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Review of Emergency Ambulance Services Commissioning Arrangements

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Collaborative commissioning arrangements have helped drive some important changes for emergency ambulance services in Wales; however, the maturing arrangements require greater commitment by some partners.

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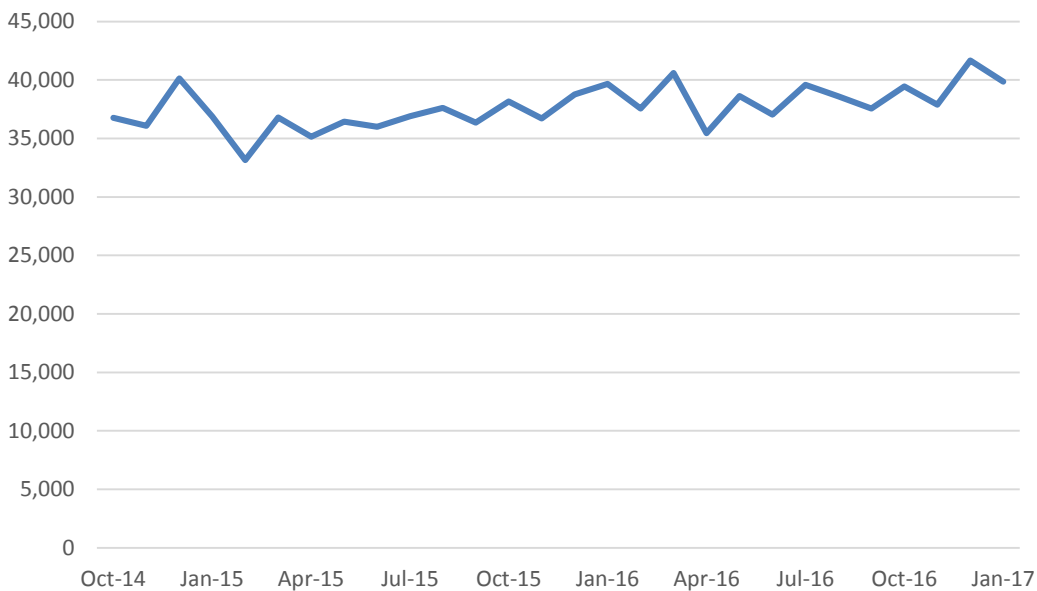
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Summary report

Background

- 1 Ambulance services in Wales are provided by the Welsh Ambulance Services NHS Trust (WAST). WAST is responsible for responding to all emergency calls, and taking appropriate pre-hospital care action under its Emergency Medical Services (EMS) remit. On average, WAST responds to 37,000 emergency (including urgent) calls per month, rising to around 41,000 during busy periods¹ (Exhibit 1).

Exhibit 1: total number of calls received by WAST between October 2014 and January 2017



Source: Stats Wales

- 2 As part of the NHS Wales Delivery Framework, WAST has been required to meet a number of performance targets in relation to how quickly it is able to deal with these calls. The most obvious target being the need for 65% of category A calls, ie immediate life threatening, to be responded to within eight minutes.
- 3 Historically, WAST has struggled to meet performance targets set by Welsh Government, particularly in relation to response times, and both WAST and health boards have struggled to meet performance targets for timely handover of patients between ambulance crews and emergency departments.

¹ Average based on the number of calls received by WAST between October 2014 and January 2017.

- 4 For many years, the EMS provided by WAST was funded by health boards through the Welsh Health Specialised Services Committee (WHSSC)² who agreed service requirements for health board areas in the form of a contract. WAST also received separate funding from Welsh Government for capital programmes, along with funding directly from NHS bodies in relation to its Non-Emergency Patient Transport Service (NEPTS)³ and NHS Direct Wales⁴. It was formally accountable for the delivery of services to Welsh Government.
- 5 The way in which WAST was funded and managed, and the impact these issues may have had on its ability to meet Welsh Government targets was a widespread concern resulting in significant scrutiny of WAST. In 2013, the Minister for Health and Social Services commissioned **A Strategic Review of Welsh Ambulance Services**. The review was led by Professor Siobhan McClelland (the McClelland Review) and was tasked with making recommendations to enable high-quality and sustainable ambulance services for the people in Wales.
- 6 The review found a fundamental problem with the accountability and governance arrangements for ambulance services in Wales which at the time were ‘multiple, complex and lacking in clarity and transparency’. As a result, in 2013 the then minister requested the creation of a national delivery model based on a commissioner-provider relationship. He stated the need for ‘clarity and transparency in governance arrangements’ and felt there was a need to ‘put in place a future structure that is simple, clear and aligned directly with better delivery for patients’.
- 7 Following the publication of the McClelland Review, the Welsh Government published the **National Health Service, Wales: The Emergency Ambulance Services Committee (Wales) Regulations 2014**. The regulations required the seven health boards in Wales to work jointly to exercise functions relating to the planning and securing of emergency ambulance services. These regulations made provision for the establishment of the Emergency Ambulance Services Committee (EASC), along with the creation of a Chief Ambulance Services Commissioner (the Commissioner). The regulations also clarified the role of WAST as a delivery organisation.

² The WHSSC is responsible for the joint planning of specialised and tertiary services on behalf of local health boards in Wales.

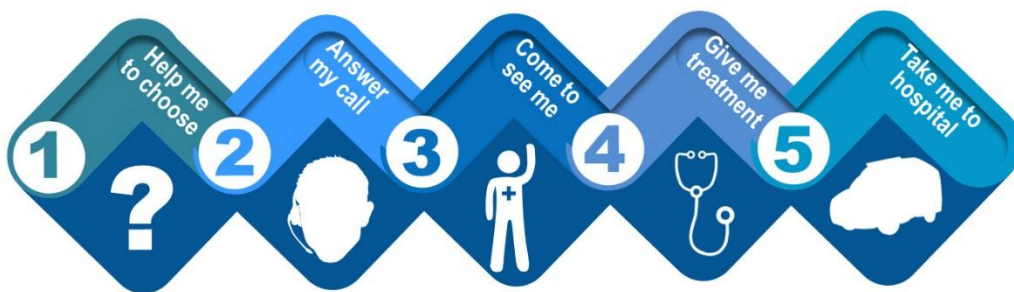
³ The NEPTS involves taking people to and from routine outpatient appointments at clinics, hospitals and day centres.

⁴ NHS Direct Wales is a health advice and information service available 24 hours a day, every day.

- 8 On 1 April 2014, EASC came into being with the stated purpose of the committee to undertake the 'functions of planning and securing the provision of emergency ambulance services in line with both the Welsh Government and NHS planning framework'.
- 9 Membership of the committee consisted of a Chair, who is appointed by the Welsh Minister for Health and Social Care, the seven chief executive officers of the health boards in Wales, one of whom acts as the Vice-Chair, and the Chief Ambulance Services Commissioner. The Commissioner is appointed by the Chair and host health board (currently Cwm Taf University Health Board). There are also three associate members of the committee; the chief executive officers of WAST, Velindre NHS Trust and Public Health Wales NHS Trust.
- 10 EASC took some time to establish itself. At that time, commitment to the new commissioning approach from all parties involved was a problem. Personnel changes in key posts such as the Chief Executive Officer of WAST and the Chief Ambulance Services Commissioner, along with the increasing support from the then Deputy Minister for Health during 2014-15 provided some much needed impetus to make the new commissioning arrangements work.
- 11 Considerable work has since taken place to decouple EASC from WHSSC and to establish its own governance arrangements. This work was recognised by the host body's internal audit service who placed 'reasonable assurance' on the progress made up to June 2016. Members of EASC that we spoke to felt strongly that the committee has developed well since its establishment in 2014. Whilst there is recognition that the committee remains on a journey and that there are further ways in which it can improve, there is a general sense by members that many of the developments that have happened would not have taken place had it not been for EASC. It is also recognised by members that the commitment and dedication of the EASC Chair and Commissioner to make sure that the new arrangements work has been a key driver.
- 12 An interim collaborative commissioning agreement was set in place for 2014-15 prior to the establishment of the National Collaborative Commissioning: Quality and Delivery Framework Agreement 2015-18 (the Framework Agreement). The Framework Agreement between health boards and WAST on key areas of service provision sets out details of what is required (commissioning); how assurance is given for 'what is required' (quality); and how the 'what is required' will be achieved (delivery). The Agreement will need to be renewed or revised in 2017.

- 13 One of the main ambitions of EASC is to encourage and enable patients to access services through other, more appropriate means before their needs become urgent and/or life-threatening, and require a response from the emergency ambulance service. In 2015, EASC developed a new, citizen-centred pathway which describes a five-step process that supports the delivery of emergency ambulance services within Wales. The Ambulance Patient Care Pathway (referred to as the five-step model) is set out in the [Exhibit 2](#).

Exhibit 2: the five-step model

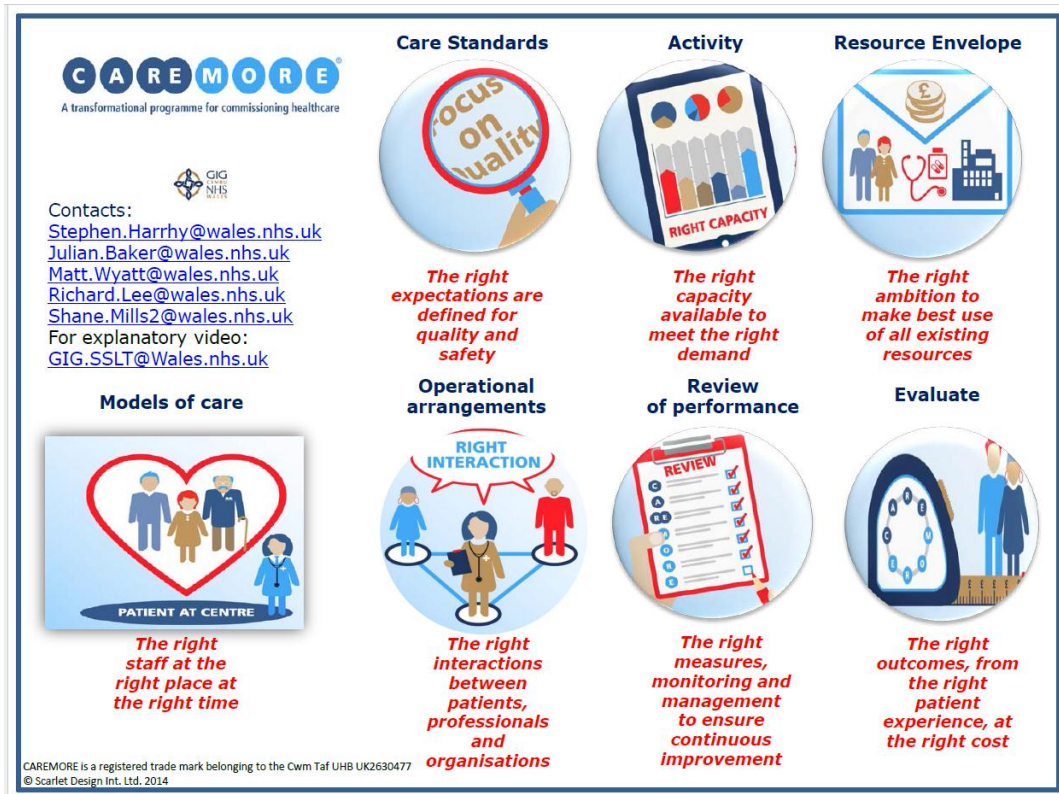


Source: Emergency Ambulance Services Committee

- 14 To support the development of the Framework Agreement, EASC sponsored the use of the CAREMORE® model⁵ which had successfully been used to commission other services previously. The CAREMORE® model defines the expected care standards to be met for each of the five steps of the Ambulance Patient Care Pathway; as well as setting out activity, performance and resource management information available for each of the steps of the pathway. It also details the outcomes required in pursuit of improving patient experience; improving patient's clinical outcomes and demonstrating value for money. The principles of the CAREMORE® model are set out in [Exhibit 3](#).

⁵ The CAREMORE® model is a 'made in Wales' commissioning method. Its registered trademark belongs to Cwm Taf University Health Board on behalf of NHS Wales.

Exhibit 3: the principles of the CAREMORE® model



Source: Emergency Ambulance Services Committee

- 15 One of the key issues highlighted by the McClelland Review was that the method for measuring performance of emergency ambulance services needed further development. The sole reliance on response times relating to reaching calls categorised as red was described in the review as ‘restrictive and a poor reflection of ambulance service work’. The review called for more intelligent performance targets that are more focused on the experience and outcome of patients.

- 16 In July 2015, the then Deputy Minister for Health announced in a written statement⁶ that WAST would move to a new way of delivering and measuring how it responds to emergency ambulance calls. In October 2015, WAST implemented a new clinical response model on a pilot basis which divides 999 calls into three types:
- **red:** immediately life-threatening calls – someone is in imminent danger of death, such as a cardiac arrest. There is compelling clinical evidence to show an immediate emergency response will make a difference to a person's outcome. The eight-minute target has been retained for this group of calls with an initial target of 65% receiving an eight-minute response.
 - **amber:** patients with conditions which may need treatment and care at the scene and fast transport to a healthcare facility, if needed. Patients will be prioritised on the basis of clinical need and patients will receive a fast, blue-light response. There is no time-based target for amber calls, instead the new Ambulance Quality Indicators (AQIs) introduced by EASC measure the quality, safety and timeliness of care being delivered alongside patient experience information.
 - **green:** non-serious calls, which can often be managed by other health services, including healthcare advice or through self-care. This category also includes calls from healthcare professionals.
- 17 The aim of the new clinical model is to ensure that patients receive the right clinical care at the right time, which may not always be the dispatch of an emergency ambulance. The new clinical model is designed to allow WAST to quickly identify the clinical need of a 999 caller and the correct response to be provided. This may be an ambulance or a paramedic in a rapid response vehicle for red or amber calls which have received a higher priority. For many lower-priority amber and green incidents, advice may be provided for the caller over the telephone by a nurse or a paramedic.
- 18 Prior to the introduction of the new clinical model, red calls amounted to approximately 40% of calls received by WAST and the performance target for responding to these calls in eight minutes was frequently missed. Since the implementation of the new clinical model, red calls now amount to approximately 5% of the calls received by WAST, which allows WAST to focus its resources on the most urgent, life-threatening cases. In October 2016, the use of the pilot was extended until March 2017 to allow an evaluation of the model to be completed. In February 2017, the Cabinet Minister for Health, Well-being and Sport announced that the new model would be implemented permanently.

