Agenda – Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:
Ystafell Bwyllgora 3 – Senedd
Dyddiad: Dydd Iau, 3 Rhagfyr 2015
Amser: 09.15

I gael rhagor o wybodaeth cysylltwch a:
Llinos Madeley
Clerc y Pwyllgor
0300 200 6565
SeneddIechyd@Cynulliad.Cymru

1 Cyflwyniadau, ymddiheuriadau a dirprwyon

(09.15)

2 Ymchwiliad dilynol i berfformiad y Gwasanaethau Ambiwlans yng Nghymru: sesiwn dystiolaeth 1

(09.15 – 10.00) (Tudalennau 1 – 58)

Darron Dupree, UNSAIN Cymru
Nathan Holman, GMB
Richard Munn, Undeb Unite
Lisa Turnbull, y Coleg Nyrsio Brenhinol

3 Ymchwiliad dilynol i berfformiad y Gwasanaethau Ambiwlans yng Nghymru: sesiwn dystiolaeth 2

(10.00 – 10.45) (Tudalennau 59 – 69)

Stephen Harrhy, Prif Gomisiynydd y Gwasanaethau Ambiwlans
Yr Athro Siobhan McClelland, Cadeirydd – y Pwyllgor Gwasanaethau Ambiwlans Brys

Egwyl (10.45-11.00)

4 Ymchwiliad dilynol i berfformiad y Gwasanaethau Ambiwlans yng Nghymru: sesiwn dystiolaeth 3

(11.00 - 11.45) (Tudalennau 70 - 85)

Adam Cairns, Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Allison Williams, Bwrdd Iechyd Prifysgol Cwm Taf

5 Ymchwiliad dilynol i berfformiad y Gwasanaethau Ambiwlans yng Nghymru: sesiwn dystiolaeth 4

(11.45 - 12.30) (Tudalennau 86 - 101)

Mark Giannasi, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru

Tracy Myhill, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru

6 Papurau i'w nodi

(12.30)

Cofnodion y cyfarfodydd ar 19 a 25 Tachwedd 2015

(Tudalennau 102 - 124)

Etifeddiaeth Pwyllgor Cyllid y Pedwerydd Cynulliad: gohebiaeth gan y Pwyllgor Cyllid

(Tudalennau 125 - 126)

P-04-532 Gwella Gwasanaethau Niwrogyhyrol Arbenigol yng Nghymru: gohebiaeth gan y Pwyllgor Deisebau

(Tudalennau 127 - 128)

7 Cynnig o dan Reol Sefydlog 17.42 (vi) a (ix) i benderfynu gwahardd y cyhoedd o weddill y cyfarfod hwn

(12.30)

8 Ymchwiliad dilynol i berfformiad y Gwasanaethau Ambiwlans yng Nghymru: trafod y dystiolaeth

(12.30 - 12.45)

9 **Etifeddiaeth Pwyllgor y Pedwerydd Cynulliad: ystyried ymgynghoriad y Pwyllgor Cyllid ynglŷn ag etifeddiaeth**

(12.45 - 12.50) (Tudalennau 129 - 130)

10 **Blaenraglen waith y Pwyllgor.**

(12.50-12.55) (Tudalennau 131 - 138)

Mae cyfyngiadau ar y ddogfen hon

Y Pwyllgor Iechyd a Gofal Cymdeithasol
Health and Social Care Committee

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Vaughan Gething AC
Y Dirprwy Weinidog Iechyd

31 March 2015

Annwyl Vaughan,

Y Pwyllgor Iechyd a Gofal Cymdeithasol: ymchwiliad i berfformiad y gwasanaeth ambiwlans yng Nghymru

Rwy'n ysgrifennu i roi manylion am ganlyniadau ymchwiliad byr y Pwyllgor ar y pwnc uchod.

Fel Pwyllgor, rydym yn cydnabod bod y gwasanaeth ambiwlans brys yn chwarae rôl hanfodol o ran darparu gwasanaethau iechyd i bobl Cymru. Yn unigol, mae staff rheng flaen y gwasanaeth ambiwlans yn cyflawni swyddi heriol i safon uchel, gan ddarparu help a chymorth i bobl sydd mewn angen. Fodd bynnag, yn gyffredinol, mae amseroedd ymateb y gwasanaeth ambiwlans yn cwympo islaw'r lefelau perfformiad y mae pobl Cymru yn iawn i'w disgwyl.

Fe wnaethoch gydnabod hynny yn eich datganiad ysgrifenedig ddydd Llun 23 Chwefror 2015 ar y cynnydd a wnaed i weithredu argymhellion yr Adolygiad McClelland, fel y gwnaeth y Pwyllgor Gwasanaethau Ambiwlans Brys, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru a'r byrddau iechyd lleol wrth iddynt roi tystiolaeth lafar i ni ddydd Iau 5 Mawrth 2015.

Rydym yn sylweddoli bod gwaith sylweddol yn digwydd i gyflwyno gwelliannau ym mherfformiad y gwasanaeth ambiwlans. Fodd bynnag, nid ydym wedi'n hargyhoeddi bod cynnydd yn digwydd yn ddigon cyflym er mwyn gwella amseroedd ymateb. Rydym wedi nodi nifer o feysydd y credwn sydd angen cynnydd pellach. Mae'r rhain wedi'u nodi yn yr Atodiad i'r llythyr hwn.

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Rydym yn bwriadu gwneud gwaith dilynol ar ein hymchwiliad yn ddiweddarach eleni i asesu'r cynnydd a wnaed. Byddwn hefyd yn dwyn y Pwyllgor Gwasanaethau Ambiwlans Brys, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru a'r byrddau iechyd lleol i gyfrif ar y sicrwydd a'r ymrwymiadau a roddwyd inni yn ystod eu tystiolaeth lafar. Rydym yn disgwyl gweld gwelliannau gwirioneddol. Credwn y dylid cadw ffocws rheolaidd ar wasanaethau ambiwlans hyd nes y gall y Cynulliad fod yn hyderus bod gwasanaethau wedi gwella'n ddibynadwy ac yn gynaliadwy, ac rydym yn bwriadu gwneud argymhelliad i'r perwyl hwn yn ein hadroddiad etifeddiaeth.

Rwy'n siŵr y byddwch yn rhannu ein pryderon am berfformiad diweddar y gwasanaeth ambiwlans, a hefyd yn awyddus i weld gwella cyflym a pharhaus. Gobeithiaf y byddwch yn gweithio gyda'r rhai sy'n gyfrifol am gomisiynu a darparu gwasanaethau ambiwlans yng Nghymru i wella perfformiad ar draws y system gofal heb ei drefnu, ac i gryfhau hyder y cyhoedd yn y gwasanaeth hanfodol hwn.

Rwy'n anfon copi o'r llythyr hwn at y rhai a roddodd dystiolaeth i'n hymchwiliad, ac at Brif Weithredwyr holl fyrddau iechyd lleol Cymru.

Yn gywir,

David Rees AC
Cadeirydd y Pwyllgor Iechyd a Gofal Cymdeithasol

cc Stephen Harrhy, Prif Gomisiynydd y Gwasanaethau Ambiwlans
Yr Athro Siobhan McClelland, Cadeirydd y Pwyllgor Gwasanaethau Ambiwlans Brys
Mick Giannasi, Cadeirydd Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Tracy Myhill, Prif Weithredwr, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Paul Roberts, Prif Weithredwr, Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg
Judith Paget, Prif Weithredwr, Bwrdd Iechyd Prifysgol Aneurin Bevan
Trevor Purt, Prif Weithredwr, Bwrdd Iechyd Prifysgol Betsi Cadwaladr
Adam Cairns, Prif Weithredwr, Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Allison Williams, Prif Weithredwr, Bwrdd Iechyd Prifysgol Cwm Taf
Steve Moore, Prif Weithredwr, Bwrdd Iechyd Prifysgol Hywel Dda
Carol Shillabeer, Prif Weithredwr, Bwrdd Iechyd Addysgu Powys

Atodiad

Dangosyddion Perfformiad

1. Fe wnaeth Prif Gomisiynydd y Gwasanaethau Ambiwlans ("y Comisiynydd"), Cadeirydd y Pwyllgor Gwasanaethau Ambiwlans Brys ("EASC"), Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru ("WAST") a'r byrddau iechyd lleol oll geisio sicrhau'r Pwyllgor bod camau'n cael eu cymryd i wella perfformiad gwasanaethau ambiwlans yng Nghymru. Er bod y Pwyllgor yn croesawu llawer o'r camau hynny, ni all anwybyddu'r gwahaniaeth rhwng y sicrwydd a roddwyd yn y dystiolaeth a'r perfformiad yn erbyn y targedau allweddol.

2. Bu llawer o ddadlau ynghylch a yw'r targed ymateb presennol o wyth munud ar gyfer galwadau brys categori A yn ystyried canlyniadau cleifion yn ddigonol. Cytunodd y Comisiynydd a Chadeirydd EASC bod angen adolygiad yn seiliedig ar dystiolaeth ar gyfer y targed categori A presennol o wyth munud. Nodwyd y dylid cynnal yr adolygiad o dan arweiniad clinigol, gan ymgysylltu gyda'r cyhoedd, i wella canlyniadau clinigol a phrofiad cleifion, ac arwain at werth am arian.[1]

3. Mewn datganiad diweddar, nododd y Dirprwy Weinidog Iechyd bod Llywodraeth Cymru yn bwriadu gwella'r data cyd-destunol sydd ar gael drwy ryddhau gwybodaeth fisol am alwadau brys Coch 1.[2] Mae'r Gweinidog Iechyd a Gwasanaethau Cymdeithasol wedi nodi, yn dilyn cyhoeddi cynllun peilot newydd ar gyfer amseroedd ymateb ambiwlansys yn Lloegr, ac ar sail cynrychiolaethau a wnaed iddo gan WAST, ei fod yn bwriadu gweithio gyda

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[1] Cynulliad Cenedlaethol Cymru, y Pwyllgor Iechyd a Gofal Cymdeithasol, *Cofnod y Trafodion [paragraffau 207-211]*, 5 Mawrth 2015

[2] Llywodraeth Cymru, Vaughan Gething (y Dirprwy Weinidog Iechyd), *Cynnydd yn erbyn Argymhellion Adolygiad McClelland*, Datganiad Ysgrifenedig gan y Cabinet, 23 Chwefror 2015. Mae galwadau brys Coch 1 yn ymwneud â chleifion gyda'r cyflyrau gwaethaf sy'n bygwth bywyd.

chlinigwyr i ddatblygu a phrofi mesurau ymateb ambiwlansys newydd ar gyfer Cymru. Caiff y gwaith hwn ei lywio gan y gwaith yn Lloegr.[3] 1.

4. Mae'r Pwyllgor yn croesawu'r camau hyn. Mae o'r farn bod yn rhaid i unrhyw fesurau ymateb ambiwlansys newydd ar gyfer Cymru fod yn seiliedig ar dystiolaeth, a rhaid iddynt ystyried canlyniadau a phrofiadau cleifion. Mae'r Pwyllgor yn cydnabod os bydd mesurau yn wahanol, y gallai hynny effeithio ar y gallu i feincnodi perfformiad ar draws y DU. Fodd bynnag, mae'n disgwyl, lle bo angen, y bydd y Gweinidog a'r Dirprwy Weinidog yn ceisio gweithio gyda'u cymheiriaid ledled y DU i sicrhau cymhared.

5. Mae'n amlwg i'r Pwyllgor, ar hyn o bryd, nad yw perfformiad o ran amseroedd ymateb o safon ddigonol. Er y dylid ystyried gwella'r ffordd y caiff perfformiad ei fesur, ni ddylai'r ffocws symud oddi wrth wella amseroedd ymateb, gwella canlyniadau i gleifion, a sicrhau bod cleifion yn derbyn gwasanaethau priodol i'w hanghenion.

Casgliad: Rhaid i'r Pwyllgor Gwasanaethau Ambiwlans Brys, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru a'r byrddau iechyd lleol weithio gyda'i gilydd ar frys i wella amseroedd ymateb ambiwlansys brys a gwella canlyniadau i gleifion.

Rhaid i'r mesurau perfformiad fod yn briodol yn glinigol gan roi digon o ystyriaeth i ganlyniadau cleifion. Felly, dylai'r gwaith mae'r Gweinidog Iechyd a Gwasanaethau Cymdeithasol wedi'i gyhoeddi ynghylch adolygu'r mesurau ymateb ambiwlansys ddigwydd yn gyflym, o dan arweiniad clinigol, wedi'i lywio gan arfer gorau ac wedi'i gynllunio i alluogi meincnodi ar draws y DU.

Atebolrwydd ac Ymgysylltiad

6. Yn dilyn cyhoeddi Adolygiad Strategol o Wasanaethau Ambiwlans Cymru [4] yn 2013 ("Adolygiad McClelland"), bu newidiadau sylweddol i'r trefniadau ar gyfer comisiynu a darparu gwasanaethau ambiwlans. Mae'r Pwyllgor yn

[3] Cynulliad Cenedlaethol Cymru, y Pwyllgor Iechyd a Gofal Cymdeithasol *HSC(4)-09-15 Papur 1 - Papur gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol*, 19 Mawrth 2015

[4] McClelland, S., *Adolygiad Strategol o Wasanaethau Ambiwlans Cymru*, Ebrill 2013

croesawu sefydlu EASC a swydd y Comisiynydd fel mecanweithiau sy'n cefnogi byrddau iechyd i gydweithio er mwyn cynllunio a sicrhau darpariaeth gwasanaethau ambiwlans cenedlaethol sy'n diwallu anghenion lleol. Fodd bynnag, bydd y trefniadau hyn ond yn gwneud gwahaniaeth i'r gwasanaethau mae pobl Cymru yn eu cael os ydynt yn gweithio'n effeithiol. Mae'r Pwyllgor wedi gofyn i EASC ddarparu copi o'r cytundeb dros dro gyda byrddau iechyd ar gyfer 2014-15 ac, ar ôl cytuno arno, y Fframwaith Ansawdd a Chyflawni Comisiynu a fydd yn ei ddisodli.

7. Yn eu tystiolaeth i'r Pwyllgor, dywedodd tystion bod angen dull system gyfan ar gyfer gofal heb ei drefnu, gyda byrddau iechyd lleol yn cymryd cyfrifoldeb am daith y claf o'r ymateb brys i gael eu rhyddhau o'r ysbyty.[5] Roedd y Pwyllgor yn cytuno gyda hynny, ond roedd hefyd yn rhannu pryderon yr Athro McClelland,[6] Cadeirydd EASC, a Stephen Harry,[7] y Comisiynydd, am gyflymder y newid.

8. Mae'r Pwyllgor yn arbennig o bryderus ynghylch yr amrywiaeth yn lefelau ymgysylltu byrddau iechyd gwahanol gyda WAST, ac i ba raddau y gallai hynny fod yn rhwystr i welliannau ym mherfformiad gwasanaethau ambiwlans. Amlinellodd yr Athro McClelland yr heriau ar gyfer byrddau iechyd, gan ddweud bod y trefniadau atebolrwydd newydd wedi gwneud iddynt newid y ffordd y maent yn meddwl ac yn gweithio.[8]

9. Roedd Tracy Myhill, Prif Weithredwr WAST, yn cydnabod bod ymgysylltu yn amrywio rhwng byrddau iechyd. Dywedodd fod rhai byrddau iechyd yn eithriadol ond bod ysbytai penodol yn achosi heriau penodol, yn rhannol oherwydd y gwahanol wasanaethau maent yn eu darparu, a'u dulliau trosglwyddo cleifion.[9]

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[5] Cynulliad Cenedlaethol Cymru, y Pwyllgor Iechyd a Gofal Cymdeithasol, *Cofnod y Trafodion [paragraffau 217 a 219]*, 5 Mawrth 2015

[6] Ibid, *Cofnod y Trafodion [paragraffau 217-218]*

[7] Ibid, *Cofnod y Trafodion [paragraff 219]*

[8] Ibid, *Cofnod y Trafodion [paragraff 269]*

[9] Ibid, *Cofnod y Trafodion [paragraffau 372-384]*

10. Mae'r Pwyllgor yn croesawu'r gydnabyddiaeth gan y byrddau iechyd, WAST ac EASC fod angen dull gweithredu system gyfan. I'r dull hwn fod yn effeithiol, mae angen cynnwys y byrddau iechyd ac ymgysylltu a hwy yn barhaus a chyson. Clywodd y Pwyllgor gan Brif Weithredwr WAST ei bod mewn cyswllt rheolaidd â phrif weithredwyr y byrddau iechyd a'u bod yn gweithio gyda'i gilydd i wella perfformiad.[10] Fodd bynnag, clywodd hefyd gan yr Athro McClelland mai dim ond yn y misoedd diwethaf y mae'r ymrwymiad a'r ymgysylltiad hwnnw wedi cryfhau.[11]

11. Ni ddarbwyllwyd y Pwyllgor fod byrddau iechyd, wrth ystyried newidiadau i'w gwasanaethau lleol, yn cymryd digon o ystyriaeth o'r effaith ar WAST. Dywedodd Mick Giannasi, Cadeirydd WAST, bod newid mawr wedi digwydd a bod byrddau iechyd bellach yn fwy parod i ymgysylltu â WAST yn gynharach yn y broses wrth ystyried newid i wasanaethau.[12] Adleisiwyd hynny gan Brif Weithredwr WAST, a ddywedodd bod WAST yn rhan sylfaenol o ddatblygu cynlluniau ar gyfer newid gwasanaethau lleol.[13] Er enghraifft, nododd bod WAST wedi cymryd rhan mewn trafodaethau cyn penderfyniad Bwrdd Iechyd Prifysgol Betsi Cadwaladr i atal gofal mamolaeth dan arweiniad meddyg ymgynghorol yn Ysbyty Glan Clwyd.[14] Er bod y Pwyllgor yn cydnabod bod Ms Myhill wedi cymryd rhan mewn trafodaethau, roedd yn pryderu i nodi mai dim diwrnod cyn cyfarfod y Bwrdd y cynhaliwyd y trafodaethau hynny.[15] Er mwyn sicrhau bod yr effaith ar wasanaethau ambiwlans yn cael ei hystyried yn briodol, rhaid i WAST gymryd rhan mewn trafodaethau yn gynnar yn y broses.

