQI 7ii has been added capturing how quickly the 999 calls received by the Welsh Ambulance Services NHS Trust, as reported in AQI 7i, are answered.

The information contained in this document is not restricted and is classified for general release

Produced by the Welsh Ambulance Services NHS Trust Health Informatics Department commissioned by the Emergency Ambulance Services Committee in accordance with the National Collaborative Commissioning: Quality and Delivery Framework

	AGENDA ITEM 3.1
GIG CYMRU NHS WALES — Pwyllgor Gwasanaethau Ambiwlans Brys / Emergency Ambulance Services Committee	**10 September 2019**

Emergency Ambulance Services Committee Report
REGIONAL ESCALATION

Executive Lead: Stephen Harrhy – Chief Ambulance Services Commissioner
Author: Ross Whitehead – Assistant Director Quality and Performance, Hugh Bennett – Assistant Director Commissioning and Performance
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Purpose of the Emergency Ambulance Services Committee Report
The purpose of this paper is to set out a proposal for consideration which would improve the arrangements for regional and national escalation to manage system risk across NHS Wales.

Governance	
Link to the Commissioning Agreement	The Committee's overarching role is to ensure its Commissioning Strategy for Emergency Ambulance Services utilising the five step patient pathway outlined within the National Collaborative Commissioning Quality and Delivery Agreement and the related outcomes for each care standard aligned with the Institute of Healthcare Improvement's (IHI) 'Quadruple Aim' are being progressed. This report focuses on all the above objectives, but specifically on **providing** strong governance and assurance.
Supporting evidence	The Collaborative Commissioning Quality and Delivery Framework for Emergency Medical Services
Engagement – Who has been involved in this work?	
WAST; EASC; Health Boards	

Emergency Ambulance Services Committee Resolution to:						
APPROVE	√	**ENDORSE**	√	**DISCUSS**		**NOTE**	
Recommendation		The Emergency Ambulance Services Committee is asked to: • **DISCUSS** the proposal • **APPROVE** the next steps for implementation of this work.				

Summarise the Impact of the Emergency Ambulance Services Committee Report	
Equality and diversity	There are no implications arising directly from this report
Legal implications	There are no implications arising directly from this report.
Population Health	No impact
Quality, Safety & Patient Experience	Ensuring the Committee and its Sub Groups make fully informed decisions is dependent on the quality and accuracy of the information presented and considered by those making decisions. Informed decisions are more likely to impact favourably on the quality, safety and experience of patients and staff.
Resources	The financial resource requirements are outlined in the body of the report.
Risks and Assurance	Identified within the report
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf The work reported in this summary and related annexes take into account many of the related quality themes in particular timely care.
Workforce	Identified within the report.
Freedom of information status	Open

REGIONAL ESCALATION

1. SITUATION / PURPOSE OF REPORT

The purpose of this paper is to set out a proposal for consideration which would improve the arrangements for regional and national escalation to manage system risk across NHS Wales.

2. BACKGROUND / INTRODUCTION

At the Emergency Ambulance Services Committee development session in July 2019, Members held a discussion on regional escalation with a particular focus on improving and enhancing the purpose and outputs of the 11am national teleconference call.

The current arrangements are outlined below.

A series of policies and practices are in place across Wales which were originally designed to support the wider unscheduled care system to effectively manage demand and capacity, particularly at times of high pressure.

A **national emergency pressures escalation and de-escalation action plan** was agreed in March 2014 and is still extant. Its stated aim is to 'enhance the effectiveness of patient flow and maintain patient safety through implementation of procedures that support best practice through proactive management'.

This action plan sets out the criteria / measures that are used to determine the **escalation status** of each Health Board, and Health Boards are required to report on their escalation status each day.

An **integrated unscheduled care dashboard** is in place, drawing key information on activity and performance automatically from Health Board and Ambulance service systems, and displaying these visually. All organisations are able to access and utilise this dashboard.

A **national teleconference call** is held each day at 11 a.m., attended by Health Boards, the Welsh Ambulance Services NHS Trust (WAST) and Welsh Government. All organisations provide information on their current escalation status and highlight any areas of concern. The meeting is chaired in rotation by Executive leads from each Health Board, and additional calls can be scheduled at any time, dependent on pressures faced across the system. Participants on the call vary in their level of seniority, knowledge and delegated authority.

Each Health Board and Trust has its own internal escalation policies and procedures, along with an **on-call system**. At any point, on-call leads are able to liaise with their counterparts in other organisations to seek agreement on support required.

Members asked the WAST CEO to develop a proposal for discussion at EASC. The draft WAST proposal is attached at Appendix 1 for consideration by the Members.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

It is generally agreed that more can be done to develop the current system and its supporting policies and procedures to move from a reactive position into a proactive position that protects patient safety and experience.

Adopting the proactive approach will be particularly beneficial at times of increased escalation but will also support the normal running of the system by reducing the need to escalate.

In relation to the systems and processes currently in place to address these pressures, it is evident that they do not function effectively. In relation to the daily teleconference call, the following observations are offered:
- The meeting is used in the main as a mechanism for sharing information, as opposed to taking action (here and now and what happened yesterday or last night)
- The rotation of the chair means that there is little consistency in how the meetings are run, and there no record of the discussion is kept;
- Accountability for the delivery of actions is limited with no action log being maintained and
- In the main, the meetings are also used to discuss the immediate problems presenting in the system, rather than proactively looking ahead 24/48 hours, or further.
- Participants knowledge of national and organisational escalation policies is variable, and participants are not always aware of the expectations on them as part of the meeting.

It is therefore proposed that action is taken to refocus the systems and processes between Health Boards and WAST and to address some of the long standing challenges set out above.

The WAST proposal focus on 3 main areas:

Strengthening the Arrangements for the Daily Conference Call

- Call to be chaired by a system leader (rather than a rotating chair) to improve continuity, with the call being serviced and supported by WAST
- Purpose of call to be agreed through development of a terms of reference
- Establish a set agenda with a focus on action against escalation plans
- Call notes to be recorded and supplied by the system leader and action log updated.

Developing and Agreeing Intelligence-led Protocols for Movement of Patients across the System
- It is proposed that protocols are developed and agreed which would allow for the mobilisation of other resources (e.g. community teams) and where required the movements of ambulances across the system, where there are excessive delays in ambulance turnarounds and / or A&E demand that might highlight potential patient safety concerns.

Building an improved, system-wide, intelligent and live information base as an aid to decision making
- The main live information source for unscheduled care is the Integrated Unscheduled Care Dashboard. This contains data on ambulance handover delays, ambulances inbound, numbers in A&E, numbers of hospital admissions and beds occupied, potential numbers fit for discharge and numbers of delayed transfers of care.
- However, it is currently very secondary-care based. There would be a significant benefit in developing this further to include the position within Primary Care, Community Care or Social Care as part of a key performance indicator (KPI) set. As an example, shortfalls in out of hours (OoHs) services are likely to impact on emergency departments (ED) and the hospital but are not included currently. Ambulance waits in the community are also not currently included, and provide an indicator of potential short term demand, but also highlight potential system wide risks

Members are asked to discuss the content of the attached draft proposal at **Appendix 1** and to provide a steer on the elements of the paper that should be taken forward or require amending.

In addition, Members are asked to **APPROVE** three additional actions to:
- By 5pm 20 September, submit each organisations
  - Individual site escalation plans
  - Individual site full capacity plans
  - The list of individuals that will undertake the national escalation calls this winter on behalf of each organisation.
- The establishment of task and finish group (aimed at assistant Chief Operating Officers) to provide a peer review process for the above plans, and finalise the proposals for enhancing the national escalation calls.
- The development of a bespoke training course for representatives on the call based on the Exercise Wales Gold course, with a specific focus on managing health services during periods of escalation.
- The revised process to be live by the 1 December 2019.

4. RECOMMENDATION

Members of the Emergency Ambulance Services Committee are asked to;
- **DISCUSS** the draft proposal
- **APPROVE** the additional actions identified in this paper.

Freedom of information status	Open

IMPROVING MANAGING PATIENT FLOW ACROSS THE UNSCHEDULED CARE SYSTEM

A DISCUSSION PAPER
August 2019

INTRODUCTION

1. The purpose of this paper is to set out a proposition for consideration which would improve the arrangements for managing patient flows and system risk across NHS Wales at all times and, in particular, during period of increased escalation and pressure, ensuring that the quality and safety of patient care is maintained.

2. The Chief Ambulance Service Commissioner and Director of Unscheduled Care has requested that these proposals be prepared in the light of on-going pressures subsequent to discussions at EASC in July.

3. In summary, WAST are well placed as a national provider with pan Wales system oversight and local in reach to every Local Health Board and Emergency Department to support the unscheduled care system across Wales, leading changes which are urgently required to provide solutions to the ongoing challenges of escalation and high pressure through:

   - Leading and strengthening the arrangements for the daily conference call;
   - Developing and agreeing intelligence-led protocols for the proactive movement of patients across the system;
   - Building an improved, system-wide, intelligent and live information base as an aid to decision making;
   - Coordinating the system wide management and response during periods of extreme pressure.

BACKGROUND

4. A series of policies and practices are in place across Wales which were originally designed to support the wider unscheduled care system to effectively manage demand and capacity, particularly at times of high pressure.

5. A **national emergency pressures escalation and de-escalation action plan** was agreed in March 2014 and is still extant. Its stated aim is to 'enhance the effectiveness of patient flow and maintain patient safety through implementation of procedures that support best practice through proactive management'.

6. This action plan sets out the criteria / measures that are used to determine the **escalation status** of each Health Board, and Health Boards are required to report on their escalation status each day.

7. An **integrated unscheduled care dashboard** is in place, drawing key information on activity and performance automatically from Health Board and Ambulance service systems, and displaying these visually. All organisations are able to access and utilise this dashboard.

8. A **national teleconference call** is held each day at 11 a.m., attended by Health Boards, WAST and Welsh Government. All organisations provide information on their current escalation status and highlight any areas of concern. The meeting is chaired in rotation by Executive leads from each Health Board, and additional calls can be scheduled at any time, dependent on pressures faced across the system.

9. Each Health Board and Trust has its own internal escalation policies and procedures, along with an **on-call system**. At any point, on-call leads are able to liaise with their counterparts in other organisations to seek agreement on support required.

10. As a result of these arrangements, agreement is reached at times to **divert ambulances** from one hospital to another. This is always as a result of discussions between Health Board leads, and Executive level approval is usually required. WAST's Health Informatics function does not record the use of diverts, but the Ambulance Daily Occurrence Log for August 2019 (to 18 August 2019) has 97 entries relating to diverts (entries is not the same as the number of diverts or the number of ambulances diverted, but it does give a flavour of the level of activity).

CASE FOR CHANGE

11. Whilst policies and procedures are in place as referenced above, there is more that could be done to coordinate both the improvement of proactive management action and the response at all times and, in particular, during periods of increased escalation to improve patient safety and patient experience across the system. Some of the on-going issues are set out in the paragraphs below.

12. From an ambulance perspective, there continues to be significant numbers of patients who are conveyed to hospital that are delayed in their transfer into the Emergency Department in a timely fashion. This has a two-fold effect for patients: the patients in the back of the ambulances are not able to access the care and treatment that they require; and with ambulance resource thus tied up, there are insufficient ambulances to respond to patients waiting for an ambulance in the community. The graphs below show:

- the number of lost hours month by month, which is showing a deteriorating trend, despite the fact that fewer patients were conveyed to EDs in Apr – June 2019 compared to the same period last year (45,979 patients v 55,740);
- the increasing response times for red category patients;
- the increasing response times for amber category patients. As an example, in April 2019, the 95th centile response time was 3:06 hours, compared with 2:22 hours the year before.

13. There are around 100 patients each month who wait over 12 hours for an ambulance response (amber and green categories).

Response Times against Lost Hours to Notification to Handover Delays

Legend: SB Lost Hours, AB Lost Hours, BCU Lost Hours, C&V Lost Hours, CTM Lost Hours, Hywel Dda Lost Hours, Powys, RED Median, AMBER Median

% of emergency responses to red calls arriving within (up to and including) 8 minutes against Red Calls 95th percentile

Legend: % of emergency responses to red calls arriving within (up to and including) 8 minutes; Target 65%; Red Calls - 95th percentile response time

14. WAST continues to deal with high numbers of serious adverse incidents, which, in the main, relate to these delayed ambulance responses to patients in the community.

15. The following table shows the total numbers of serious adverse incidents reported to Welsh Government by Health Board area. The high level of SAIs in 2017/18 was a key trigger for the Amber Review, but it can be seen that the level of SAIs was actually higher in 2018/19.

SAIs Reported to WG								
	ABHB	SBHB	BCUHB	CVHB	CTHB	HDHB	POHB	Total
2017/18	17	10	12	6	2	1	0	48
2018/19	11	7	13	15	1	4	0	51
2019/20 to date	6	5	0	0	1	1	0	13

16. A number of key strategic actions are underway across Wales to support the unscheduled care system and EDs. These include:

- WAST's EMS Demand & Capacity Review, which will forecast future incident demand (over five years) and model the maximum impact WAST can have on reducing conveyance to major EDs through "shift left" activities;
- Work within WAST to identify and develop national clinical and process pathways that could avoid conveyance to an ED;
- the NCCU's development of the ED QDF; and
- Transformation work in the primary care sector designed to keep patients away from emergency departments and avoid hospital admission.

17. At a tactical level Health Boards and WAST will also continue to focus on tactical planning, for example, winter planning.

18. However, despite all of the good work being undertaken, the pressures continue to be evident across most parts of Wales with the majority of circumstances likely to be forecastable with the opportunity for proactive mitigating management action to be taken.

19. In relation to the systems and processes put in place to address these pressures, it is evident that they do not function effectively. In relation to the daily teleconference call, the following observations are offered:

- The meeting is used in the main as a mechanism for sharing information, as opposed to taking action;
- The rotation of the chair means that there is little consistency in how the meetings are run, and there no record of the discussion is kept;
- Accountability for the delivery of actions is limited with no action log being maintained; and

- In the main, the meetings are also used to discuss the immediate problems presenting in the system, rather than proactively looking ahead 24/48 hours, or further.

20. At a more fundamental level, individual Health Boards and WAST are held directly accountable by Welsh Government for a range of performance targets specific to their organisation. This performance management system does not generally lend itself to organisations freely supporting others, where this support could affect their own performance.

PROPOSED OPPORTUNITIES

21. It is therefore proposed that action is taken to refocus the systems and processes between Health Boards and WAST and to address some of the long standing challenges set out above. Three linked proposals are set out for consideration.

Strengthening the Arrangements for the Daily Conference Call

22. There is an opportunity to improve the management of the daily Conference Call between Health Boards, WAST and Welsh Government. WAST is proposing the following:

- Call to be chaired by a system leader (rather than a rotating chair) to improve continuity, with the call being serviced and supported by WAST;
- Purpose of call to be clarified through development of a terms of reference;
- Set agenda (see Appendix 1 for example agenda, which also includes template report for each organisation on the call) to be agreed in three parts:
  - Review of last 24 hours (agreed actions, demand, capacity, performance, patient safety etc.);
  - Consideration of current position;
  - Look forward to next 24 hours (demand, capacity, performance, patient safety and agreed actions – initial focus to be 24 hours;
- Call notes to be recorded and supplied by the system leader and action log updated.