⁶ [Written statement by Deputy Minister for Health - Clinical review of ambulance response time targets, July 2015](#)

About this report

- 19 Our previous work on unscheduled care in 2009 and 2013 highlighted challenges across Wales in managing emergency and urgent demand, manifesting themselves in significant pressures within services, delays for patients and difficulties in meeting key performance targets.
- 20 Given that EASC has now been in place since 2014, the Auditor General set out his intention in his 2016 audit plans for NHS bodies to review the arrangements for commissioning emergency ambulance services. The aim was to understand whether they are improving services for patients, and the wider unscheduled care system. This report presents the findings from that work and sets out a number of recommendations for Welsh Government and NHS bodies.
- 21 It is important to note, however, that the report has not focused in detail on how WAST itself operates and whether its governance arrangements are effective in responding to how it is commissioned as a service. Our separate structured assessment work, which focuses on the governance of NHS bodies, provides commentary on the governance arrangements for WAST. This report is available on the Wales Audit Office website.

Our approach

- 22 Our approach has involved observation and review of EASC and its subcommittees which together make up the commissioning framework, and fieldwork visits to all health boards and trusts across Wales, with the exception of Velindre NHS Trust⁷. Visits included reviewing relevant documents and meeting a range of senior and operational staff. Further details of our audit approach are provided in [Appendix 2](#).

⁷ Due to the nature of Velindre NHS Trust, there is currently no interface between the trust and the emergency ambulance service.

Main conclusions

- 23 The overall conclusion from our review is that the new collaborative commissioning arrangements have helped to drive some important changes for emergency ambulance services in Wales; however, these arrangements are not yet mature and will require greater commitment by some partners to demonstrate their full impact.

EASC has helped to drive some important changes; however, there is a lack of clarity surrounding the structures and roles to secure accountability for emergency ambulance services

- 24 Our work has found that there is scope to clarify the respective roles of EASC, Welsh Government and the Commissioner in relation to the oversight and scrutiny of emergency ambulance service performance, finance, and service modernisation. Within the existing arrangements, there are multiple arrangements for scrutinising emergency ambulance service performance and holding WAST to account. EASC and its constituent health board members commission services directly from WAST and hold them to account for delivery of those services. The Commissioner also has responsibility for holding WAST to account on behalf of the seven health boards. In parallel to these arrangements, Welsh Government continues to hold discussions with WAST throughout the year on its performance, financial position and strategic planning through various mechanisms including Joint Executive Team meetings, the Clinical Model Assurance meetings and the NHS Planning Framework. The Commissioner attends all of these meetings. In addition, emergency ambulance service performance is considered through the National Unscheduled Care Programme Board.
- 25 Whilst the approval and allocation of funding for emergency ambulance services is the responsibility of EASC, there continue to be examples of funding going directly to WAST from Welsh Government, without going through the EASC process. This typically happens due to the length of time it takes for EASC to approve and action funding decisions. As an illustration, the EASC funding for 2016-17 for WAST was still to be received at month seven of the financial year, despite being confirmed in the 2016-17 three-year Integrated Medium Term Plan (IMTP) for WAST which was signed off by the Commissioner. Capital funding also goes directly from Welsh Government to WAST despite service modernisation being the responsibility of EASC.

- 26 The formation of EASC has supported all-Wales ownership of emergency ambulance services with all health board chief executive officers now attending the meetings and participating fully as commissioners of the service. Discussions at EASC to date, however, have largely been focused on operational aspects of delivery, both from a performance point of view as well as financially. At times, this has required WAST to produce a raft of information and a significant proportion of the time allocated for meetings has been focused on the detail. Whilst more recent meetings have shown signs of improvement in the quality of discussions taking place, the committee is not yet fully utilising its role in taking a high-level view and setting the strategic direction for emergency ambulance services. There is also scope to allow WAST to engage much more in the commissioning dialogue as WAST members are currently invited to attend for only part of the meetings. Involving WAST more would allow the discussions to benefit from the knowledge and experience that WAST brings to the table, although we recognise that there remains a need to maintain a clear boundary between the commissioner-provider relationship.
- 27 For EASC to work successfully, it is vital that partners strengthen their roles in the commissioning process over and above just attending the EASC meetings. EASC and the Commissioner only have a limited resource available to administer the commissioning process, and so are reliant on health boards acting on what is required of them outside of the meetings, as set out in the commissioning framework. This is particularly important now that the remit of EASC has recently been extended to include NEPTS as well as the Emergency Medical Retrieval and Transfer Service (EMRTS).
- 28 Our work has found that the subgroup structure underpinning EASC lacks clarity and purpose, which is impacting on attendance at the subgroups and the ability of these groups to make a meaningful contribution to the commissioning arrangements. Despite some examples of good work being produced by the Quality Assurance and Improvement Panel (QAIP), many stakeholders are unclear on the role and purpose of the subgroups. Discussions taking place in some of the subgroups suggests that the focus of these groups has deviated from their original intentions, and a lack of communication between chief executive officers and their executive teams is resulting in inconsistent attendance.

Partners are supportive of the commissioning model but there is variation in the pace in which health boards are driving the necessary changes to enable it to work as intended, and the model lacks consideration for regional or cross-border activity

- 29 Within health boards, ownership has become more evident. Board members are now much more aware of their responsibilities for the populations they serve in relation to emergency ambulance services. Despite some of the challenges with EASC and its subgroups, there is a general willingness of partners to work together to improve these services. At a local level, we have found a range of joint initiatives in place between health boards and WAST to enable better use of ambulance resources. The extent to which there are positive operational working relationships in place, however, varies with tensions between some WAST and health board staff still evident, particularly during times of pressure.
- 30 The level of ownership of some of the problems facing the emergency ambulance service is also variable across health boards, particularly at board level. While all NHS bodies receive the minutes, not all boards formally receive the EASC minutes within their meetings so remain unsighted of some decisions which have the potential to impact on health board performance. All boards understand the new clinical response model, but the focus of board scrutiny remains in most cases on the Welsh Government eight-minute response times target and handover delays. There is little, if any, focus on what health boards are doing to ensure that emergency ambulance services are used appropriately and patients are signposted to alternative services.
- 31 To fully realise the benefits of the five-step model, health boards need to be developing local services that can better meet patients' unscheduled care needs and avoid unnecessary conveyances to hospital by the emergency ambulance service. However, the extent to which this is evident through health boards' planning documents, such as their three-year IMTPs, is variable. In addition, Welsh Government issued a Welsh Health Circular on new handover guidance and more recently EASC approved the Ambulance Availability Protocol which was subsequently issued to health boards. These are both designed to enable better use of ambulance resources and require health board commitment to effectively implement. We have found evidence that health boards and even individual hospital sites vary in the extent to which they are implementing these new ways of working.

32 The focus of EASC is very much at a national level with health boards playing their role in improving emergency ambulance services for their local populations. However, cross-border (between Wales and England) and cross-boundary (between different health board areas) flows do not currently feature in commissioning discussions. This is an important factor for EASC to consider given that changes in demand and processes in one health board can have a significant impact on the provision of services in another and the availability of ambulance resources across Wales. Cross-border and boundary flows are currently reliant on local relationships and where issues arise, actions taken to resolve them are often reactive and have the potential to be contradictory to the work on EASC. Having all seven health boards around the table within the EASC meetings presents a real opportunity for regional issues to be raised on the agenda.

Commissioning arrangements are underpinning some improvements to emergency ambulance services; however, in a number of areas it remains too soon to comment definitively and important information on patient outcomes and experience is absent

- 33 Since the introduction of the new clinical response model, WAST has consistently met its target to respond to red calls within eight minutes. The agreements made by EASC, particularly in relation to the Ambulance Availability Protocol, hold further potential to improve the performance of the emergency ambulance service. However, such improvement is reliant on health boards fully implementing these agreements, and performance data suggests that more work is needed across all health board areas.
- 34 Planned service changes, despite them not being evident in IMTPs, and performance monitoring arrangements are now increasingly being aligned with the five-step model with examples of health boards using the model to develop their services in primary care, and shift the focus of their performance monitoring arrangements onto indicators which measure ambulance avoidance. However, in the main, performance monitoring and subsequent intervention continues to be focused on ambulance response times and conveyance to hospital, the latter stages of the five-step model. In general, health boards need to develop a broader range of primary and community care options if the benefits of the five-step model are to be fully realised, particularly during the times of the year when services experience winter pressures.

35 Finally, while there is a significantly improved and broader set of performance measures through the development of the AQIs, partners are not yet doing enough to properly determine patients' outcomes and experiences. Although there is recognition that there is more work needed to refine and develop the AQIs, partners have not yet monitored patient experience despite it being a requirement of the commissioning framework. Until information systems have the capacity to be joined up, it remains a challenge to understand the whole system outcomes of patients who have received a part of their treatment from the emergency ambulance service.

Recommendations

The following table sets out the recommendations arising from our review of ambulance commissioning arrangements.

Recommendations	
R1	<p>There is a need to clarify the role and purpose of the EASC and the Commissioner. The commissioning team, including the Chair of EASC and the Commissioner, should:</p> <ul style="list-style-type: none"> a. update the standing orders for EASC to reflect the fact that its governance arrangements are now separate to those of WHSSC; and b. ensure that there is a clear job description for the role of the Commissioner.
R2	<p>There is a need to clarify the respective roles of partners currently involved in providing scrutiny for emergency ambulance services to minimise duplication of efforts, reduce the burden from scrutiny on WAST and to ensure that there are no gaps in the scrutiny process. EASC should therefore work with Welsh Government and WAST to revise the Memorandum of Understanding (MoU) currently in place between EASC and Welsh Government. The revised MoU should include WAST and health boards. It should seek to clarify the roles and responsibilities of all partners in providing scrutiny of emergency ambulance services and how these align.</p>
R3	<p>There is a need to clarify the relationship between EASC and wider all-Wales unscheduled care structures to ensure that the focus of EASC is consistent with the unscheduled care ten-step model. EASC should therefore work with the Commissioner and Welsh Government to identify opportunities and mechanisms to strengthen the alignment of EASC with the NHS Wales Unscheduled Care Programme.</p>

Recommendations

- R4 The subgroup structure of EASC lacks clarity and purpose which is impacting on the ability of the subgroups to make a meaningful contribution to the commissioning agenda. **EASC should urgently review the structures, roles and memberships of its three subgroups to ensure they are mutually exclusive, have a clear purpose and appropriately support the work of EASC.**
- R5 Currently cross-border and cross-boundary flows are not discussed at EASC despite these flows potentially having an impact on the availability of ambulance resources across Wales. **EASC should discuss cross-border and regional activity and issues on a biannual basis as a minimum by requiring members to submit relevant points and suggestions in a timely way prior to these meetings.**
- R6 It is unclear whether the staffing resources available to support the work of EASC are sufficient, with the increasing remit of EASC in relation to NEPTS and EMRTS a concern. **The EASC Chair and Commissioner should review the current workload for the central commissioning team and any anticipated increase in that workload due to the delegation of NEPTS and EMRTS to EASC.**
- R7 There are opportunities to simplify and strengthen the funding mechanisms for emergency ambulance services. **The Welsh Government and EASC should review the funding mechanisms for WAST, recognising and maximising opportunities to:**
- a. **speed up the process for the allocation of WAST funding;**
 - b. **clarify the circumstances when it is appropriate for funding to go directly from Welsh Government to WAST without EASC involvement and address any issues where this is a result of inefficiency in EASC decision-making processes;**
 - c. **have a shared understanding of capital requirements and funds available so there is a clear link with the revenue allocation through EASC; and**
 - d. **provide opportunity for EASC to apply directly for additional monies such as the Intermediate Care Fund, removing the need for it to rely on members to apply for funding on its behalf.**
- R8 There are opportunities to simplify the funding for EASC to operate as a committee which is currently devolved through WHSSC. **Welsh Government should review and simplify the funding mechanisms for EASC ahead of the 2017-18 financial year by shortening the process for the agreement and allocation of funding made available to enable EASC and its commissioning team to operate.**

Recommendations

R9 Communication mechanisms for cascading information between EASC and its subgroups, and between its members and their respective executive teams are not yet effective. **The Commissioner and health board chief executives should strengthen mechanisms for communicating messages and decisions taken at EASC to all relevant staff of member bodies, which could include forums such as Executive Team meetings. The role of the 'EASC champion' should also be reviewed to ensure appropriate allocation of responsibility and clarity of purpose.**

R10 There is variability in the extent to which boards are engaged with the EASC commissioning process and local implementation of the five-step model. **Chief executives of all NHS bodies should increase the visibility of decisions taken by EASC through greater inclusion of EASC minutes, compliance with EASC agreements and consideration of AQLs performance data in board meetings, utilising opportunities to seek assurance through respective board subcommittee processes.**

R11 Health board three-year IMTPs are not yet consistent with the CAREMORE® and five-step model:

- a. **the Commissioner should ensure EASC members are aware of and understand the requirements of CAREMORE® and the five-step model; and**
- b. **health board chief executives should ensure that the Commissioner is given opportunity to comment on draft IMTPs to ensure that they are consistent with the commissioner framework.**

R12 Health boards and WAST are not yet doing enough to properly determine patients' whole system outcomes and experiences, despite this being a requirement of the commissioning framework. **Health boards and WAST need to ensure that they evolve existing information systems to enable the collection and monitoring of whole system outcomes and experiences for patients receiving emergency ambulance services.**

Source: Wales Audit Office

Part 1

EASC has helped to drive some important changes; however, structures and roles to secure accountability for emergency ambulance services are unclear

36 The EASC structure is made up of the main committee which is supported by three subgroups. In this section, we look at whether the committee structure is formed and operating correctly.