Casgliad: I gynnal momentwm ac i weithio tuag at ddull system gyfan ar gyfer gofal heb ei drefnu, rhaid i bob bwrdd iechyd fod wedi ymgysylltu'n llawn â gwaith Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru drwy waith y

[10] Cynulliad Cenedlaethol Cymru, y Pwyllgor Iechyd a Gofal Cymdeithasol, *Cofnod y Trafodion [paragraff 372]*, 5 Mawrth 2015
[11] Ibid, *Cofnod y Trafodion [paragraff 269]*
[12] Ibid, *Cofnod y Trafodion [paragraff 403]*
[13] Ibid, *Cofnod y Trafodion [paragraff 406]*
[14] Ibid, *Cofnod y Trafodion [paragraffau 411-431]*
[15] Ibid, *Llythyr gan Brif Weithredwr Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru*, 18 Mawrth 2015

Pwyllgor Gwasanaethau Ambiwlans Brys yn genedlaethol, ac yn uniongyrchol gyda'r Ymddiriedolaeth yn lleol.

Rhaid i fyrddau iechyd ystyried yr effaith ar Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru wrth ddatblygu gwasanaethau newydd neu ystyried gwneud newidiadau i wasanaethau presennol. Rhaid i fyrddau iechyd hefyd sicrhau bod Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru yn rhan o'r trafodaethau yn ddigon cynnar er mwyn galluogi rhoi ystyriaeth briodol i'r effaith ar ei wasanaethau.

Arweinyddiaeth, Newid Sefydliadol a Staffio

12. Mae'r Pwyllgor yn cydnabod bod y problemau sy'n wynebu WAST yn hirsefydlog, a bod y Prif Weithredwr presennol yn gymharol newydd i'r swydd. Mae'n cydnabod y gwaith y mae hi wedi'i wneud hyd yma, ac mae wedi'i galonogi gan y camau ymarferol y mae hi'n eu cymryd i ddarparu arweinyddiaeth gref ac i ysgogi newid sefydliadol, newid i wasanaethau a newid diwylliannol. Mae'r camau hyn yn cynnwys gwella'r berthynas gydag undebau llafur a chymryd camau i leihau salwch staff ac i wella gwerthusiadau a datblygiad staff.[16] Rhaid i'r broses hon o reoli newid barhau, i sicrhau bod staff yn teimlo eu bod yn cael cefnogaeth a'u bod wedi'u grymuso i ddarparu'r gwasanaeth hanfodol hwn. Mae'r Pwyllgor wedi gofyn am gopi o gynllun gweithredu WAST ar gyfer gwella yn y flwyddyn i ddod, er mwyn llywio'r gwaith dilynol yn hwyrach eleni.

13. Clywodd y Pwyllgor dystiolaeth am anghysondebau ymddangosiadol yn nhelerau ac amodau staff ambiwlans ledled Cymru, yn arbennig o ran amserlenni staff. Mae'n bryderus y gallai anghysondebau, anghydbwysedd ac aneffeithlonrwydd o ran trefniadau amserlenni staff gael effaith ar y gwasanaeth i gleifion, a thrwy hynny ar eu canlyniadau. Nododd pob panel o dystion bod mynd i'r afael â'r diffyg cyfateb rhwng amserlenni staff presennol

[16] Cynulliad Cenedlaethol Cymru, y Pwyllgor Iechyd a Gofal Cymdeithasol, *Cofnod y Trafodion [paragraff 309-12]*, 5 Mawrth 2015

â'r amseroedd prysuraf a thawelaf disgwyliedig o ran y galw ar gyfer gwasanaethau ambiwlans yn allweddol o ran ysgogi perfformiad.[17]

14. Dywedodd Prif Weithredwr WAST fod amserlenni mewn rhai ardaloedd o Gymru wedi cael eu hadolygu yn aml, tra bod amserlenni mewn rhannau eraill o'r wlad heb gael eu hadolygu ers rhai blynyddoedd.[18] Mae'r Pwyllgor yn croesawu'r cynnydd a amlinellwyd gan Ms Myhill o ran y cytundeb ar gyfer amserlenni diwygiedig mewn rhai ardaloedd o Gymru, ond mae'n annog cytundeb buan ynghylch yr amserlenni yn yr ardaloedd sy'n weddill. Ar ôl gorffen hyn, mae'r Pwyllgor yn disgwyl y caiff trefniadau eu rhoi ar waith i atal diffyg cyfateb tebyg rhwng amserlenni staff a'r amseroedd prysuraf a thawelaf disgwyliedig o ran galw yn y dyfodol.

Casgliad: Rhaid dod i gytundeb rhwng Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru, undebau llafur a staff cyn gynted â phosibl o ran yr amserlenni staff diwygiedig ar gyfer y rhannau hynny o Gymru lle nad oes trefniadau diwygiedig ar waith eto. Rhaid i Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru, gan weithio mewn partneriaeth gydag undebau llafur a'r staff, roi trefniadau ar waith i adolygu'r amserlenni staff ar gyfnodau priodol i osgoi diffyg cyfateb yn y dyfodol rhwng staffio a galw disgwyliedig.

Cludo cleifion nad ydynt yn achosion brys

15. Nododd Ms Myhill bod disgwyl i brosiect moderneiddio parhaus wneud argymhellion erbyn mis Hydref 2015 ynghylch darparu gwasanaethau cludo cleifion nad ydynt yn achosion brys. Nododd nad oedd hi'n rhagweld y byddai WAST yn parhau i ddarparu'r holl wasanaethau hynny, [19] ond y byddai angen gweithio gyda phartneriaid i bennu'r ffordd orau i roi'r cludiant mwyaf addas i gleifion pan fyddant ei angen.[20]

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[17] Ibid, *Cofnod y Trafodion [paragraffau 227, 318 a 574]*

[18] Ibid, *Cofnod y Trafodion [paragraff 352]*

[19] Roedd llythyr gwreiddiol y Pwyllgor (a gyhoeddwyd ar 31 Mawrth 2015) yn nodi'n anghywir nad oedd Ms Myhill yn rhagweld y byddai WAST yn parhau i ddarparu'r gwasanaethau hynny. Cyhoeddwyd fersiwn gywir o'r llythyr ar 9 Ebrill 2015.

[20] Cynulliad Cenedlaethol Cymru, y Pwyllgor Iechyd a Gofal Cymdeithasol, *Cofnod y Trafodion [paragraff 386]*, 5 Mawrth 2015

16. Mae'r Pwyllgor yn cydnabod pwysigrwydd gwasanaethau cludo cleifion nad ydynt yn achosion brys, a'u rôl o ran bodloni anghenion clinigol cleifion. Fodd bynnag, mae gwahaniaeth clir rhwng y gwasanaethau hyn a gwasanaethau ambiwlans brys. Mae'r Pwyllgor o'r farn mai blaenoriaeth WAST yw darparu gwasanaethau ambiwlans brys. Mae'n cymeradwyo argymhelliad 2 Adolygiad McClelland, sef y dylai gwasanaethau cludo cleifion nad ydynt yn achosion brys (gwasanaethau cludo cleifion) gael eu dadgyfuno o'r gwasanaethau ambiwlans brys.[21]

Casgliad: Rhaid i Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru flaenoriaethu darparu gwasanaethau ambiwlans brys. Mae angen gwneud gwaith i ddod o hyd i fecanweithiau priodol ar gyfer darparu gwasanaethau cludo cleifion nad ydynt yn achosion brys, er mwyn dadgyfuno'r gwasanaethau hynny oddi wrth yr Ymddiriedolaeth yn unol ag argymhelliad 2 Adolygiad McClelland. Rhaid i'r Ymddiriedolaeth gael cynllun clir ar gyfer dadgyfuno'r ddau wasanaeth, gan nodi'r costau a'r amserlen. Mae'r Pwyllgor yn disgwyl cael diweddariad ar y cynllun hwn cyn gwneud y gwaith dilynol ar yr ymchwiliad hwn yn ddiweddarach eleni.

Trosglwyddo cleifion

17. Mae'r dystiolaeth ysgrifenedig a ddarparodd WAST cyn y sesiynau tystiolaeth yn dangos bod 40,000 o oriau wedi'u colli yn 2014 o ganlyniad i oedi o fwy na 15 munud wrth drosglwyddo cleifion rhwng yr ambiwlans a'r adran damweiniau ac achosion brys. Roedd hynny i fyny o tua 35,000 awr yn 2013 a 32,000 awr yn 2012.[22] Dywedodd Ms Myhill wrth y Pwyllgor fod y polisi trosglwyddo newydd, sy'n cryfhau'r broses yn ei barn hi, wedi'i lunio i wella prydlondeb asesu cleifion gan adrannau achosion brys.[23] Nododd Adam Cairns o Fwrdd Iechyd Prifysgol Caerdydd a'r Fro bod gwelliant sylweddol wedi

[21] McClelland, S., *Adolygiad Strategol o Wasanaethau Ambiwlans Cymru*, Ebrill 2013, pp 65

[22] Cynulliad Cenedlaethol Cymru, y Pwyllgor Iechyd a Gofal Cymdeithasol *HSC(4)-09-15 Papur 4 - Tystiolaeth gan Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru*, 5 Mawrth 2015

[23] Ibid, *Cofnod y Trafodion [paragraff 284]*, 5 Mawrth 2015

bod ym mherfformiad trosglwyddo'r bwrdd iechyd, a dywedodd fod disgwyl i'r polisi trosglwyddo newydd ychwanegu ysgogiad pellach.[24]

18. Mae'r Pwyllgor yn croesawu'r polisi newydd i leihau oedi wrth drosglwyddo cleifion ac i wella'r rhyngwyneb rhwng gwasanaethau ambiwlans brys ac unedau achosion brys. Er mwyn i'r polisi fod yn llwyddiannus, rhaid ei roi ar waith yn gyson ledled Cymru. Nododd Mr Cairns, fel prif weithredwr ac arweinydd y bwrdd iechyd ar ofal heb ei drefnu, ei fod wedi arwain ar waith i nodi arfer da ym mhob bwrdd iechyd. Caiff adroddiad ei gyhoeddi ym mis Ebrill 2015, ac yn ystod y chwarter nesaf bydd Mr Cairns yn ymweld â phob bwrdd iechyd eto i adolygu cynnydd ac asesu cysondeb.[25]

Casgliad: Rhaid i'r Pwyllgor Gwasanaethau Ambiwlans Brys, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru a'r byrddau iechyd lleol weithio gyda'i gilydd i leihau nifer yr oriau coll o ganlyniad i oedi wrth drosglwyddo cleifion. Rhaid gweithredu'r polisi trosglwyddo newydd yn gyson ledled Cymru, a rhaid datrys unrhyw faterion a gaiff eu nodi yn ymweliadau dilynol y prif weithredwr ac arweinydd ar ofal heb ei drefnu yn gyflym.

Modelau Defnydd o Ambiwlansys

19. Ar hyn o bryd, yr ambiwlans sy'n cael ei anfon i ddigwyddiad yw'r ambiwlans sydd agosaf at y digwyddiad hwnnw. Gall hyn arwain at ambiwlans yn cael ei gadw i ffwrdd o'i ardal am gyfnodau hir. Yn benodol, gall clystyru ambiwlansys yn yr ardaloedd sydd agosaf at adrannau damweiniau ac achosion brys achosi oedi i'r bobl sydd angen ambiwlansys brys mewn ardaloedd gwledig neu anghysbell.

20. Esboniodd Cadeirydd WAST fod y model defnydd hwn yn ceisio mynd i'r afael â'r risgiau uniongyrchol i'r rheiny sydd wedi gofyn am gymorth mewn argyfwng. Cydnabu nad oedd yn ystyried y risg posibl i bobl mewn cymunedau sydd heb ffonio'r gwasanaeth ambiwlans eto.[26] Clywodd y Pwyllgor fod

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[24] Ibid, *Cofnod y Trafodion [paragraffau 457-458]*

[25] Ibid, *Cofnod y Trafodion [paragraffau 460 a 555]*

[26] Cynulliad Cenedlaethol Cymru, y Pwyllgor Iechyd a Gofal Cymdeithasol, *Cofnod y Trafodion [paragraff 342]*, 5 Mawrth 2015

prosiect peilot ar y gweill ym Mwrdd Iechyd Prifysgol Cwm Taf i brofi hyfywedd model "dychwelyd at ôl-troed". O dan y model hwn, ystyrir bod ambiwlans sy'n teithio tu hwnt i'w ardal gwasanaeth ond ar gael ar gyfer y galwadau brys mwyaf difrifol, hyd nes ei fod wedi dychwelyd at ei ôl-troed cartref. Eglurodd Allison Williams, Prif Weithredwr Bwrdd Iechyd Prifysgol Cwm Taf, fod cynllun peilot cychwynnol dros gyfnod o 48 awr wedi cyflawni gwelliannau sylweddol i berfformiad amseroedd ymateb ambiwlansys. Mae cynllun peilot ehangach ar waith.[27]

21. Mae'r Pwyllgor yn pryderu am ambiwlansys yn cael eu clystyru a'r effaith ar gymunedau mwy anghysbell. Mae o'r farn y dylid rhoi ystyriaeth ar frys i ddod o hyn i fodelau defnydd mwy addas, gan ddefnyddio arfer gorau o rannau eraill o'r DU. Mae'r Pwyllgor yn croesawu'r peilot dychwelyd at ôl-troed, ac yn credu y dylid archwilio'r dull gweithredu hwnnw a'i werthuso ar sail ehangach.

Casgliad: Dylai Prif Gomisiynydd y Gwasanaethau Ambiwlans, y Pwyllgor Gwasanaethau Ambiwlans Brys ac Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru fynd i'r afael ar frys gyda'r broblem o ambiwlansys yn cael eu tynnu i ffwrdd o'u hardaloedd. Wrth wneud hynny, dylent geisio canfod arfer gorau ledled y DU a dysgu ohono.

Dylid blaenoriaethu archwilio'r cynllun peilot 'dychwelyd at ôl-troed' ar sail ehangach a'i werthuso.

Galwyr mynych

22. Mae'r Pwyllgor yn cydnabod, mewn blynyddoedd diweddar, bod pobl yn gynyddol yn derbyn gofal yn eu cartrefi neu eu cymunedau eu hunain yn hytrach nag mewn cartrefi preswyl neu ysbytai cymunedol.