23. These arrangements will bring a consistency to the management of the call, and would be designed to be more action focused and proactive, with an expectation of an increased level of support across Health Boards and WAST in responding to pressures across the system.

24. As a national provider, WAST is well placed to understand pressures across Wales, and as a service commissioned collaboratively by all Health Boards, would operate in the best interests of all Health Boards.

Developing and Agreeing Intelligence-led Protocols for Movement of Patients across the System

25. It is proposed that protocols are developed and agreed which would allow for the movements of ambulances across the system, where there are excessive delays in ambulance turnarounds and / or A&E demand that might highlight potential patient safety concerns.

26. Any such protocols would be dependent on agreed and intelligent escalation or trigger points, rather than lengthy negotiations between organisations. **As an example**, one health system in England is currently piloting a similar approach, with the following trigger points identified:

    - Two or more ambulance handover delays exceeding 60 minutes in the last 2 hours
    - Wait to be seen in A&E exceeding 3 hours.
    - Potential 12 hour breaches identified in the A&E.
    - Disproportionate number of ambulances on single site or potentially inbound

27. Key issues to take into account in the development of such an approach would include:

    - The need to ensure that decisions are taken in context and with the support of wider data metrics;
    - Consideration of the development of a 'hub' where decisions would be made. This could be developed within WAST, with virtual links to appropriate operational colleagues within Health Boards;
    - The need for the rationale for decisions to be captured, shared and utilised to build trust and support learning where required.

28. Consideration would also have to be given to the patients to be diverted to alternative hospitals. Options would include temporarily moving the traditional catchment boundaries for each hospital or to select patients for diversion based on clinical presentation e.g. selecting patients who are less likely to require admission, thereby avoiding difficulties encountered when patients are admitted to hospitals a distance from their families / support mechanisms. There would clearly be certain patients, again based on clinical presentation, who could not be diverted and would need to continue to be taken to their nearest hospital or to the hospital with the required services provided (e.g. major trauma / stroke).

29. It is recognised that, in a system as complex as healthcare, decisions of this type are not simple, and any proposal will be worked up collaboratively with colleagues from all stakeholders.

Building an improved, system-wide, intelligent and live information base as an aid to decision making

30. The main live information source for unscheduled care is the Integrated Unscheduled Care Dashboard. This contains data on ambulance handover delays, ambulances inbound, numbers in A&E, numbers of hospital admissions and beds occupied, potential numbers fit for discharge and numbers of delayed transfers of care.

31. However, it is currently very secondary-care based. There would be a significant benefit in developing this further to include the position within Primary Care, Community Care or Social Care. As an example, shortfalls in OoHs services are likely to impact on ED and the hospital but are not included currently. Ambulance waits in the community are also not currently included, and provide an indicator of potential short term demand, but also highlight potential system wide risks.

32. There may also be benefit in supplementing this with other information. For example, WAST has invested in powerful modelling software, Optima Predict. Whilst the use of Optima Predict is at the pilot stage, if linked to weekly demand forecasts and rostering information, it offers the potential to provide a performance forecast and ambulance conveyance forecast by destination. Similarly WAST is currently undertaking an Emergency Medical Services Demand & Capacity Review. An output of this Review could be the daily conveyance demand pattern for each ED, which can be used to aid roster design. The emerging ED Quality & Delivery Framework also includes a focus on ED demand forecasting capability. Systems are also being developed in other parts of the UK which appear to be adding value e.g. SHREWD (a just-in-time framework/software/app for health and social care organisations that re-organises actions around the urgent care process, rather than by organisational hierarchy. Escalation pushes alerts to pre-designated teams when pressure changes and tracks the response in real time. This enables an instant view of how each system is responding to unplanned increases in demand and provides assurance to health system leaders. The actions can be tracked live and the aim is that you never have to write another escalation plan). These maximise the use of technology to push information across the system and also to track actions that are being taken in response to levels of escalation. These may be worthy of further exploration.

33. Improvements will be required in order to aid decision making described in the section above to facilitate the protocols for the movement of patients, as the current dashboard does not include sufficient information in relation to likely triggers; however, there are significant benefits to a sustained focus on improving the information available versus the risks of not acting.

Improved System-Wide Intelligent and Live Information Base as an Aid to Decision-Making

Benefits (of acting)	Risks (of not acting)
Prediction and pro-active management of emerging problems.	Reactive and historic focus.

Co-ordinated system led responses.	Uncoordinated separate responses.
Improved utilisation of available capacity.	Available capacity not used to support areas of higher escalation and/or additional capacity not put in place.
Improved patient safety.	Further deterioration in patient safety.
Improved understanding of drivers of system and how to manage them.	Ad-hoc, un-evidenced responses that may not work.

NEXT STEPS

34. Chief Executives are asked to endorse the proposals contained within this discussion paper to enable WAST to lead a small task and finish group with representatives from each organisation to develop the proposals further.

35. Due consideration will need to be given to the work already underway across the system, and it is therefore proposed that the Unscheduled Care Board would provide the most appropriate forum to agree these proposals. They would ensure that this work complemented work already underway.

36. There may be resource implications initially in completing this work, which will be worked through by the proposed task and finish group.

NHS Wales Daily Gold Call
11:00 – 12:00, Insert Date
VC Bridge VC xxxxx Audio Dial in xxxxx
Chair: WAST Gold
AGENDA

Item No.		Lead	Papers/ Item
1.	Confirmation of Gold Representatives	Chair	
2.	Review of Last 24 Hours (By Site, WAST, By Exception) - Review of Agreed Actions (include capture of benefits, good practice and lessons) - Review of Key Issues e.g. escalation Levels, demand, capacity performance, patient safety etc. - Other	Each Gold to Provide Update	Insert Notes from Previous Call Reports Per HB EMS Daily EMS Ops Daily Meeting (006).pdf Action Log 11-00GoldCallAction Loghb20190822.xlsx
3.	Current Position	Each HG Gold to Provide Update	http://nww.iuscdash.wales.nhs.uk/activity/home
4.	24 Hour # Forward Look (By Site, WAST, By Exception) - Forward look e.g. demand, escalation levels, capacity, performance, patient safety etc. - Agreed Actions - Other # 24 hours initially	Each Gold to Provide Update	11-00Gold24ForwardTemplatehb2019082
5.	Any Other Business	Chair	-
6.	**Next Meeting**: 11-00 Following Day (Mon-Fri)		-

GIG CYMRU NHS WALES	Pwyllgor Gwasanaethau Ambiwlans Brys Emergency Ambulance Services Committee

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Emergency Ambulance Services Committee Report

1% A HEALTHIER WALES COMMISSIONING ALLOCATION 2019/20

Executive Lead: Julian Baker, Director Collaborative Commissioning

Author: James Rodaway

Contact Details for further information:
James.Rodaway@wales.nhs.uk

Purpose of the Emergency Ambulance Services Committee Report
The purpose of this report is to provide EASC with an update on progress on the proposals agreed through the Healthier Wales Awarding & Evaluation Panel (HWAEP) on the EASC 1% 'A Healthier Wales' Commissioning Allocation 2019/20 and ongoing evaluation.

Governance	
Link to the Commissioning Agreement	The Committee's overarching role is to ensure its Commissioning Strategy for Emergency Ambulance Services utilising the five step patient pathway outlined within the National Collaborative Commissioning Quality and Delivery Agreement and the related outcomes for each care standard aligned with the Institute of Healthcare Improvement's (IHI) 'Quadruple Aim' are being progressed. This report focuseson all the above objectives, but specifically on providing strong governance and assurance.
Supporting evidence	The Collaborative Commissioning Quality and DeliveryFramework for Emergency Medical Services
Engagement – Who has been involved in this work?	
Chair of EASC, CASC, NCCU, all HBs, C3 Faculty Swansea University	

Emergency Ambulance Services Committee Resolution to:							
APPROVE		**ENDORSE**	√	**DISCUSS**	√	**NOTE**	

The Emergency Ambulance Services Committee is asked to:
- **ENDORSE:** the Chairs action on the advice of the Healthier Wales Awarding Evaluation Panel (HWAEP) for the Green and rejected submissions.
- **DISCUSS:** the next steps of the Amber + & - submissions to progress the potential Chair's actions contained within Appendix 1 & 2 in light of the emerging financial and service delivery risks around Emergency Ambulance Services. (WAST Relief Gap Paper & EASC: Reference Document circulated to EASC Members in August 19.)

Summaries the Impact of the Emergency Ambulance Services Committee Report

Equality and diversity	There are no implications arising directly from this report.
Legal implications	There are no implications arising directly from this report.
Population Health	No impact
Quality, Safety & Patient Experience	Ensuring the Committee and its Sub Groups make fully informed decisions is dependent on the quality and accuracy of the information presented and considered by those making decisions. Informed decisions are more likely to impact favorably on the quality, safety and experience of patients and staff.
Resources	No direct impact
Risks and Assurance	Identified within the report.
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf The work reported in this summary and related annexes take into account many of the related quality themes in particular timely care.
Workforce	Identified within the report.
Freedom of information status	Open

1% A HEALTHIER WALES COMMISSIONING ALLOCATION 2019/20

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is to update EASC on the progress made since the committee meeting July 19 on the EASC 1% 'A Healthier Wales' Allocation.

This report asks EASC to:
- **ENDORSE:** the Chairs action on the advice of the Healthier Wales Awarding Evaluation Panel (HWAEP) for the Green and rejected submissions.
- **DISCUSS:** the next steps of the Amber + & - submissions to progress the potential Chair's actions contained within Appendix 1 & 2 in light of the emerging financial and service delivery risks around Emergency Ambulance Services. (WAST Relief Gap Paper & EASC: Reference Document circulated to EASC Members in August 19.)

2. BACKGROUND / INTRODUCTION

The 1% 'A Healthier Wales' funding is provided to support additionality as clarified by the Welsh Government in correspondence dated 18 January 2019, with their expectations that:

- Evidence is provided to demonstrate this additional allocation is used to secure further service provision
- EASC discusses with the Welsh Ambulance Services NHS Trust (WAST) how this additional funding can be best utilised to further improve performance and outcomes
- The Welsh Government is advised in due course on the detail of the additional service provision which has been funded.

At the meeting of EASC in March 2019, the Committee discussed and approved the proposed use of the 1% 'A Healthier Wales' funding commissioning allocation for WAST.

At the July 19 meeting of EASC discussed and approved:
- The recommendations of the HWAEP Chair by correspondence following the HWAEP Panel discussion on the 26th July 19.
- The EASC 1% A Healthier Wales additionality funding to develop and enable evaluation of NPUC Winter Funded and 1% A Healthier Wales initiatives across HBs & WAST.
- Funding from the 2019/20 1% A Healthier Wales allocation to recruit a band 6 researcher to fully support the design of the evaluation framework and delivery of evaluation against the Quadruple Aim.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

The EASC Management Group met on the 12 July 2019 to discuss the 23 submissions received by WAST & Health Boards. The Management Group categorised the bids into National and Local ahead of the HWAEP.

The HWAEP panel met on 26 July 2019 to review the 23 submissions received by WAST & Health Boards.

The submissions were categorised into the following categories:
- Green: required level of information and relevance within the bid for immediate approval.
- Amber +: Bid approved for funding following HWAEP actions being implemented or provided.
- Amber -: Bid approved for funding following HWAEP actions being implemented or provided.
- Further work needed: These were submitted as 'local projects' but have the potential to be scaled up nationally. Further discussions to take place around these areas.
- Rejected: Rejected by the panel as they did not meet the criteria, worthwhile exploring other sources of funding (external and internal) in order to progress further.

Chairs Action on HWAEP Submissions
The HWAEP panel has met and reviewed the submissions. It was agreed at EASC 23 July 19 that following the panel meeting, the bids would be signed off through Chairs action. The following appendices contain a summary of the bids and Chair's Action and a summary of the associated finances.
- Appendix 1: 1% Healthier Wales Awarding Evaluation Panel, Summary of shortlisted bids & actions.
- Appendix 2: 1% HWAEP financial summary of shortlisted bids & actions.

The HWAEP requested supplementary information to finalise the bids and progress to delivery. The supplementary information is included in full in the following appendices:
- Appendix 3: Mental Wellbeing By Design - enabling colleagues to sustain a longer, more fulfilling, healthier and happier working life
- Appendix 4: Transport solutions: Right transport, right patient, right time
- Appendix 5: Intelligence Led Joint Response Unit Pilot (WAST and Police)
- Appendix 6: Shifting left on mental health and crisis care – building a more responsive workforce and a more efficient response
- Appendix 7: Welsh Ambulance Service NHS Trust - Volunteer Strategy

Monitoring financial performance
NCCU will monitor and report the financial performance of these initiatives to EASC. Any slippage in available funding will be utilised as a commissioning allocation in line with the principles agreed for HWAEP and service continuity for EASC commissioned services.

EASC Priorities
An allocation of £150k was listed in the EASC IMTP to support the 24/7 expansion of EMRTS.

EASC are asked to discuss the potential Chair's actions for the Amber + & - submissions in light of the emerging financial and service delivery risks around Emergency Ambulance Services (WAST Relief Gap Paper & EASC: Reference Document circulated to EASC Members in August 19.)

4. RECOMMENDATION

Members of the Emergency Ambulance Services Committee are asked to:

- **ENDORSE:** the Chairs action on the advice of the Healthier Wales Awarding Evaluation Panel (HWAEP) for the Green and rejected submissions.
- **DISCUSS:** the next steps of the Amber + & - submissions to progress the potential Chair's actions contained within Appendix 1 & 2 in light of the emerging financial and service delivery risks around Emergency Ambulance Services. (WAST Relief Gap Paper & EASC: Reference Document circulated to EASC Members in August 19.)