There is scope to clarify the roles of EASC, Welsh Government and the Commissioner in relation to emergency ambulance service performance, finance and service modernisation

37 The EASC is responsible for commissioning emergency ambulance services from WAST. The committee's role encompasses approving and providing funding for WAST to support performance and service modernisation, and to discuss and scrutinise the performance of emergency ambulance services.

38 However, EASC is not the only forum where the performance of emergency ambulance services is currently scrutinised. There are a number of other groups and partners involved. Firstly, health boards often discuss local issues relating to ambulance services directly with WAST through the role of the WAST local head of operations for their health board area. Secondly, the Commissioner can act on behalf of the seven health boards in engaging in discussions with WAST and holding the service to account. Lastly, Welsh Government holds regular discussions with both WAST and health boards on issues of performance, finance and strategic planning. Welsh Government discussions include direct contact with health boards and WAST through Joint Executive Team meetings and regular unscheduled conference calls, as well as through the National Unscheduled Care Programme Board.

39 There is an MoU in place for the operation of EASC; however, this currently relates only to the relationship between the committee, the Commissioner and Welsh Government. It does not clarify how these entities interact with health boards nor with WAST to provide scrutiny either of operational or financial performance for emergency ambulance services.

40 As a result, during our fieldwork we found that a number of members of EASC are not clear about whose responsibility it is to provide scrutiny for ambulance services. Consequently, we also found examples of WAST being subjected to the same questions in a number of different forums and being asked to provide the same information in various formats to different groups and individuals.

- 41 We also found that discussions around the role of health boards in influencing emergency ambulance performance, such as their handling of handover delays, are not taking place at EASC. EASC has the potential to provide a useful forum for such discussions given its role in bringing each of the seven health boards together. Clarity about the roles of those overseeing the performance of emergency ambulance services would enable forums to maximise their value and minimise the risks of duplications and gaps in scrutiny.
- 42 The confusion surrounding the various roles relating to emergency ambulance services is also evident in the understanding of the role of the Commissioner. The current Commissioner is employed as a director of a health board reporting to the relevant chief executive. He is also a member of EASC reporting to the Chair of EASC. He is the Director of the Unscheduled Care Programme Board reporting to the NHS Wales Chief Executive and as Commissioner is responsible to the Welsh Government, specifically the Cabinet Secretary for Health, Well-being and Sport, in an advisory role. These multiple roles are not fully understood by a number of the members of EASC.
- 43 There is scope to strengthen the clarity surrounding the role of both the committee and the Commissioner. At the time of our review, there was no job description for the Commissioner role. Developing one would be a comparatively straightforward means of clarifying the various roles of the Commissioner to EASC members. Additionally, the committee relies on standing orders to provide clarity for its purpose, powers and governance arrangements. However, these standing orders relate to both EASC and WHSSC. A paper that went to EASC in March 2016 on 'progress against governance arrangements' makes reference to plans to develop an EASC specific document, but this had not been progressed at the time of our fieldwork. Given the committee's ongoing process of de-coupling its governance arrangements from that of WHSSC, the development of an EASC specific document could prove useful for members in clarifying the role and purpose of the committee. EASC could also further develop the MoU which is in place between the committee and Welsh Government to help clarify relationships with and between WAST and the health boards.
- 44 As well as aspects of performance, EASC is also responsible for approving and allocating funding for emergency ambulance services in Wales. However, since the introduction of EASC there have been, and continue to be, examples of WAST receiving funding directly from other sources.
- 45 During 2015-16, WAST received over £8 million from Welsh Government in additional funding for winter pressures. This money was provided directly to WAST without utilising the EASC infrastructure. This was because of the urgency of the need for additional funding and a perception that using the committee structure to seek approval would take too long. To illustrate this, as at month seven of the financial year 2015-16, WAST was still to receive its annual revenue allocation despite EASC approving the WAST IMTP and the required allocation that was set out within it.

- 46 Welsh Government also approves and allocates capital funding directly to WAST. Given that the IMTP for WAST requires EASC approval and that performance and service modernisation are also functions of EASC, some of which will require capital investment, it would appear illogical for the capital funding for WAST to be a separate arrangement to the allocation of revenue funding.
- 47 Health boards themselves have also commissioned services directly from WAST which has seen the transfer of funds directly between a health board and WAST. For example, a number of health boards have commissioned additional emergency vehicles, such as the Dedicated Ambulance Vehicle in Hywel Dda University Health Board, or the Cardiac Transfer Vehicle in Abertawe Bro Morgannwg University Health Board, albeit that some, if not all, of these arrangements were in place prior to EASC. The creation of EASC should not preclude the development of local initiatives; however, it is unclear where decisions relating to this type of funding should be made going forward, should these services need to be reviewed.
- 48 Some funding sources that would be ideally suited to EASC would be those available to support modernisation and innovation such as the Intermediate Care Fund or the Primary Care Monies. Currently EASC is unable to access these funds as it is not a statutory body, so is reliant on health boards accessing the funds on its behalf.

The formation of EASC has supported all-Wales ownership of emergency ambulance services although EASC needs to do more to drive through service transformation

- 49 Over the first two years since EASC has been established, the attendance by its members, specifically chief executives of the seven health boards, has improved substantially.
- 50 The first few meetings of the committee saw a number of health boards represented by executive officers other than chief executives, such as directors for commissioning and chief operating officers. Unfortunately there have been occasions where those who have represented a health board in the absence of a chief executive have not had the authority or willingness to make decisions on their behalf. In addition, attendance by different members of a health board executive team created problems with the continuity of discussions and the ability of the committee to make effective, well-informed decisions.
- 51 More recently, attendance at EASC by health board chief executives has significantly improved. This is a welcome sign that members are responding to the opportunities that collaborative commissioning presents and the impact they can have as members. However, members of the committee need to be aware of the necessity to maintain this level of attendance, to ensure that discussions can improve and mature and lead to better decision making for improving ambulance services.

- 52 The McClelland Review identified that health boards would need to commit to their responsibility as both a commissioner and provider to enable the commissioning model to work effectively. Along with improved attendance, we found a clear improvement in the recognition by health boards that they are responsible for emergency ambulance services in their area.
- 53 Speaking to executive teams for health boards across Wales, we found a greater sense of ownership for ambulance services than had been previously reported in the McClelland Review. Health boards are now recognising that their responsibility for the populations they serve extends to the response the public receives from the ambulance service despite the fact that it is a separate organisation. A number of health boards also recognise that handover delays in emergency departments significantly impair WAST's ability to respond to any new calls from a patient in the community.
- 54 The development of a collaborative commissioning approach is likely to be a key reason for this improved level of engagement and ownership. The approach has required all stakeholders to take part in setting the standards and outcomes that they will be held to account for delivering against. Health boards are now much closer to the emergency ambulance service which has enabled them to better understand the factors that affect performance and quality of services, thus encouraging greater joint working of health boards with WAST to the benefit of the patient.
- 55 In the spirit of collaborative commissioning, there is scope for the committee to consider whether the approach should extend to greater inclusion of WAST as a member entitled to attend the entirety of EASC meetings. In contrast to health board members, as well as to the other two associate members of the committee, WAST is only currently invited to part of the meeting, that relating mostly to performance, and representatives are expected to vacate the meeting before wider discussions surrounding commissioning take place.
- 56 While we identified that some members of EASC feel strongly that these arrangements enable clarity in terms of a split between commissioner and provider, there were others who felt differently. Some feel that WAST could contribute in a meaningful way to wider discussions than they currently take part in. Engaging WAST more in the commissioning discussions would also allow consistent communication to be heard by all stakeholders, reducing the need for communication of particular matters to be relayed outside of the meeting, as currently is the case. The commissioner and provider split is complex with regard to ambulance services, with those seen as the commissioners, ie the health boards, also acting to an extent as the provider in enabling ambulance services to operate effectively. The committee should therefore carefully consider whether, in the interest of encouraging and enabling collaborative, constructive decision making, WAST should be provided with a greater role in EASC discussions.

- 57 The functioning of EASC and the Commissioner role is heavily reliant on the commitment of NHS bodies and their staff to play their role in the commissioning framework, and to ensure that they act on what is required of them outside of the meetings. However EASC does receive a small amount of funding for central support, predominantly focused on the administration of the committee and its subgroups, and the information required to underpin the CAREMORE® model. The funding required for EASC, however, is considered and approved by WHSSC which itself is funded by contributions made by NHS bodies. This can be a time-consuming process given that the EASC funding can only be considered and approved once the WHSSC funding has been signed off. This delay has resulted in capacity gaps in the team, as vacancies have not been able to be filled until the funding has been approved.
- 58 Our review has raised a number of questions regarding the availability of resources to support the effective operation of EASC. Unlike the arrangements for WHSSC, there is no current full-time member of staff to support the running of EASC. The EASC team⁸ currently consists of five individuals that work part-time, with some limited administrative support made available from the host health board, Cwm Taf. In addition, there is no admin support for the Commissioner in relation to his Director of Unscheduled Care role, creating workload pressures which may impact on his ability to deliver the Chief Ambulance Services Commissioner role.
- 59 We identified examples of papers being distributed late before meetings of the committee and its subgroups. The delay can impact on the quality of discussion as members may not be as prepared as they would if they were given adequate time to consider items.
- 60 The question of whether EASC can draw upon sufficient resource and capacity is of particular concern given that the committee has now also taken on commissioning responsibilities for NEPTS, provided by WAST and the EMRTS which is currently hosted by Abertawe Bro Morgannwg University Health Board. These commissioning responsibilities will come into full effect from April 2017.
- 61 As part of this review we observed a number of EASC meetings as well as reviewing minutes from past meetings. We reviewed the quality of discussion taking place between members and the efficiency with which decisions were made. Previously, the committee has shown a tendency to become entrenched in the financial and operational detail of the services delivered by WAST. While prudence is to be welcomed, at times the extent of the scrutiny of detail has presented risks to ambulance services in terms of delayed funding decisions, and has required funding to be provided directly from Welsh Government to expedite the process.

⁸ The EASC team consists of the Chief Ambulance Services Commissioner, the Chair of EASC, the assistant Chief Ambulance Services Commissioner, the Collaborative Commissioning Lead, and the Performance and Information Senior Support Officer.

- 62 More recent meetings have shown signs of improvement in the quality of discussion taking place. Greater consistency in attendance and involvement in the commissioning process is leading to better focused discussions. However, the committee occasionally still struggles to maintain an appropriate balance between involvement in operational detail and looking to drive strategic and transformational change for emergency ambulance services.
- 63 While improvements have been made, the committee is not yet fully exercising its role as a body that sets the direction for emergency ambulance services in Wales. Some interviewees continue to liken the relationship between a member of EASC and WAST to that of a health board executive team with one of its directorates. The distinction between that relationship and a collaborative commissioning relationship is, perhaps, not clear to all members.

The subgroup structure which underpins EASC lacks clarity and purpose, which is impacting on attendance and the ability of the subgroups to make a meaningful contribution

- 64 There are three subgroups that feed into the EASC. The intention was for these groups to have their own area of responsibility so as to be able to make decisions and provide EASC with assurance on a broad range of issues. The three groups are:
- the QAIP whose role it is to review the quality, efficiency and effectiveness of service improvement ideas. Members include WAST and representatives from the EASC team, with input from external members such as Welsh Government representatives and Academi Wales. The group meets quarterly.
 - the Performance Delivery Group (PDG) is tasked with considering the current performance of ambulance services across Wales and providing challenge. Membership includes the chief operating officers/directors of operations from the seven health boards, the Commissioner and representatives from WAST. The group meets monthly.
 - the Collaborative Commissioning Delivery Group (CCDG) whose role it is to manage and monitor the progress of the National Collaborative Commissioning: Quality & Delivery Framework. Group membership includes nominated ambulance commissioning ‘champions’⁹ from each health board. The group meets quarterly.

⁹ Champions represent primary care, planning, commissioning and community care functions with their primary purpose to promote the work of EASC within their respective health boards.