23. Dywedodd WAST wrth y Pwyllgor fod ceisiadau am ambiwlansys gan alwyr mynych oedrannus wedi cynyddu gan 253 y cant yn y saith mlynedd

[27] Ibid, *Cofnod y Trafodion [paragraffau 568-574]*

diwethaf.[28] Mae'r Pwyllgor yn cytuno gyda'r Athro McClelland[29] a chynrychiolwyr y byrddau iechyd lleol[30] nad teithio mewn ambiwlans i'r adran ddamweiniau ac achosion brys yw'r ffordd iawn i ymateb i alwadau o'r fath bob tro. Dywedodd y byrddau iechyd wrth y Pwyllgor, er mwyn ymateb i bwysau cynyddol ar wasanaethau gofal heb ei drefnu ym misoedd y gaeaf, eu bod yn dod o hyd i ddulliau amgen i ymdrin â galwyr mynych oedrannus. Mae'r dulliau hynny'n cynnwys gwelyau cyfatebol, asesiadau yn y gymuned a chydweithio gydag awdurdodau lleol i ddarparu timau adsefydlu. Nododd Allison Williams o Fwrdd Iechyd Prifysgol Cwm Taf bod meysydd o arfer da ledled Cymru, lle mae sefydlu dewisiadau amgen cymunedol yn lleihau derbyniadau i'r ysbyty ac yn cyflawni gwell canlyniadau i gleifion.[31]

Casgliad: Wrth ddarparu gofal heb ei drefnu, rhaid i fyrddau iechyd ac Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru ystyried anghenion unigol y claf. Rhaid i fyrddau iechyd ac Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru sicrhau bod asesiadau, gofal a thriniaeth yn cael eu darparu mewn ffyrdd sy'n diwallu anghenion unigol y claf, ac yn eu helpu i gyflawni'r canlyniad gorau posibl iddynt. Dylai hyn gynnwys defnydd priodol o asesu, gofal a thriniaeth wedi'u darparu yn y gymuned, yn ogystal â darpariaeth mewn ysbyty.

Rhagweld galw am wasanaethau

24. Pwysleisiodd y Comisiynydd bwysigrwydd deall a rhagweld y galw tebygol ar gyfer gwasanaethau ambiwlans o ran comisiynu a darparu'r gwasanaethau hynny.[32] Nid yw'r Pwyllgor wedi'i ddarbwyllo bod ystyriaeth ddigonol wedi'i chymryd, nac yn cael ei chymryd, o'r newidiadau demograffig hirsefydlog ac adnabyddus yn y tymor canolig a'r hirdymor o ran cynllunio gwasanaethau ambiwlans brys. Dywedodd cynrychiolwyr y byrddau iechyd fod heriau

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[28] Cynulliad Cenedlaethol Cymru, y Pwyllgor Iechyd a Gofal Cymdeithasol *HSC(4)-09-15 Papur 4 - Tystiolaeth gan Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru*, 5 Mawrth 2015

[29] Ibid, *Cofnod y Trafodion [paragraff 213]*, 5 Mawrth 2015

[30] Ibid, *Cofnod y Trafodion [paragraffau 500-507]*

[31] Ibid, *Cofnod y Trafodion [paragraff 505*]

[32] Cynulliad Cenedlaethol Cymru, y Pwyllgor Iechyd a Gofal Cymdeithasol, *Cofnod y Trafodion [paragraff 222], 5 Mawrth 2015*

penodol ym mhob ardal bwrdd iechyd. Nodwyd fod gwaith yn parhau i ragweld y galw yn y dyfodol ar gyfer gwasanaethau iechyd, gan gynnwys gwasanaethau ambiwlans, a sicrhau bod gwasanaethau wedi'u cynllunio'n briodol. Fodd bynnag, roeddent yn cydnabod fod yr ymateb wedi bod yn rhy araf. [33]

25. Rhaid gwella amseroedd ymateb ambiwlansys yn y tymor byr. Fodd bynnag, er mwyn i'r gwelliannau mewn perfformiad fod yn gynaliadwy yn y tymor canolig a'r hirdymor, rhaid cysoni cynllunio a chomisiynu gwasanaethau gyda'r galw tebygol ar gyfer gwasanaethau o'r fath. Rhaid i hyn gynnwys cynllunio gweithlu a recriwtio priodol. Mae'r Pwyllgor yn derbyn bod rhagweld galw yn y dyfodol yn her, ond rhaid i fyrddau iechyd, EASC a WAST ystyried y newidiadau demograffig a ragwelir yn eu gwaith cynllunio. Yn sail i hyn, rhaid casglu data a'i ddadansoddi mewn ffordd gadarnhaol, ar gyfer tueddiadau tymor byr a newidiadau demograffig hirdymor. Mae'r Pwyllgor hefyd o'r farn bod cyfrifoldeb ar bobl i sicrhau eu bod ond yn ffonio am gymorth brys gan ambiwlans pan fydd yn angenrheidiol iddynt wneud hynny.

Casgliad: Rhaid i wasanaethau ambiwlans yn y tymor canolig a'r tymor hwy berfformio'n dda gan gyd-fynd â'r galw. Felly, dylai byrddau iechyd, y Pwyllgor Gwasanaethau Ambiwlans Brys ac Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru wneud gwaith blaengynllunio cadarn ac effeithiol sy'n ystyried newidiadau demograffig a ragwelir.

[33] Ibid, *Cofnod y Trafodion [paragraffau 490 -495]*

Vaughan Gething AC / AM
Y Dirprwy Weinidog Iechyd
Deputy Minister for Health

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref : SF/VG/1251/15

6 Mai 2015

David Rees AC
Cadeirydd, y Pwyllgor Iechyd a Gofal Cymdeithasol

Annwyl David,

Y Pwyllgor Iechyd a Gofal Cymdeithasol: Ymchwiliad i berfformiad y gwasanaeth ambiwlans yng Nghymru

Diolch am eich llythyr dyddiedig 31 Mawrth lle rydych yn rhoi manylion am ymchwiliad y Pwyllgor i berfformiad Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru (WAST).

Rwy'n croesawu canfyddiadau'r Pwyllgor a'r gydnabyddiaeth a roddir i'r cynnydd a wnaed gan yr holl randdeiliaid ers i *Adolygiad Strategol o Wasanaethau Ambiwlans Cymru* McClelland (2013) gael ei gyhoeddi. Rwyf hefyd yn cydnabod bod mwy o waith i'w wneud i adeiladu ar y cynnydd cynnar, a chyflymu'r broses o wneud gwasanaethau ambiwlans brys yn rhan allweddol o'r elfen cyn-ysbyty o'r system gofal heb ei drefnu.

Nid yw amseroedd ymateb ambiwlansys wedi bod cystal ag y byddai'r byrddau iechyd, Cyd-bwyllgor Gwasanaethau Ambiwlans Brys (EASC), WAST, Llywodraeth Cymru a'r cyhoedd, am iddo fod, dros y misoedd diwethaf. Fodd bynnag, dylid edrych ar y perfformiad yn erbyn y targed amser ymateb cenedlaethol o wyth munud dros gyfnod diweddar y gaeaf yng nghyd-destun pwysau sylweddol ar y gwasanaeth ambiwlans brys yn arwain at gynnydd o 24% yn y galwadau mwyaf difrifol o gymharu â mis Ionawr 2014.

Mae'r gwelliannau ym mherfformiad categori A a Coch 1 ar lefel genedlaethol ers mis Rhagfyr wedi fy nghalonogi, ond rwy'n cydnabod bod gwahaniaethau annerbyniol o hyd ar lefel leol. Rwy'n nodi pryderon y pwyllgor am gyflymdra'r gwelliannau mewn amseroedd ymateb, ond dylid cydnabod, ac mae wedi cael ei dderbyn yn eang, nad yw mwyafrif y galwadau i'r gwasanaeth ambiwlans angen cael ymateb mewn wyth munud. Dylai ansawdd y gofal i gleifion ar sail eu hangen clinigol fod yn ffactor allweddol bob tro.

Yn hyn o beth, mae'r gwaith moderneiddio clinigol i wasanaethau ambiwlans brys er mwyn gwella'r ffordd y caiff gofal ei ddarparu wedi bod yn elfen allweddol o raglen drawsnewid strategol WAST sy'n llunio ymateb yr Ymddiriedolaeth i adolygiad McClelland. Mae wedi arwain at ddatblygu nifer o fentrau arloesol, fel y 'ddesg glinigol' mewn canolfannau rheoli

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ambiwlansys, sy'n helpu i sicrhau bod cleifion yn cael yr ymateb iawn wrth gysylltu â'r gwasanaeth ambiwlans gan gynnwys cyngor am ofal iechyd a mynediad at ystod o wasanaethau gofal amgen.

Rwy'n croesawu eich sylwadau am y gwaith pwysig sy'n cael ei wneud gan randdeiliaid i sicrhau atebolrwydd cliriach drwy sefydlu EASC a rôl prif gomisiynydd y gwasanaethau ambiwlans. Bydd Llywodraeth Cymru yn parhau i fonitro cynnydd yn agos ac yn gweithio gyda'r Athro McClelland, Stephen Harrhy a WAST i sicrhau bod gwasanaethau ambiwlans brys clinigol prydlon a theg, sy'n perfformio'n dda yn cael eu darparu i bobl Cymru.

Rwyf am droi at y casgliadau a wnaed gan y pwyllgor, ac er hwylustod, fe ymatebaf iddynt yn eu trefn.

Casgliad 1

Rhaid i'r Pwyllgor Gwasanaethau Ambiwlans Brys, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru a'r byrddau iechyd lleol weithio gyda'i gilydd ar frys i wella amseroedd ymateb ambiwlansys brys a gwella canlyniadau i gleifion.

Rhaid i'r mesurau perfformiad fod yn briodol yn glinigol gan roi digon o ystyriaeth i ganlyniadau cleifion. Felly, dylai'r gwaith mae'r Gweinidog Iechyd a Gwasanaethau Cymdeithasol wedi'i gyhoeddi ynghylch adolygu'r mesurau ymateb ambiwlansys ddigwydd yn gyflym, o dan arweiniad clinigol, wedi'i lywio gan arfer gorau ac wedi'i gynllunio i alluogi meincnodi ar draws y DU.

Derbyn

Roedd hwn yn argymhelliad clir yn Adolygiad McClelland, ac rwy'n croesawu'r ffaith fod y pwyllgor yn cefnogi adolygu targedau amser ymateb ambiwlansys. Mae'r targed presennol o wyth munud yn seiliedig ar ddata o astudiaethau a gyhoeddwyd mwy na 40 mlynedd yn ôl a oedd yn canolbwyntio ar drin achosion o ataliadau ar y galon y tu allan i'r ysbyty yn unig. Mae'n bwysig nodi nad oedd yr astudiaethau'n ystyried mathau eraill o gyflyrau brys cyn-ysbyty, ac nid oes llawer o ymchwil empiraidd ar gael ar yr amseroedd ymateb i unrhyw fath arall o alwadau brys. Roedd yn arbennig o galonogol gweld cefnogaeth y pwyllgor i sicrhau bod cleifion yn derbyn gwasanaethau sy'n briodol i'w hangen sy'n cyd-fynd yn uniongyrchol ag egwyddorion gofal iechyd darbodus. Dylai hyn fod yn sbardun allweddol mewn ymatebion clinigol brys.

Mae'n bwysig ein bod yn parhau i ddatblygu perfformiad clinigol a chanlyniadau i gleifion fel y prif safonau ar gyfer asesu perfformiad gwasanaethau ambiwlans brys i fodloni disgwyliadau'r cyhoedd o ran bod yn atebol ac yn dryloyw.

Casgliad 2

I gynnal momentwm ac i weithio tuag at ddull system gyfan ar gyfer gofal heb ei drefnu, rhaid i bob bwrdd iechyd fod wedi ymgysylltu'n llawn â gwaith Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru drwy waith y Pwyllgor Gwasanaethau Ambiwlans Brys yn genedlaethol, ac yn uniongyrchol gyda'r Ymddiriedolaeth yn lleol.

Rhaid i fyrddau iechyd ystyried yr effaith ar Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru wrth ddatblygu gwasanaethau newydd neu ystyried gwneud newidiadau i wasanaethau presennol. Rhaid i fyrddau iechyd hefyd sicrhau bod

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru yn rhan o'r trafodaethau yn ddigon cynnar er mwyn galluogi rhoi ystyriaeth briodol i'r effaith ar ei wasanaethau.

Derbyn

Mae cynnydd sylweddol wedi'i wneud o ran y lefel o gyfrifoldeb ar gyfer gwasanaethau ambiwlans brys ar lefel leol ymysg byrddau iechyd. Mae hyn yn ganolog i gynnwys y gwasanaethau ambiwlans yn y system gofal heb ei drefnu. Mae'r cytundeb gynnar hwn ar gyllideb WAST ar gyfer 2015/16 yn dystiolaeth glir o'r cynnydd yn y maes hwn, ac mae'n cynrychioli newid sylweddol yn y cydweithio rhwng byrddau iechyd a'r Ymddiriedolaeth.

Mae fframwaith ansawdd a chyflawni comisiynu cydweithredol cenedlaethol y gwasanaeth ambiwlans yn ysgogi atebolrwydd a chyfrifoldeb ymhlith byrddau iechyd drwy amrywiaeth o gamau. Mae hyn yn cynnwys y gofyniad i bob bwrdd iechyd enwebu 'Hyrwyddwr' y Gwasanaeth Ambiwlans Brys i fod yn bwynt cyswllt i'w sefydliad er mwyn sicrhau bod y fframwaith yn rhedeg yn llwyddiannus ac yn parhau i ddatblygu. Mae grŵp cyflawni perfformiad cydweithredol sy'n adrodd yn uniongyrchol i EASC wedi cael ei sefydlu a bydd yn ystyried ac yn cynghori ar y materion rheoli a pherfformio. Bydd hyn yn cynnwys prif swyddogion gweithredu o bob bwrdd iechyd a chaiff ei gadeirio gan y Prif Gomisiynydd Gwasanaethau Ambiwlans.

Mae cadeiryddion ac aelodau annibynnol byrddau iechyd yn cael diweddariadau ac adroddiadau cynnydd rheolaidd gan eu cyfarwyddwyr gweithredol eu hunain, a byddant yn gwahodd WAST i fynychu cyfarfodydd y byrddau neu is-bwyllgorau. Bydd cadeirydd EASC a phrif gomisiynydd y gwasanaethau ambiwlans yn mynychu pob cyfarfod o'r bwrdd iechyd o leiaf unwaith y flwyddyn.

Bydd y fframwaith, sy'n cynnwys nifer o fesurau ar y cyd, hefyd yn galluogi WAST a byrddau iechyd i ddangos sut y byddant yn cefnogi gwelliannau i amseroedd ymateb ambiwlansys ac ansawdd y ddarpariaeth yn eu cynlluniau integredig tymor canol.

Rwyf wedi cael sicrwydd ffurfiol gan Dr CDV Jones, cadeirydd Bwrdd Iechyd Prifysgol Cwm Taf bod pob bwrdd iechyd wedi ymrwymo i gyflawni'r amcan hwn. Gan ystyried argymhelliad y pwyllgor, byddaf yn ceisio sicrwydd pellach gan gadeiryddion byrddau iechyd bod y momentwm hyd yma wedi'u fabwysiadu ar bob lefel. Byddaf hefyd yn ceisio sicrwydd gan bob bwrdd iechyd bod eu prosesau ar gyfer sicrhau bod yr holl randdeiliaid perthnasol, gan gynnwys WAST, yn cymryd rhan mewn trafodaethau am gynigion i newid gwasanaethau yn gynnar.

Casgliad 3

Rhaid dod i gytundeb rhwng Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru, undebau llafur a staff cyn gynted â phosibl o ran yr amserlenni staff diwygiedig ar gyfer y rhannau hynny o Gymru lle nad oes trefniadau diwygiedig ar waith eto.

Rhaid i Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru, gan weithio mewn partneriaeth gydag undebau llafur a'r staff, roi trefniadau ar waith i adolygu'r amserlenni staff ar gyfnodau priodol i osgoi diffyg cyfateb yn y dyfodol rhwng staffio a galw disgwyliedig.

Derbyn

Mae sicrhau bod capasiti staff y rheng y flaen i gyd-fynd â'r lefelau galw disgwyliedig yn ganolog i wella amseroedd ymateb ambiwlansys. Mae trefniadau newydd ar waith yn ardal

Caerdydd a'r Fro, ac mae disgwyl i'r trefniadau diwygiedig gael eu rhoi ar waith yn ardaloedd byrddau iechyd Cwm Taf ac Aneurin Bevan erbyn diwedd mis Mai.

Mae trafodaethau'n mynd rhagddynt mewn perthynas ag amserlenni staff yn ardaloedd Abertawe Bro Morgannwg, Betsi Cadwaladr, Hywel Dda a Phowys. Mae'r fframwaith ansawdd a chyflawni yn ei gwneud yn ofynnol i WAST beidio â bod mor ddibynnol ar staff yn gweithio oriau ychwanegol, a bydd hyn yn ei hun yn sbardun i sicrhau bod amserlenni cadarn yn eu lle ar gyfer staff y rheng flaen a'r ganolfan cyswllt clinigol. Buddsoddodd EASC £7.5m i helpu i recriwtio staff ychwanegol sy'n helpu i hwyluso'r amserlenni diwygiedig.