Freedom of information status	Open

Appendix 1: 1% 'A Healthier Wales' Awarding Evaluation Panel, Summary of shortlisted bids & actions

Green Category:

Reference	Organisation	Title	Lead	HWAEP Actions	Chairs Action
WAST5	Welsh Ambulance	The Welsh Ambulance Services NHS Trust (WAST) Older Peoples Framework: making better decisions with Older People by bringing additionality to the older people we come into contact with in the community	Rachel Marsh	• Final Figure to be determined • Make clear what are we expecting WAST to delivery in the future with this scheme • Identify any gaps in the system, and the impact • Possible considerations around it being a joint appointment, and to reconsider the analyst function	• Approved • WAST to recruit lead but delay recruitment of other posts until Lead is in post.
WAST6	Welsh Ambulance	Mental Wellbeing By Design - enabling colleagues to sustain a longer, more fulfilling, healthier and happier working life	Rachel Marsh	• Final Figure to be determined • Supportive in principle, however considerations are needed around delivery model e.g. job roles and possibilities of buying in this service	• Approved

Amber + Category:

Reference	Organisation	Title	Lead	Actions	Chairs Action
WAST1	Welsh Ambulance	Transport solutions: Right transport, right patient, right time	James Rodaway / Mark Harris /	• Needs further clarity surrounding outcomes and benefits to patients. • Also clarification around outputs • Finalise costings	Awaiting Decision

				Nicola Bowen	• What would ongoing costs be? What level of support is required etc. (Initial start-up costs, and longer term running costs)	
WAST2	Welsh Ambulance	Falls Response Model- Providing a timely, appropriate and proportionate response to patients who have fallen		Rachel Marsh	• Should this be managed from within WAST? • Currently operating hours 12hrs, 7 days, are we targeting at the right time? Review what the optimum hours would be? • How will other falls resources be affected?	Awaiting Decision
WAST3	Welsh Ambulance	Intelligence Led Joint Response Unit Pilot (WAST and Police)		Rachel Marsh	• Needs further clarification in terms of: 1) Funding commitments 2) Evaluation process – who would lead? 3) Governance structures for a JRU • What additional benefits would this service bring to the NHS (as opposed to benefits to the police service)	Awaiting Decision

Amber - Category:

Reference	Organisation	Title	Lead	Actions	Chairs Action
P1	Powys	Respiratory MDT Response	Samantha Ruthven-Hill / James Houston / Rachel Marsh	• Stephen Harrhy to discuss with Welsh Government in the first instance. • Bid needs to be worked up in more detail and clarification around outcomes and costs to be confirmed	Awaiting Decision
WAST4	Welsh Ambulance	Shifting left on mental health and crisis care – building a more responsive workforce and a more efficient response	Rachel Marsh	• More work around contextual information needed • Merit in pursuing this scheme but costings etc. need to be confirmed.	Awaiting Decision
WAST7	Welsh Ambulance	Welsh Ambulance Service NHS Trust - Volunteer Strategy	Rachel Marsh	• Refine bid submission (restrict/refine) • Greater clarity around the scheme needed – how will this be embedded into the organisation	Awaiting Decision

Further work needed category:

These were submitted as 'local projects' but have the potential to be scaled up nationally. Further discussions to take place around these areas.

Reference	Organisation	Title	Actions
BC1	Betsi Cadwaladr	Development of SICAT to support community hospital and care homes	Develop proposals for EASC to consider.
SB1	Swansea Bay	Acute GP Review of patients waiting on the WAST Live Stack	
SB2	Swansea Bay	Swansea Bay Health Board Acute Clinical Teams (Swansea and NPT) provide an alternative integrated response model to ED	

Rejected bids:

The submissions below were rejected by the panel as they did not meet the criteria, however there is merit in the bids and would be worthwhile exploring other sources of funding (external and internal) in order to progress further.

Reference	Organisation	Title	Comments	Chairs Action
BC2	Betsi Cadwaladr	APP joint working in Ysbyty Alltwen Minor Injury Unit	• Candidate for Winter Funding. • At present no resources to pull APP for a period of 3 months	Rejected
CTM1	Cwm Taf Morgannwg	Increasing Capacity to Improve Handover Times	• Local - Internal Funding	Rejected
CTM2	Cwm Taf Morgannwg	Extension to 3rd Sector Discharge Scheme from A&E	• Local - Internal Funding	Rejected
CV1	Cardiff & Vale	Increasing the Use of Alternative Referral Pathways : Improving and Evolving the Use of the Community Falls Pathway and Services in Cardiff & the Vale UHB	• Local Level - HB staff. How do we target the resource better? Conversation to take place between WAST & Cardiff	Rejected
CV2	Cardiff & Vale	Clinical Pathway Redesign for Patients Diagnosed with non-ST Elevation Acute Coronary Syndrome (NSTEACS)	• Local- not suitable for EASC funding	Rejected

Reference	Organisation	Title	Comments	Chairs Action
HD1	Hywel Dda	WAST & Hywel Dda University Health Board - Hospital Ambulance Liaison Officer (HALO)	• Local Internal Funding - needs a HB person to co-ordinate. Happy to have the conversation	Rejected
HD2	Hywel Dda	WAST & Hywel Dda University Health Board – Out of Hours primary Care / GP Services Collaboration with Advanced practitioners (Paramedic / Nurse)	• There will be discussions with Health Boards as part of the APP Scheme	Rejected
HD3	Hywel Dda	Hywel Dda University Health Board – radiology Support and extended operational hours of Minor Injury Unit (MIU) in rural areas	• Would encourage Radiology service to put in place - not appropriate source of funding	Rejected
HD4	Hywel Dda	WAST & Hywel Dda University Health Board – Category 1 Falls Assistance / Welfare	• Local Level - HB staff. How do we target the resource better? Conversation to take place between WAST & Hywel Dda	Rejected

Reference	Organisation	Title	Comments	Chairs Action
HD5	Hywel Dda	WAST & Hywel Dda University Health Board – Inter-Hospital Transfer Vehicle	• Conversation around the need of changes in service (Demand & Capacity review) would need conversation of what resources are needed	Rejected
SB3	Swansea Bay	Hospital Ambulance Liaison Officer (HALO)	• Local Internal Funding - needs a HB person to co-ordinate. Happy to have the conversation	Rejected
SB4	Swansea Bay	Frequent services users nurse – Morriston ED	• Local Health Board Funded	Rejected

Appendix 2: 1% HWAEP financial summary of shortlisted bids & actions

1% Healthier Wales Awarding Evaluation Panel
Friday 26th July 2019

Figures in £m

				2019 / 20	2020 / 21	2021 / 22
Funding from 1% Healthier Wales				**1.705**	**TBC**	**TBC**
Less approved Project spend:	Welsh Ambulance Service	Falls Service - to end of September'19	Non Recurrent	0.300	-	-
	EMRTS	EMRTS Expansion	Recurrent	0.150	0.150	0.150
	NCCU	Research and Evaluation (1% and Winter Evaluation)	Recurrent	0.080	0.080	0.080
Available Funding from 1% Healthier Wales				**1.175**	**TBC**	**TBC**

Shortlisted Projects:

	Reference	Organisation	Project Title	Recurrent / Non Recurrent	2019 / 20	2020 / 21	2021 / 22	Total Project Spend Requested
GREEN	WAST5	Welsh Ambulance Service	The Welsh Ambulance Services NHS Trust (WAST) Older Peoples Framework: making better decisions with Older People by bringing additionality to the older people we come into contact with in the community	Recurrent	0.074	0.148	unknown	**0.222**
	WAST6	Welsh Ambulance Service	Mental wellbeing by design - enabling colleagues to sustain a longer, more fulfilling, healthier and happier working life	Recurrent	0.065	0.197	unknown	**0.262**
AMBER+	WAST1	Welsh Ambulance Service	Transport solutions: Right transport, right patient, right time	Recurrent	0.188	0.272	unknown	**0.46**
	WAST2	Welsh Ambulance Service	Falls Response Model- Providing a timely, appropriate and proportionate response to patients who have fallen	Recurrent	0.612	0.722	unknown	**1.334**
	WAST3	Welsh Ambulance Service	Intelligence Led Joint Response Unit Pilot (WAST and Police)	Non Recurrent (6 months)	0.046	-	-	**0.046**
AMBER-	P1	Powys Teaching Health Board	Respiratory MDT Response - 3 month trail	Non Recurrent (3 months)	0.081	-	-	**0.081**
	WAST4	Welsh Ambulance Service	Shifting left on mental health and crisis care – building a more responsive workforce and a more efficient response.	Recurrent	0.091	0.222	unknown	**0.313**
	WAST7	Welsh Ambulance Service	Welsh Ambulance Service NHS Trust - Volunteer Strategy	Recurrent	0.153	0.337	unknown	**0.49**
	Subtotal				**1.310**	**1.898**	**-**	**3.208**

Scenario Analysis

If Green Projects Approved		If Green & Amber+ Approved		If All Projects Approved	
Total Available Funding	1.705	Available Funding	1.705	Available Funding	1.705
Less approved project spend	0.530	Less approved project spend	0.530	Less approved project spend	0.530
Green Projects Spend 2019 / 20	0.139	Green & Amber+ Project Spend 2019 / 20	0.985	All Project Spend 2019 / 20	1.310
Total Funding Remaining	**1.036**	**Total Funding Remaining**	**0.190**	**Total Funding Remaining**	**-0.135**
Funding needed for 2020 / 21	0.575	Funding needed for 2020 / 21	1.569	Funding needed for 2020 / 21	2.128

Appendix 3: Mental Wellbeing by Design

Welsh Ambulance Service NHS Trust

1% Healthier Wales Fund – Mental Wellbeing by Design

Note to Panel following discussion on 26 July 2019

GREEN – FULL YEAR COST £197K

Introduction

1. This brief note seeks to respond to the panel's queries and provide additional supporting information regarding the bid titled "Mental Wellbeing by Design". In summary, **the proposal is to enhance our existing occupational health and wellbeing services with in-house professional psychology.**

Background / Context

2. We have been working with Dr Adrian Neal, Consultant Psychologist, Employee Wellbeing, Aneurin Bevan University Health Board to assist our thinking about our future organisational wellbeing needs, reflecting upon learning from current evidence and research. A recent report from the **Health Education England - Commission into NHS Staff and Learner Mental Wellbeing** set out a compelling, powerful narrative of the importance of promoting and supporting the wellbeing of NHS staff and learners. This description could be speaking directly to the experiences of our own workforce. The report states '*working and learning in the healthcare sector is like no other employment environment. Daily our staff are confronted with the extremes of joy, sadness and despair. [..] this emotional labour is often exhausting.*' It goes on to describe how, '*many of our clinical staff retain a collection of curated, traumatic memories of death and dying. Many [...] see the horrors of extreme trauma; they see the aftermath of major road traffic accidents, suicide, and they see children in distress or dying and they help families cope with the loss of a loved one. They see the effects of deprivation and many see [...] 'life in the raw.'*

3. These inherent demands of the job can profoundly impact upon the wellbeing of staff. Cumulatively, exposure to primary stress may bring about psychosocial injury and disruption to lifestyles, and in more extreme circumstances, may require a significant period of recovery. The knock on effects may also affect family, friends, work colleagues and wider communities.
Most of us can all think of individuals among our staff whose personal experiences and stories move us to want to do better.

4. Our proposal is to invest into in-house professional psychology in order to increase the capacity, skills and capability within the Trust to shape development of our Wellbeing by Design Strategy and to offer greater access to a higher level of psychological support and individual intervention for those individuals at greatest need. Reflecting upon the recommendations of the HEE Commission report (recommendation 2) it is proposed this post could fulfill the role of *Workplace Wellbeing Lead* – working closely with the Executive Director of Workforce and OD, across the Board and Executive Management Team and wider organisation to safeguard individual and organisational health and wellbeing.

5. The rationale and what we hope to achieve has been set out within the EARTH template and has been approved in principle subject to some additional information and clarity on the following points:

Why professional psychology input? Is this clinical psychology or occupational psychology?

6. Our reading points to a need for employers to develop a deeper, more psychosocially informed understanding of the complex demands and psychological aspects of their work as well as what internal and external resources employees need over time to do their job safely. Traditional Occupational Health is mostly focused on illness and in particular reactive interventions to help with physical illness. We now know that the best performing and sustainable workforces work in environments where the psychosocial aspects of wellbeing is proactively addressed. The HSE, and legislation, do a good job protecting and understanding physical health at work but given now most of sickness absence (and potentially also underperformance, conflict, errors and poor morale) is linked to psychological and social factors it seems logical to draw upon the expertise of a professional psychologist to lead workplace wellbeing going forward.

7. What's more, a psychologist will help the organisation identify, measure and understand the psychosocial needs of the workforce allowing us to design wellbeing proactively into the way we do business – into our jobs, systems, practices and environments – this challenge sits at the heart of our emerging strategic wellbeing ambitions. A consultant psychologist, preferably a clinical psychologist with an understanding of occupational psychology / organisation behaviours, would enable us to substantially develop our capacity to address (both reactively and, importantly, proactively) the psychological needs of our workforce and deliver patient facing care as appropriate.

8. At a simple level, most high performing sports teams now have direct input from a professional psychologist to help address their psychosocial needs, why should #TeamWAST be any different?

Employ or Buy In?
How will WAST ensure appropriate professional leadership and clinical supervision for an in house psychology resource?

9. Given the scope and expectations of these roles, we believe full time employment / secondment (see above) is a preferable option to buying in resource on a sessional basis. We require individuals who will immerse themselves in understanding the organisation, the cultures, frontline roles and demands, build relationships and feel personally and professionally invested in delivering positive outcomes for the organisation and its workforce.

10. We understand the Healthier Wales funding is recurrent which would allow for substantive appointments to be made. This may be an appropriate arrangement at consultant level provided arrangements can be made with Health Board colleagues to access professional leadership necessary for appraisal, revalidation and CPD requirements – we are confident this can be agreed. We are basing this on the experience and advice of Dr Adrian Neal, presently employed as a Consultant Psychologist, Employee Wellbeing Lead within the Organisational Development Directorate of Aneurin Bevan University Health Board, who has minimal contact with the Health Board's clinical psychology department.

11. However, we are advised that a secondment arrangement whereby the overall responsibility for professional leadership continues to lie with the originating/seconding organisation, would be a more appropriate arrangement for the Band 8a clinical psychologist. This post holder will carry a much more direct patient facing case management role, providing clinical leadership, supervision and oversight of our TRiM practitioner network and development of our mental wellbeing pathways. In this circumstance, the Professional Lead from the host organisation would still hold ultimate responsibility for all matters professional (planning CPD, Governance, HCPC related matters). It would however be important to establish clear line management within the host organisation (WAST) and this is best placed within OH. Without this there may be issues around agreed goals, accountability and appraisal. Typically the host manager will conduct the annual appraisal and the professional lead will attend to offer guidance.

12. We are keen to move swiftly to recruit to these crucial posts so that we may begin to describe what an enhanced Occupational Health Service might look like, and to realise the benefits of meeting agreed organisational priorities around the psychosocial needs of staff. These include, for example, improved wellbeing; improved morale and engagement; improved psychologically based mental health; improved team work; a strengthened culture of compassion & psychological safety, supported by appropriate leadership training and development; improved management of complex cases where mental illness is implicated; better psychosocial risk assessment (suicide, DSH and capability to work); and the design of validated psychometric tools specifically for this population; and delivery of a range of evidence based psychological therapies.

Please let me know if further information is required.
Claire Vaughan, Executive Director of Workforce & OD
06 08 2019

Appendix 4: Transport solutions: Right transport, right patient, right time

Welsh Ambulance Service NHS Trust

1% Healthier Wales Fund – Non Emergency Patient Transport Service

Note to Panel following discussion on 26 July 2019

AMBER PLUS - £272K for first year, one post to be reviewed thereafter

Introduction

1. This brief note seeks to respond to the panel's queries in relation to the bid entitled "Transport solutions: Right transport, right patient, right time'.

Background and Context

2. The NEPTS Healthier Wales bid "Right transport, right patient, right time", was developed in partnership through the NEPTS Delivery Assurance Group and with the full support of all partners. Members of the DAG held several sessions to develop the bid and to develop the proposed concept into a deliverable proposal.

3. During the development process we have also sought the views of Welsh Government, CHC Cymru and other parties and the proposal has received their support and has been welcomed as a positive way forward.

4. The bid has been developed to contribute towards achieving several of the aims of the NEPTS business case which was approved by the Minister in 2016 and to contribute to achievement of the 2019/20 commissioning intentions for NEPTS.