- 65 There is recognition by those attending that discussions at each of these groups has developed and improved since their inception. Members also recognised some of the good work produced by the subgroups, particularly by the QAIP in relation to some of the service change ideas that have been approved by the panel. For example, WAST has submitted in the region of 15 service change initiatives, which spread across the five-step model and support the principle of preventing conveyance to hospital, where it is safe to do so, to ensure that patients are managed appropriately. For example, QAIP funding enabled an additional post for the WAST frequent callers initiative that aims to improve clinical outcomes and reduce ambulance activity for frequent callers.
- 66 However, we also found a sense of confusion amongst members of EASC as well as members of the subgroups as to the role and purpose of the three groups. Due to the evolving nature of discussion and issues around communicating messages from EASC, we found indications that the work programmes of these groups have deviated from what was originally envisaged.
- 67 QAIP was originally created to review service improvement ideas. However, its role now also involves the approval of funding for implementing service change proposals, and reviewing the IMTPs of EASC member bodies to ensure they meet the committee's criteria, particularly in relation to reflecting the five-step model. However, this extended role presents a challenge as there is limited health board representation on the membership of QAIP.
- 68 The PDG has evolved to include discussions on a range of operational issues not strictly associated with emergency ambulance services. This is partly due to the fact that at the time of the review, it was the only forum which brings together the chief operating officers/director of operations of each health board at a national level, and therefore provides them with the opportunity to discuss much broader issues than emergency ambulance services. In addition to this, despite being intended as the forum to scrutinise operational performance of ambulance services, the group only began to receive performance data in July. The other groups had been receiving performance data for some time despite not having a role in scrutinising performance.
- 69 Finally, observations and reviews of minutes of the CCDG indicates a shift in the group's focus from managing the collaborative commissioning framework to primarily receiving updates and information from EASC and other subgroups. As a result, we found limited evidence of decision making by this group.
- 70 The three subgroups are therefore not currently operating strictly as was originally intended. In general, there is a need to review and clarify the role they need to fulfil going forward, and the membership needed to achieve this.

- 71 The lack of clarity over the subgroups' role and purpose has contributed to inconsistent and sometimes poor attendance by members to subgroup meetings, particularly with regard to the CCDG. Members of this group told us that they did not understand their role as members of the group nor as 'champions' for their health boards. As a result of this confusion, members often send other representatives on their behalf.
- 72 The inconsistency in attendance is further exacerbated by weak mechanisms for communicating messages from EASC and its subgroups to wider staff within health boards. It became clear to us during our fieldwork that members of EASC and its subgroups do not always utilise opportunities to share information and ideas with their colleagues. As a result, committee and subgroup meetings are often dominated by the need to provide updates from previous meetings and decisions taken by other groups. This again creates challenges for the pace of decision making for improving emergency ambulance services.

Part 2

Partners support the commissioning model but the pace in which health boards are driving the necessary changes to enable it to work as intended varies, and the model does not consider regional or cross-border activity

73 The new commissioning model for emergency ambulance services is predicated on collaborative working across the NHS. It requires a collective commitment to improving emergency ambulance services and a willingness to work together. In this section, we have examined the dynamics of the relationships between the health boards and WAST, and the approaches to working together.

There is a general willingness of WAST and health boards to work together to improve ambulance services, but the level of ownership of emergency ambulance performance and pathway modernisation by health boards is variable

- 74 At an operational level, we generally found positive, constructive relationships between health boards and the WAST team for the respective health board area. Within each health board area, we found a number of joint initiatives between the local WAST team and the health board. It was also evident that discussions take place between the WAST Head of Operations for a health board area and the health board executive team that are relevant to the needs of the local population.
- 75 These joint initiatives are however varied. Some encourage patients to utilise other services, such as within primary care, to free up the capacity of WAST. Other initiatives are aimed at tackling a particular issue for the local population which places a high demand on the ambulance service. For example, there has been a joint initiative between Aneurin Bevan University Health Board and WAST to provide lifting equipment and training to nursing and elderly homes to enable them to treat elderly fallers without the need to call out an ambulance. Another example is the alcohol treatment centre established jointly between Betsi Cadwaladr University Health Board and WAST to reduce demand on emergency ambulance services. These are only two of a number of initiatives currently in place across Wales. [Appendix 2](#) sets out a full list of joint initiatives either in place or planned across Wales.
- 76 The initiatives we heard of at a local level were generally well-reasoned and considered, with clear plans in place articulated through WAST local development plans for each health board area. The willingness shown by health boards to engage with WAST at a local level again reinforces the increased recognition by health boards of their own responsibility in improving ambulance services.

- 77 However, while each health board could provide details of initiatives agreed with local WAST teams, the quality of initiatives as well as operational working relationships in implementing these initiatives varied. The need to respond to pressures in the unscheduled care system has, in some instances, put a strain on the joint working arrangements between health board and emergency ambulance service staff. For example, initiatives that are heavily focused on increasing the pace of handovers, as opposed to addressing some underlying pressures. In some instances, the pressure to increase pace has led to increased levels of tension between paramedic teams and emergency department staff. Such examples indicate that, while ownership of emergency ambulance services by health boards has improved, there is still scope for some health boards to demonstrate a greater commitment to joint working with WAST to reduce demand.
- 78 At board level, we similarly found increased levels of interest and ownership of emergency ambulance performance within health boards. In our discussions with board chairs and through reviews of board minutes and health board performance reports, we found a greater level of understanding of the commissioning arrangements; for example, an understanding that WAST now operates under a new clinical response model, albeit that it is in a pilot phase. Boards also recognised the role of the Commissioner and the Chair of EASC, who had presented an update on work by EASC to each board during 2015 and again in 2016.
- 79 The regulations set by Welsh Government describe EASC as a joint committee of the health boards. However, we found limited evidence that health boards are sighted of the decisions taken by the committee which impact on the treatment of patients within their respective areas.
- 80 Hywel Dda and Cwm Taf University health boards are currently the only two health boards that receive the minutes of EASC to their board meetings. Having regular sight of EASC minutes ensures that the board is fully aware of any decisions made by the committee. This is important given that the decisions taken by EASC have the potential to impact on health board performance, both operational and financial. It is also important that the board be aware of these decisions in order to ensure that it can receive assurance that the health board is complying with any decisions made at EASC.
- 81 All boards understood that WAST is now also working to the five-step model. However, the focus of board scrutiny remains, in most cases, on the Welsh Government eight-minute target for red calls, as well as handover delays. Opportunities to focus on the earlier steps of the Ambulance Patient Care Pathway and to draw on broader performance information such as availability of services to prevent the need for an emergency ambulance, or more general patient experience are not currently being utilised by health boards.

WAST is properly responding to EASC agreements; however, health boards' compliance and level of understanding of the requirements set out in CAREMORE® varies

- 82 Following an interim agreement in place for EASC during its first year, the Commissioning Quality and Delivery Framework was agreed in 2015. The document contains a number of schedules which are structured in line with the CAREMORE® approach which aims to ensure that robust consideration is given to each of its principles such as care standards, activity and resource envelope. This model is in keeping with, and supportive of, the five-step model.
- 83 The framework provides a good and logical structure to support partners of EASC to make decisions and apply robust performance scrutiny. While the framework is focused primarily at actions that WAST should fulfil and data for WAST to provide, it identifies that this can only be effectively achieved if health board partners play their part as well. For example, within the care standards section of the framework, it states that WAST must only convey patients to Accident and Emergency (A&E) where no alternative (eg community care or direct ward admission) is safe or available to meet the care needs of the patient.
- 84 The framework is still developing and EASC has made good progress thus far. However, the EASC commissioning team recognises that there is still some further work to be done to refine and strengthen the framework within an expectation that the framework will continually evolve.
- 85 There are opportunities to adapt the framework to ensure that it helps focus discussions at the right level. For example, the 'Resource Envelope' section of the framework provides a lot of detailed information on costs of WAST by skill mix (retrospectively). It is questionable as to whether EASC needs to get involved in this level of operational detail as such a focus may be at the expense of the more strategic discussions which are necessary.
- 86 The framework is supportive of the five-step model for emergency ambulance services. As previously noted, one of the main ambitions of EASC is to encourage and enable patients to access services through a variety of means before their needs become urgent. This will therefore alleviate the pressures on emergency ambulance services to provide urgent care and allow the service to focus on those with truly urgent, life-threatening needs. The principle objective of the five-step model is often referred to as encouraging a 'shift left', where it is safe and clinically appropriate to do so. This means that less patients need to receive ambulance care and be conveyed to hospital (steps three to five) and more patients are signposted to more appropriate services, have better access to alternative services and wherever possible have their needs met at home (steps one and two).

- 87 Each member of EASC is expected to sign up to the five-step model, a demand management approach that encourages services to 'shift left'. Health boards are expected to plan according to the various steps of the model, aiming to provide alternative services that provide effective options available for patients to choose the service most relevant to their needs.
- 88 In order to evaluate the commitment of health boards to achieving the objectives of the five-step model, we looked specifically at IMTPs or annual operating plans where relevant. The extent to which health boards demonstrate a commitment to providing alternative services and recognising the positive impact of such commitment was variable across health boards.
- 89 Some health boards are more advanced than others in responding to and demonstrating their recognition of the five-step model. A number of health boards showed great commitment to the pathway through their IMTP, with easily recognisable references and plans to develop a variety of alternative services. For example, the IMTP for Powys Teaching Health Board provides a strong definition of its plans for changing community based unscheduled care services. It identifies a range of actions, timeframes for delivery, associated risks and measures, all of which align to the five-step model.
- 90 Another good example is the use of the ten-step unscheduled care model to inform the structure of the Unscheduled Care section in the IMTP for Betsi Cadwaladr University Health Board. The ten-step model further builds on the five-step model used for the Ambulance Patient Care Pathway by also including steps after the point in which the patient is taken to hospital, through to the point in which they are discharged. Within its IMTP, the health board has demonstrated clear plans which align to the five-step model and are planned over the short to medium term. The ten-step model is set out in [Exhibit 4](#).

Exhibit 4: the National Unscheduled Care Programme ten-step model



Source: Welsh Ambulance Services NHS Trust

- 91 However, other health boards' plans do not currently demonstrate the same level of commitment to implementing the objectives of the five-step model, and instead focus attention on reaching the eight-minute red-call target and reducing handover delays. Some health board plans, for example those in Hywel Dda University Health Board and Abertawe Bro Morgannwg University Health Board had very limited discussion of ambulance services beyond these metrics, and provided little, if any, commentary on the work of EASC and how the health board is planning to deliver against the five-step model. More generally, the plans we reviewed typically failed to provide details about metrics to track the activity of the health board in implementing plans for developing alternative, non-urgent care pathways.
- 92 In addition to reviewing the commitment shown by partners to implementing the framework and pathway, we also looked at the extent to which partners have implemented other agreements made at EASC. Recent agreements have included the development and approval of the clinical response model and AQIs, the development and distribution of handover guidance, as well as the Ambulance Availability Protocol. The former two agreements relate specifically to WAST in terms of implementation, with the latter two requiring greater health board commitment to effectively implement.

- 93 The agreements regarding the new pilot clinical response model and the AQI have been in operation for 12 months. There is recognition that a number of the AQIs need some further development and refinement, and that following the evaluation recently completed by Public and Corporate Economic Consultants (PACEC) and University of Sheffield¹⁰, the clinical response model may require some change. However, WAST has fully implemented both of these agreements in their current form.
- 94 The way in which health boards have implemented agreements relating to handover guidance and the Ambulance Availability Protocol has been less consistent. The handover guidance was approved in early 2016. Its aim is to clarify, strengthen and create consistency in the processes used by WAST and hospital staff in conducting timely handover of patients. However, we found evidence that suggests that this guidance is not implemented in full by some health boards, largely because of a lack of capacity to receive patients within the emergency department.
- 95 The Ambulance Availability Protocol aims to put in place a process to ensure that ambulances are always immediately released when available emergency ambulance service resources in a specific geographical area become scarce. This is to ensure that emergency ambulance resources are available and ready to receive high clinical priority calls as and when they are received. Under such circumstances, the crew would not be delayed by the need to first handover a patient before they are able leave the hospital site. However, we found a lack of understanding of this protocol and what conditions are necessary for it to apply. Some health boards were implementing the protocol on the basis of releasing an ambulance only once a category red call had been received, and not, as should be the case, when there are no ambulances providing coverage of a geographical area.
- 96 These examples would indicate that agreements reached through EASC are not always effectively communicated to operational staff within health boards, resulting in an inconsistent application of processes that are designed to safeguard the quality of emergency ambulance services across Wales.

¹⁰ [Clinical Model Pilot Evaluation, Public and Corporate Economic Consultants \(PACEC\) and University of Sheffield](#)

Cross-border and cross-boundary activity currently does not feature in commissioning discussions

- 97 The variation in the delivery and quality of emergency ambulance services between health boards is not something which is currently discussed at EASC. There is variation in the demand and capacity of the ambulance service in neighbouring health board areas, as well as in the geography and use of processes by health boards. Health boards operate within a defined geographical area, and while an ambulance service will be allocated to a particular health board area, WAST provides a national service. Changes in demand and processes in one health board area can have a significant impact on the demand and activity of an ambulance service in the immediate, as well as neighbouring, areas.
- 98 For example, one health board may have been successful in reducing delays caused by handovers with the result that more ambulances are available to cover other health board areas where handover delays, and ambulance availability, is more of a problem. The obvious consequence is that the health board that has been successful in addressing handover delays may still experience problems with ambulance availability as a result of problems in other health board areas.
- 99 In response to this issue, during 2015 Cwm Taf University Health Board piloted a project aimed at ring fencing ambulance services within its geographical area, referred to as the Explorer project. This meant that ambulances did not cross health board boundaries except in the event of a category red call which requires urgent care. This project has supported the health board in maintaining good performance on handover delays. However, we found evidence that the ring fencing had to be breached on a number of occasions due to the urgent need for ambulance services in neighbouring health board areas where handover delays are high. A subsequent evaluation of the project has found that the model adopted was expensive, was set in the context of the previous response model, and was not considered a sustainable model for the future. A further pilot is now being explored through the use of a community based paramedic.
- 100 During the review we were made aware of numerous examples of handover delays in some health boards impacting on the availability of ambulance crews to respond to calls in neighbouring health boards. We found that discussions regarding these types of issues are dependent on local relationships between operational teams and that there are currently no formal mechanisms to consider regional performance. EASC would appear to be the natural forum for such discussions, although to date, this opportunity has not been used.