Mae prif gomisiynydd y gwasanaethau ambiwlans wedi comisiynu datblygu offeryn 'galw a gallu' gan Brifysgol Caerdydd, mewn cydweithrediad ag uned modelau gwelliant parhaus bwrdd iechyd Aneurin Bevan. Bydd hyn yn helpu i ragweld y galw a deall ble i roi adnoddau rheng flaen yn ystod cyfnodau o alw uchel ac isel a ragwelir mewn gweithgarwch i gefnogi defnydd effeithlon.

Bydd y Comisiynydd yn parhau i fonitro'r sefyllfa'n agos a sicrhau bod amserlenni staff yn cael eu hadolygu'n rheolaidd.

Casgliad 4

Rhaid i Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru flaenoriaethu darparu gwasanaethau ambiwlans brys. Mae angen gwneud gwaith i ddod o hyd i fecanweithiau priodol ar gyfer darparu gwasanaethau cludo cleifion nad ydynt yn achosion brys, er mwyn dadgyfuno'r gwasanaethau hynny oddi wrth yr Ymddiriedolaeth yn unol ag argymhelliad 2 Adolygiad McClelland. Rhaid i'r Ymddiriedolaeth gael cynllun clir ar gyfer dadgyfuno'r ddau wasanaeth, gan nodi'r costau a'r amserlen. Mae'r Pwyllgor yn disgwyl cael diweddariad ar y cynllun hwn cyn gwneud y gwaith dilynol ar yr ymchwiliad hwn yn ddiweddarach eleni.

Derbyn

Mewn ymateb i'r argymhellion a amlinellwyd yn Adolygiad McClelland, bydd y GIG yng Nghymru yn cyflwyno cynlluniau i foderneiddio'r ddarpariaeth o wasanaethau gofal cleifion.

Mae cam cyntaf yr agenda moderneiddio wedi cynnwys trosglwyddo gwasanaethau cludwyr iechyd o WAST i Bartneriaeth Cydwasanaethau'r GIG. Mae'r broses drosglwyddo wedi bod yn llwyddiannus a dechreuodd y gwasanaeth newydd ar 1 Ebrill 2015. Roedd gwaith caled pawb a oedd yn rhan o'r broses fanwl o drefnu'r trosglwyddiad wedi sicrhau na amharwyd o gwbl ar y gwasanaeth.

Mae trosglwyddo unrhyw fath o drafnidiaeth i gleifion nad ydynt yn achosion brys o WAST yn fwy cymhleth. Rydym am wneud yn siŵr nad yw unrhyw newidiadau arfaethedig yn ansefydlogi'r ddarpariaeth o wasanaethau ambiwlans brys, nac yn eu rhoi yn y fantol. Yn hyn o beth, mae Llywodraeth Cymru yn gweithio'n agos gyda GIG Cymru a WAST ar gynlluniau i foderneiddio trafnidiaeth i gleifion nad ydynt yn achosion brys.

Mae bwrdd y prosiect yn ystyried nifer o opsiynau ar gyfer moderneiddio trafnidiaeth i gleifion nad ydynt yn achosion brys. Fel rhan o'r gwaith hwn, rwyf wedi egluro fy mod yn disgwyl i'r bwrdd ystyried ffyrdd o weithio mewn partneriaeth gydag awdurdodau lleol a

darparwyr eraill i wella effeithlonrwydd ar draws y sector cyhoeddus, gan gynnwys trafnidiaeth gyhoeddus.

Casgliad 5

Rhaid i'r Pwyllgor Gwasanaethau Ambiwlans Brys, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru a'r byrddau iechyd lleol weithio gyda'i gilydd i leihau nifer yr oriau coll o ganlyniad i oedi wrth drosglwyddo cleifion. Rhaid gweithredu'r polisi trosglwyddo newydd yn gyson ledled Cymru, a rhaid datrys unrhyw faterion a gaiff eu nodi yn ymweliadau dilynol y prif weithredwr ac arweinydd ar ofal heb ei drefnu yn gyflym.

Derbyn

Mae oedi hir wrth drosglwyddo cleifion yn hollol annerbyniol.

Mae canllawiau cenedlaethol ysbytai ar drosglwyddo cleifion yn ddatganiad clir o fwriad sy'n ei gwneud yn ofynnol i fyrddau iechyd gymryd cyfrifoldeb am sicrhau bod cleifion yn cael eu trosglwyddo'n ddiogel i dimau'r ysbyty o fewn 15 munud. Mae'r canllawiau'n nodi 10 cam allweddol i fyrddau iechyd ac ymddiriedolaethau eu cynnwys yn eu protocolau presennol i sicrhau bod cleifion yn cael eu trosglwyddo'n brydlon. Ymddengys bod y cyfnodau oedi yn dechrau lleihau yn y mwyafrif o adrannau brys. Mae'r wybodaeth ddiweddaraf ar gyfer mis Mawrth yn dangos bod gostyngiad o 23% wedi bod yn nifer y cleifion sy'n aros am dros awr i gael eu trosglwyddo, ers mis Rhagfyr 2014.

Casgliad 6

Dylai Prif Gomisiynydd y Gwasanaethau Ambiwlans, y Pwyllgor Gwasanaethau Ambiwlans Brys ac Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru fynd i'r afael ar frys gyda'r broblem o ambiwlansys yn cael eu tynnu i ffwrdd o'u hardaloedd. Wrth wneud hynny, dylent geisio canfod arfer gorau ledled y DU a dysgu ohono. Dylid blaenoriaethu archwilio'r cynllun peilot 'dychwelyd at ôl-troed' ar sail ehangach a'i werthuso.

Derbyn

Rydym yn disgwyl darpariaeth gwasanaeth ambiwlans brys mor deg â phosibl i bawb yng Nghymru, waeth ble maent yn byw, gyda'r lefelau gofynnol o staff rheng flaen i helpu i ymateb yn effeithiol ac yn amserol bob tro. Rydym hefyd yn disgwyl i'r adnodd clinigol iawn gael ei anfon gan WAST yn seiliedig ar angen y claf.

Gall y targed presennol o wyth munud ysgogi ymddygiad gwrthnysig wrth i sawl criw ac ambiwlans gael eu hanfon er mwyn cyrraedd y targed hwn. Mae gwella'r ffordd y mae adnoddau brys yn cael eu defnyddio i gyflawni'r canlyniad gorau posibl i gleifion yn rhan o gynlluniau y gwasanaeth ar gyfer moderneiddio clinigol.

Mae cynllun peilot 'dychwelyd at ôl-troed' yn mynd rhagddo yn ardal Bwrdd Iechyd Prifysgol Cwm Taf, sydd wedi arwain at gynnydd mewn amseroedd ymateb sy'n cyd-fynd â dechrau'r cyfnod treialu. Mae prif gomisiynydd y gwasanaethau ambiwlans wedi sefydlu panel gwelliannau a sicrhau ansawdd sy'n adrodd i EASC a bydd yn adolygu ac yn gwerthuso mentrau gwella gwasanaethau fel y cynllun peilot yng Nghwm Taf. Mae aelodau'r panel yn cynnwys uwch-arweinwyr clinigol ac academyddion amlwg.

Casgliad 7

Wrth ddarparu gofal heb ei drefnu, rhaid i fyrddau iechyd ac Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru ystyried anghenion unigol y claf. Rhaid i fyrddau iechyd ac Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru sicrhau bod asesiadau, gofal a thriniaeth yn cael eu darparu mewn ffyrdd sy'n diwallu anghenion unigol y claf, ac yn eu helpu i gyflawni'r canlyniad gorau posibl iddynt. Dylai hyn gynnwys defnydd priodol o asesu, gofal a thriniaeth wedi'u darparu yn y gymuned, yn ogystal â darpariaeth mewn ysbyty.

Derbyn

Rwy'n croesawu casgliad y Pwyllgor bod angen gwneud mwy ar y cyd i drin cleifion mor agos i'r cartref â phosibl, gan ganolbwyntio ar anghenion unigol cleifion i osgoi gorfod cael eu cludo yn ddiangen gan ambiwlans brys i'r ysbyty. Rydym wedi cyhoeddi ein cynllun cenedlaethol ar gyfer gwasanaethau gofal sylfaenol i Gymru i helpu i ysgogi hyn.

Yn seiliedig ar egwyddorion gofal iechyd darbodus a'r rheini yn y cynllun gofal sylfaenol, mae'r llwybr gofal cleifion ambiwlans pum cam yn y fframwaith ansawdd a chyflawni yn disgrifio disgwyliadau EASC am sut y dylai'r gwasanaeth ambiwlans ddarparu gwasanaethau i bobl Cymru. Mae disgwyl i WAST fodloni cyfres o ofynion craidd, mesurau ansawdd a dangosyddion clinigol a ddisgrifir o dan pob un o'r pum cam.
Mae'r llwybr gofal cleifion ambiwlans pum cam yn amlinellu'n glir bod gwasanaeth ambiwlans brys WAST yn wasanaeth clinigol o fewn y system gofal iechyd integredig ehangach yng Nghymru, ac mae'n rhan o ddull aml-asiantaethol, cydweithredol rhwng byrddau iechyd a WAST i ddatblygu gwasanaethau clinigol cyn-ysbyty, sy'n perfformio'n dda. Ei ddiben yw sicrhau bod cleifion yn cael y gofal iawn ar yr amser iawn gan y clinigwr iawn i sicrhau'r canlyniad gorau i bob claf.

Mae llawer wedi cael ei wneud fel rhan o'r gwaith moderneiddio clinigol i'r gwasanaethau ambiwlans brys i wella'r broses o asesu cleifion yn y gymuned drwy ddatblygu nifer o fentrau a dulliau. Mae ymgynghorwyr adrannau brys a pharafeddygon yn brysbennu galwadau y gellid ymdrin â nhw yn well yn nes at y cartref o bosibl. Ochr yn ochr â hyn, mae'r *Manchester Triage System* wedi cael ei chyflwyno i ganolfannau cyswllt clinigol i wneud asesiad clinigol gwell o gleifion. Mae WAST hefyd wedi gweithredu offeryn Braenaru Parafeddygon. Mae hyn galluogi amrywiaeth o brosesau brysbennu seiliedig ar dystiolaeth sy'n ddiogel, cyson ac yn glinigol ddiogel i gael eu defnyddio, sy'n galluogi parafeddygon i gynnal asesiadau cywir wyneb yn wyneb o anghenion gofal claf unigol, pan maent yn cyrraedd y lle, gan eu galluogi i gyfeirio at leoliadau gofal iechyd eraill yn y gymuned lle mae'n briodol.

Mae modd trin cleifion sydd wedi dod dros bwl o epilepsi neu hypoglycaemia, neu gleifion sydd wedi cwympo drwy WAST ym mhob ardal bwrdd iechyd, lle mae miloedd o gleifion yn cael eu cyfeirio yn ddiogel at leoliad gofal iechyd priodol ar wahân i ysbyty.

Mae'r rhain, a mentrau tebyg, wedi arwain at gyfraddau WAST ar gyfer cleifion na chafodd eu cludo gan ambiwlans sydd bellach ymhlith yr uchaf yn y DU, gan gadw capasiti gofal brys gwerthfawr i ymateb i gleifion sydd ag angen clinigol am ymateb cyflym, ac ysgafnhau pwysau ar Adrannau Brys.

Casgliad 8

Rhaid i wasanaethau ambiwlans yn y tymor canolig a'r tymor hwy berfformio'n dda gan gyd-fynd â'r galw. Felly, dylai byrddau iechyd, y Pwyllgor Gwasanaethau Ambiwlans Brys ac Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru wneud gwaith blaengynllunio cadarn ac effeithiol sy'n ystyried newidiadau demograffig a ragwelir.

Derbyn

Rwy'n croesawu casgliad y pwyllgor bod cael strategaeth recriwtio effeithiol a chynlluniau cadarn ar gyfer y capasiti sydd ei angen i fodloni'r galw a ragwelir, yn hanfodol ar gyfer gwasanaeth ambiwlans brys sy'n perfformio'n dda. Mae cynllunio ar gyfer y tymor canolig a'r tymor hwy yn hanfodol er mwyn cyflawni hyn.

Mae disgwyl i WAST ddarparu cynllun tymor canolig integredig y mae'n rhaid iddo ystyried newid demograffig, datblygiadau yn y gwasanaeth, anghydraddoldebau iechyd, anghenion gofal sylfaenol ynghyd â gofynion clinigol penodol fel iechyd meddwl ac ystyriaethau iechyd mamolaeth a phlant. Mae'r cynlluniau hyn yn amlinellu bwriad sefydliadau, eu blaenoriaethau a'r ddarpariaeth ddisgwyliedig ar gyfer y tair blynedd nesaf. Mae Llywodraeth Cymru yn defnyddio'r cynlluniau hyn i lywio trafodaethau am ansawdd a rheoli perfformiad drwy gydol y flwyddyn.

Yn gywir

Vaughan Gething AC / AM
Y Dirprwy Weinidog Iechyd
Deputy Minister for Health

UNISON Cymru Wales submission to the Health and Social Care Committee: Inquiry into the performance of the ambulance service in Wales

As the largest trade union in the Welsh Ambulance Service, UNISON is very pleased that the voice of staff across the Trust and across all professions and grades is being listened to by the Health and Social Services Committee. UNISON Cymru Wales represents some 35000 NHS staff across all grades and disciplines, 1200 of whom work for the Welsh Ambulance Services NHS Trust.

For some years UNISON and has absolutely strived, often under very difficult circumstances, to maintain professional and high trust partnership working. This is not just in conventional industrial relations with WAST but also with;

- With Welsh Govt, Health Minister, Deputy Health Minister
- With opposition Health Shadows over UNISONs commitment to improvement in WAST and the requirement for broad cross party support for robust clinical outcome indicators.
- With the media
- By leading the debate, internally and externally, about the need for performance improvement and judging the effectiveness of patient experiences via clinical outcomes not just how fast the ambulance arrived. The debate around demand, clinical outcomes and Choose Well is what UNISON has been very publicly campaigning on for a number of years.
- UNISON has a proud record of being a part of the solution, not the problem in transforming the performance of WAST.

Industrial Relations

There has been a significant improvement in industrial relations since the appointment of Tracy Myhill and Tracy earned the personal respect of colleagues and UNISON very quickly. It would be fair to say that the culture and high standards that Tracy is seeking to implement has challenged the status quo profoundly and that continues to be a challenge to the behaviour of some.

At the same time, UNISON has determined that it had improvements to make in its own structures, some of which did not add value to what we are trying to achieve at WAST. We have dealt with this via the creation of one all Wales UNISON Ambulance Branch that went live on July 1st 2015.

UNISON has long believed that, whilst there has been ‘partnership working’ in name, real partnership working has been anecdotal and not embedded throughout the organisation. For a number of years UNISON committed to move into real

partnership working, with shared objectives around the success of the organisation: where high trust, high performance and a commitment to wanting to be the best Ambulance Service in the UK was critical for us.

Since her appointment, Tracy Myhill has been committed to introducing that same true partnership working within WAST and in recent months there has been a cross flow of ideas on what that might be and where we start from. It was Tracy's initiative to hold three high level seminars across Wales to identify what partnership working could look like.

UNISON added considerable value to this process by inviting WAST and fellow trade unions to consider partnership working case studies from across Wales from world class companies whose partnership working drives them to be globally competitive, high performance leaders. As a result, a case study on how workplace partnership drove high performance at Airbus at Broughton was delivered and we hope to visit Airbus in the near future. We also introduced WAST colleagues and leaders to the exemplar workplace partnership work of United Utilities and Dwr Cymru – Welsh Water which were blueprints for the Airbus experience.

Whilst there have been significant improvements delivered from the top, by Tracy Myhill, Claire Vaughan, Estelle Hitchon and for many years previous, Judith Hardisty, which has challenged the culture of 'top down management' throughout the organisation, partnership at a local level is often not where it needs to be. There are still too many occasions where the views of trade union partners are an afterthought or where some meetings go ahead without invited trade unions being in attendance because of resource issues.

The key headlines noted during the last Inquiry still hold true.

- Rota's
- On time meal breaks
- and over-runs.

UNISON supports in principle the requirement for rota's to be clinically demand led and for those rota's to support patients as well as ensure good work life balance. But in many parts of Wales, rota's are still not right with a feeling that many were introduced in haste not least because many were introduced outside of established partnership working. Our members still report that they are not getting very significant numbers of their meal breaks within their windows. And many staff are routinely carrying out significant shift over-runs. It is important to consider that many shifts are 12 hours long and significant over-runs are clinically dangerous as well as coming at a high personal cost to staff.

So there have been serious improvements, and the new management regime has been key. But our belief is that it is not yet embedded. We would particularly

welcome future Health and Social Care Committee encouragement in its recommendations to support real, high trust, partnership working at WAST.