5. A small scale trial of this service was undertaken for patients with a T1 mobility in Aneurin Bevan in July 2018. The trial saw no concerns raised by patients or their representatives and reduced both overall numbers of journeys undertaken and the level of social conveyance.

6. Should the bid be approved, it will allow us to enhance and transform the interface between the public, Health Care Professionals and the service, whilst also delivering improvements to quality and transforming service delivery across all 5 steps of the NEPTS pathway.

Expected Benefits and Outcomes

7. The panel indicated that they would want to be assured of the benefits and outcomes for this scheme, both from a qualitative and quantitative perspective. The following paragraphs therefore attempt to describe more succinctly the purpose of the service solution against each of the NEPTS steps.

Step 1

8. There is very little consistency across Wales, either from Health Boards or WAST, in how NEPTS is promoted or accessed. This has led to a patchwork quilt of provision across Wales where different access routes are promoted from a clinic level upwards and patients are uninformed and confused about what NEPTS is, who it is for and how it is accessed. This is demonstrated by a

study undertaken of one Health Board's appointment confirmation letters, where over 40 different versions were identified with wide variation on the guidance provided for NEPTS provision and the methods of accessing the service.

9. The variability and inadequacies of this aspect of provision was also identified and highlighted by the CHC Cymru report, Non-emergency transport: The picture across Wales, which stated, *"Any framework must be well communicated to front line staff and patients and ensure equitable and safe provision across Wales."*

10. The proposal will establish a focus on step 1 of the NEPTS 5-step model that currently does not exist. The proposal will identify the key messages that patients need to know to allow them to make informed decisions about NEPTS and how they can access healthcare provision. The proposal will introduce NEPTS 'help me choose' messaging that will help meet the current unmet needs of patients and deliver a system that is clear, well publicised and reflects actual service provision.

11. As the signposting of non-eligible patients increases and the alternative options for provision grow, the list of local alternative provision will need to be kept live and reflect actual provision available to ensure a good patient experience. The proposal will provide the required staffing capacity to ensure this happens.

12. The NEPTS business case and CASC commissioning intentions both require a reduction in the conveyance of non-eligible patients. This shift away from the current situation of almost universal provision for non-eligible patients will make it more important than ever that clear guidance and advice is given to patients and HCP's on eligibility and the alternatives to NEPTS provision. This proposal will allow us to do this without having to divert resources away from other areas of service delivery and risk reducing patient care.

Step 2

13. The current process required to make bookings for NEPTS journeys also varies across Wales with bookings being made on line, by telephone, in person and by fax. There are also 2 separate Health Board operated centres in Powys & Ty Elai.

14. When a patient contacts NEPTS to make a booking for transport they are subjected to several sets of questions (Patient Needs Assessment – PNA) to establish:

    *   Are they a HCP? If so, there is an assumption that the HCP has undertaken the assessment for eligibility and the patient is automatically determined as being medically eligible.
    *   Are they medically eligible – if yes, booking accepted. If no, booking could be accepted or passed to alternative providers.

15. For all non-eligible patients, the WHC advises that the provider only has to "consider" the request for transport, but does not define what this consideration should take account of.

16. The proposal will allow for the PNA to be reviewed to ensure it correctly identifies medically eligible patients and also supports those without a medical need for transport to identify and secure alternatives. The proposal will define what 'consideration' means and establish a framework to establish a conversation with patients to identify what non-medical needs for transport exist and match these to the most suitable available alternative provision.

17. The proposal also allows the service to Quality Assure booking requests and ensure that the operators and the process are most effectively meeting patients' transport needs. This audit will also allow the service to identify areas of unmet need and to link with the Help Me Choose lead and the Alternative Provider team to develop/access appropriate solutions within the community and build these additional services into future call scripts.

Step 3

18. NEPTS journeys are currently planned the day prior to travel and the resource availability is based on historical activity. However, NEPTS demand is highly variable with significant differences in volume, acuity and location of journeys every day. The current system timeframes do not allow enough time to adjust resource availability to ensure optimal service provision. This can result in either not enough or too much resource being available or the wrong type/location of resource being in the plan.

19. As most NEPTS journeys are planned journeys, it should be possible to predict demand and to adjust resource availability/profile to ensure it is more closely aligned with actual demand.

20. The proposal allows for the development of a daily analysis of actual demand and historical demand to identify shortfalls or surplus of resource in a more timely manner that allows the service to respond appropriately.

21. This analysis, combined with the work of the Alternative Provision team, will ensure that our utilisation of additional resources is minimised and that the most cost effective appropriate solution is procured.

Step 4 & 5

22. All of the above steps will contribute to an overall improvement, where demand into the service is managed appropriately, where the quality of bookings will increase and therefore patient needs are captured more consistently and accurately. This, combined with increased awareness of NEPTS demand and appropriate resourcing, will increase the likelihood of the appropriate resource being available to meet the patients' needs. Right transport, right patient, right time.

23. Our proposal will also deliver the following specific performance improvements, as well as contributing to performance improvements across many of the NEPTS indicators. It should be noted at this stage that further discussions will need to take place through the DAG with partners to confirm and agree these planned improvements and they may therefore be subject to some change as the detailed service implementation planning commences.

   Step 1

   - a 20% increase month on month for the first 12 months in the number of patients signposted to alternative providers

   Step 2

   - a 50% reduction on 2018-19 levels on the level of abandoned calls
   - a 100% reduction on 2018-19 levels of bookings taken by fax in year 1

   Step 3

- a 20% reduction on 2018-19 levels on bookings received after 12 noon the day before travel

Will the resources identified be required recurrently?

24. The panel requested further clarification as to whether the resources put forward in the bid would be required recurrently or whether an element would be considered as non-recurrent implementation costs.

25. The additional resources described in steps 1 & 2 and the Demand Planning Manager would be required for the initial set up of the proposals and would then become a key part of any future service provision. These posts would be required to both manage the service provision and also to ensure that the service remained live and continued to maximise the impact going forward. These posts will also allow for the service to respond to future changes in service provision, so will need to be funded on a recurrent basis.

26. Although there will always be a need to have high quality analyst support within the service, it is accepted that once the demand analysis and reporting system is established and mature there may not always be a need for the proposed level of analyst support. It is therefore proposed to review the post of NEPTS demand analyst after 12 months to establish if it is still required.

Mark Harris
Interim Deputy Director for NEPTS

Appendix 5: Intelligence Led Joint Response Unit Pilot

Welsh Ambulance Service NHS Trust

1% Healthier Wales Fund – Joint Response Unit

Note to Panel following discussion on 26 July 2019

AMBER PLUS - £46k non recurrent

Introduction

27. This brief note seeks to respond to the panel's queries in relation to the bid entitled "Intelligence Led Joint Response Unit Pilot". This should be read in conjunction with the EARTH template previously submitted.

Background and Context

28. WAST have been operating Joint Response Units (JRU's) for several years together with the three Southern Wales Police Forces. Following constructive challenges both internally at WAST, from our Senior Clinical Directorate colleagues, and externally, from JESG Chief officers and the Tri-service Demand & Intelligence Hub Team, a decision was made to review the value of the JRU(s) and to test any variation or waste.

29. The WAST Assistant Director of Operations worked with the Health Informatics Team to look at an Intelligence Led list of criteria, to establish if the remaining three JRU's were located appropriately, and operated with the right skills in the right places. A clear objective was to test if the JRU's use of a paramedic was proportionate and necessary as compared with the alternative of working on a conventional RRV.

30. It was agreed that the previous self-tasking JRU models would need to be tested against the more auditable and accountable methodology of being tasked by the WAST Clinical Contact Centre in partnership with the Police Public Service Centre. The WAST calls/code sets were agreed as being mutually beneficial to patients and the communities across South Wales, allowing clear Terms of Reference for the service.

What are the proposed benefits of the service, from a WAST and a police perspective?

31. It is proposed that the Call Code sets that the JRUs respond to are Mental Health, RTCs, Deaths and Overdoses and Violent calls. The aim of the pilot will be to establish the benefit of the joint response to these types of calls. The paragraphs below attempt to describe the benefits that are expected.

32. Improved attendance at Mental Health Calls: The benefit here is that the right resources are sent in a timely fashion together. If there is violence, the police will take primacy. If the patient needs treatment then the paramedic will assess the patient and consider A&E or an alternative pathway. We will measure the number of calls which provide added value from both emergency services perspective.

33. Improved attendance at RTCs: We will measure the number of calls which provide added value from both emergency services. The joint response to these calls should allow the paramedic to assess, treat and address patient needs, and allow the police to assess the danger and deal with RTC.

34. Improved service provided in the event of a death or overdose: Both police and WAST are called to deaths and overdoses. The benefits here will be in relation to timely joint responses which avoids long delays waiting for one of the emergency services to assist the other.

35. Improved attendance at calls with potential violence: It is anticipated that this will bring significant benefits to both parties. Having the police presence will allow the paramedic to treat the patient and decide on the best course of medical intervention without risk of getting hurt themselves.

36. Reduction in adverse incidents: Adverse incidents are often raised by both WAST and the police where there are delays in attendance to mental health patients. This will reduce the number of adverse incidents raised therefore, at the same time as improving the patients experience and keeping staff safe.

37. As the three proposed pilot sites use a WAST Rapid Response Vehicle and respond primarily to WAST calls, it is likely that the main benefits will accrue to WAST. However, the ability for a police officer to support a paramedic is seen as a win-win by avoiding the need for the police units to attend themselves and to have to convey patients or attempt to deal with Mental health or other vulnerable patients without the requisite skills.

38. In conclusion, whilst both WAST and SWP/Gwent Police will benefit through reducing inappropriate attendances, it is clear that the main beneficiaries will be our patients and the wider communities of South Wales and Gwent.

What will the governance arrangements be for this service and how will decisions be made about long term recurrent funding?

39. The Governance route will be via the leads from the Tri-service Demand & Intelligence Hub reporting into the Chief Officers from JESG Executive. This will involve briefing CFO Hugh Jakeaway SWFR as the ambassador of JESG who will agree any additional criteria for measuring success. It was hoped that the leads from the Tri-service Demand & Intelligence Hub could present initial findings to the next JESG in November 2019. However, this will depend on whether the bid is successful, and the project is able to commence as soon as possible, to meet that deadline. Alternatively it would need to be presented at the following JESG in April 2020 which may allow for a longer evaluation window and for the benefits to be delivered over the busy winter months.

40. However, whilst it is proposed that the evaluation and review of these pilots would be taken to JESG, it is clear that any funding requirements would need to be agreed by EASC as the WAST commissioner. WAST can confirm that any agreement to these pilots does not constitute an agreement for long term funding.

Submitted By
Robert Tooby
Assistant Director of Operations
(WAST Lead for the Tri-Service Demand & Intelligence Hub)

Appendix 6: Shifting left on mental health and crisis care – building a more responsive workforce and a more efficient response

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Welsh Ambulance Service NHS Trust

1% Healthier Wales Fund – Mental Health Bid

Note to Panel following discussion on 26 July 2019

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AMBER – FULL YEAR COST £222K

Introduction

1. This brief note seeks to respond to the panel's queries regarding the bid titled "Shifting left on mental health and crisis care – building a more responsive workforce and a more efficient response".

Have other bids been submitted to other funding bodies?

2. WAST can confirm that no other mental health bids have been submitted to Welsh Government, or indeed to any other funding body in Wales or the wider UK. The 1% Healthier Wales submission is our only live or proposed bid on mental health.

Will it be possible to recruit staff to these posts? Could this undermine frontline mental health services?

3. Practice development roles are relatively common in the UK and these roles are benchmarked against existing roles in the NHS. Our market testing tells us that these posts will be attractive to mental health professionals in Wales and beyond, particularly people who want to grow into clinical teaching or academic positions, and this proposal provides a career structure for them within WAST.
4. The three Band 7 posts will be situated to support staff and work with partners across three regions in Wales, and as such we will only be looking to recruit one person in each region (North Wales, Central and West Wales, South East Wales). This will have a minor impact workforce planning within Health Board areas.
5. WAST will also work in partnership with Directors of Nursing to explore joint appointments with Health Boards or other organisations to share skills and extend the reach of practice improvement across the crisis care systems. However this approach may require additional investment from LHBs/others to achieve this approach with regards to travel costs etc.

How is WAST ensuring that newly qualified paramedics emerge from university with all of the skills required? Wouldn't that reduce the need for practice development?

6. WAST is currently working with Swansea University to develop the degree programme for paramedicine, and specifically the mental health content included within it. However, this degree programme will not commence until 2020, and first graduates will only emerge in 2023. The existing diploma programme content is set, and not something Swansea are keen to change given that it will soon be phased out.

7. Furthermore, the degree programme will have little impact on our existing staff. Ongoing learning of the nature described in the bid will be key to helping keep our staff in post across all our services up to date with changes to population needs, new interventions and maintaining good practice, ultimately to provide safe timely and effective evidence based care and to ensure patients are signposted to the right service.

Is this proposal additional to what WAST has been doing already?

8. The proposal is significantly different and additional to our current offer, or what we are currently funded for. The paper attached below sets out our delivery plan for 2019-20 that is set within our current resource allocation. The longer term strategy is not articulated in a document, and therefore the delivery plan provides the best information on the work that is currently on-going.

9. This plan for 2019-20 has been agreed with commissioners and Welsh Government. Our three year mental health improvement plan is embedded within that document. The plan for this year reflects a substantial amount of work that is underway in readiness for the outcomes from the mental health and crisis care access review.

10. WAST is already providing education to our staff around mental health, including e-learning and single day training on suicide intervention. However, whilst we know this is beneficial, the evidence suggests that this model is expensive to buy-in. Furthermore, we know that releasing staff to participate in training is costly and difficult, particularly over winter. This currently represents a minimum offer.

11. This proposal for the practice educators seeks to support learning as people work. Rather than release people for training away from their workplace, practice develop facilitators will work alongside an individual or a small group in their role to support applying new interventions in real practice circumstances, to grow confidence and competence, to reflect and embed skills in the context that they will be used in, and to ensure that the skills are used. An example of application in practice:

    - Have a short introduction to the intervention being learned
    - 'Hear and treat' or 'see and treat' patients together
    - Try out the intervention in the real world
    - Reflect on how things went
    - Try the skill again, until confidence and competence is achieved

12. Practice development facilitators will all work to the same model of practice, ensuring that there is consistency to what is being delivered and how it is being taught. They will collect substantial amounts of data on practice change, and on outcomes for the public. This model is sustainable, achieve better skills within the workforce and improve outcomes for the public.

Summary

13. We feel that this proposed offers a sustainable approach that will embed better crisis care practice in WAST without hollowing out existing mental health services. It will improve outcomes for people, provide better data for commissioners and a better learning experience for our staff.

14. We hope that this note clarifies key points for the panel. However we would welcome any further questions to assist the panel.

Appendix 7: Volunteer Strategy

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Welsh Ambulance Service NHS Trust

1% Healthier Wales Fund – Volunteer Strategy

Note to Panel following discussion on 26 July 2019

AMBER – REVISED FULL YEAR COST OF C£59K

</div>

Introduction

1. This brief note seeks to respond to the panel's queries in relation to the bid entitled "Volunteer Strategy" and **refines the resources requested** accordingly.