- 101 In addition to discussions about cross-boundary activity within Wales, there is scope for EASC and/or its subgroups to consider cross-border activity between Wales and England, as a number of health boards see their patients flow across the border to England. This is either for specialist treatment or because there is no capacity for an emergency department to receive them within their own catchment area. The flow of patients to English hospitals which, in some cases, are some distance away, has implications for the availability of ambulance resources within Wales, and therefore also its performance. Yet EASC does not currently consider such issues. Ambulance crews, for example, can routinely be held up outside English hospitals, yet such initiatives as the Ambulance Availability Protocol are not applied to English hospitals, in relation to Welsh patients. This again creates a reliance on local teams to consider and manage this activity independently and in a reactive way.
- 102 While cross-border and cross-boundary activity only accounts for a small proportion of emergency ambulance activity, planned reconfiguration of services across boundaries will have a broader impact on the availability of ambulance resources. For example, plans for a major trauma centre in South Wales will impact on the availability of emergency ambulance resources across a wide geographical area. Although there are forums in place to discuss reconfiguration, the Commissioner is not currently represented at these forums. Accessing these forums, whilst also using the opportunities presented through EASC, will allow the impact of cross-border and cross-boundary flows to be considered.

Part 3

Commissioning arrangements are underpinning some improvements to emergency ambulance services; however, in a number of areas it is too soon to comment definitively and important information on patient outcomes and experience is absent

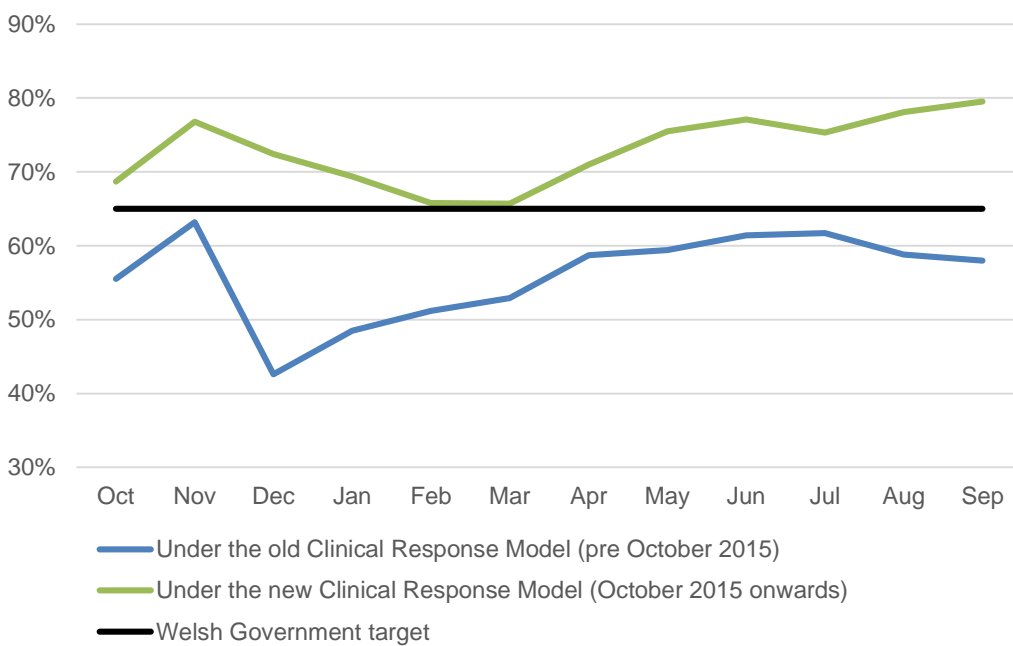
103 The fundamental purpose of the new commissioning arrangements is to ensure a better delivery of emergency ambulance services for patients. This section of our report looks at the impact of decisions taken by EASC in terms of performance of emergency ambulance services in Wales as well as the impact on patient experience and outcome.

The introduction of the new clinical response model is supporting partners to achieve Welsh Government performance targets with the potential for further performance improvements from recently agreed initiatives

- 104 As previously noted, Welsh Government approved a new clinical response model to be piloted that alters the categorisation of emergency calls to the ambulance service. This new model has been implemented on a 'trial' basis across Wales since October 2015, initially for a period of 12 months. In October 2016, approval was received from the Cabinet Minister for Health, Social Care and Sport to extend the trial through to March 2017, with a recent announcement by the Cabinet Minister that following the evaluation, the clinical model will now be implemented permanently.
- 105 As a result of the new clinical model, WAST feels better able to concentrate its efforts on the most life-threatening red cases such as a cardiac arrest, severe choking, severe bleeding and patients that are not breathing or are unconscious. While an evaluation of the new clinical response model is currently underway, during our fieldwork we found strong support for it and a recognition that the model has multiple benefits for patients as well as for the members of EASC.
- 106 There is recognition within WAST that the new clinical response model has enabled existing capacity to be used in a more intelligent and effective manner than that previously possible under the old clinical model. The ability of WAST to focus resources on reaching the most life-threatening cases, where a rapid response can have the most positive impact on the patient's care, has a positive impact on both WAST staff and resources.

- 107 Those we spoke to told us that the new model is more in keeping with the needs and technologies of today. Under the new model, the reduction in red calls has also reduced the need to send multiple vehicles to a red call in order to meet the time-based target and 'stop the clock'. This means that there is greater stability and multiple vehicle dispatches are only deployed when there is a clinical need for them. As a result, WAST staff feel that the model enables them to work more effectively, to recognise that a red call will be truly an urgent, life-threatening need and that resources are more likely to be available to meet that need.
- 108 Since the new clinical response model has been in place, WAST has consistently met the eight-minute response performance target for red calls at an all-Wales level. This is demonstrated in Exhibit 5 which compares the figures between October and September before and after the introduction of the new clinical response model with the Welsh Government target.

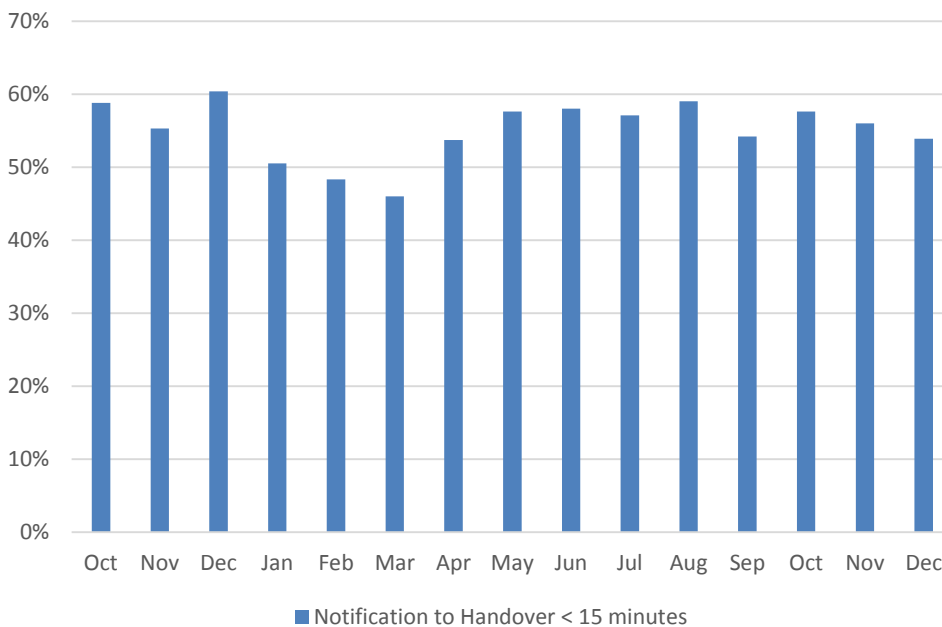
Exhibit 5: percentage of red calls responded to in eight minutes across Wales before and after the implementation of the new clinical response model, compared with the Welsh Government target (October 2014 to September 2015, October 2015 to September 2016)



Source: Stats Wales

- 109 The decision by Welsh Government to pilot the new clinical model, coupled with effective leadership for piloting this approach within WAST, has driven this important change in the delivery of the ambulance service. The context and stability added by EASC was an important factor in instilling a sense of trust and faith in the emergency ambulance service system to undertake this pilot. Members are clear on the implications and the benefits of this decision for emergency ambulance performance.
- 110 Handover delays, however, continue to present a challenge in terms of emergency ambulance service performance, as demonstrated in [Exhibit 6](#), and health boards and WAST will need to continue to work closely to improve this aspect of performance. The percentage of patients handed over to emergency departments within 15 minutes, an indicator within the AQIs, was low for each health board between October 2015 and December 2016, with some particular health boards consistently struggling. The winter pressures faced by each health board between December and April provided particular challenges for handover performance during 2016.

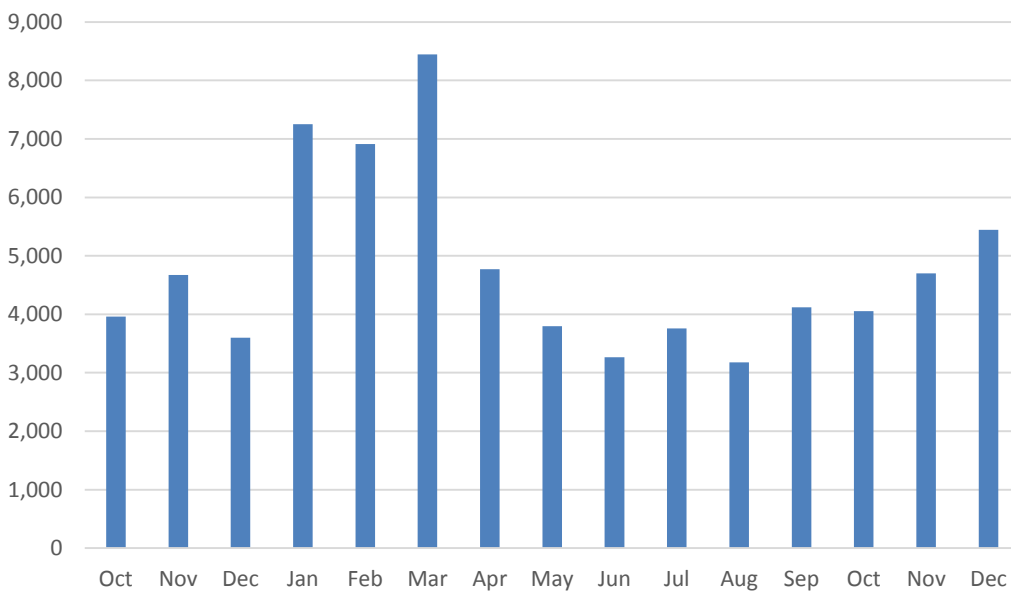
Exhibit 6: percentage of patients handed over to emergency departments within 15 minutes across Wales (October 2015 to December 2016)



Source: Ambulance Quality Indicator data

111 On average, between October 2015 and December 2016, only 55% of handovers were completed within 15 minutes across Wales. The average number of lost hours was 4,795 each month, with a peak in lost hours between January and March 2016 ([Exhibit 7](#)).

Exhibit 7: total hours lost as a result of handover delays over 15 minutes (October 2015 to December 2016)

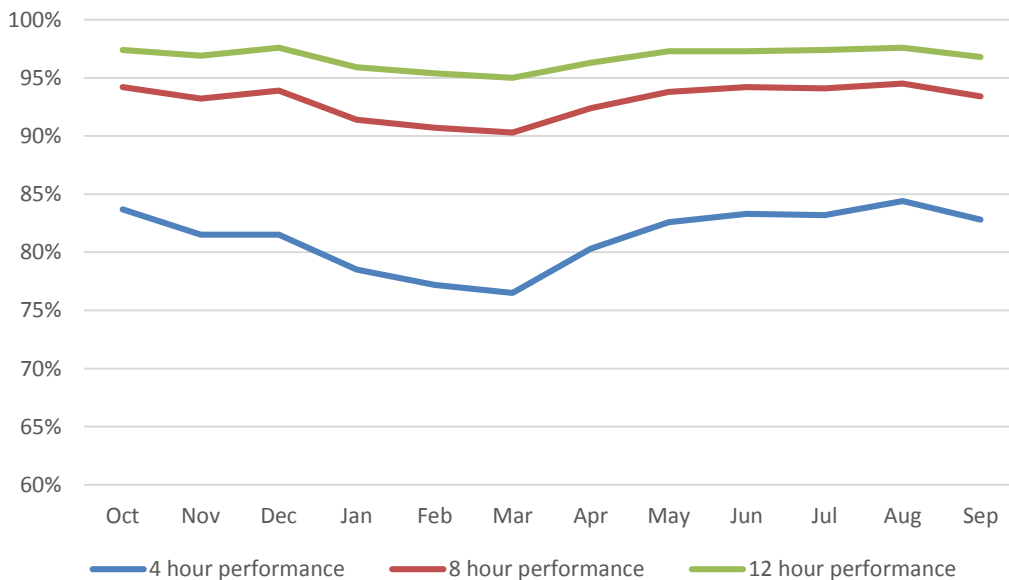


Source: Ambulance Quality Indicator data

112 There is, however, much variation between health boards. For example, in September 2016, 86% of handovers were completed within 15 minutes in Cwm Taf University Health Board, while in Betsi Cadwaladr University Health Board, only 41% were completed within 15 minutes. Overall, performance in this regard does not appear to be improving or deteriorating at present. Further details of performance relating to emergency ambulance services by health board are set out in [Appendix 3](#) of this report.

113 Handover performance can be influenced by pressures within the emergency department and the inability to move patients through the unscheduled care system. When considering health boards' waiting times performance in emergency departments in relation to the percentage of patients waiting less than 4, 8 and 12 hours, there is a correlation between the deterioration in performance for emergency waiting times, handover delays and the emergency ambulance eight-minute response time. This is particularly evident during what is considered to be the 'winter pressures' period between January and March. Waiting times performance is shown in **Exhibit 8**.