Performance

UNISON is also absolutely committed to getting a world class ambulance service that is fit for purpose in a country that does not always lend itself to vehicles going from A-B in prescribed times. That is why clinically measuring patient outcomes is so important to us.

UNISON has led the debate for some time on the striking evidence that A8 times are not clinically important (apart from the most critically ill and life threatened patients), only measure what the ambulance did before arrival, not what EMS professionals did after and can often divert resources in order to 'chase the eight'. We implore the Health and Social Care Committee to consider the need to place clinical outcomes (which do matter) above the need to post A8 times (which don't, other than for around 150 people a day) and to oversee the clinically led response model pilot developed over the summer.

Politicians of all colours never feel the heat as much as frontline EMS staff who are upset and appalled at the monthly assault that they get over response times, notwithstanding that it is not intentionally directed at them. All official and unofficial staff surveys/interviews support this feeling from staff. They are not interested in the fact that there was a general election looming or a National Assembly election next year. They are interested in the fact that they are saving lives every day, often in the most difficult and extreme of circumstances, and then suffer the devastating blow of getting the now regular monthly attack on their response times.

UNISON is not opposed in principle to clinical outcome indicators being comparable across home country borders if this could assist in the provision of cross party support in the Senedd for a clinically led set of performance indicators.

UNISON also believes that we need more volunteer community first responders (CFRs) in Wales as a key to cardiac arrest survival and recovery. Irrespective of one's views on the clinical outcome model it is a mainstream view that for the most urgent cardiac arrests, an eight minute response can be too long in any case. Therefore a package of care with CFRs attending within minutes and EMS responses just after, should be promoted by the active recruitment of more volunteer CFRs. We have also called for a substantial increase in publicly available automated external defibrillators. During the McClelland review we noted that Seattle has one of the world's highest survival rates for cardiac arrest at around 20%, with King County in Seattle having a 62% survival rate. Seattle has one of the highest number proportionally of volunteer community first responders and a significantly high

number of publicly available automated external defibrillators. The average survival rate is around 10% in Wales and across the UK.

Demand

UNISON has consistently been arguing in Wales that demand for emergency ambulances is increasing by over 5% a year, every year and has done so for over a decade, which is unsustainable. This has had a profound effect on the ambulance service as well as the capacity of Emergency Department's. It is also a desperately dispiriting experience for those patients who could have achieved earlier clinical advice instead of sitting in an Emergency Department.

We have consistently talked about the need for alternative pathways that are 'always on'. It was important for UNISON therefore to see what we could do practically to support the *Choose Well* campaign.

So UNISON, as the largest public service trade union determined to use its reach, reputation and relationships with public service employer's right across Wales to encourage them to formally sign up to the *Choose Well* campaign. This was so that we could encourage employers we had a relationship with to deliver key messages to both their staff and their services users such as students, tenants, clients and the general public. Our inaugural #ChooseWellChampion was Hafal, the charity supporting those with a serious mental illness who will deliver choose well messages to their 200 staff and 3000 service users across all 22 counties in Wales. After this autumn's campaign, we hope to talk to the Wales TUC to see whether cross union networks could be used which could open up key messages to Wales' 500,000 trade union members and their employers.

In helping to reduce demand on 999 and Emergency Departments, UNISON has continually called on the Minister, Deputy Minister, WAST and the wider NHS estate in Wales to look at the innovative examples that some English Ambulance Services use to educate the general public on the appropriate use of 999 and ambulance services.

For example, ambulances in East Midlands have vibrant and informative Choose Well messaging on ambulances. There really seems to be a barrier somewhere in the system to putting out these messages on NHS assets in Wales. We have also called for a schools and colleges education campaign that could include an art competition that will result in an on-ambulance poster for the winner/s. We have also called on the Welsh Government and Visit Wales to work together on an 'enjoy Wales, stay safe in Wales' campaign to deliver Choose Well messages to the hundreds of thousands of visitors that we attract in Wales.

Patient Care Service

It is UNISONs firm belief that the 'non-emergency patient transport' that the Committee Inquiry discussed in its last outcome in March 2015 is in fact a Patient Care Service (PCS). For example, each PCS ambulance carries a defibrillator and staff who are trained to use them. It would be wrong to conclude that WAST is somehow distracted from its central role of providing EMS services by its provision of PCS services. In fact in terms of resilience, finance and robust support at major incidents, a strategically managed PCS is absolutely critical to the EMS function of WAST. We have some reason to believe that the appetite for Health Boards to take on PCS has slipped away since the McClelland review and that a reformed PCS would be best placed within a clinically led WAST.

Concluding comments

UNISON completely accepts that the performance of WAST has to improve on many levels. We believe that we now have in place a Chief Executive who can make this happen by engaging with trade unions (and staff more widely). Equally, UNISON is supporting the demand for high standards from both staff side unions as well as WAST leaders.

UNISON can evidence that it has long been a part of the WAST solution, not part of the WAST problem. Our combined contribution towards real partnership working, supporting world class clinical outcomes and reducing demand by highlighting alternative pathways is unsurpassed.

Our personal commitment to improving WAST performance is that we will not change our strategic approach which we believe will contribute to an ambulance service that we all, the people of Wales, want to be proud of.

Darron Dupre
Ambulance Lead
UNISON Cymru Wales

14th October 2015

Written Evidence to the National Assembly for Wales' Health and Social Care Committee, November 2015 to Inform the Follow Up Inquiry Into the Performance of the Ambulance Services in Wales

The GMB has responded to each of the eight areas that the committee identified in its original inquiry into the performance of Ambulance Services in Wales, in the order that the letter was sent to the Deputy Minister for Health, Vaughan Gething.

Conclusion 1 : The Emergency Ambulance Services Committee, the Welsh Ambulance Services NHS Trust and local health boards must work together urgently to improve emergency ambulance response times and optimise patient outcomes. Performance measures must be clinically appropriate and take sufficient account of patient outcomes. Therefore the work announced by the Minister for Health and Social Services to review ambulance response measures should be rapid, clinically-led, informed by best practice and designed to enable benchmarking across the UK where possible.

Performance Indicators

Since the report the clinical response model has changed and a trial of a clinically led response outcome has been introduced from the 1st October 2015. Data is now being collated to ascertain what best practise should be. As an organisation, the GMB completely supports this trial, however, we are concerned that the appropriate training to support the clinicians (i.e. paramedics) is still not in place. We believe that this training is essential for this model to succeed.

Conclusion 2 : To maintain momentum and work towards a whole system approach to unscheduled care, all health boards must be fully engaged with the work of the Welsh Ambulance Services NHS Trust through the work of

the Emergency Ambulance Services Committee on a national level, and directly with the Trust on a local level. Health boards must take due account of the impact on the Welsh Ambulance Services NHS Trust when developing new services or considering making changes to existing services. Health boards must also ensure that the Welsh Ambulance Services NHS Trust is involved in discussions at a sufficiently early stage to enable it to give proper consideration to the impact on its services.

Accountability & Engagement

Whereas the GMB accepts and welcomes these proposals and recommendations we are currently unable to comment on how they have progressed as we have not been approached to be involved in this process so far.

Conclusion 3 : Agreement must be reached between the Welsh Ambulance Services NHS Trust, trades unions and staff at the earliest opportunity on revised staff rosters in those parts of Wales for which revised arrangements are not yet in place. The Welsh Ambulance Services NHS Trust must, working in partnership with trades unions and staff, put in place arrangements to review staff rosters at appropriate intervals to avoid future mismatches between staffing and anticipated demand.

Leadership, Organisational Change & Staffing

The roster reviews have been started and are currently on-going, however, the GMB has raised concerns with WAST that in some areas new rotas have been signed off by management that have not been agreed in partnership and have failed to follow the agreed process. We have also raised concerns where we believe that the priority for rota charge is financially led and not necessarily to the benefit of either patients or the health and wellbeing of the staff.

With regard to the new arrangements that were put in place in the Cardiff & Vale, Cwm Taf and Aneurin Bevan Health Board areas we can make the following comments;

Cardiff & Vale:- Rota's were implemented, however, they were not agreed in partnership and did not follow the agreed process. The end product of this

is that the response targets worsened in that area but a financial saving was made. This is currently being investigated by the Trust. The GMB has not been asked to participate in this process.

Cwm Taf:- This locality has seen the introduction of ring fencing of resources which has had a positive effect on targets and staff morale. The trial has significantly increased the number of vehicles available by utilising external companies to supplement the existing resources.

Morale has improved due to crews now being able to take rest breaks more appropriately/regular and there has been a clear reduction in shift overruns.

Aneurin Bevan:- At Aneurin Bevan the rotas are still being worked on in partnership and both the management and Trade Unions have questioned the data as it is suggesting that a reduction in resources is required. However, the current response targets are not being met and by reducing resources the problem will get worse. In the meantime the Trust is looking to fill vacancies wherever possible but this will take time to take effect.

Of the three examples given the Cwm Taf model is clearly, based on evidence produced during the trial, the indicator for best practice, based on the correct available resources.

The suggestions that recruitment of additional staff will help to facilitate revised rotas we believe is yet to be seen. We believe that the £7.5 m investment has prevented the service from falling backwards but, without further investment, will not enable the service to move forward.

Whereas we welcome the ambulance services commissioner developing the "demand and capacity" tool we would appreciate being involved in that development but to date we have not been asked to be involved.

Conclusion 4 : The Welsh Ambulance Services NHS Trust must prioritise emergency ambulance services provision. Work is required to identify appropriate mechanisms for the provision of non-emergency patient transport services, and to disaggregate those services from the Trust in accordance with recommendation 2 of the McClelland Review. The Trust

must establish a clear plan for the disaggregation, with identified timescales and costs. The Committee expects to receive an update on this plan before it follows up its inquiry later this year.

Non Emergency Patient Transport

The GMB still has concerns around the disaggregation of patient transport services as we identified to Mark Drakeford, Minister for Health, after the publication of the McClelland review.

Part of our concern was that the GMB as an organisation had been left out of the review and were not invited to give evidence. Furthermore it was evident that the National Programme Board which was dealing with the patient transport services at the time had not reached a conclusion to disaggregate the service and had not been asked to take part in the McClelland review, in fact, the National Programme Board findings were contrary to the McClelland findings. However, there has been progression and the GMB understands that discussions are on-going and a final business case has been submitted to the minister outlining a partnership view on how the service should evolve. This business case would see patient transport services run hand in hand with the Emergency Medical Services (EMS).

Conclusion 5 : The Emergency Ambulance Services Committee, the Welsh Ambulance Services NHS Trust and local health boards must work together to reduce the number of hours lost as a result of patient handover delays. The new handover policy must be implemented consistently across Wales, and any issues identified in the follow up visits made by the chief executive-lead on unscheduled care must be resolved swiftly.

Patient Handover

Patient Handover continues to be an issue especially when the system is under pressure. The GMB welcomes all attempts by Health Boards and Trusts to improve on handover times but we feel that such improvements are not within the gift of the Ambulance Service.

Conclusion 6 : The Chief Ambulance Services Commissioner, the Emergency Ambulance Services Committee and the Welsh Ambulance Services NHS Trust should urgently address the issue of ambulances being 'pulled away' from

their areas. In doing so, they should seek to identify and learn from best practice across the UK. The 'return to footprint' pilot should be explored and evaluated on a wider basis as a priority.

Models of Development

The GMB totally supports this principle, as referred to in conclusion 2. We would support this model being rolled out across the service. However, to do so would require additional resources.

Conclusion 7 : In providing unscheduled care, health boards and the Welsh Ambulance Services NHS Trust must take account of the patient's individual needs. Health boards and the Welsh Ambulance Services NHS Trust must ensure that assessment, care and treatment are provided in ways which meet the patient's individual needs, and help them achieve their optimum outcome. This should include appropriate use of assessment, care and treatment provided in the community, as well as hospital-based provision.

Frequent Callers

The GMB totally supports this conclusion. However, for this to work sufficient resources need to be allocated WAST to fully educate staff across the organisation i.e. frontline, control, NHSD/111 Services etc. Without the additional skills it is not possible to effectively supply the service requirements, nor would it be safe to do so.

Conclusion 8 : Ambulance services in the medium and longer term must be high performing, and aligned to demand. Therefore health boards, the Emergency Ambulance Services Committee and the Welsh Ambulance Services NHS Trust should undertake robust and effective forward planning which takes anticipated demographic changes into account.

Anticipation the Demand for services

We support this move to a three year development plan and we are happy to assist with this process wherever we can.

Paul Gage
Lead NHS Officer
GMB Wales and South West November 2015

Unites Submission to the Social Care Committee

November 2015

Introduction

Unite has some 6000 members in the heath sector in wales. Of that we have some 600 in the Ambulance service covering all aspects of the service.

The submission below is intended to give our initial responses to the submission made by the Minister and will follow the same sequence of responses that he has made.

We look forward to discussing these matters further and expanding on our responses where required when we meet on 3rd December.

Comments on the Ministers Response

Conclusion 1
The Emergency Ambulance Services Committee, the Welsh Ambulance Services NHS Trust and local health boards must work together urgently to improve emergency ambulance response times and optimise patient outcomes.
Performance measures must be clinically appropriate and take sufficient account of patient outcomes. Therefore the work announced by the Minister for Health and Social Services to review ambulance response measures should be rapid, clinically-led, informed by best practice and designed to enable benchmarking across the UK where possible.

Accept
This was a clear recommendation in the McClelland Review and I welcome the committee's support for the review of ambulance response time targets. The existing eight-minute target is based on data from studies published more than 40 years ago which focused on the treatment of out-of-hospital cardiac arrest only. It is important to note the studies did not consider any other type of pre-hospital emergency condition, and there is little empirical research available on response times to any other type of emergency calls. I was particularly encouraged to note the committee's support for ensuring that patients receive services appropriate to their need which aligns directly to the principles of prudent healthcare. This should be the key driver in an emergency clinical response.
It is important we continue to develop clinical performance and patient outcomes as the main standards for assessing the performance of emergency ambulance services to meet public expectation of accountability and transparency.

Unite still feels there is inequity in rural areas and that there is understaffing at all grades. Resources are pulled out of rural areas to service the more urban areas, this

whirlpool effect is created by higher demand in these areas and therefore more calls can be hit in 8 minutes. There are less options for patients as to where they can get seen if hospital admission is not necessary. Many minor injury units are only open during day time working hours therefore travel to the nearest DGH is the only option. Rural communities are therefore let down both on timeliness and their experience of the service provided, not just by WAST but by the wider NHS.

For Ambulance staff this is exacerbated by poor rest break management which is caused in our view by low staff levels as is the ability of crews to finish on time.
In addition rural crews have to deal with high travel mileage as well as issues such as no time to meet with line manager, be able to take up training opportunities, manage infection control.
As a result there are high sickness levels some due to irregular meals, as well as musculoskeletal issues due, we believe, to long time spent in vehicles as well as linked to manual handling. In our experience the stress and burnout staff suffer is on the increase as staff have to cope with an ever increasing workload and higher public expectations while staff numbers remain relatively static.

Conclusion 2
To maintain momentum and work towards a whole system approach to unscheduled care, all health boards must be fully engaged with the work of the Welsh Ambulance Services NHS Trust through the work of the Emergency Ambulance Services Committee on a national level, and directly with the Trust on a local level.
Health boards must take due account of the impact on the Welsh Ambulance Services NHS Trust when developing new services or considering making changes to existing services. Health boards must also ensure that the Welsh Ambulance Services NHS Trust is involved in discussions at a sufficiently early stage to enable it to give proper consideration to the impact on its services.

Accept
There has been considerable progress in the level of responsibility for emergency ambulance services at a local level among health boards. This is central to embedding the ambulance services in the unscheduled care system. The early agreement on WASTs budget for 2015/16 is tangible evidence of progress in this area and a step change in the collaboration between health boards and the Trust.
The emergency ambulance service's national collaborative commissioning quality and delivery framework drives accountability and responsibility among health boards through a range of actions. This includes the requirement for the nomination from each health board of an Emergency Ambulance Services 'Champion' to act as their organisation's point of contact for the successful operation and ongoing development of the framework. A collaborative performance delivery group which reports directly to EASC has been established and will consider and advise on the management of performance issues. This will include chief operating officers from each health board and will be chaired by the Chief Ambulance Services Commissioner.
Health board chairs and independent members receive regular updates and progress reports from their own executive directors and will invite WAST to attend board meetings or sub-committees. The chair of EASC and the chief ambulance services commissioner will attend each health board meeting at least once annually.
The framework, which includes a number of joint measures, will also enable both WAST and health boards to detail how they will support improvements to ambulance responsiveness and quality of delivery within their integrated medium term plans.
I have received formal assurance from Dr CDV Jones, chair of Cwm Taf University Health Board that all health boards are committed to achieving this objective. In view of the

committee's recommendation I will seek further assurance from chairs of health boards that the momentum achieved to date is fostered at all levels. I will also seek assurance from all health boards about their processes for ensuring all relevant stakeholders, including WAST, are engaged in discussions about service change proposals at an early stage.