Background and Context

2. Our inaugural three year Volunteer Strategy will articulate our ambition and form an integral part of our three year People and Culture Strategy, which aims to enable people to be their best. The strategy will also make an important contribution to the implementation of the Wellbeing of Future Generations (Wales) Act 2015 and Welsh Governments 'A Healthier Wales' vision. It is currently anticipated that the Strategy will be considered at the September Trust Board meeting.

What additionality is delivered as a result of this bid?

3. At the evaluation panel meeting, the panel expressed the view that a large part of the bid related to work that was 'business as usual', given that we have supported volunteering within the Trust for many years. As such, a number of elements of the bid were not supported.

4. The panel indicated that it would be supportive however of a reduced bid, where this demonstrated additionality.

5. Our vision is to create an organisation that embraces volunteering as a means of uniting the Trust with our communities and enabling the public to give something back. Working with our Patient Engagement, Community Involvement team our focus will be to increase the diversity of our volunteers so that we embrace cultural diversity, engage with young people and those that are most marginalised within our communities and face segregation due to language barriers, isolation and loneliness, mental health conditions and religious beliefs. This will be one area of additionality.

6. The strategy will also look more widely at the greater contribution that volunteers can make to enhancing all parts of the organisation and services, not just as Community First Responders or as volunteer car drivers.

7. The proposed Senior Volunteer Manager role is seen as integral, offering leadership and direction to ensure we deliver our ambitions set out in our strategy. There will also be considerable focus on ensuring that all our current and future volunteer opportunities and in particular community first responders are effectively recruited, developed and deployed to support WAST in achieving target response times and improving the experience and service we offer our patients and service users across Wales.

8. We are therefore proposing that we put forward a revised bid for the Senior Volunteer Manager. The annual cost for this post would be £59k, with an in year cost of £20k for a candidate starting in December 2019.

9. The revised offer should still be read in the context of the full information in the EARTH template, which sets out the benefits of the implementation of the Volunteer Strategy.

Emergency Ambulance Services Committee Report

ESTABLISHMENT OF THE SOUTH, MID AND WEST WALES TRAUMA NETWORK – WELSH AMBULANCE SERVICES NHS TRUST BUSINESS CASE

Executive Lead: Stephen Harrhy – Chief Ambulance Services Commissioner

Author: Ross Whitehead – Assistant Director Quality and Performance

Contact Details for further information: ross.whitehead@wales.nhs.uk

Purpose of the Emergency Ambulance Services Committee Report

The purpose of the report is to seek Members endorsement of the Welsh Ambulance Service NHS Trust element of the programme business case for the establishment of the South, Mid and West Wales Major Trauma Network and to discuss the funding arrangements for implementation.

Governance

Link to the Commissioning Agreement	The Committee's overarching role is to ensure its Commissioning Strategy for Emergency Ambulance Services utilising the five step patient pathway outlined within the National Collaborative Commissioning Quality and Delivery Agreement and the related outcomes for each care standard aligned with the Institute of Healthcare Improvement's (IHI) 'Quadruple Aim' are being progressed. This report focuses on all the above objectives, but specifically on **providing** strong governance and assurance.
Supporting evidence	The Collaborative Commissioning Quality and Delivery Framework for Emergency Medical Services

Engagement – Who has been involved in this work?

WAST; EASC; Health Boards

Emergency Ambulance Services Committee Resolution to:

APPROVE		ENDORSE	√	DISCUSS	√	NOTE	
Recommendation		The Emergency Ambulance Services Committee is asked to: • **ENDORSE** the Welsh Ambulance Service NHS Trust element of the Major Trauma Programme Business Case • **DISCUSS** the funding arrangements for implementation.					

Summarise the Impact of the Emergency Ambulance Services Committee Report	
Equality and diversity	There are no implications arising directly from this report
Legal implications	There are no implications arising directly from this report.
Population Health	No impact
Quality, Safety & Patient Experience	Ensuring the Committee and its Sub Groups make fully informed decisions is dependent on the quality and accuracy of the information presented and considered by those making decisions. Informed decisions are more likely to impact favourably on the quality, safety and experience of patients and staff.
Resources	The financial resource requirements are outlined in the body of the report.
Risks and Assurance	Identified within the report
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf The work reported in this summary and related annexes take into account many of the related quality themes in particular timely care.
Workforce	Identified within the report.
Freedom of information status	Open

ESTABLISHMENT OF THE SOUTH, MID AND WEST WALES TRAUMA NETWORK – WELSH AMBULANCE SERVICES NHS TRUST BUSINESS CASE

1. SITUATION / PURPOSE OF REPORT

The purpose of the report is to seek the endorsement from Committee Members for the content and assumptions within the Welsh Ambulance Services NHS Trust element of the programme business case for the establishment of the South, Mid and West Wales Major Trauma Network.

In addition, Members are asked to discuss the available options for funding the implementation of this element of the case.

2. BACKGROUND / INTRODUCTION

South, Mid and West Wales are currently the only region of the UK that does not have a trauma network. The current trauma network programme is aims to have an operational network in place by April 2020.

Each of the respective elements of the programme have produced their own elements of the programme business case. Whilst the Welsh Health Specialised Services Committee are the main commissioner for the establishment of the network, EASC are required to endorse the Welsh Ambulance Services NHS Trust element of the case.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

The current Welsh Ambulance Services NHS Trust element of the major trauma programme business case is attached at **Appendix 1** to this report. Members should note that the case has been through a number of rounds of scrutiny, by the programme board, the Chief Ambulance Services Commissioner and his team and external peer review.

The feedback received from the external peer review has also been attached at **Appendix 2** for consideration by Committee Members.

The Chief Ambulance Services Commissioner support the contents of the case as a reasonable position, whilst recognising that a number of the activity components are 'worst case' scenarios and will need to be reviewed post-implementation.

Committee members will note the content of the email attached at **Appendix 3** to this papers that outlines the NHS Collaborative position on the funding requirements for the implementation of this case, notably:

"Major trauma network development needs to be funded from within existing allocations"

Committee members should be aware that the requirement for any funding for the WAST element is contingent on the enactment of the network via the funding of other elements of the programme business case. If the network does not go live there will be no funding requirements for WAST.

Committee members will be aware that to date EASC has not allocated any of its funding directly to the provision of major trauma service for the Welsh Ambulance Service. As such members are asked to discuss the allocation of funding for this case against the various other priorities for EASC funding and to provide the CASC with a steer on the actions to be taken in regards to the implementation of the WAST case.

4.   RECOMMENDATION

Members of the Emergency Ambulance Services Committee are asked to;

- **ENDORSE** the Welsh Ambulance Services NHS Trust element of the Major Trauma Programme Business Case
- **DISCUSS** the funding arrangements for implementation.

Freedom of information status	Open

South Mid and West Wales Trauma Network

Welsh Ambulance Services NHS Trust
Business Case

1. Context

1.1   The WAST internal context

Welsh Ambulance Service NHS Trust (WAST) is a critical enabler in the success of the South Wales and South Powys Major Trauma Network. For the vast majority of patients who suffer major trauma their first contact with NHS Wales will be with the ambulance service when they receive initial care at scene.

The service will also play a critical role in taking these same patients either home following care in the secondary care setting or onwards for their specialist rehabilitation.

The role which the ambulance service is being asked to play within the new network aligns seamlessly with the organisations recently agreed long term strategy for ambulance services in Wales - Delivering Excellence. A strategy which articulates a desire, by 2030 to;

> ➢   Ensure quality is at the heart of everything we do;
> ➢   Provide the right care, in the right place wherever and whenever it is needed;
> ➢   Enable our people to be the best they can be

However the ambulance service will be unable to play this leading role within the network unless it is resourced appropriately. Whilst the anticipated numbers of patients being cared for within this new model are not expected to change from historic numbers the new clinical model for major trauma will result in the ambulance service making many more 'new' journeys, journeys which may often involve significant distance. Existing resources may be taken out of its local area for much longer period of time.

These longer journeys will also result in some cases, patients needing to be cared for by Ambulance crews for much longer. This will be a significantly different way of working for our staff and they are going to need support to ensure they can care for their patients as well as they will want to.

Failure to ensure both these aspects are fully acknowledged and commissioned will ultimately result in the erosion of wider operational performance and patients not getting conveyed to the right location first time.

1.2   The wider context

Welsh Ambulance and EASCs 2019/20 Integrated Medium Term Plan both articulate a commitment to develop an All Wales Transfer and Discharge service.

With many more journeys relating to Major Trauma taking place across South Wales and South Powys the establishment of such a service will play a critical role in the success of the network.

However, early funding to support the establishment of this model will also play a role in supporting improvements in wider system flow. The creation of this model for major trauma will act as a 'spring board' to potential further expansion and rollout to support the transfer and discharge needs of other strategic service changes - most notably the opening of the new Grange hospital in ABHB which will flow circa twelve months after the major trauma network goes live.

1.3   The financial context

WAST makes ongoing commitments within its integrated medium term plans (IMTPs) to be a full and active partner in supporting the successful delivery of a major trauma network for South Wales and South Powys.

However, as a commissioned service through the Emergency Ambulance Services Committee (EASC) our current, and future, plans will stop short of being able to offer assurance on the service being fully funded from an Ambulance perspective until all of the elements of the new service have been agreed and funded by our commissioners.

1.4   1.4 Definitions

For the purpose of this business case WASTs definitions of the following terms are;

Repatriation	When a patient is taken from one hospital to another for specialist treatment
Transfer	When a patient is taken from one hospital to another
Conveyance	When a patient is taken from the scene of an incident to the relevant hospital
Discharge	When a patient is taken home or nursing home / home of carer

2. Description of the clinical and operational model for WAST

WASTs clinical and operational model that will support the major trauma network will be complementary to the organisations nationally agreed clinical model (below).

Designed with permission using the CAREMORE® 5 Steps. Copyright, 2017 WAST.

Step 2 – Answer my call

All calls which the Ambulance receives via 999 are classified as follows;

RED – BLUE LIGHTS	**Immediately life-threatening calls**	Multiple dispatch Blue light emergency response
AMBER – BLUE LIGHTS	**Life-threatening / Serious calls**	Blue light emergency response
GREEN 2 and 3– NORMAL ROAD SPEED	**All other calls**	Face to face response Clinical telephone assessment

The vast majority of major trauma cases will be classified as a red response – *immediately life threatening.*

Step 3 – Come to see me

Effective pre-hospital decision making will take place within this step and decisions will be taken as to the most appropriate response to send to each case- WAST, EMRTS or both.

This decision process would be facilitated by a Major trauma desk located within the Ambulance Services Clinical Contact Centre (CCC).

It is the assumption of this business case that EMRTS will be a 24/7 service by the time the major trauma network goes live.

Step 4 – Give me treatment

WAST has developed a pre-hospital triage tool in conjunction with the Major Trauma Network, which will be used to support pre-hospital decision making at this step with regard to direct transfer from scene to the MTC in appropriate cases. Good discussions have taken place with all stakeholders and refinements have also been made to the tool following the peer review workshop on the 13th August. It is now expected that this tool will be signed off at the major trauma network board in September '19

This tool will be supplemented with live clinical decision support of a major trauma desk (see section six) for more borderline cases.

Step 5 – Take me to hospital

 Decision taken in step 4 guided by the effective use of the two major trauma triage tools will
then determine if in this stage patients are conveyed to the nearest trauma unit or directly to the
major trauma centre.

3. Overview of governance arrangements

WAST is a full member of the Major Trauma Network Board and has both clinical and planning representation on the group. WAST has also nominated individuals to all relevant task and finish groups which sit under the network board.

Internally WAST has established a Major Trauma project group which is constituted of all personnel who represent the organisation at the above external boards and task and finishes groups. This project group will meet monthly until the network goes live on the 01 April 2020.

The following specific governance arrangements have been agreed around the training elements;

Pre-hospital triage tool –the network will 'own' this tool.

Responsible – WAST will be responsible for developing the tool

Accountability – Network board will approve the tool. Monitoring of the tool through Network Board on behalf of WHSSC/EASC, however this will require data from WAST on compliance/LHB issues.

Consulted – WAST clinical governance/EMRTS/network governance subcommittee.

Informed – Providers

Online & face to face training

Responsible – WAST will be responsible for developing both of these elements

Accountability – EASC

Consulted – WAST learning and development, network training and education lead, HEIW

Quality Assure – HEIW and EMRTS (as preferred provider)

Informed – Providers

4. Phased Implementation

In an approach that is complementary to an underlying principle of the wider major trauma network board WAST is taking a 'phased approach' in regards to support of the network. We are committed to ensuring that the network is safe and effective on the 01 April 2020 and that from this point forward the service will be on a trajectory of continued improvement and maturity.

In this respect our phased approach is outlined below;

	Activities	Why	Additional Resource Required
Essential in place For Day 1	• Trauma Triage Tools	Supports patients being apparently triaged and conveyed to most appropriate location	See section 5
	• Online training for staff in relevant geographical areas	Further supports paramedic triage of patients and conveyed of patient to most appropriate location	See section 5
	• Trauma Support Desk / Expansion of EMRTS Desk to fulfil this function (including recruitment of relevant posts)	Final line of support in triage of patient by offering clinical leadership to on scene paramedics. Ensures most appropriate on scene car is provided and plays a system co-ordination role	See section 6
	• Agreement on commissioned activity levels for year 1	Ensures WAST is deploying the most appropriate amount of resources on any given day and that the go live of the network does not destabilise wider WAST operational performance and its ability to attend other non-major trauma cases in the community.	See section 5
Essential in Year 1	• Commencement and completion of 'face to face' staff training • Governance structure in place both network wide and internal to WAST (where relevant) to support decision making. • Transfer and discharge service		See section 7
Essential in Year 2-3	• Ongoing data collection • Dedicated EMRTS vehicle		
Essential in Year 4-5	• Ongoing data collection		
Desirable & aspirational goals	It is desirable for some face to face training to begin prior to go live		

5. Any additional resource requirements for increased ambulance journey's, based on the attached dataset signed off by network board (Figure 7 and the section on 'care closer to home' and any local HB work undertaken (e.g. Hywel Dda).

WAST have identified that the development of a major trauma network will have a significant impact on its resources. In beginning to quantify and understand these implications a number of existing policies, Welsh Health Circulars and agreed stances of Emergency Ambulance Services Committee (EASC) have been considered. These include;

➤ WHC (2017) 008 *NHS Wales policy for repatriation of patients*
➤ Designed for Life *Welsh guidelines for the transfer of the critically ill adult*
➤ Developing a Once for Wales approach to quantifying the impact of Health Board strategic service changes (26 June 2018)

In noting the documented implications on the Ambulance service in this paper it is important to note that it has been necessary to use a number of assumptions over and above those used in the production of the Predicted data activity for the Wales Trauma Network v0.8 (May 2019) paper which is the basis of the whole networks board planning.

Individual assumptions which have been used for particular areas are clearly documented within the relevant section of this paper. An Executive decision of the organisation was taken that where assumptions need to be used that 'worst case scenario' assumptions should be used.

In light of this it is highly recommended that after year one of the service when accurate 'actual' activity has been collected that further commissioning conversations are held regarding pre-hospital conveyance, secondary conveyance, repatriations and follow up rehabilitation activity.