Exhibit 8: percentage of patients waiting less than 4, 8 and 12 hours in emergency departments across Wales (October 2015 to September 2016)



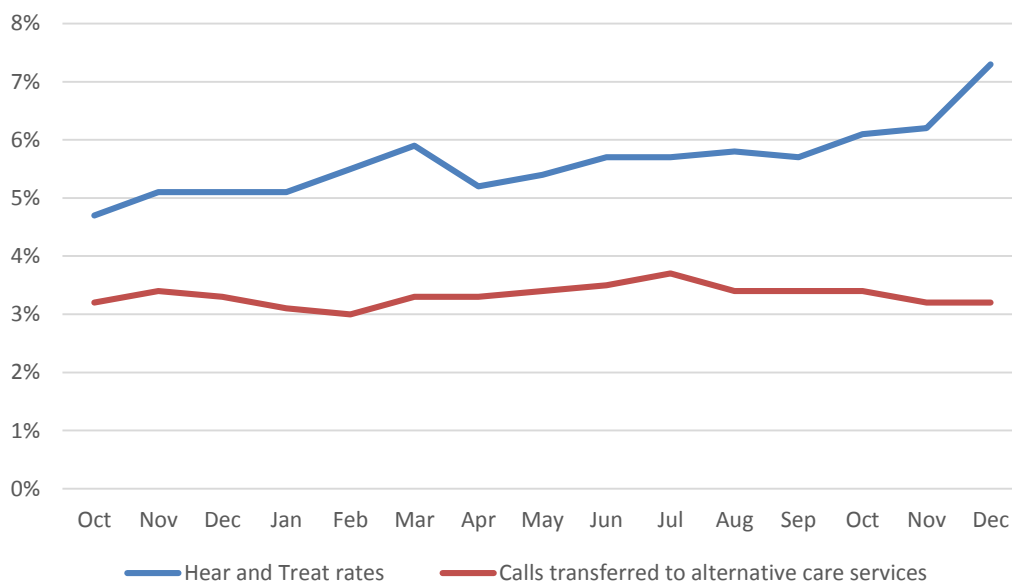
Source: Stats Wales

114 More recent decisions by EASC, such as the development and distribution of handover guidance and the Ambulance Availability Protocol, have potential to further improve performance during times of great pressure. However, as previously noted, these improvements are dependent on the commitment by health boards to effectively communicate and respond to these agreements as they have for others.

Planned service changes and performance monitoring of partners are now increasingly aligned with the five-step model but more consistency is needed across health boards and it is too soon to say if this is having an impact

- 115 We looked at the implications of decisions taken by EASC beyond that of the impact of the new clinical response model on WAST and its ability to meet the Welsh Government performance target. Again, we reviewed the integration of the five-step Ambulance Patient Pathway within health board processes, this time from the perspective of the performance monitoring and management arrangements within health boards.
- 116 We found a number of positive examples of health boards incorporating the five-step model into their performance management arrangements. Whilst not always evident in IMTPs, some health boards, such as Aneurin Bevan University Health Board could demonstrate planning and performance monitoring examples using the five-step model, including through specific separate plans for alternative pathways within primary care. Others, however, showed less maturity in this respect. It is also positive that health boards are incorporating and recognising the commonality between the five-step model for ambulance services and the unscheduled care ten-step model.
- 117 However, we found that a number of health boards are continuing to focus their activity and attention towards steps three to five of the five-step model. Step three 'come to see me' places the focus of care on unscheduled, urgent care, as opposed to increasing the focus on putting in place preventative or alternative services at an earlier stage. The objective of the five-step model is to increase the capacity of alternative services and to enable patients to make the right choice about their treatment at the right time. In order to enable an effective 'step left' which will reduce demand for urgent, ambulance care, a number of health boards will need to be more proactive in addressing primary and community care options.
- 118 An indicator of success in line with the five-step model is the effective treatment of patients via hear and treat services, despite initial delays in getting these services funded. This is where patients are provided the necessary advice or signposting to more appropriate services over the phone, thereby reducing the need for any further intervention from the ambulance service. These calls are either ended after the patient has spoken to a member of NHS Direct Wales or after they have spoken to a member of the WAST Clinical Desk. Data for hear and treat rates, shows a gradual increase over the last 12 months in the percentage of ambulance service calls that fall into this category ([Exhibit 9](#)).

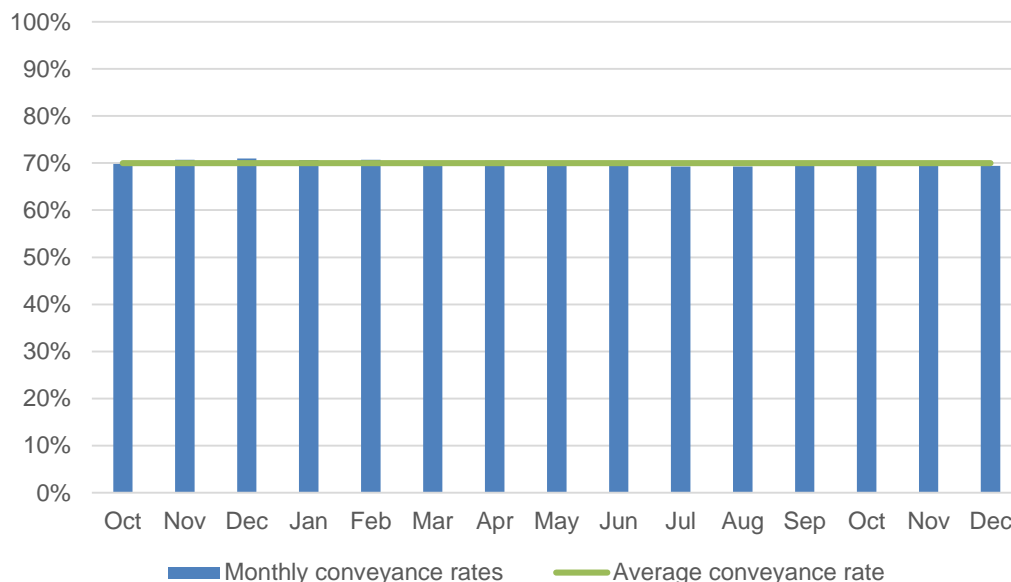
Exhibit 9: percentage of calls to emergency ambulance services ended following a telephone assessment (ie hear and treat) / calls ended through transfer to alternative care service providers (October 2015 to December 2016)



Source: Ambulance Quality Indicator data

- 119 Whilst the gradual increase in activity along earlier steps of the five-step model, such as shown in Exhibit 9 for 'hear and treat' is to be welcomed. The overall quantum of calls that fall into this category remains relatively low, suggesting that sufficient alternative services may not yet be fully in place or that there is not full awareness of such services.
- 120 A good indicator that the 'step left' is being achieved would be a reduction in the number of patients conveyed to hospital by an ambulance following a call to the emergency service. However, a decline in conveyance is not yet being observed (Exhibit 10).

Exhibit 10: percentage of patients conveyed to hospital following a face-to-face assessment (October 2015 to December 2016)



Source: Ambulance Quality Indicator data

- 121 The data shows that the conveyancing of patients over the last year has remained relatively consistent in that around 70% of patients who call 999 are conveyed to hospital each month. Of these, each month between 91% and 92% were taken to a hospital emergency department with the remaining patients taken to other wards and departments. The data for those taken to wards and departments other than the emergency department also shows a consistent performance each month.
- 122 The pattern of data shown in Exhibit 10 is perhaps not surprising given that many health board changes, to provide alternative services that have the potential to reduce conveyancing, have only been recently introduced and have not yet been fully tested by winter pressures. It will be important, however, for EASC and individual NHS bodies to look for positive changes in conveyance rates as part of their assurances that the five-step model is securing its intended benefits.

There is a significantly improved and broader set of measures which focus on activity and performance but partners are not yet doing enough to properly determine patients' outcomes and experience

- 123 With the implementation of the new clinical response model came a new suite of indicators for reporting the performance of emergency ambulance services. The AQIs provide a much broader view of activity and performance indicators than before. The 24 indicators go beyond looking at time-based targets; they provide greater information around the number of calls that WAST receives, what happens to those calls and the treatment provided by paramedics to the patient when a crew has been dispatched. These indicators are made available on a quarterly basis through the EASC website and since June 2016 provide data on a health board level as well as in terms of the all-Wales picture.
- 124 In addition, EASC has been working with the NHS Benchmarking Network to create a suite of indicators that can be used to benchmark performance internally across the seven health board areas. The toolkit produced by NHS Benchmarking builds on the data available through the AQIs along with a range of core operational data, such as skill mix, available directly from WAST.
- 125 The AQIs represent a step in the right direction towards understanding patient outcomes. For example, AQI 16i reports on 'number of patients suffering cardiac arrest with a return of spontaneous circulation (ROSC)' and AQI 16ii reports on 'number of stroke patients who are documented as receiving appropriate stroke care bundle'. Such data on ambulance service performance was not publically reported on a regular basis before the introduction of the AQIs. This signals an appetite to better understand the outcomes of patients after their treatment by paramedic teams. It also indicates a greater recognition of the clinical service provided by the ambulance service, the development of which was a key recommendation of the McClelland Review in 2013.
- 126 However, there is recognition that these indicators are still developing and require further refining to ensure they demonstrate key data in a clear way. There are opportunities to improve the presentation of some indicators so that they become more accessible and understandable to readers; for example, the mixture of numbers and percentages as well as the language used for some indicators could be confusing to a reader attempting to understand the patient journey.
- 127 In addition, there are opportunities to make the indicators more meaningful in understanding patient outcomes and patient experiences. Currently, data relating to the outcome of patients is limited to seven indicators, which indicate whether the patient received the right care, as opposed to what the outcome was for that patient. Despite the fact that the Commissioning Framework sets out the requirement that members of EASC monitor the patient experience, the committee has thus far made little progress in this regard.

- 128 Those we spoke to during our fieldwork explained that there are a number of complexities involved in linking information between WAST and health boards in order to track the experience and outcome of a patient from the beginning to the end of their treatment. The use of different systems and processes for recording and sharing patient information means that this is an area where little progress has been made to date.
- 129 There is a plethora of data available that EASC members can draw upon in order to continue to make important changes to improve emergency ambulance services for Wales. However, the alignment and sharing of data is not yet in place to enable this to work most effectively. Additionally, members are not yet fully recognising and making the most of the potential that this information holds to inform decisions for improving the quality of ambulance services for patients across Wales.

Appendix 1

Audit approach

The review of emergency ambulance services commissioning arrangements took place between March and September 2016. Details of the audit approach are set out below:

Document review

We reviewed relevant documents for all health boards and WAST including:

- three-year IMTP or one-year operational plans where appropriate
- relevant operational plans, eg unscheduled care and primary care plans
- annual reports
- relevant board and subcommittee papers

In respect of EASC, we reviewed:

- EASC and subgroup papers
- the collaborative commissioning framework and supporting documentation

Interviews

Focusing on the form and functioning of EASC and its subgroups, as well as emergency ambulance services and their role in the wider management of unscheduled care, we interviewed the following:

- Chair of EASC
- Chief Ambulance Services Commissioner
- chief executive officers of all NHS bodies, excluding Velindre NHS Trust
- chief operating officers, or equivalent for all health boards and WAST
- directors of planning for all health boards and WAST
- directors of primary care for all health boards
- chairs of all health boards and WAST
- Medical Director for WAST
- Director of Quality, Safety and Patient Experience for WAST
- Director of Finance for WAST
- Chief Executive, NHS Wales
- Deputy Chief Executive, NHS Wales
- Director, Delivery Programme, HSSG, Welsh Government
- Interim Head of Emergency Care, HSSG, Welsh Government
- Head of Operations for WAST
- Assistant Director, Commissioning & Performance, WAST

- the lead clinician, nurse and manager for each major emergency department in Wales
- Collaborative Commissioning Lead for EASC
- Assistant Chief Ambulance Service Commissioner

As part of this review, we have also observed and interviewed staff within the three regional ambulance control centres.

Observations

Focusing on attendance, and the quality of discussion and decision making, we observed the:

- Emergency Ambulance Services Committee in March and June 2016
- QAIP in May 2016
- PDG in July 2016
- Collaborative Commissioning Group in July 2016

Data review

We reviewed and analysed data relating to emergency ambulance services available through the Stats Wales website and the AQIs. We have also considered the data contained in the NHS Benchmarking toolkit for emergency ambulance services.

Appendix 2

Joint health board and WAST local initiatives

Below are some of the local initiatives that we identified were in place (or were about to be implemented) between health boards and WAST during 2015-16.