This response in our view is all at the very high level of the service and we feel not reflected at ground level.
Ambulances waiting outside hospitals is now a daily occurrence and has not improved significantly at all. Because our provision of resources is tightly aligned to predicted demand, having vehicles unable to respond has a knock on effect on other vehicles travel to scene times and contributes to the whirlpool effect mentioned in the previous point.
Our members are still struggling to get direct access to wards with some patients. Everything has to go via ED which creates a bottle neck and they are experiencing delays in admission wards as well as ED.
Indeed Admission wards seem to be becoming another bottle neck in the system as all patients, be they direct GP admissions or ED admissions, have to go through an admission ward for assessment. Because of a lack of capacity (no beds) crews are regularly kept waiting in the corridor.

Conclusion 3
Agreement must be reached between the Welsh Ambulance Services NHS Trust, trade unions and staff at the earliest opportunity on revised staff rosters in those parts of Wales for which revised arrangements are not yet in place.
The Welsh Ambulance Services NHS Trust must, working in partnership with trades unions and staff, put in place arrangements to review staff rosters at appropriate intervals to avoid future mismatches between staffing and anticipated demand.

Accept
Aligning frontline staffing capacity to meet predicted levels of demand is central to improving ambulance responsiveness. New arrangements are in place in the Cardiff and Vale area, and revised arrangements are due to be implemented in the Cwm Taf and Aneurin Bevan health board areas by the end of May.
Discussions are ongoing in regard to staff rosters in the Abertawe Bro Morgannwg, Betsi Cadwaladr, Hywel Dda and Powys areas. The quality and delivery framework requires WAST to reduce reliance on overtime and this will in itself act as a driver to ensure robust staff rosters are in place for frontline and clinical contact centre staff. EASC invested £7.5m to support the recruitment of additional staff which helps facilitate the revised rosters.
The chief ambulance services commissioner has commissioned the development of a 'demand and capacity' tool by Cardiff University, in collaboration with Aneurin Bevan health board's continuous improvement modelling unit. This will help to forecast demand and the understanding of where to position frontline resource during predicted peaks and troughs in activity to support efficient deployment.
The Commissioner will continue to monitor the situation closely and ensure a regular review of staff rosters.

We believe that the way in which demand is predicted needs to be examined and developed to provide better rosters. Especially now that the data is different because of the new response model.
The cycle times of crews and increasing workloads have been included to an extent, however we feel that the data should also include other information other than pure call numbers, an allowance for the day to day occurrences that cannot be planned for such as vehicle breakdowns and prolonged on scene times (such as large incidents even

major incidents) to create head room for the management of the fluctuating demands on a daily basis. If hospital waiting is not addressed then that needs to feature in the calculations as well.
At present we feel that rotas are too closely matched to pure demand, which ignores the other things that may occur during the day which affects capacity and the capability to deal with the workload. It would be good, for instance, to be able to stand a crew down from operational duties for meetings with their line manager, be it to carry out PDR or sickness review or team briefings but this is utterly impossible as things stand without affecting response times and patient care. Currently staff are asked to attend such meetings on their days off to avoid affecting resource levels.

Conclusion 4
The Welsh Ambulance Services NHS Trust must prioritise emergency ambulance services provision. Work is required to identify appropriate mechanisms for the provision of non-emergency patient transport services, and to disaggregate those services from the Trust in accordance with recommendation 2 of the McClelland Review. The Trust must establish a clear plan for the disaggregation, with identified timescales and costs. The Committee expects to receive an update on this plan before it follows up its inquiry later this year.
Accept
In response to the recommendations set out in the McClelland Review, the NHS in Wales continues to bring forward plans to modernise the provision of patient care services.
The first step of this modernisation agenda has involved the transfer of health courier services from WAST to the NHS Shared Services Partnership. The transfer has been successfully completed and the new service started on 1 April 2015. The hard work of everyone involved in the detailed planning for the transfer ensured that there was no disruption in service. Any transfer of non-emergency patient transport from WAST is more complex. We want to make sure any planned changes do not destabilise and put in jeopardy the provision of emergency ambulance services. To this end, the Welsh Government is working closely with the Welsh NHS and WAST on plans for modernising non-emergency patient transport.
A project board is considering a number of options for modernising non-emergency patient transport. As part of this work, I have made it clear that I expect the board to build on the findings and recommendations set out in the Win Griffith's report including the transfer of best practice that has seen different service models emerge involving partnership working with local authorities to improve efficiencies across the public sector as well as increased provision by community and voluntary sector transport providers.

The NEPTS side of the service does not interfere with EMS, in actual fact it supports it. PCS have been a standalone service for many years but integral to what we do. To fragment the service by taking PCS away would be destabilising for the EMS side as it can be used as surplus capacity during times of extreme need such as Major Incidents and winter pressures.

Conclusion 5
The Emergency Ambulance Services Committee, the Welsh Ambulance Services NHS Trust and local health boards must work together to reduce the number of hours lost as a result of patient handover delays. The new handover policy must be implemented consistently across Wales, and any issues identified in the follow up visits made by the chief executive-lead on unscheduled care must be resolved swiftly.

Accept

Lengthy patient handover delays are entirely unacceptable.
The national hospital handover guidance is a clear statement of intent that requires health boards to take responsibility for ensuring the safe handover of patients to hospital teams within 15 minutes. The guidance sets out 10 key actions for health boards and trusts to incorporate in their existing protocols to ensure timely handover. The indications are that delays are beginning to reduce at the majority of emergency departments. The latest information for March indicates there has been a 23% reduction in the numbers of patients waiting over an hour for handover since December 2014.

Our concern is that the data sample that is being looked at was during a period when we would expect improvement. The issues that we have raised above do in our opinion need examining as we head towards this year's winter pressures. Hospital Waiting seems to be here to stay as no real answers are forthcoming. The capacity for patient throughput in ED's are always strained therefore more resources and upskilled staff (as mentioned below in C 6) should be made available to WAST. That in itself will not cure the problem, possibly just add to the que outside ED but there are patients not being responded to and it effects staff as many over runs are caused by hospital waiting.

Conclusion 6
The Chief Ambulance Services Commissioner, the Emergency Ambulance Services Committee and the Welsh Ambulance Services NHS Trust should urgently address the issue of ambulances being 'pulled away' from their areas. In doing so, they should seek to identify and learn from best practice across the UK. The 'return to footprint' pilot should be explored and evaluated on a wider basis as a priority.

Accept
We expect as equitable level of emergency ambulance service provision as possible for all Welsh residents, regardless of where they live with the required levels of frontline cover to support an effective and timely response at all times. We also expect the right clinical resource to be dispatched by WAST's based on a patient's need.
The existing eight-minute target can drive perverse behaviour through the dispatch of multiple crews and ambulances in order to achieve the target. Improving the way emergency resources are dispatched to achieve the best possible outcome for patients form part of the service's clinical modernisation.
A 'return to footprint' pilot is underway in the Cwm Taf University Health Board area, which has resulted in an uplift in responsiveness which correlates with the commencement of the trial. The chief ambulance services commissioner has established a quality assurance and improvement panel which reports to EASC and will review and evaluate service improvement initiatives like the trial in Cwm Taf. Membership of the panel includes senior clinical leaders and eminent academics.

Unite feels return to footprint pilot was extremely successful.
What it did show was that the amount of resource available is also critical to cover workload. For this reason we feel that either the rural areas need to be bolstered by increased staffing or in the more populated areas of Wales there is additional resource provided to prevent the whirlpool effect that draws resources out of rural areas into the populated areas to meet increasing demand (as mentioned in responses to conclusions 1 and 3)
By doing this, rural crews could return to their areas to maintain cover.
In addition the further development of Paramedics skills to treat at scene and introducing more Advanced Practice Paramedics (APP) would also reduce the pressure in this situation by becoming a pathway of referral for Paramedic crews and reduce the

need conveyance to ED. This along with better pathway availability would both reduce pressure at the door of ED and keep crews in their designated areas.
Possibly each area within WAST should be subject to a safe staffing study/guidance as is done for hospital wards.

Conclusion 7
In providing unscheduled care, health boards and the Welsh Ambulance Services NHS Trust must take account of the patient's individual needs. Health boards and the Welsh Ambulance Services NHS Trust must ensure that assessment, care and treatment are provided in ways which meet the patient's individual needs, and help them achieve their optimum outcome. This should include appropriate use of assessment, care and treatment provided in the community, as well as hospital-based provision.

Accept
I welcome the Committee's conclusion that more needs to be done collectively to treat patients as close to home as possible, with a focus on a patient's individual needs to avoid unnecessary conveyance by emergency ambulance to hospital. We have published our national plan for a primary care service for Wales to help drive this.
Underpinned by the principles of prudent healthcare and those featured in the primary care plan, the five-stage ambulance patient care pathway in the quality and delivery framework describes EASC's expectations for how the ambulance service should provide services to Welsh residents. WAST is expected to meet a series of core requirements, quality measures and clinical indicators described under each of the five stages.
The five-step ambulance patient care pathway clearly marks out WAST's emergency ambulance service as a clinical service within the wider integrated Welsh healthcare system, and forms part of a multiagency, collaborative approach between health boards and WAST to develop high-performing pre-hospital clinical services. It is intended to ensure patients receive the right care, at the right time from the right clinician to achieve the optimum outcome for every patient.
Significant work has been undertaken as part of the clinical modernisation of emergency ambulance services to improve assessment of patients in the community through the development of a number of initiatives and tools. Emergency department consultants and paramedics triage calls that may be better dealt with closer to home. Alongside this the introduction of the Manchester Triage System to clinical contact centres to provide enhanced clinical assessment of patients. WAST has also implemented the Paramedic Pathfinder tool. This allows the use of a range of safe, consistent and clinically safe, triage and evidence-based processes, which enable paramedics to conduct accurate face-to-face assessment of individual patient's care needs, when they arrive on scene, allowing them to refer to other healthcare settings in the community where appropriate.
Alternative care pathways for patients with resolved epilepsy resolved hypoglycaemia and for patients who have fallen are now supported by WAST in all health board areas with several thousand patients being safely referred to an appropriate healthcare setting other than hospital. These and similar initiatives has resulted in WAST non-conveyance rates which are now among the highest in the UK, conserving precious emergency care capacity to respond to patients who have a clinical need for a timely response and relieving pressure on Emergency Departments.

We totally agree with this approach, however there needs to a dramatic increase in the numbers of staff qualified to the appropriate level to action the clinical model. This problem is not unique to Wales but we can lead the way by allocating the appropriate resources to the training of new staff, the upskilling of present staff to ensure the appropriate response is given to those requesting help from the service.

Closing statement

We are most appreciative for this chance to comment on these issues, issues which are very complex in nature. We are fully prepared to support WAST in moving forward, we believe we are moving in the correct direction but the pace, in areas where we think are important to our membership, is slow which makes it difficult for us to bring our membership with us, years of disengagement have taken their toll on engagement.

The Paramedic profession is very young profession, when compared to Nursing for instance, and has huge potential to improve outcomes and benefit patients both in the Acute/ Critical care arena and the management of chronic conditions in the community. To do this we need to move forward with the wider NHS framework that Paramedics work within so that the profession can realise its potentials. Paramedics and colleagues do not want to be stuck outside hospitals for huge chunks of their shifts, it is both tiring and demoralising and is possibly the priority in all of this; numbers and skill levels count for very little if you cannot get them to the patient.

Follow-up inquiry into the performance of ambulance services in Wales.

Submission from the Royal College of Nursing, Wales
Presented to the National Assembly for Wales Health & Social Care Committee

ABOUT THE ROYAL COLLEGE OF NURSING (RCN)

The RCN is the world's largest professional union of nurses, representing over 400,000 nurses, midwives, health visitors, nursing students and healthcare support workers, with over 25,000 members in Wales. The majority of RCN members work in the NHS with around a quarter working in the independent sector. The RCN works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care, and public policy as it affects health and nursing.

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

INTRODUCTION

The RCN recognises the immense pressure in providing holistic healthcare is to be able to provide for unscheduled care. This requires all those involved in health delivery, including preventative health and social care services, to recognise and plan for the challenges presented by unscheduled demands on the service provided.

One of the largest contributors to this provision is the Welsh Ambulance Service Trust (WAST). It is an historic and continual challenge to ensure that other partners care, including those strategically planning and operationally running A&E, the care home sector, acute hospital provision, primary care and community nursing care recognise how the services they run impact on WAST operations. In the last decade of primarily acute service reorganisation there has been a failure to include the ambulance emergency services in planning. In addition demographic and changes to the complex nature of care required have also had their impact e.g. all care services are now generally responding to a much older and frailer patients with usually complex co-morbidities such as dementia, diabetes etc.

This has resulted in the service always having to 'run' to catch up, and in many circumstances they have not been able to do so.

EIGHT CHALLENGES TO WAST

1. Performance Indicators

The revised Clinical Response Model went live on the 1st October 2015. As part of this all Ops staff are utilising Digipen technology which will allow a much more timely analysis of PCR's to be able to report on agreed quality outcome targets and providing feedback to staff on their performance thus improving/maintaining quality standards. To date the Red standard remains in excess of 65%, and work will soon commence to look at the quality indicators/patient outcomes going forward.

The Clinical Modernisation Board Programme is closely monitoring the effects of the effect of the changes in the model and EASC (Chair of EASC is Siobhan McClelland and Commissioner is Stephen Harry) are monitoring additionally.

It is the view of the Royal College of Nursing that the patient should receive the most appropriate clinical response to deliver the best outcome. The new system may help remove inefficiency and perverse consequences from the system and may help deliver better patient outcomes. It is important the new system continue to have the assessment and judgment of a registered clinical professional at its heart. We look forward to a robust evaluation.

Transparent and accessible performance indicators for any public funded service are extremely important. They show the outcomes achieved, can drive up performance and are necessary for future planning. The new system should not mean that this transparency is lost.

2. Accountability and Engagement

WAST requires greater engagement with Health Boards to ensure that they are involved in discussions at the earliest opportunity where health board actions are likely to have an impact on its service. There are early indications of greater engagement and more importantly an appetite to do things differently. We believe the work of EASC is playing positively into this dynamic. However when considering service change (particularly at short notice) a transferral of funding that is inclusive of the impact on ability to provide the service WAST should be considered.

There is also excellent work ongoing in developing clinical pathway such as those for Neck of Femur, Mental Health, and End of Life Care whilst clinical pathways for stroke and Myocardial Infarction are relatively well established. A clinical pathway is the care pathway the patient may already be on, and if this is known, the patient is directed to that area instead of Accident & Emergency.

A major benefit of this is the ability of paramedics to refer patients to other sources of help than A&E. Paramedic Pathfinder is being introduced across Wales. This is an excellent initiative but, of course, it relies on the existence of agreed clinical pathways to refer patients into.

The skill set of paramedics is also an issue and even today, paramedics are leaving education having been trained in the traditional way to deal with the top 10% of demand which is the high end trauma or cardiac arrest etc. Instead responding to chronic disease management should be the emphasis.

Advanced Paramedic Practitioners (APP's) are an important part of the team response however numbers of these are low within the Trust with just 6 APP's. There is a requirement for workforce planning to recognise this skill set and to ensure that these skills are more widely available within the service.

3. Leadership, organisational change and staffing

Whilst progress has been made in reviewing rota's this process did not deliver the financial savings which were forecast. The Revised Clinical Response Model (RCM) may suggest further rota reviews are needed in order to align both resources (vehicles) and staff resource (skill mix) given the revised approach. With the evolvement of the 111 service, there will be a need to ensure the employment of additional nurses as early clinical input in 999 calls is critical to appropriate outcomes. Indeed, given the reliance on professional nursing advice it is vital that the Nurse Director remains a member of the Executive Board to ensure professional accountability for that clinical input and appropriate strategic advice.

4. Non-emergency patient transport

The RCN supports the recommendation of separating non-emergency patient transport from emergency ambulance provision**.** However there appears to be no appetite from the health Boards to take on the provision of non-emergency transport. We are also aware that WAST is currently working up a business case to retain the

Non-Emergency Patient Transport Services (NEPTS) albeit however, with this service disaggregated from EMS Ops and with robust and separate line management and leadership. It would be helpful to all in the NHS to have a clear policy statement from Welsh Government on their intentions for this service.