5.1   Emergency Conveyance Times (job cycle times)

The implication here derives from the fact that traditional suspected major trauma cases would have been conveyed from scene to the nearest appropriate hospital. The new model will see the patient conveyed either to the nearest Trauma Unit (TU) or direct to the Major Trauma Centre (MTC) at the University Hospital of Wales, Cardiff (UHW).

Assumptions

I.   NHS Wales is collectively unable to determine exactly where suspected major trauma incidents take place. To mitigate this an assumption has been made that they all happen at the hospital site to which they would have been conveyed under the existing model. This is clearly not reality.

II.   Because existing incident locations are not known existing conveyance distances/times have not been able to be deducted to understand the 'new' element of activity.

III.   HDHB are currently consulting on the status of Bronglais and Withybush hospitals within the new model. Whilst it is proposed that both sites become designated rural trauma facilities given this is not yet agreed and the granularity of detail as to what this

actually means is also not yet known the assumptions adopted in this paper remain that all forecast activity for these hospitals will initially be conveyed to Glangwilli only.

IV. It has been agreed between WAST, EMRTS and office of the CASC that there should be no attempt to split the total activity requiring conveyance between WAST and EMRTS and that instead it is clinically appropriate to model on the basis that WAST will have a role to play in all initial 999 major trauma calls.

5.2 Secondary transfers (transfer from TU to MTC)

The implication here for the ambulance services derives from the fact that in some cases it will be appropriate for the patient to be conveyed to the MTC via a TU, for stabilisation for example.

Within the traditional model it would have been unlikely for the patient to have ever been moved from the destination of their first conveyance thus this represents new activity for WAST.

5.3 Repatriations (back to TU and/or patients local DGH, to specialist rehabilitation site, home or home of a carer)

Whilst repatriations will have been a feature of current service provision there are 'new' implications for WAST in that there will now be a greater number of people in UHW that will now need repatriation.

Assumptions

i. Whilst some data exists to project the proportion of patients who will pass away whilst in UHW and some whom will require repatriation or transfer to specialist rehabilitation sites (and thus these numbers are built into modelling).

ii. No data exists to indicate that when a patient is ready to be discharged home / nursing home / home of carer etc. how they return to these places. It has therefore been assumed that WAST will undertake all of these discharges.

iii. In addition to the above existing places of residence and other key data information which determine where patients might need to be conveyed does not exist thus modelling is always based back to a local DGH. This will not reflect reality.

iv. A lack of data means it is not possible to understand existing repatriation distances/times and to deduct it in order to understand the 'new' element of repatriation activity.

v. Repatriations will be undertaken by WAST UCS and NEPTs crews in line with existing NHS Wales policy.

Key risks and Issues

As work continues with Morriston hospital to determine what acuity of patient it can treat as part of being an 'enhanced' trauma unit this could affect the quantified implications for the Ambulance service.

At the time of submitting this business case conversations continue regarding 'Orthoplastics' flow to this site. Suggestions are that the majority of cases are already going there directly (with EMRTS response road or air) but this has not yet been qualified by the Ambulance service and if proven not to be the case could have a material impact on patient flows with, for example, a Newport (Gwent) patient being triaged to Morriston.

As part of approving this business case commissioners should be aware there will be a requirement to review this situation retrospectively.

1. Staff Training

1.1 Background and Proposed Approach

The system of major trauma networks proposed for South Wales will require patients with identified injuries to be transported to the major trauma centre. A triage tool (and where necessary silver triage tool) would be used to identify patients who fall into the major trauma category and these patients would be taken directly to a Major Trauma Centre for optimal care.

This may require WAST EMS staff to manage patients with serious traumatic injuries for longer periods of time. This will require training of the management of trauma patients using the current trauma equipment supplied by WAST. It will also be necessary for staff to undertake training in utilisation of the pathway and familiarisation with the Trauma Network.

Whilst many of the organisations Emergency Medical Service (EMS) colleagues get 52 hours CPD time, others receive less (it is hoped that this allocation will be standardised across all staff in this group once an internal roster review exercise has been complete). In addition there is a long standing agreement with the organisations trade union partners that only fifteen hours of total CPD time is 'directed' by the organisation

The organisation recognises that the annual CPD programme for WAST colleagues would usually be the best option for delivery of such training, however, the directed fifteen hours' time for the next year has been ring-fenced for the Band 6 education process (which has been planned since 2017) and other standard mandatory training which staff are required to undertake.

Mandating staff to also use their CPD hours for the required major trauma training would require detailed conversations with our trade union partners to extend the number of CPD hours which the organisation currently ring-fences. Early discussions with trade union partners have begun but at this moment in time negotiations are ongoing. This business case is therefore predicated on the assumption that CPD hours cannot be utilised as this represents the worst case scenario financially for commissioners to plan against.

WAST is the only provider of emergency transport in Wales, operating in a complex environment in terms of geography and topography. Whilst the establishment of the South Wales Trauma Network presents many benefits and opportunities, it should be recognised that it compounds already existing service delivery challenges. We must ensure that our practitioners are fully equipped in terms of decision making and clinical intervention skills to fully support this initiative.

WAST currently operates from 105 sites across Wales meaning that education and training of colleagues is not a straightforward and simple task. It is important that we recognise and utilise the expertise of EMRTS colleagues in relation to trauma in order to ensure quality of learning. Support is therefore required from EMRTS colleagues in relation to delivering Train the Trainer sessions for our staff and quality assurance of our delivery.

Potential delivery options have been reviewed in collaboration with the Consultant Leads for the Major Trauma Network and the preferred option is set out below:

- All colleagues complete the eLearning module (1 hour) by 31st March 2020. This learning will be provided in workbook format for those colleagues who require it
- EMRTS have agreed to carry out 'Train the Trainer' training and quality assurance for WAST as part of their business as usual. Following this colleagues will then receive a 1 day (7.5 hours), face to face Trauma Network training session delivered by the recruited trained WAST tutors. These roles will need to be filled on a secondment basis, as the existing small Education and Training delivery team in WAST is fully committed to a challenging workforce / training plan. Additionally, there will be a need to recruit a Trauma Network Lead Tutor to oversee delivery, recording and reporting (please see **Fig. 1** below for details of team).

Fig. 1

The team would comprise:

- 1 x Lead Tutor (responsible for overseeing project delivery and reporting **and** delivery of training) – 12 month secondment at band 7
- 3 x Tutors (responsible for delivery of training) – 3 x 7 month secondments (delivery of South Wales training) and 3 x 5 month secondments (delivery of Mid and North Wales training) all at band 7

WAST recognises that whilst the face to face training is a one-off cost it will still represent a significant investment from the wider system which commissions Ambulance Services in Wales. Detailed conversations have taken place not only internally but also with the network board, commissioners and through the external peer review exercise as to the most appropriate way to roll out this training. Discussions allowed three options to be considered;

1. Do nothing – *have no face to face training.*
2. Conduct face to face training of all staff during 2020/21 with a prioritisation of staff in the most geographically important areas of Wales during quarter 1
3. Phase training over three years with a prioritisation of staff in the most geographically important areas of Wales during 2020/21

Option one was immediately discounted because of the significant impact of quality of service provision and the wider implications this would have for the success of the network.

A SWOT analysis of options two and three were subsequently undertaken (see annex 5). This has resulted in option 2 being the preferred option.

In summary this SWOT analysis confirmed that the totality of the required investment cannot be reduced and any phased approach to the delivery of training possess a disproportionate level risk to the success of the network compared to any benefits of spreading the cost of training over three years.

Training in year one will still be prioritised according to geographical complexity, i.e. recognising the challenges faced by colleagues in Hywel Dda and South Powys (longer journey times).

Timelines for training can be found in Annex 3 although it is still recognised that some face to face training may be able to be achieved prior to go live in year, if the wider system wishes to release in year funding to support this.

Whilst BCU and North Powys staff are already operating within an established English trauma network it is important that the service equity principles described in A Healthier Wales are 'lived' and that Ambulance staff operating in North Wales ultimately receive the same training as colleagues in the south so that they can continue to offer the best possible care to the people of North Wales.

Benefits of this approach:

- Timely delivery
- High quality training
- Appropriately skilled workforce
- Existing training plan is not adversely affected – ensure business continuity
- Enhanced trauma management skill set for colleagues across Wales
- Fully supports the Trauma Network initiative

As an organisation we work closely with our staff representatives and consequently we know what works and what does not work so well. As mentioned above our staff are geographically dispersed across Wales but also, in addition, are collectively a very different demographic from perhaps many other clinical workforces in Wales. A high proportion will not be IT literate or have experience in accessing clinical training online and/or remotely thus the face to face training is an important 'safety net'.

The 'face to face' exercise is also a very important opportunity for the organisation to win the hearts and minds of its clinical workforce and ensure that the principles and aims of the wider major trauma network are instilled within staff mind-sets and they see an understand the true value of embracing the networks way of working and not merely defaulting to existing working practices.

As part of the peer review exercise undertaken on the 13 August we have taken advice to evaluate the effectiveness and uptake of the proposed training at appropriate intervals.

ONLINE TRAINING

Our preferred supplier is Onclick as WAST is already using this company for other eLearning. Onclick are building a very good portfolio of eLearning packages and remain competitive in this field. Our operational and training teams are currently working through the training programme and elements needed to be included and ensuring it meets the requirements of EMRTS and revises the concept of the trauma network, the use of the triage tool and the role of the desk, as well as the trauma care concepts and equipment focussing on high risk key interventions. (Our timeline to rolling out the eLearning can be found in Annex 2).

COSTS

ELearning

Costs associated with the e-learning focus on the design and development of an interactive Major Trauma Triage tool, for installation on the WAST Learnzone. This will include instructional design and copywriting of content, custom graphic design and eLearning build. In addition a bank of multiple choice, case study-based assessment to be built within learning platform, with certification on successful completion. Further signposting and resources to be embedded within WAST Learnzone. Scheduled report to be set up for WAST and South Wales Trauma Network. £8,100

Duration of eLearning = 1 hour

Backfill costs (at time and a half) for eLearning: £35,969

- Paramedics (band 6): 949 @ £27.48hr = £26,078
- APPs (band 7): 19 @ £32.93hr = £626
- AEMTs / EMT3s (band 5): 92 @ £23.84 = £2,193
- EMT1 / EMT2 (band 4): 374 @ £18.91 = £7,072

We will be working with OnClick to ensure monitoring of our staff compliance and following a recommendation from the Professional Peer Review will be aspiring to achieve a minimum 70% trust wide compliance at 'go live' with an increase to 85% by three months in.

Face to face

Total number of staff to be trained: 1434

- Paramedics (band 6): 949
- APPs (band 7): 19
- AEMTs / EMT3s (band 5): 92
- EMT1 / EMT2 (band 4): 374

For the purpose of this business case we have costed for all EMS staff to be trained assuming that they all might need to use and initiate the major trauma triage tool and use relevant trauma skills to transport patients further to the major trauma centre at some point. Only providing the training to Paramedics would leave us 'at risk' as we operate double EMT crews on occasions and APP's are sometimes operating as paramedics operationally e.g. Clinical HB Leads or on an overtime basis at periods of high demand.

Delivery costs: £200,781.74

- 1 x Lead Tutor (band 7) x 12 months = £50,195.43
- 3 x Tutors (band 7) x 12 months (this would comprise 3 x 7 month secondments and 3 x 5 month secondments) = £150,586.30

As this learning will be undertaken by a separate team of educators predominately at venues close to the learners and not at WAST normal training bases, they will need to be self-sufficient and not reliant upon the existing training equipment held at the WAST training centres.

Also WASTs existing training equipment may need to be used to maintain business as usual and therefore not available for the Trauma Network training sessions which could hinder the role out. Therefore the following equipment would be required;

Equipment costs: Total approx. (incl. VAT): £31,171

4 x Windows based laptops	approx. = £3,200.00
4 x Multimedia projector	approx. = £2,000.00
4 x RSA SecurID	approx. = £320.00
4 x Airway Management Trainer	approx. = £6,560.00
4 x Cricoid stick Trainer	approx. =£2,505.60
4 x Chest Decompression Trainer	approx. =£4,272.00
8 x Quicktrack II airway device	approx. = £1,248.00
8 x Pneumofix chest decompression device	approx. = £200.00
12 x WAST trauma packs	approx. = £960.00
4 x Kendrick traction splints	approx. = £236.00
4 x Pelvic splints	approx. = £152.00
4 x EZ IO Training Kits	approx. = £1,000.00
2 x Trauma Manikins	approx. = £3,318.00

There has been a robust internal exercise to review the equipment requirements for this face to face training and we have satisfied ourselves that this ask of the training department is fair and proportionate. Included within annex 3 is a copy of a draft agenda of the training day to support evidence as to how and where equipment will be utilised

Travel costs (tutors):

£458 x 4 tutors x 12 months = £21,984

(This figure of £458 per month is based on mileage costs associated with delivery of the Band 6 education process)

Backfill costs (at time and a half) for face to face: £269,768

- Paramedics (band 6): 949 @ £27.48hr x 7.5 hrs = £195,585
- APPs (band 7): 19 @ £32.93hr x 7.5 hrs = £4,695
- AEMTs / EMT3s (band 5): 92 @ £23.84 x 7.5 hrs = £16,448
- EMT1 / EMT2 (band 4): 374 @ £18.91x 7.5 hrs = £53,040

Dependencies

This training requires the full support of WAST operational teams and resource departments to ensure staff attendance to maximise educator to student ratio.

Support is required from EMRTS in terms of Train the Trainer delivery and quality assurance. This support has been indicated from the organisation.

Support from Area Managers (WAST) is required in relation to accessing suitable teaching spaces at existing WAST sites.

The model requires full support of WAST Operations Directorate to release 4 x colleagues to facilitate this training (Lead Tutor and Tutor roles) on a secondment basis.

Full support from the Clinical and Medical Directorate is required, in terms of provision of advice, guidance and support from Health Board Clinical Leads / Consultant Paramedics.

Support from and collaboration with Trade Union partners is required, as well as engagement from staff.

Key Risks and Issues

i.   *Failure to secure commissioning for the face to face element of the training:*

Should funding not be secured for the face to face element of staff training there is an increased risk that staff do not understand and/or buy into the opportunities and benefits which a high quality major trauma network can bring. As such there is an increased chance that a proportion of staff maintain existing working practices and take patients to inappropriate locations. This will affect not only patient outcomes but also the flow assumptions of the network.

ii.   *Success is dependent on availability of funding and allocation in a timely manner.*

It is anticipated that a commissioning decision may not be taken until September 2019 when the Emergency Ambulance Services Committee (EASC) meets. Should a timely decision not be made at this meeting there runs the risk that the minimum number of, and highest priority staff, may not receive the required training before the network goes live.

The estimated implication for training is assumed to be a non-recurring cost of;

£567,774

2. The Major Trauma Desk

Recognising the vital role the trauma desk will play in supporting the network, from patient distribution through to support of crews and mobilisation of EMRTS critical care resources it has been agreed this is essential for 'go live'.