Health board	Initiative
Abertawe Bro Morgannwg	<ul style="list-style-type: none"> • Mental Health Pathway • Early Adopters Pathway • Anticipatory care programme • Hospital at home • Development of an Acute GP Pathway Pilot • Hypoglycaemia pathway • Epilepsy pathway • Implementation of a dedicated falls vehicle • Help Point Plus
Aneurin Bevan	<ul style="list-style-type: none"> • Mental Health Pathway • Fractured neck of femur pathway • Physician Response Unit • Care home pathway • Local general hospital admission pathway • Possible implementation of a dedicated falls vehicle
Betsi Cadwaladr	<ul style="list-style-type: none"> • Paramedic access criteria for all Minor Injury Units • Widening use of the Nurse Response Unit • Corridor procedure • Falls Pathway • District Nurse Pathway trial • Alcohol Treatment Centre, Wrexham • Mental Health Pathway
Cardiff and Vale	<ul style="list-style-type: none"> • Alcohol Treatment • Full implementation and constant review of Paramedic Pathfinder • Falls Pathway • Resolved Hypoglycaemia pathway • Resolved Epilepsy pathway • Mental Health Pathway • Stroke Dedicated Cardiac Network Pathway • Emergency Gynaecology Pathway • Obstetrics Pathway • Ambulatory Care Pathway • Barry Minor Injury Pathway • Potential for a practitioner response unit

Health board	Initiative
Cwm Taf	<ul style="list-style-type: none"> • Fractured Neck of Femur pathway • Ambulatory Emergency Care pathway • Community Integrated Assessment Service • Social Services pathway • Mental Health pathway • Minor Injuries Unit pathway • Chronic Obstruction Pulmonary Disease pathway • Stroke and medical pathway • TIA pilot pathway • Preventative community services • Explorer Project
Hywel Dda	<ul style="list-style-type: none"> • Access to an ABM pathways directory by Hywel Dda Paramedics • A directory of services for Hywel Dda • Rotation of advanced practitioners between WAST, Primary Care and Out of Hours • Continued development of the AP profile and GP services support to enhance 'treat at scene' and direct admissions • Specific pathways for Stroke patients in WGH
Powys	<ul style="list-style-type: none"> • Paramedic Pathfinder • Minor Injury Units • Advanced Practitioner (AP) pathways development

Source: WAST local development plans for 2015-16, and interviews

Appendix 3

Health board performance against key indicators relating to emergency ambulance services

Below we have selected a number of key indicators relating to emergency ambulance services to provide a snapshot of performance at a health board level. For the purposes of this analysis, we have chosen to focus on the most recent publication of data, July to December 2016.

We looked at a number of indicators that provide indications of the success of efforts under the five-step model to reduce demand for urgent care. The rates of 'hear and treat', 'see and treat' and non-conveyance provide helpful indications that health boards and WAST are maximising opportunities to treat patients without the need for an emergency ambulance service to admit them to emergency departments. As far as possible, we have focused the key indicators around the five-step model.

Step 2 – answer my call

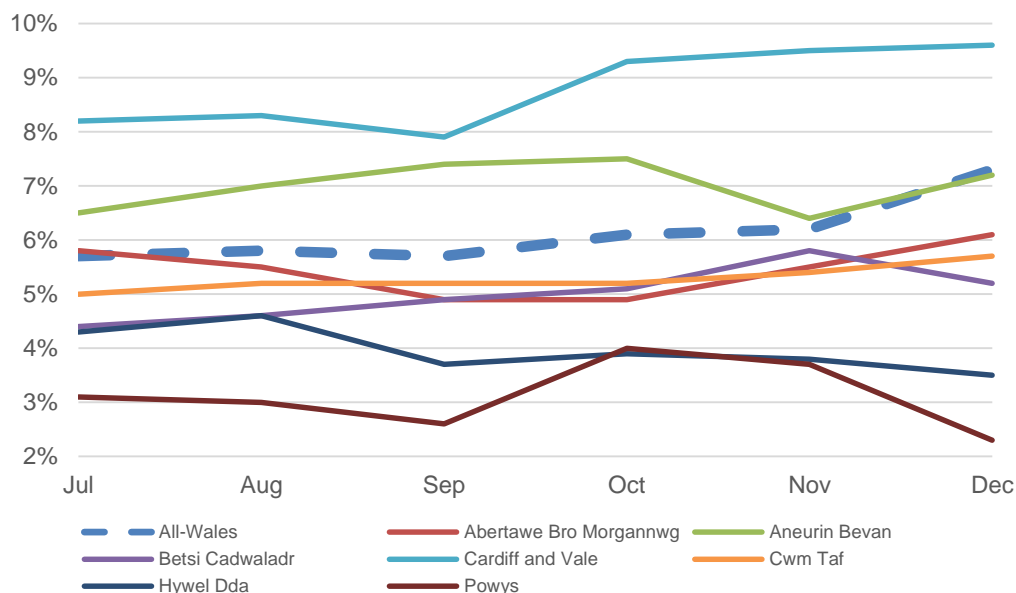
Firstly, we looked at the percentage of calls from patients in each health board area that were ended following a WAST telephone assessment, which is also termed 'hear and treat'. Performance can be influenced by the regional clinical control centres, with performance generally better in the health boards served by the South East clinical control centre, which covers Aneurin Bevan, Cardiff and Vale, and Cwm Taf university health boards. At the time of our review, this control centre was the only centre to host a clinical desk. The results between July and December reflect the position when the South East clinical control centre was the only centre to host a clinical desk. The results are shown in [Exhibits A1 and A2](#).

Exhibit A1: percentage of calls ended following WAST telephone assessment (hear and treat), July to December 2016 (all-Wales and comparative)

Health board	Jul	Aug	Sep	Oct	Nov	Dec
All-Wales	5.7%	5.8%	5.7%	6.1%	6.2%	7.3%
Abertawe Bro Morgannwg	5.8%	5.5%	4.9%	4.9%	5.5%	6.1%
Aneurin Bevan	6.5%	7.0%	7.4%	7.5%	6.4%	7.2%
Betsi Cadwaladr	4.4%	4.6%	4.9%	5.1%	5.8%	5.2%
Cardiff and Vale	8.2%	8.3%	7.9%	9.3%	9.5%	9.6%
Cwm Taf	5.0%	5.2%	5.2%	5.2%	5.4%	5.7%
Hywel Dda	4.3%	4.6%	3.7%	3.9%	3.8%	3.5%
Powys	3.1%	3.0%	2.6%	4.0%	3.7%	2.3%

Source: Ambulance Quality Indicators, July to December 2016

Exhibit A2: percentage of calls ended following WAST telephone assessment (hear and treat), July to December 2016 (all-Wales and comparative)



Source: Ambulance Quality Indicators, July to December 2016

Since this data period, some posts have moved from the South East clinical control centre to the North centre and WAST has also placed clinical staff in police control centres. These developments should support greater 'hear and treat' rates across Wales.

Step 3 – come to see me

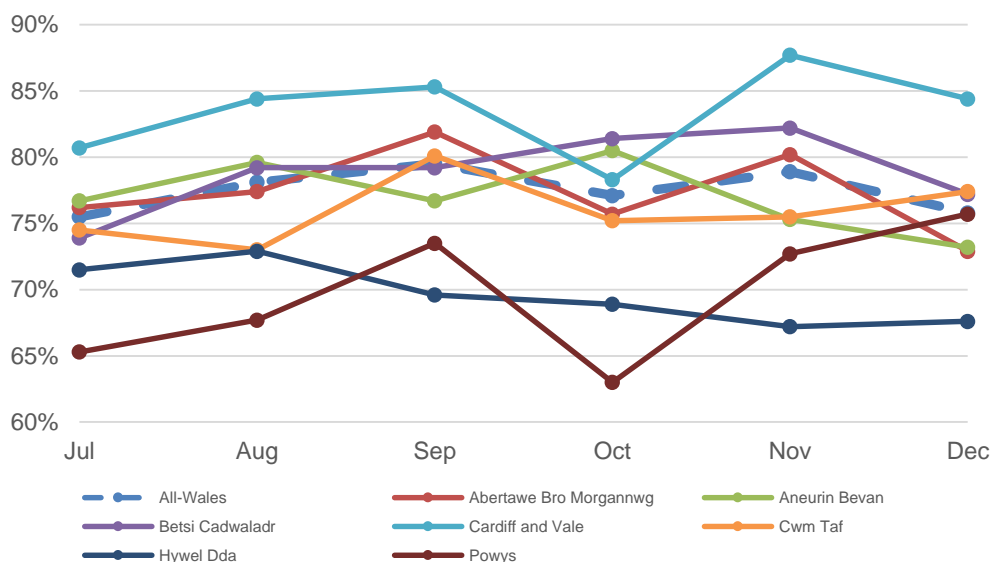
With regard to the Welsh Government tier 1 target for responding to calls categorised as red, we can see a positive picture at an all-Wales level of reaching 79.5% of red calls within eight minutes across Wales in September. This is the best performance since the new clinical response model pilot began. At a health board level, this figure ranges from 69.6% in Hywel Dda University Health Board, to 85.3% in Cardiff and Vale University Health Board. The figures for each health board are shown in Exhibits A3 and A4.

Exhibit A3: red call response performance, July to December 2016 (all-Wales and comparative)

Health board	Jul	Aug	Sep	Oct	Nov	Dec
All-Wales	75.5%	78.1%	79.5%	77.1%	78.9%	75.8%
Abertawe Bro Morgannwg	76.2%	77.4%	81.9%	75.7%	80.2%	72.9%
Aneurin Bevan	76.7%	79.2%	76.7%	80.5%	75.3%	73.2%
Betsi Cadwaladr	73.9%	79.2%	79.2%	81.4%	82.2%	77.2%
Cardiff and Vale	80.7%	84.4%	85.3%	78.3%	87.7%	84.4%
Cwm Taf	74.5%	73.0%	80.1%	75.2%	75.5%	77.4%
Hywel Dda	71.5%	72.9%	69.6%	68.9%	67.2%	67.6%
Powys	65.3%	67.7%	73.5%	63.0%	72.7%	75.7%

Source: Ambulance Quality Indicators, July to December 2016

Exhibit A4: red call response performance, July to December 2016 (all-Wales and comparative)



Source: Ambulance Quality Indicators, July to December 2016

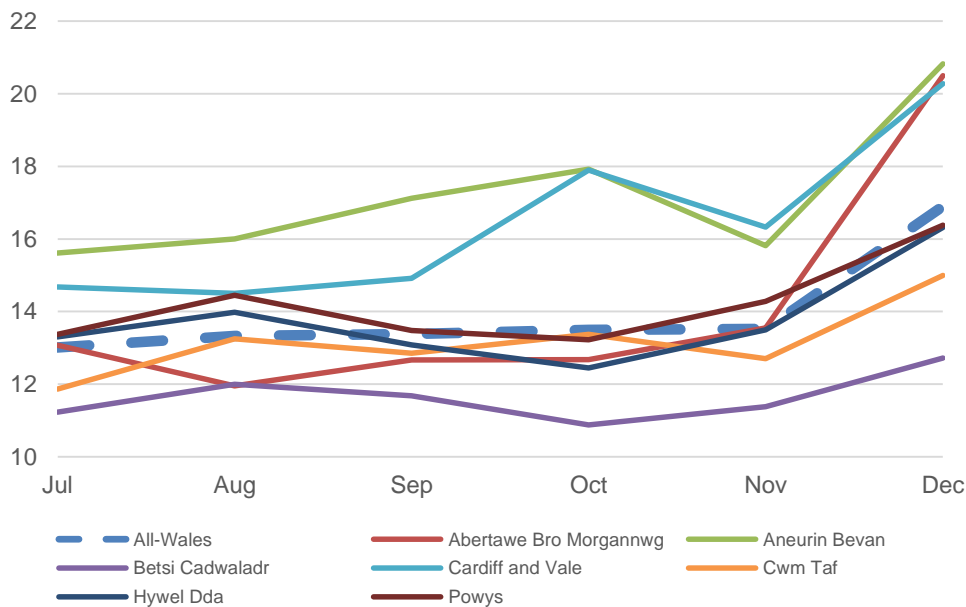
While there is no time-based target for amber calls, for the purposes of comparison we looked at the average time taken to reach an amber call within each health board area for the months between July and December 2016. This is set out in Exhibits A5 and A6.

Exhibit A5: average time in minutes taken to respond to an amber call, July to December 2016 (all-Wales and health board level)

Health board	Jul	Aug	Sep	Oct	Nov	Dec
All-Wales	13:06	13:20	13:23	13:33	13:31	16:54
Abertawe Bro Morgannwg	13:04	11:57	12:40	12:41	13:33	20:30
Aneurin Bevan	15:37	16:00	17:07	17:55	15:49	20:49
Betsi Cadwaladr	11:14	12:00	11:41	10:53	11:23	12:43
Cardiff and Vale	14:41	14:30	14:55	17:54	16:20	20:17
Cwm Taf	11:52	13:15	12:51	13:22	12:42	15:00
Hywel Dda	13:18	13:59	13:05	12:27	13:30	16:19
Powys	13:22	14:27	13:29	13:13	14:17	16:23

Source: Ambulance Quality Indicators, July to December 2016

Exhibit A6: average time in minutes taken to respond to an amber call, July to December 2016 (all-Wales and health board level)



Source: Ambulance Quality Indicators, July to December 2016

Step 4 – give me treatment

The 'see and treat' rates captured by WAST provide indications of the preparedness of WAST crews to provide treatments to patients on scene as opposed to transporting each patient to hospital. It shows an indication of the development of WAST as a clinical service that provides clinical treatment to patients and is a move away from the traditional profile of WAST as a service to transport patients alone. [Exhibit A7](#) shows the rates for 'see and treat' between July and December 2016.