5. Patient Handover

This is still an area of high challenge for the NHS. Major delays are still happening such as that of the weekend of 03/04 October 2015 when the patient flow in Betsi Cadwaldr ground entirely to a halt. Help was required from both Chester & Shrewsbury at this time. A review of a like for like period in October 2014 shows a similar pattern which demonstrates that the challenges to providing the service are not diminishing. October 2014 had a 6,860 handovers with a total lost hours of 1,082.85. The corresponding period in 2015 shows 6,595 handovers with a total lost hours of 1,174.08. The number of handovers is down but with an increase of lost hours. It is also important to note the 'lost hours' measurement does not fully capture the costs of prolonged job cycles or the effect of the emergency vehicle leaving its footprint.

A scoping exercise is currently being conducted within WAST to look at "Card 35" work calls to see how WAST can improve the patient experience. Card 35 refers to a specific protocol in the Medical Priority Despatch System. Card 35 is used by health care professionals to determine the response time for a call coded as Green 3 – usually a parameter of between 1 to 4 hours. An emerging recommendation may well be to commission a dedicated desk to manage all Card 35 work.

Too often 'leaders' in the health service resort to calling for WAST to solve the handover problem without regard to issues of patient safety at stake. Nor is the matter simply one of recalcitrant A&E staff. A patient must be safe. If there are not enough nursing staff available in A&E then the paramedic is required to wait with the patient. If there is no bed or trolley available the ambulance trolley is still needed. Utilising corridors or unsuitable treatment rooms to place patients would mean that vital lifesaving equipment may not in reach and again the patient would be potentially safer in the ambulance.

However if the patient is assessed in the ambulance by a nurse (an environment and equipment they may not be familiar with) is that nurse on WAST property and therefore operating out with any governance procedure of the Health Board?

This is an area that requires a major review and it is the view of the Royal College of Nursing in Wales that a central issue is a lack of sufficient capacity (in terms of both the physical environment and also the number of medical and nursing staff employed) in A&E facilities in Wales. Clearly there are other significant issues which impact on this problem. Some of these we have already alluded to in this paper and some of which, such as the need for nursing care beds to reduce delayed discharges the Committee will be aware of from previous Inquires. However RCN Wales is calling for a national review of A&E planning and provision.

6. Models of deployment

The 'return to footprint' Cwm Taf Pilot has now rolled into Aneurin Bevan Health Board. Results so far appear to be very favourable showing work has become aligned to the skillset of the responding crew i.e. areas do not 'lose' trained paramedics to simple conveyances to hospital.

7. Frequent callers

To successfully resolve this issue will require the engagement of social care services, community nursing teams, GP surgeries, and specialist multi-disciplinary dedicated teams (e.g. falls or end of life)

WAST are currently exploring using registered nurses as an option to facilitate falls assessments. We believe this is a very positive model.

WAST does utilise registered nurses to triage low acuity green 3 calls presenting in Emergency Medical Services (EMS) and transferred via technology to NHS Direct Wales. Of all the calls taken by these nurses approximately 50% are triaged *away* from EMS. Of the 50% of calls that continue to EMS approximately 50% receive a scheduled response from EMS or PCS/Taxi.

For example in the 4 week period 07/09 to 04/10, 2364 calls transferred to NHSDW, 1140 were directed away from EMS, 1224 returned to EMS of which 585 required an emergency response and 639 required scheduled transport (this can be with UCS, NEPTS or even Taxi). In addition WAST also run a clinical hub where both nurses & paramedics triage calls utilising the Manchester Telephony Triage System which again finds alternative pathways or alters the required timeline for response on clinical need.

If there were more care options (or clinical pathways) for the nurses to refer callers to this would resolve more calls without recourse to either A&E admission or ambulance transport. For example in Aneurin Bevan Health Board at present no telephone based assessment to refer a caller into a care pathway is permitted, instead referral can only be made following a face to face assessment by a paramedic. Another example would be an immobile patient simply requiring an antibiotic or pain relief prescription. If the community nursing team does not include a prescriber or if the GP cannot make a home visit then an ambulance will have to be dispatched to admit the patient.

8. Anticipating demand for services

WAST submitted an IMTP to WG for approval that outlines future developments. The RCN would like to draw the Committee's attention to two factors which, if achieved, we believe will deliver improvements in service.

The first is ensure that the NHS Direct Wales approach of using registered nurses to advise and triage calls is applied to the new 111 service. Experience has clearly shown (and the statistical evidence of many years demonstrates this) that results in far lower rates of referral to A&E/999 calls than that from out-of-hours GP services.

The second point is related to this. Previously NHS Direct Wales triaged calls for the GP out of hour's services for Gwent, Swansea, Gwynedd & Anglesey. There were clear and consistent KPI's applied and a performance management framework to ensure appropriateness of referral for the patient. Indeed at one point a national out of hours service was envisaged. Now however Wales appears to have fragmented its out of hours services once more. It is not clear on the comparable cost of this or its impact on WAST referrals but previous evidence would suggest that non-clinically run out of services tend to result in a higher level of emergency referrals.

Eitem 3

Follow-up inquiry into the performance of Ambulance Services in Wales / Ymchwiliad dilynol i berfformiad Gwasanaethau Ambiwlans Cymru
Evidence from Emergency Ambulance Services Committee – PAS(F)04 / Tystiolaeth gan Bwyllgor Gwasanaethau Ambiwlans Brys – PAS(F)04

Emergency Ambulance Services Committee response to the Health and Social Care Committee inquiry into the performance of the ambulance services.

Introduction:

1. Ambulance commissioning in Wales is a collaborative process underpinned by a national collaborative commissioning quality and delivery framework. All seven Health Boards have signed up to the framework.

2. The framework provides a mechanism to support the recommendations of the 2013 McClelland review of ambulance services. It puts in place a structure which is clear and directly aligned to the delivery of better care. The framework introduces clear accountability for the provision of emergency ambulance services and sees the Chief Ambulance Services Commissioner (CASC) and the Emergency Ambulance Services Committee (EASC) acting on behalf of health boards and holding WAST to account as the provider of emergency ambulance services.

3. WAST is required to meet a number of quality standards, core financial requirements and outcome indicators under each step of the innovative ambulance service care pathway – the 5 step model.

4. This submission provides clarity on the progress to date of EASC and especially the questions raised by the committee following its previous enquiry regarding ambulance services in Wales.

5. ***Performance measures must be clinically appropriate and take sufficient account of patient outcomes. The work announced by the Minister to review ambulance response measures should be rapid, clinically led and informed by best practice and be designed to enable benchmarking across the UK where possible.***

6. The ambulance clinical model pilot commenced as of 1 October 2015. A letter provided to Assembly Members in advance of the launch is appended to this submission. This pilot has retained time based performance measurers for life threatening conditions where immediate treatment is required to save life, for example a cardiac arrest or patient who is choking.

7. For other conditions the Minister has acted upon clinical evidence and the recommendations of the McClelland review and opted for measurement of the quality of care provided by the ambulance service.

8. A review of the pilot has been commissioned via EASC. This review is examining three key areas:
   a. The standard of clinical care and clinical outcomes
   b. Patient experience
   c. Value for money
9. The specification for this evaluation has been reviewed by relevant subject matter experts both from the UK and internationally.

10. EASC collates data from WAST against 23 Ambulance Quality Indicators. These indicators track WAST clinical and operational delivery against a number of key metrics. These will be published quarterly via EASC with the first release due in January 2016 covering the period 1 October 2015 – 31 December 2015.

11. EASC has engaged the NHS Benchmarking organisation to provide an assessment of the AQI performance across Wales.

12. The measurement of ambulance services in England is currently under review with a pilot running to test some of the changes already made in Wales. This makes full benchmarking of cross nation performance difficult. The clinical indicator performance is capable of being benchmarked.

13. All Health Boards must be fully engaged with the work of WAST through EASC and directly with the Trust on a local level. Health Boards must take due account of the impact on WAST when developing new services.

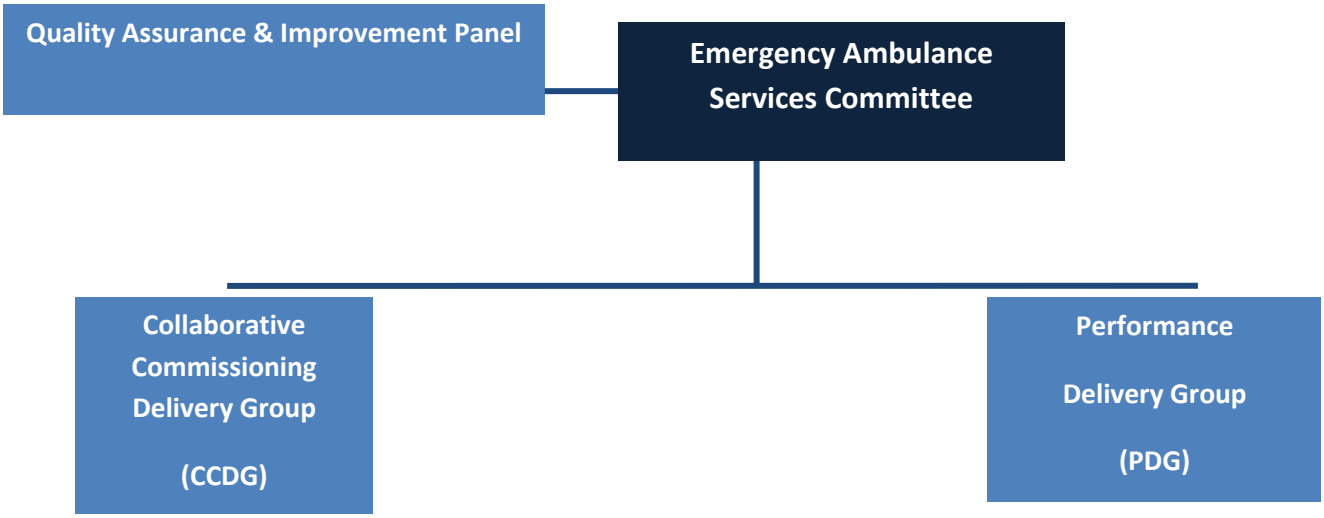
14. All seven Health Boards are engaged with EASC. EASC is provided in line with the Emergency Ambulance Services Committee (Wales) Regulations 2014. These regulations require that "*seven Local Health Boards in Wales work jointly to exercise functions relating to the planning and securing of emergency ambulance services*" The Emergency Ambulance Services Committee is attended by each of the NHS Wales Chief Executives. These meetings are bi-monthly.

15. EASC is supported by three sub committees:

a. The *Quality Assurance and Improvement Panel* ensures that service improvement ideas are clinically sound, offer good value for money and will improve patient experience. QAIP are promoting service change ideas which achieve a shift of activity from traditional hospital based care after conveyance by ambulance to increased rates of self care, telephone based care, on scene resolution or referral to a community based service. QAIP is attended by WAST the Commissioning team and is supported by Academy Wales and academic expertise.

b. The *Performance Delivery Group* is attended by the Chief Operating Officers/Directors of Operations from the seven Health Boards. Within this group, chaired by CASC, Commissioners & WAST considers current performance & advise EASC of a common position. The group will provide appropriate challenge regarding performance and agree corrective actions and escalation.

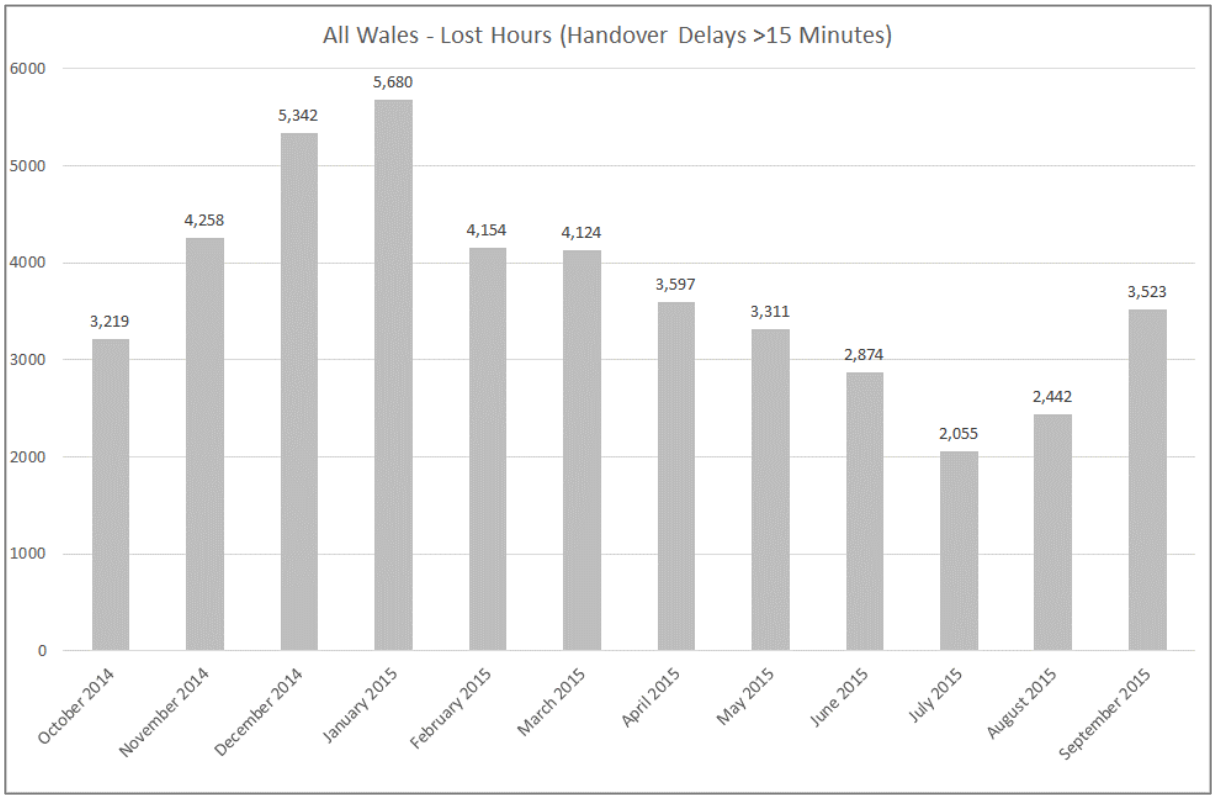
c. The *Collaborative Commissioning Group* is attended by ambulance commissioning champions from each Health Board. These champions represent primary care, planning, commissioning and community care functions within Health Boards. This group manages, maintains & monitors the implementation and development of the National Collaborative Commissioning: Quality & Delivery Framework. It is chaired by the CASC.



16. This process delivers a collaborative agreement signed off by WAST, EASC and the seven Health Boards of NHS Wales.

EASC, WAST and the Health Boards must work together to reduce handover delays. The new handover policy must be implemented consistently.

17. Handover performance for the year 2014/15 is as follows:



18. The CASC through EASC has led the development of total minutes lost as the currency for measuring handover delay rather than the previous cruder numbers of vehicles delayed. This is important because the number of ambulances delayed does not fully depict the effect and cost to WAST of handover delay.

19. Ambulance handover performance is monitored via the Ambulance Quality Indicators. This is a key agenda item at the Performance Delivery Group ensuring that health board Chief Operating Officers and WAST are actively engaged in managing process to ensure efficient discharge of ambulances at hospital.

20. Whilst EASC retains this strategic focus, the day to day implementation and operational delivery of the handover guidance is the responsibility of the health boards and WAST.

21. CASC, EASC and WAST must urgently address the issue of ambulances being pulled away from their areas. The "return to footprint" pilot should be explored on a wider basis.

22. The Cwm Taf Explorer project tested the principle of retaining ambulance resources within their home Health Board area.

23. The Explorer trial has improved responses to both immediately life threatening calls and also planned admissions undertaken on behalf of healthcare professionals. A full review of the trial has been undertaken by WAST and Cwm Taf UHB.

24. The ring fencing of resources necessitated additional staffing which was sourced from private ambulance providers.

25. The clinical outcomes of this project are now being considered by EASC via QAIP with a view to recruiting NHS staff to allow the improvements to continue on a more cost efficient basis. Further work is required to understand the applicability of such an operational model outside of this defined geographical area.

26. ***WAST and the Health Boards must ensure that care and treatment are provided in ways which meet the patients individual needs. This should include appropriate use of community as well as hospital based provision.***

27. The ambulance service care pathway (5 step model) is as follows:

28. The 5 step model of ambulance service delivery is measured by the 23 Ambulance Quality Indicators.

29. The pathway starts with prevention of ambulance calls at Step 1 by encouraging signposting to other services through citizen engagement.

30. At step 2 the pathway aims to maximise the number of patients who have their health needs managed via “hear and treat” consultations over the telephone. Increasingly across the UK ambulance services are investing in placing Paramedics and Nurses into the control room environment to provide advice to low acuity callers. In Wales this mechanism reduces ambulance dispatch rates by around 400 calls per week.