The desk will be staffed by appropriately trained and experienced senior clinicians which will give expansive depth and breadth of function. This will include;

- Scrutiny of calls on the CAD to target appropriate resources to likely major trauma and critically ill patients. This will require very close cooperation with the EMRTS clinicians to optimise appropriate resources to scene;
- Carrying out call backs on calls that may identify major trauma patients to gain additional information that may improve triage of appropriate resources, again in conjunction with EMRTS;
- Play a vital role in supporting WAST crews in decision making around destination hospital and clinical advice to support the possible distance transfer and be the final arbiters in the decision to transfer patients to the MTC or other facility;
- Assist in pre-alert and notification of major trauma cases to MTC or MTU;
- Support delayed primary transfer for those patients who have had to pit-stop at an MTU due to instability. This will also be in conjunction with EMRTS support for critical care transfer.

The screening of calls through the Major Trauma desk along with the tightness of the triage tool will hopefully reduce any potential over triage to the MTC to an appropriate level.

In order to accommodate the desk and for step two of our clinical model to operate as effectively as possible in the context of major trauma, new arrangements within WASTs clinical contact centres (CCCs) and current working arrangements with the existing EMRTS air desk have needed to be considered.

A field visit to the West Midlands Ambulance Service Air desk, who have been supporting their major trauma networks for five years, was carried out in May 2019.

Options considered included:

1. The status quo. No changes to existing practices and should paramedics on scene have queries regarding a patients suitability for conveyance to the MTC then dialogue directly with on-call MTC consultants takes place.

2. There is suitable expansion of the EMRTs air-desk in order for this service to co-ordinate the pre-hospital element of the network.

3a. The creation of a separate 'WAST' major trauma desk which works coterminously with the existing EMRTS air desk, is staffed by a band 7 clinician[1] and operates 24/7/365.

3b. As above but with a reduced operational hours. 14/7/365 (hours of the day being 0800-2200) and the function 'falling back' to the EMRTS desk out of hours.

4a. The creation of a separate 'WAST' major trauma desk which works coterminously with the existing EMRTS air desk, staffed by an additional allocator band 5 role and operates 24/7/365. Here the clinical decision making would rest with the EMRTS CCP on the desk with the band 5 freeing up CCP to make the clinical decisions, rather than undertaking non-clinical communication duties.

4b. As above but with a reduced operational hours. 14/7/365 (hours of the day being 0800-2200) and the function 'falling back' to the EMRTS desk out of hours.

Option 3b has been identified as the preferred option;

The is the creation of a separate 'WAST' major trauma desk which works coterminously with the existing EMRTs air desk, is staffed by a band 7 senior paramedic and operates 14/7/365 (hours of the day being 0800-2200) and the function 'falling back' to the EMRTS desk out of hours.

A SWOT analysis which summarises the decision making process is shown in annex 4. In reaching this preferred option the following points of the SWOT analysis were considered critical;

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[1] In parallel to the development of this business case WAST is also developing a new 'senior paramedic' role which would operate at a band 7 role. The potential to include duties on the Major Trauma desk are currently being explored. If this is not determined to be the best approach then a further 'bespoke' role will be developed.

- The desk needed to be appropriately resourced so that the existing EMRTS Clinical Care Practitioner (CCP) did not experience an experiential rise in workload. Specifically, potential queries from on scene paramedics and the application of the major trauma triage tool. This necessitated that staff has to be at band 7, senior paramedic level

- The configuration of any desk should 'future proof' itself so that it could suitably support other strategic developments potentially happening across NHS Wales. For example the developments planned in critical care as a result of the £15m investment into the service by the minister.

- Current data and predicted demand does not suggest that a 24/7/365 trauma desk offers value for money and that high quality and safe care can be provided directly by the Air Desk between the hours of 2200 – 0800.

EMRTs have confirmed that they are supportive of this preferred approach and it is recognised that the working relationship with the air desk staff is vital to the success of the desk.

To support the operation of the WAST Trauma Desk it's is essential that the clinicians maintain their clinical skills within a face to face role. Therefore, to facilitate this rotation between the Trauma Desk and operational setting, it is vital to create capacity in the clinician's roster hours to enable patient contact and the maintenance and develop of clinical skills. Therefore whilst draft versions of this business case have shown a necessity for 3.48 WTE this has been scaled up to 4 WTE to allow the aforementioned rotation.

In addition it has also been identified that to ensure the desk is providing an effective and safe service on the 01 April that it will be necessary for staff to have an element of additional training this will include operating in a 'shadow' environment for a period of time prior to go live as well as training on the systems. (The planned approach and timelines for this approach can be found in Annex 2). This business case therefore now identifies four months in year (2019/20) staff costs to facilitate this. The importance of this pre-live training and shadow form operation was again some helpful learning taken from the peer review exercise.

Key Risks and Issues

It is recognised that the banding of the WAST member of staff on the Trauma desk may create some initial disparity with the EMRTS CCP role which operates on the air desk. However it is important to recognise that CCP's only operate at a band 6 whilst they are undertaking their MSc qualification and upon completion of the course are then remunerated at band 7, thus creating parity.

Discussions have taken place with EMRTS on this issue and the service have confirmed that this is a situation that can be managed.

In confirming the preferred option for a major trauma desk it is noted that a key assumptions adopted is that the EMRTs service gets the required funding and subsequently launches its own 24/7 service.

> **The estimated revenue implication for staff is therefore assumed to be;**
>
> **£266,452.60**

3. Transfer and discharge model

With many more journeys relating to Major Trauma taking place across South Wales and South Powys the establishment of a function to effectively and efficiently co-ordinate these journeys will be critical.

An expanded additional call handler/dispatcher resource will provide the required capacity to ensure the safe delivery of journey co-ordination.

However, the need for an effective and efficient co-ordination of journeys function is not limited to the changes planned for major trauma. It will play an equally critical role in the success of other strategic developments across NHS Wales such as the opening of the Grange Hospital in AHBHB.

In recognising this both the WAST and EASC IMTPs make the commitment to develop a proposal for All Wales Transfer and Discharge service within 2019/20.

The creation of the major trauma network in South Wales and South Powys has been identified as being the ideal 'spring-board' for the potential creation of this test service that can be trialled and evaluated prior to wider rollout across Wales.

A wider piece of work is being taken forward by WAST, CASC and Health Boards to determine what the preferred model could look like. However for the purposes of this business case an assessment has been made as to what funding maybe required to support transfer and discharge service for major trauma. The figure represented in the business case for this part of the service represents the additionality in activity that is forecast to be created by the network.

> **The estimated revenue implication for an initial transfer and discharge service for major trauma is assumed to be;**
>
> **£122,530**

4. Financial Summary

	Recurring Costs		Non-Recurring Costs
Collective revenue implications for conveyances, secondary transfers and repatriations or discharge. These figures, as described in this paper, are based on 'worst case scenario' modelling. Following a year's operation of the network 'real' data will have been collected meaning a review of projected costs for years 2, 3 and beyond can be undertaken.	Year 1	£244,388	
	Year 2	£245,689	
	Year 3	£250,525	
			Total £567,774
Staff for Major Trauma desk	**2019/20	£57,954	
	Subsequent Years	£266,452.60	
Staff for Transfer & Discharge service for Major Trauma	£122,530		
Overall Cost Year 0	**£57,954**		
Overall Cost Year 1	**£1201,144.60***		
Overall Cost Year 2	**£634,671.60**		
Overall Cost Year 3	**£639,507.60**		

A proportion of this training cost could be bought forward to 2019/20 should a timely commissioning decision be taken meaning training can be mobilised earlier than indicatively planned.

*** This cost for 2019/20 will cover the Major Trauma Desk staff starting in January 2020 allowing them time to shadow EMRTS and undertake sufficient training ready for go live as recommended at the Network Board.*

South Wales Major Trauma Network

Professional Peer Review

This report collates my recommendations to the Wales Major Trauma Network in relation to the pre-hospital component of the trauma network inception. It is based on the business case supplied by WAST and subsequent discussions around this plan at the Wales Trauma Network Professional Peer Review on 13th August 2019.

I have separated my recommendations and any concerns I perceived into 4 sections as follows. The order is dictated by the need for decision making and degree of preparation prior to the proposed "go live" date.

1. Trauma Triage Tool
   a. Silver Trauma
2. WAST Trauma Desk
3. WAST Trauma Training
   a. Online
   b. Face to Face
4. Emergency Conveyance Issues

1. Trauma Triage Tool

The Trauma triage tool needs to be agreed and trained to a minimal standard before "go live" date. The tool should be owned by the Trauma Network and implemented by WAST, therefore I would recommend that it is held by the Clinical Governance team of the network with WAST representation using data from the first year to modify. As such the tool should be badged with WAST and Trauma Network emblems.

The ongoing MATTS project will hopefully aid the creation of a national unified triage tool that all networks should adopt though this may require network adaptation for local needs. This is likely to be 18months to 2 years away but will cover adults, older adults (silver trauma) and paediatrics. This may result in wholescale modifications of the tool in due course but this will be the same for all regions of England.

I fully support the removal of a defined 60 minute time frame but maintaining the concept of A &C stability as a divert to nearest.

The proposed tool is an adaptation of the tool used in WMAS and as such should be ideal as there is the plan for a trauma Desk to support crews in utilisation of the tool in a similar manner to the WMAS model. Concerns have been raised relating to potential over triage from this tool which may adversely affect the ED at MTC. However, the support of the Trauma desk will hopefully reduce this to an appropriate level. From experience with and audit of, the Wessex triage tool in SWASFT I have some recommendations relating to refining the triage tool to minimise under and over triage. Given that SWASFT do not have the support of a trauma desk some of these aspects can be mitigated at that level but having

the clarity and education in place will reduce the burden on the desk. Below is a table of suggestions relating to refinement and education to support triage.

Trigger	Recommendation	Education
GCS & Motor Score	Remove GCS 13 keep M4 or less in context of major trauma or head injury	The motor score (M4 or less) is the most sensitive indicator. It would be worth considering revision of this in the educational package given uncertainty as to differentiation of localising and flexion by some crews.
Penetrating injuries	Include torso with shock or sucking chest wound. Include buttock, axilla, groin with shock or evidence of significant bleeding. If shock is present activate to MTC if uncertain discuss with desk	This has resulted in a significant over triage in SWASFT with many patients having superficial wounds with no significant underlying injury being transferred to MTC that could be managed in ED and MTU. Much of this depends on the demographics of your patient group with interpersonal violence and penetrating injury having higher prevalence in urban areas and likely to go to MTC because of proximity, though many may also go to Morriston and Aneurin Bevan
Significant Chest Wall Injury	Include open pneumothorax	We have had significant under triage due to missed flail chest so I prefer the term significant chest wall injury. This needs to supplemented by education around full exposure and examination of the chest collating clinical findings with mechanism
2 or more proximal long bones	Mitigate by education and desk review	This has caused confusion to some crews as they consider elderly neck or femur and possible neck of humerus as triggering whereas many of these could be managed adequately in MTU. However, in the young patient bilateral forearms and lower legs is often a result of high mechanism and needs MTC care and these theoretically do not trigger.
Degloved and amputated limbs	Unless other positive marker discuss with desk	If these injuries are isolated they may be more appropriate for Morriston
Suspected Major Pelvic fracture	Refine with addition of shock with pelvic pain or PV,PU,PR bleed or scrotal haematoma.	Since the appropriate move away from springing the pelvis there has been a tendency to not even examine the pelvis. The pelvis should be visually assessed for asymmetry and deformity. The pelvis should be gently palpated for pain over iliac crests, SI joints and symphysis. In the context of mechanism these are important positive findings and a binder applied. The genitalia should be examined to look for signs of open fracture whilst maintaining dignity. Indications for application of a binder should be re-educated according to clinical guidance which should include the high risk features above. The land marking should also be reiterated. Application of a binder is not a +ve trigger in and of itself. However, if applied for appropriate indications it becomes more reliable.
Base of Skull Fracture	Refine wording and mitigate by discussion with desk	Highlight bleeding from EAM or CSF from nose. De-emphasise bilateral periorbital haematoma as this is likely to be due to local trauma to the face.
Spinal Trauma with neurology	Refine to motor neurology, if concerns around sensory discuss with desk	The frequency of transient subjective limb paraesthesia in low mechanism injuries can cause over triage. Motor is more specific.
Open fractures	Open fractures proximal to hand and forefoot	I remain uncertain as to the final decision on the destination for isolated open fractures particularly given the limited orthoplastics provision that has yet to be set up at MTC and an established unit at Morriston. Those patients with polytrauma and open fracture will go to MTC but isolated open ankle and wrist fractures will feature heavily in the elderly trauma cohort.

Silver Triage

I commend the programme on attempting to incorporate a triage tool for older adults at inception. However, this needs to be mitigated with an approach to reduce potential over triage to MTC. The main aim should be to take those in most need who will benefit from MTC care and highlight high risk patients to receive full trauma call at MTU

Options would be to

1. Highlight them as high risk group within the main tool and reinforce during education. Particularly around anticoagulation, cardiovascular response especially in those on antihypertensive medication. The trauma desk could refine triage decision.
2. Maintain specific silver triage tool with likelihood of over triage to MTC unless robustly supported by desk
3. Maintain option 1 above until national agreed tool is defined by MATTS project.

The triage tool sign off is a key step in the formation of the WAST response as it is integral to the development of the on-line training tool.

2. Trauma Desk

The trauma desk will play a vital role in supporting the network, from patient distribution through to support of crews and mobilisation of EMRTS critical care resources. As such this must be in place and functioning on "go live". The plans for collaborative working and training with the EMRTS CCP desk are excellent and essential to a cohesive approach.

There are two key areas that need to be refined at this stage to ensure success are

1. Functional Role of Trauma Desk
2. Deliverability of a staffed Trauma Desk in timeframe

Functional Role of Trauma Desk.

Whilst many involved will understand the concept of the trauma desk I feel it is vital to define to specific roles that are anticipated to be core business for the desk. If staffed by appropriately trained and experienced senior clinicians this desk can have expansive depth and breadth of function. This would be in close collaboration with the EMRTS CCP already operating on a desk which is due to expand to 24/7.

This would include:

- Scrutiny of calls on the CAD to target appropriate resources to likely major trauma patients. This will require very close cooperation with the EMRTS clinicians to optimise appropriate resources to seen.
- Call back on certain calls that may represent major trauma patients to gain additional information that may improve triage of appropriate resources, again in conjunction with EMRTS
- Support WAST crews in decision making around destination hospital and clinical advice to support distance transfer
- Assist in pre-alert and notification of major trauma cases to MTC or MTU
- Support delayed primary transfer for those patients who have had to pit-stop at MTU due to instability. This will also be in conjunction with EMRTS support for critical care transfer.

It should be stipulated that if the MTC is adopting a "universal acceptance" policy that the clinicians on the trauma desk and EMRTS should be the final arbiters in the decision to transfer to MTC. There must not be a second level of discussion with TTL at MTC or ED at MTU. Any concerns raised about inappropriate decisions will be reviewed in the governance process that will be embedded in the network structure.

Deliverability of a staffed Trauma Desk in timeframe

I received assurance that there were a cohort of sufficiently experienced clinicians within WAST who would be keen to provide this role. This is a new role and the staff need excellent communication and organisational skills in addition to the clinical experience and expertise. Given that it is a new role there will need to be defined Person specification and job description prior to advertising, selecting and appointing followed by training and then supervised practice alongside EMRTS clinicians the timeframe for having this in place for go live is very tight.