[Exhibit A7: percentage of attendances at scene that were not transported to hospital \(see and treat\), July to December 2016 \(all-Wales and comparative\)](#)

Health board	Jul	Aug	Sep	Oct	Nov	Dec
All-Wales	11.5%	12.1%	12.0%	11.3%	12.0%	12.0%
Abertawe Bro Morgannwg	9.9%	10.7%	11.9%	10.9%	10.9%	11.5%
Aneurin Bevan	11.1%	10.8%	10.1%	10.5%	11.4%	11.3%
Betsi Cadwaladr	15.2%	16.5%	16.6%	15.7%	17.5%	16.7%
Cardiff and Vale	9.8%	10.3%	10.9%	8.9%	9.2%	10.2%
Cwm Taf	6.1%	6.2%	5.0%	5.0%	6.4%	6.5%
Hywel Dda	11.6%	11.9%	11.5%	11.5%	12.5%	10.6%
Powys	14.5%	12.1%	11.1%	11.4%	10.3%	11.2%

Source: Ambulance Quality Indicator, July to December 2016

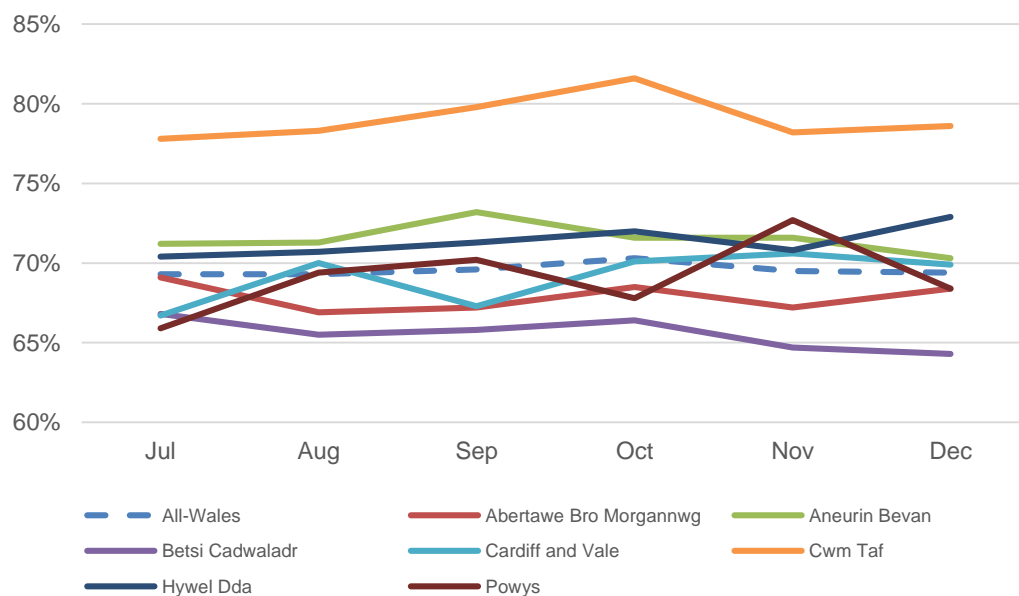
In addition, we looked at the conveyance rate for emergency ambulance services in each health board area. Interestingly, the figures for conveyance to hospital, together with the figures for those treated at the scene do not correspond to meet 100%. This reflects how some indicators can cause confusion and potentially mislead the reader.

Exhibit A8: conveyance rates for patients to hospital following a face-to-face assessment, July to December 2016 (all-Wales and comparative)

Health board	Jul	Aug	Sep	Oct	Nov	Dec
All-Wales	69.3%	69.3%	69.6%	70.3%	69.5%	69.4%
Abertawe Bro Morgannwg	69.1%	66.9%	67.2%	68.5%	67.2%	68.4%
Aneurin Bevan	71.2%	71.3%	73.2%	71.6%	71.6%	70.3%
Betsi Cadwaladr	66.8%	65.5%	65.8%	66.4%	64.7%	64.3%
Cardiff and Vale	66.7%	70.0%	67.3%	70.1%	70.6%	69.9%
Cwm Taf	77.8%	78.3%	79.8%	81.6%	78.2%	78.6%
Hywel Dda	70.4%	70.7%	71.3%	72.0%	70.8%	72.9%
Powys	65.9%	69.4%	70.2%	67.8%	72.7%	68.4%

Source: Ambulance Quality Indicators, July to December 2016

Exhibit A9: percentage of patients conveyed to hospital following a face-to-face assessment, July to December 2016 (all-Wales and comparative)



Source: Ambulance Quality Indicators, July to December 2016

Step 5 – take me to hospital

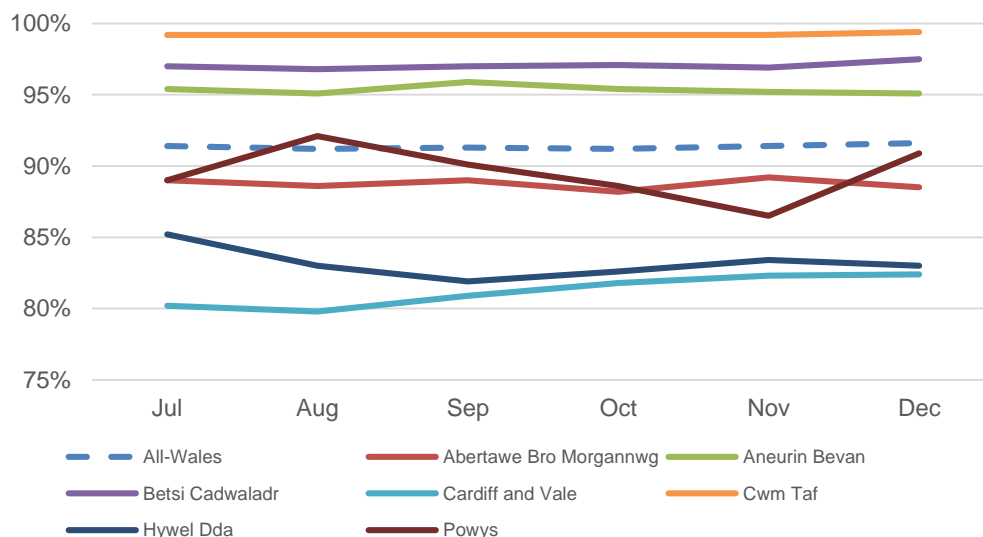
The AQI data provides an indication of whether health boards and WAST are working to reduce demand on emergency departments by providing alternative settings for patients to be treated. The data for July to December, however, shows that an overwhelming majority of patients that are conveyed to hospital by WAST paramedics are transported to an emergency department, or major A&E unit. On average, only 8.7% of patients are transported to another location within a hospital which can include a medical assessment unit, minor injuries unit or mental health unit. The data for each health board is included in Exhibits A10 and A11.

Exhibit A10: percentage of patients conveyed to a major A&E department, July to December 2016 (all-Wales and comparative)

Health board	Jul	Aug	Sep	Oct	Nov	Dec
All-Wales	91.4%	91.2%	91.3%	91.2%	91.4%	91.6%
Abertawe Bro Morgannwg	89.0%	88.6%	89.0%	88.2%	89.2%	88.5%
Aneurin Bevan	95.4%	95.1%	95.9%	95.4%	95.2%	95.1%
Betsi Cadwaladr	97.0%	96.8%	97.0%	97.1%	96.9%	97.5%
Cardiff and Vale	80.2%	79.8%	80.9%	81.8%	82.3%	82.4%
Cwm Taf	99.2%	99.2%	99.2%	99.2%	99.2%	99.4%
Hywel Dda	85.2%	83.0%	81.9%	82.6%	83.4%	83.0%
Powys	89.0%	92.1%	90.1%	88.6%	86.5%	90.9%

Source: Ambulance Quality Indicator, July to December 2016

Exhibit A11: percentage of patients conveyed to a major A&E department, July to December 2016 (all-Wales and comparative)



Source: Ambulance Quality Indicators, July to December 2016

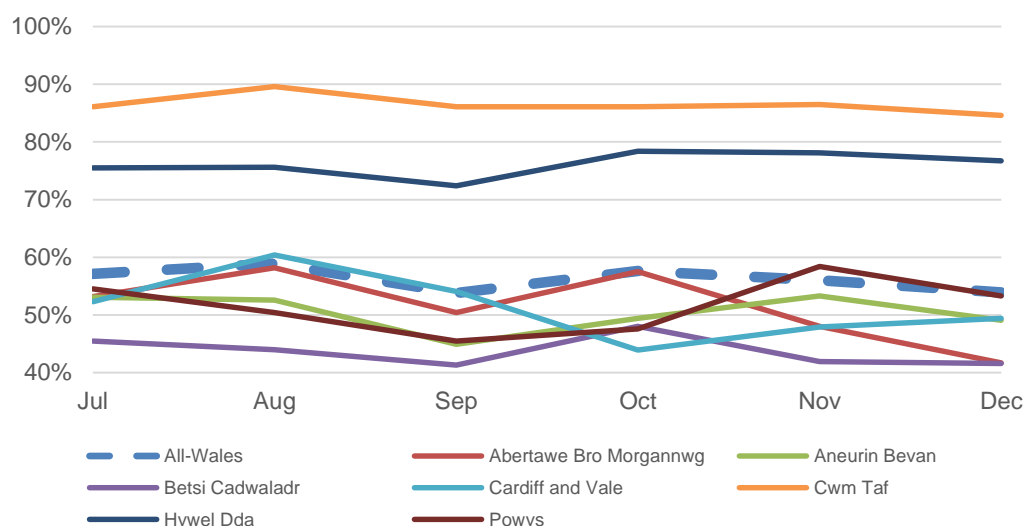
The data for handover delays at a health board level shows a great degree of variation in performance. For example, Cwm Taf University Health Board, who have prioritised minimising handover delays as far as possible had an average performance of 86.5% between July and December 2016, whereas in Betsi Cadwaladr University Health Board the average performance for this period was 43.7%. The data for each health board and at an All-Wales level is presented in Exhibits A12 and A13.

Exhibit A12: percentage of notification to handover within 15 minutes of arrival at hospital, July to December 2016 (all-Wales and comparative)

Health board	Jul	Aug	Sep	Oct	Nov	Dec
All-Wales	57.1%	58.9%	53.8%	57.6%	56.0%	53.9%
Abertawe Bro Morgannwg	53.2%	58.2%	50.4%	57.5%	48.0%	41.7%
Aneurin Bevan	53.1%	52.6%	44.9%	49.4%	53.3%	49.1%
Betsi Cadwaladr	45.5%	44.0%	41.3%	48.0%	41.9%	41.6%
Cardiff and Vale	52.3%	60.4%	54.1%	43.9%	47.9%	49.4%
Cwm Taf	86.1%	89.6%	86.1%	86.1%	86.5%	84.6%
Hywel Dda	75.5%	75.6%	72.4%	78.4%	78.1%	76.7%
Powys	54.5%	50.4%	45.5%	47.6%	58.4%	53.3%

Source: Ambulance Quality Indicators, July to December 2016

Exhibit A13: percentage of notification to handover within 15 minutes of arrival at hospital, July to December 2016 (all-Wales and comparative)



Source: Ambulance Quality Indicators, July to December 2016

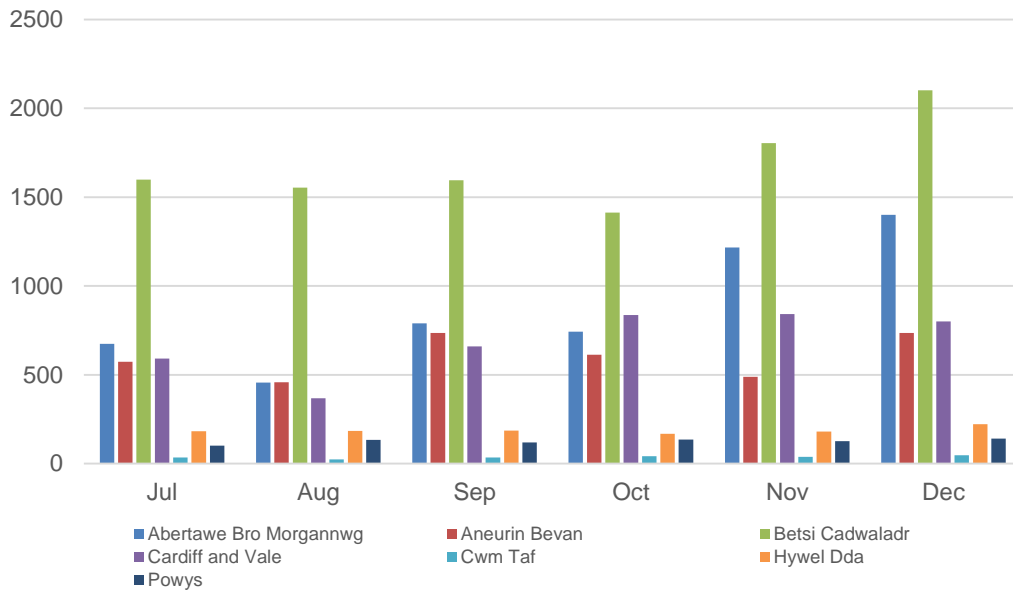
AQIs also capture the data relating to the amount of lost hours that each handover delay causes. Lost hours refers to the amount of time that each ambulance is waiting to offload a patient into a hospital and is therefore unable to respond to any other calls received by WAST until the patient has been safely transferred. In the period between July and December 2016, an average of 4,209 hours were lost across Wales due to handover delays. The data for each health board is presented below in Exhibits A14 and A15.

Exhibit A14: total number of lost hours following notification to handover over 15 minutes, July to December 2016 (all-Wales and comparative)

Health board	Jul	Aug	Sep	Oct	Nov	Dec
All-Wales	3,756	3,177	4,122	4,054	4,698	5,447
Abertawe Bro Morgannwg	674	456	789	743	1,216	1,401
Aneurin Bevan	573	458	735	614	488	735
Betsi Cadwaladr	1,599	1,554	1,596	1,413	1,805	2,102
Cardiff and Vale	592	368	660	837	842	800
Cwm Taf	35	24	34	42	38	47
Hywel Dda	182	185	187	168	181	222
Powys	101	133	120	135	127	141

Source: Ambulance Quality Indicators, July to December 2016

Exhibit A15: total number of lost hours following notification to handover over 15 minutes, July to December 2016 (all-Wales comparative)



Source: Ambulance Quality Indicators, July to December 2016

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