I feel we need to see a full proposal containing the following:

- Job description and Person Specification
- Staff numbers in wte
- Draft roster for staffing of the Trauma Desk by Band 7 WAST clinicians within the agreed hours.
- Operating Plan detailing contingencies for band 7 trauma desk clinician being off at short notice. What is fall back EMRTS CCP or another WAST clinician
- Training plan for appointed band 7 clinicians. This training include the triage tool and working through case studies. I would suggest it also include clinical shifts with EMRTS to increase exposure to major trauma critical care, MTC shifts to understand reception of patients and ongoing pathway together with shifts with EMRTS dispatch CCP.

It would be beneficial to produce a GANT chart given the limited timeframe and multiple steps that are linked.

Whilst this may be an attractive proposition when the role is introduced there must be some planning for ongoing resilience. The option of this as the only role may be ideal for some clinicians but others may wish to retain clinical contact and explore other options for job satisfaction. Consideration should be made to ensure that these clinicians maintain a number of clinical shifts with road crews, EMRTS and perhaps in the MTC to maintain cotemporaneous exposure. It may be feasible to have an increased number of less than whole time clinicians who have portfolio job plans including clinical shifts or training shifts. Indeed, this may offset the need for trainers for face to face training in subsequent years as they will be fully embedded and understand the system.

3. WAST Trauma Training

The business case provided included online eLearning and face to face training. There are definite benefits to using multiple modalities to the trauma training to include all staff members and I would support this proposal.

Online eLearning

The online training needs to have been rolled out well in advance of "go live" date. The proposal to use an established provider using an interface familiar to the staff is valid. However, we have not got evidence as to the uptake and penetration of this format within WAST as there has been limited use to date. Therefore I think it would be wise to allow an extended period to gain uptake by the staff using the proposed 1.5 hours overtime plan described. This online training should focus on the concepts of a major trauma network, the role and the trauma triage tool.

A proposal with agreed content, format and timeline is also required for this to ensure that it has been achieved in time for "go live"

Given that there is not, as yet, an ePCR facility within WAST there will need to be some method of ensuring all crews and vehicles are equipped with a copy of the triage tool from day one. Whether this is provided by laminated copies or in vehicle stickers will be at the discretion of WAST but some form of immediately available information must be provided. This will have cost implications not factored into the business case.

I would suggest that there is a defined uptake and completion rate of online training that must be achieved by "go live". This should be minimum 70% trust wide at "go live" with an increase to 85% by 3-months in. Consideration could be made to increasing the focus in the more distant regions as it could be argued that crews based in Cardiff & vale will default to MTC as closest unit. However, given the mobility of WAST crews it is very important that staff close to MTC are not neglected.

Consideration could be made for the network to financially incentivise the uptake of this training with WAST.

Face to Face Training

The key priority for "go live" is the uptake of the online training module any supplementary training can occur following "go live". However, if some face to face training can be achieved at the prior that would be beneficial. I support the idea to focus the first wave of face to face training in those geographical areas some distance from the MTC as these are the crews that will be most affected by the extended journey times.

There needs to be a proposal drafted for the content and delivery of the ace to face training. The current proposal is for a 7.5 hour contact day on overtime. This appears to be a solution to the need to deliver the training in a timely fashion given that there is a pre-existing training plan for WAST staff that is agreed. I am slightly concerned as to the uptake and penetration of this format as having recently been involved in a similar project in SWASFT we did not achieve the degree of uptake we had envisaged even offering the shifts on overtime.

Content

The 7.5 hours of contact time is relatively short and the initial part of the day should revise the concept of the trauma network, the use of the triage tool and the role of the trauma desk. Even if the online training has been undertaken shortly before this it is likely that at least 2-3 hours will need to be dedicated to these vital principles to ensure thorough understanding.

This will leave a 4-5 hours for face to face revision of trauma care concepts and equipment. I would advocate focussing on key interventions that are high risk, infrequently used or will become more frequent with extended transfer times. Therefore my suggestions are as follows:

- Haemorrhage control & Resuscitation
    - Tourniquet use, appropriate need and location including the remove on potentially viable limbs once pressure dressing applied within ideally 20 minutes and mandatory removal after 2 hours unless amputation. The prolonged transfer times to MTC mean that inappropriate placement will risk iatrogenic limb loss or significant complications.
    - Haemostatic gauze and pressure dressings. Appropriate wound packing techniques and correct application of pressure dressing
    - Pelvic binders. Revising indications, pelvic examination and placement of binder including tying the feet together.
    - Long bone traction, manual traction and application of KTD
- IO access via humeral head, titrated fluid resuscitation in patients with ongoing bleeding.
- Chest procedures
    - Examination of chest and recognition of life threatening chest pathology
    - Indications and landmarks for needle decompression
    - Application of chest seal for open pneumothorax

I think this is more than enough to fill the remaining time if done to a high standard.

I would omit airway interventions as the unmanageable airway would mandate transfer to nearest appropriate receiving facility. Revision of airway can be incorporated in planned WAST mandatory training as part of core business.

This refined model of training would reduce the kit list requirements supplied in the business case and focus on those areas with maximal need for major trauma patients being transferred within the MTN

Trainers

The development of experienced and competent trainers to deliver the face to face training is important. The business case states that there is insufficient capacity within the WAST Education and Training team to deliver this training given the pre-agreed Trust training plans and a proposal is made to establish 3 secondment placements for up to 12-months to deliver this.

My concerns around this proposal are as follows.

- Where are the staff taking these secondments coming from? If it is from within the established Education and Training team this will further denude them of capacity and negates the initial argument unless further posts are backfilled on secondment. This will increase the timeframe to release them for "train the trainer" teaching.
- Will some of these staff be potential candidates to apply for the trauma desk role? If this is the case unless there is a very large cohort of potential applicants for both roles it may reduce uptake in one or both.
- It is essential that established members of the Education and Training team are included in the trauma training or at minimum the train the trainers education to ensure they are able to respond to queries from road crew that will undoubtedly occur in the first year.

The development of these trainers to perform the role requires input from EMRTS and I fully support that concept. However, this will take a finite time to accomplish once they are in post.

Again I think we need some form of proposal including job description and person specification to confirm the expectations of these secondment roles and a robust timeframe to have them trained and in post, though "go live" is not dependant on the face to face training.

Roll Out

The roll out of this face to face training should occur close to "go live" date. If any can be achieved prior to this date it would be beneficial but may be challenging to achieve high numbers through the programme. The closer this can be delivered to the online training then there is likely to be improved understanding and embedding of the education.

I support the concept to train all staff and focus on those clinicians in Hywel Dda and Powys in the first wave. Though I would recommend considering including all members of the Education and Training team and perhaps considering local champions in other regions. The uptake from keen staff to attend the EMRTS CPD days that have already proven successful would make this concept viable.

I have some minor concerns on a proposed 3-year roll out plan to cover the entirety of WAST. This will give a significant time delay between completion of online training and the reinforcing face to face education for those in the northern part of WAST. However, I do support the plan to perform the face to face teaching in the south and mid-Wales first as the north already operates partially within an English trauma network. The format of the second and third years of face to face training should be modified in relation to feedback from staff attending in year one and any issues raised through network governance. That way the education will evolve to satisfy the needs of WAST and its place within the MTN. After year 3 the trauma training should be incorporated in the WAST Education and Training as business as usual >

Again there needs to be some form of agreement around the uptake and completion of the face to face training. I would expect 60% uptake in the focussed areas within 6-months of

commencement. If the uptake does not achieve 75-80% after 12-months a consideration has to be made as to whether it is value for money.

4. Emergency Conveyance Issues

There has been suitable recognition of the potential significant impact the instigation of a major trauma network will have on resources within WAST. The modelling and use of "worst case" scenarios appear an appropriate starting point. I also support the position they have taken in the modelling calculations not to include any input from EMRTS in primary transfer to MTC. Whilst the EMRTS critical care team will have an impact on these transfers it is difficult to assess the degree of this. This is particularly given that a number of transfers are already undertaken by this team on clinical grounds prior to the creation of the trauma network model and the operational hours of this team is expanding.

The impact on job cycle times and overruns is not to be underestimated. This has immediate effects on crew availability in remote areas and subsequent effects on rota negotiation and geographical deployment structures.

The recognition of delayed primary transfer, secondary transfer and repatriation is appropriately acknowledged in the business case. Whilst many time critical transfers may be supported by EMRTS they will not be able to provide cover for multiple simultaneous transfers particularly out of hours. A system must be introduced to appropriately clinically prioritise urgent but not time critical transfers that are principally going to be delivered by WAST. The potential role of the clinician on the Trauma desk in the triage and timely allocation of transport to this patient group should be considered.

Whilst the Welsh national system does not have the ARP (Ambulance Response Programme) and IFT (Inter-Facility Transfer) currently used within the ambulance services it would be worth reflecting on data from the introduction of these two systems to help support progress. I would certainly challenge the statement in the business case that "*The vast majority of major trauma cases will be classified as red response- immediately life threatening*". Whilst I am not entirely au fait with the Welsh triage system I would question whether the vast majority of major trauma cases will fit into the red response as a significant percentage in SWASFT and other UK ambulance services trigger an equivalent to amber response in ARP and I understand that the Welsh system generates less red responses than ARP.

The plan to review the actual change in activity after year one of service is <u>essential</u> to create a support structure for WAST to deliver their component of the conveyance both primary, secondary and repatriation. This will guide commissioning conversations for the ongoing delivery of the network strategy.

Summary

Overall the business case provided by WAST has acknowledged the keys areas that require development and there is much within the content that is excellent. My key concerns relate to the translation of this business case into a deliverable plan that is ready for "go live".

The preparation of a WAST system ready for "go live" requires work to focus on staff appointment and training together with systems to support this.

The recommendations in order of priority are as follows:

1. Trauma Triage Tool agreed at network level.
   - **Essential**
2. Creation of online Trauma training package to ensure adequate dissemination and uptake of information prior to "go live"
   - **Essential**
3. Creation of the Trauma Desk with adequately trained staff and the systems required ready on day 1. This must have a discrete business plan to ensure resilience and sustainability together with interaction with EMRTS desk.
   - **Essential**
4. Preparation of Year 1 face to face trauma training with staffing model and agreed content. This requires input from the core staff from WAST Education and Training to maximise effect and sustain ongoing development. This should be reviewed at end of Year 1 adapt content appropriately.
   - **Highly Recommended**

Please feel free to contact me should you require any further information and I wish all stakeholders involved the best in creating a system to give the major trauma patients of Wales the care they deserve.

Mr Phil Cowburn BSc(Hons) MBChB FRCS FRCEM DipIMC

Consultant in Emergency Medicine, University Hospitals Bristol NHSFT

Acute Care Medical Director, SWASFT

Consultant Trauma Team Leader, Severn Major Trauma Centre, NBT

Consultant Pre-Hospital Emergency Medicine, GWAAC

Dear Stephen

The current position regarding funding is that the major trauma network development needs to be funded from within existing allocations and therefore need to be prioritised through the various commissioning arrangements. In support of this, you will be aware that additional, independent scrutiny of business case submissions has been facilitated through professional peer review. You will have received the advice in respect of the WAST business case and I trust this helps to inform your own scrutiny and reporting to EASC.

Please could we discuss so I can support reporting to EASC in September. I will follow up with a call or otherwise my number is 07976 627117

Also, I had referred in my earlier email to in-year costs being considered via WHSSC. Please note that the recommendations from WHSSC Management Group will be considered via WHSSC Joint Committee this Friday.

With many thanks
Rosemary

From: Stephen Harrhy (Cwm Taf UHB - Corporate Development) <Stephen.Harrhy@wales.nhs.uk>
Sent: 23 August 2019 09:57
To: Rosemary Fletcher (NHS Wales Health Collaborative) <Rosemary.Fletcher2@wales.nhs.uk>
Cc: Ross Whitehead (CTUHB - NCCU) <Ross.Whitehead@wales.nhs.uk>
Subject: RE: Major trauma - EASC 10/9/19

Thanks Rosemary

What is the current position on sources of funding please?

Regards

Stephen

From: Rosemary Fletcher (NHS Wales Health Collaborative)
Sent: 23 August 2019 08:16
To: Stephen Harrhy (Cwm Taf UHB - Corporate Development) <Stephen.Harrhy@wales.nhs.uk>
Cc: Ross Whitehead (CTUHB - NCCU) <Ross.Whitehead@wales.nhs.uk>; Tracy Myhill (Swansea Bay UHB - Corporate) <Tracy.Myhill@wales.nhs.uk>; Jason Killens (Welsh Ambulance Service NHS Trust - 020) <Jason.Killens@wales.nhs.uk>
Subject: Major trauma - EASC 10/9/19

Dear Stephen

You will be aware of the significant work being undertaken to prepare for the major trauma network for South, Mid and West Wales. Planning proceeds for a 'go live' of April 2020 which also coincides with the extension of EMRTS to 24/7.

The critical path requires in-year release of funding for time critical elements of business cases. For the MTC, specialist services and the ODN, this is already being considered through WHSSC Joint Committee and Management Group; a copy of the paper that was being considered at yesterday's Management Group is attached, this was also received for noting at Trauma Network Board on 19th.·

I presented an update on the network development to Chief Executives at Collaborative Executive Group this week, on 20th. Through this, it was noted and agreed that a similar report would need to be submitted to EASC for its meeting on 10th September in order for consideration of the WAST business case and approval to funding release for critical in year posts and other costs for WAST as the critical path for April 2020 is based on the assumption of funding being approved in September.

I would be very grateful if you could advise me of arrangements for reporting to EASC. Please let me know if you would like to discuss and if there is any support needed from the Programme Team in preparing reports and briefings required in preparation for the September EASC meeting.

With thanks for your help.

Best wishes
Rosemary

Rosemary Fletcher
Cyfarwyddwr

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Rydym yn croesawu gohebiaeth yn Gymraeg. Byddwn yn ymateb yn Gymraeg heb oedi
We welcome correspondence in Welsh. We will respond in Welsh without delay

EMERGENCY AMBULANCE SERVICES COMMITTEE FORWARD LOOK

Meeting	Standing items	Additional items	Governance	Development session
12 November 2019 WHSSC, Unit G1, The Willowford, Main Ave, Treforest Industrial Estate, Pontypridd CF37 5YL 09:30hrs	Minutes and action log Chair's report Chief Ambulance Services Commissioner's report AMBER Implementation Finance Report Forward Work Programme	EASC Draft IMTP Outline WAST IMTP EMRTS Commissioning Framework Demand and Capacity Review Report (WAST)	Risk Register	IMTP Risk Appetite and Commissioning intentions
28 January 2020 WHSSC, Unit G1, The Willowford, Main Ave, Treforest Industrial Estate, Pontypridd CF37 5YL 1.30 p.m.	Minutes and action log Chair's report Chief Ambulance Services Commissioner's report Finance Report Forward Work Programme	NEPTS Progress Report (Quarterly report)		TBC
10 March 2020 WHSSC, Unit G1, The Willowford, Main Ave, Treforest Industrial Estate, Pontypridd CF37 5YL 09:30	Minutes and action log Chair's report Chief Ambulance Services Commissioner's report Finance Report Forward Work Programme	Evaluation of the Sub Groups Ambulance Quality Indicators	Risk Register	TBC