31. Step 3 and 4 concern the treatment provided to the patient by a “see, treat and refer” or preferably “see and treat” response. Ambulance crews are able to refer patients with health needs that do not require attendance at hospital units to community services such as the District Nurse or Out of Hours GP service. In some cases the ambulance crew will be able to provide treatment to resolve the patients needs at the scene with no further onward referral. WAST currently conveys around 61% of 999 patients to hospital.

32. Step 5 of the model should involve the smallest number of patients as these are cases where the patient requires conveyance to hospital. WAST currently conveys around 61% of 999 patients to hospital.

33. The improvement schemes identified via QAIP are designed to provide a non conveyance solution for some patients and decrease the use of emergency ambulances for others. The system requires a shift from conveyance to patient education and self help to increase opportunities for community care. Health can learn from the successes of Fire and Rescue in this area who has reduced their fire response by community safety improvements.

34. Engagement with communities by WAST is key to this process as well as ensuring that other key stakeholders such as Community Health Councils and third sector are well briefed. Measuring WAST community engagement is a key part of the information gathered within the AQIs. The performance of WAST against this objective is measured on a monthly basis through the activity and care model schedules of the CAREMORE process. This information is scrutinised by EASC and specific development ideas are taken forward via QAIP.

35. In order for this process to be successful further work is required within WAST to ensure that all clinically appropriate alternatives to conveyance to hospital are actively discounted and with Health Boards to ensure that all community services accept referrals from WAST.

36. An excellent example of progress in this area is the opening up of a referral pathway between WAST and the Cardiff and Vale Mental Health Crisis Team. This pathway has been operating for 12 months and so far 132/164 patients have received specialist mental health care and not required conveyance to hospital via WAST. This is more efficient for the ambulance service and the Health Board

but more importantly a much better experience and clinically appropriate solution to the needs of vulnerable patients.

37. The QAIP process has recommended that this pathway is extended into all seven health board areas.

38. EASC, WAST and the Health Boards should undertake robust and effective forward planning which takes anticipated demographic changes into account.

39. The WAST Integrated Medium Term Plan (IMTP) has been signed off via EASC for one year. Future IMTP submissions from WAST will be subject to scrutiny and sign off by EASC via the CASC. This will ensure a joined up approach to planning and the QAIP and collaborative commissioning framework.

40. Health Board IMTP and other key planning documents such as winter plans are required to demonstrate how ambulance demand will be managed. The 5 step model provides an ideal way of describing key actions and reinforces the design of services to centre on steps 1-3 reducing the use of conveyance to hospital

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Our ref/ein cyf: QAITEASC/30092015/AM's
Date/dyddiad: 30/09/2015
Tel/ffôn: 02920
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Dear

Following Ministerial approval, the Welsh Ambulance Services NHS Trust will commence a pilot of a new clinical model on 1 October 2015. This announcement follows the McClelland review of ambulance services in 2013 and the NHS England ambulance response pilot changes in 2014. This letter provides additional clinical and operational detail regarding the pilot in Wales. Individual briefings can be provided for members as required. These can be arranged via the office of the Chief Ambulance Services Commissioner (CASC) by contacting [redacted].

The current ambulance service model has a performance management framework which has its origins in 1974 when the ambulance service became part of the NHS. The ambulance service is currently managed on how long it takes to get an ambulance to a 999 call. There is no measurement of the quality of the care provided or the eventual outcome for the patient. This has led to a situation where a fast response with a poor patient outcome is recorded as a success but a longer response with an excellent clinical outcome a failure.

Ambulance services have changed immeasurably since 1974. Ambulance Paramedics and other clinical staff provide sophisticated assessment and care both face to face and over the telephone to patients. The provision of ambulance services in Wales has similarly developed. The McClelland review of 2013 brought about the creation of the Emergency Ambulance Services Committee (EASC) and the first ever ambulance service National Collaborative Commissioning Quality and Delivery Framework Agreement.

The design of the new clinical model was led by Dr Brendan Lloyd, WAST Executive Medical Director. The process was informed by advice received in England by Professor Keith Willets the UK Government Unscheduled Care Lead and also correspondence between Dr Bruce Keogh the NHS England CMO and Chief Executive. The proposals in WAST build upon a trial of a revised ambulance response model in two areas of England where clinical benefits have been reported.

The design of the new model included consultation with the Association of Ambulance Chief Executives, Welsh BMA, Royal College of Emergency Medicine, Royal College of Nursing and College of Paramedics. WAST trades

union organisations are supportive of a move to measuring clinical outcomes rather than time based response standards. This pilot will be quality assured and monitored by EASC via the CASC.

The pilot will assess the clinical and experience outcomes for patients in three categories of ambulance call:

RED Calls will be those incidents where the patient's life can be saved by a fast response and immediate clinical care from the ambulance service and first responders. Conditions such as cardiac arrest, catastrophic bleeding, unconsciousness or choking are examples of this type of call. Modelling shows there will be around 60 of these calls per day across Wales. These calls will remain subject to the current 8 minute response standard. This information will continue to be published on a monthly basis.

AMBER Calls will be incidents where following assessment the patient requires transfer to specialist care such as an Emergency Department, Cardiac Catheterisation Laboratory, stroke unit or maternity unit. Some amber patients will receive a secondary telephone triage from a nurse or paramedic which will provide a better indication of the response they require. There will be around 700 amber calls per day. Amber calls which require face to face assessment will receive a blue light emergency response, usually from an ambulance capable of conveying the patient to treatment and will be measured by clinical indicators. A clinical indicator consists of the performance of WAST clinicians on meeting a series of metrics for a given condition. As an example the stroke care bundle comprises:

1. *FAS T*est completed.
2. Blood Sugar Measured (low blood sugar can mimic a stroke)
3. Blood pressure measurement
4. Level of consciousness assessment
5. The number of FAS Test positive patients taken to a hospital which provides acute stroke care on arrival.

Following significant capital investment, (£1.1m) WAST has introduced digital pen technology to 1750 clinical staff that allows for immediate capture of this data at the patients side. This will ensure that clinical indicator data is available to local communities in a timely manner. For many conditions, heart attack and stroke being the most prominent the NICE guidance mandates specialist treatment being provided within specified timeframes. It is important that WAST plays its part in ensuring that the right patients are taken to the right treatment centre to achieve this.

GREEN Calls will continue to be either low acuity calls, the majority of which require telephone assessment and self help advice or referral to another NHS provider such as primary care, or pre- planned journeys to admit patients to hospital or transfer patients from one hospital to another.
The current model is exclusively focussed on an eight minute response. This paradoxically leads to many patients with less serious conditions waiting

longer for an ambulance as WAST has to dispatch multiple resources to the high volumes of category A calls to meet the A8 target. Under the pilot model WAST will continue to dispatch resources to red calls as soon as the patient's condition is known to be life threatening. This will often be achieved by technology in the call taking systems which listen out for key phrases from callers which signal serious conditions. For amber and green calls no response will be made to a call until the ambulance call taker has finished the questioning of the patient and a full MPDS dispatch code (MPDS – Medical priority Dispatch System) has been reached. This process will take a maximum of 120 seconds to complete. Taking this additional time to identify the patient's needs will allow WAST to send the right resource for the patients needs.

There are clinical and experience benefits to patients from this change. More patients will receive telephone advice from a nurse or paramedic. At present the need to get to calls within 8 minutes means that there is not sufficient time to provide a quality telephone clinical assessment. Under the new model a number of MPDS codes (Approximately 385 per week) have been identified for which a telephone assessment is preferable to sending an ambulance. This will provide an improved experience for the patient as well as releasing the ambulance resource to attend a call where an ambulance is required.

Ambulance crews are currently responded to incidents once the address is known but whilst the MPDS code information is still being gathered. This will continue to be the case for red emergencies. For amber and green calls a clinically led analysis has been made of all 1800 MPDS codes to identify what the ideal response to the patients needs is. This might be an ambulance, an advanced paramedic practitioner, a taxi or, as previously identified, secondary telephone triage from a nurse or paramedic. This review has been informed by the UK Ambulance Medical Directors group as well as learning from concerns and serious incidents. This will mean that once an ambulance is dispatched to a call it will go directly to the incident scene. Currently crews are stood down and diverted from one incident to another because they are dispatched before the true acuity of the situation is known. This has been identified as a key factor in work place stress for ambulance staff.

The performance management of WAST will continue in line with the Collaborative Commissioning Quality and Delivery Framework Agreement. The Ambulance Quality Indicators within this framework provide an effective, clinical and quality focussed method of ensuring that WAST is providing effective patient care as well as playing its full part in the wider unscheduled care services in Wales. Clinical indicators are already reported for stroke, fractured hip and heart attack care. The introduction of digital pen technology for WAST clinical staff has greatly improved the timeliness of information being received and therefore the production of clinical indicator reports. Clinical indicator information will be published on a quarterly basis via EASC.

An independent evaluation of the model has been requested by the Deputy Minister via the EASC group. This evaluation will ensure that a robust and rigorous assessment of the new arrangements is made. The evaluation will

combine clinical outcomes with patient satisfaction and an assessment of the value for money and contribution to the overall efficiency of NHS Wales that this change to the ambulance service brings.

I hope you will agree that this pilot is clinically sound and will allow the ambulance service to deliver better care for patients and play its part in the wider unscheduled care system of Wales.

Yours sincerely,

Mr Stephen Harrhy
Chief Ambulance Service Commissioner
Prif Gomisiynydd y Gwasanaethau Ambiwlans

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Follow-up inquiry into the performance of Ambulance Services in Wales / Ymchwiliad dilynol i berfformiad Gwasanaethau Ambiwlans Cymru
Evidence from Welsh NHS Confederation – PAS(F)05 / Tystiolaeth gan Conffederasiwn GIG Cymru – PAS(F)04

	The Welsh NHS Confederation response to the Health and Social Care Committee inquiry into the performance of the ambulance services.
Contact:	Nesta Lloyd – Jones, Policy and Public Affairs Officer, the Welsh NHS Confederation. Tel: XXXXX XXXXXX
Date created:	6 November 2015

Introduction

1. The Welsh NHS Confederation, on behalf of its members, welcomes the opportunity to respond to the follow-up inquiry into the performance of ambulance services in Wales. Our response will highlight the progress that has been made by Local Health Boards across Wales and the Welsh Ambulance Services NHS Trust (WAST) to bring about improvements in the eight key areas identified during the initial inquiry conducted by the Health and Social Care Committee in March 2015.

2. By representing the seven Health Boards and three NHS Trusts in Wales, the Welsh NHS Confederation brings together the full range of organisations that make up the modern NHS in Wales. Our aim is to reflect the different perspectives as well as the common views of the organisations we represent.

3. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work. Members' involvement underpins all our various activities and we are pleased to have all Local Health Boards and NHS Trusts in Wales as our members.

4. The Welsh NHS Confederation and its members are committed to working with the Welsh Government and its partners to ensure there is a strong NHS which delivers high quality services to the people of Wales.

Summary

5. The role of WAST is to provide high quality pre-hospital and emergency care to the people of Wales. The Service is focused on delivering a clinically-led model of care, with a remit which extends beyond the traditional "transport" model of services to one which is firmly rooted in the overall unscheduled care system in Wales.

6. As highlighted previously, in considering WAST current performance it is important to put it into the context of the overall unscheduled care system and the changing societal, demographic and financial landscape in which the WAST is operating. The issues that we

see with ambulance performance are not just about what the ambulance service does. There is pressure on the whole unscheduled care system which has sometimes led to handover delays at emergency units. Health Boards take responsibility for the whole of the unscheduled care pathway because they are able to determine, as integrated Health Boards, what happens at the front end of the service, including in primary and community settings, through to the flow through the hospital, which impacts on the numbers of ambulances waiting outside Accident and Emergency and the ability to hand over as quickly as is needed.

7. Through the National Collaborative Commissioning Quality and Delivery Framework, WAST is working closely with Health Board colleagues to address the issues discussed by the Health and Social Care Committee in its initial inquiry in March 2015. As our response will highlight a number of the conclusions made by the Committee have been actioned by Health Boards and WAST.

Conclusion 1: The Emergency Ambulance Services Committee, the Welsh Ambulance Services NHS Trust and local health boards must work together urgently to improve emergency ambulance response times and optimise patient outcomes.

8. Since the initial inquiry, WAST and Health Boards have worked closely together to improve emergency ambulance response times. Overall ambulance performance has improved month on month over the course of 2015.

9. The revised ambulance clinical model pilot began in October 2015. The pilot model measures the speed and quality of responses to life threatening calls and the quality of care for less serious conditions. This pilot is a UK first and sets the highest level of ambition for ambulance services in Wales as well as underpinning the need for ambulance services to be an integrated part of wider NHS services.

10. Across Wales many new processes and initiatives have been put in place. The commissioning process for ambulance services in Wales has matured since the Committee's initial inquiry into ambulance services. All seven Health Boards are engaged in this collaborative process via the Emergency Ambulance Services Committee (EASC) and its supporting sub committees.

11. There are local service delivery initiatives in each Health Board area. Service improvement ideas are considered via the Quality Assurance Improvement Panel, or QAIP. This subcommittee of EASC has approved several schemes for pan Wales roll out. These are:
    i. Mental Health Crisis pathway;
    ii. Paramedic Pathfinder decision support tool;
    iii. Improved arrangements for receiving and co-ordinating Healthcare Professional Calls;
    iv. National co-ordination of frequent 999 caller management; and
    v. Within the Cwm Taf University Health Board the "explorer" project has examined the effects of ring-fencing ambulance resources in their home Health Board area.

12. The new initiatives across Local Health Boards are highlighted below:

13. In **Hywel Dda University Health Board (UHB)** the Unscheduled Care Board, and its terms of reference, are being revised to ensure all acute, community, social services and WAST partners review pathway performance. This will be chaired by a Board Director.

14. In **Aneurin Bevan UHB** fortnightly meetings are held between the Chief Operating Officer, General Manager responsible for emergency services and the Ambulance Management Team to review performance and explore potential improvement opportunities. A comprehensive action plan has been developed to address a number of issues that impact on ambulance performance.

15. **Cardiff & Vale UHB** has worked closely with WAST through its regular meetings with the Ambulance Commissioner and fortnightly local operational meetings. As part of this process the UHB has run local planning sessions in preparation for the introduction of the revised clinical model for WAST. The services have been aligned to support the new outcomes-based model and the Health Board continues to review processes to allow it to embed and succeed. Clinicians within the Health Board have been fully engaged in this process.

16. A range of initiatives have been taken forward in **Abertawe Bro Morgannwg UHB**. These include:
    i. A telehealth pilot is in place between WAST, 15 care homes and the GP out of hours service to provide additional support to care home staff to maintain residents within the care home, with the aim of reducing conveyances to hospital. This went live in April 2015 and there has been positive feedback from users of telehealth.
    ii. A new pathway for mental health patients is being piloted in the Swansea/Neath Port Talbot localities from the 30th November 2015. This will ensure the appropriate conveyance of patients and the appropriate access to care.
    iii. There are advice lines available for paramedic crews to speak to consultants to support clinical decision making.
    iv. Introduction of Paramedic Pathfinder. All WAST staff within ABMU Health Board have now been trained, with the exception of those on long term sick leave.
    v. The development and introduction of structured directory of operating procedures within ABMU Health Board from July 2015 for WAST crews to ensure consistency of approach to conveyances to the appropriate health care environment. This is also now being extended to incorporate standard operating procedures for Prince Philip hospital to support decision making of ambulance personnel for patients on the hospital borders.
    vi. Ensuring WAST clinical team leaders are involved with the ambulatory care work being progressed on all hospital sites within the Health Board.
    vii. The planned introduction on the 30th November 2015 of a pilot to implement a dedicated ring-fenced urgent care service for GP expected patients in the Swansea and Neath Port Talbot areas who require conveyance by an ambulance. This will bring forward the conveyance of these patients to earlier in the day and help to smooth the arrival of patients at hospital. Experience in other Health Boards suggests that this change in the process/pathway supports earlier senior clinical review and investigation of patients, resulting in reduced length of stay, reduced hospital admissions and improved patient experience.

viii. Additional WAST support has been secured to support the review of patients who have been identified as being frequently conveyed by ambulance to hospital from care homes. This work is being progressed jointly between WAST, the Health Board, care homes and GP out of hours service.

ix. WAST staff have been trained to identify patients with long standing neurology conditions, resulting in a better patient experience for this group of patients.

x. The multi-agency help point plus service (Swansea) to support admission avoidance from the city centre at weekends/bank holidays. The service has been in place since the autumn 2014 and there is evidence that paramedic attendance at Wind Street in Swansea has reduced.

xi. New pathways are being jointly developed between WAST, GP out of hours and the Health Board as part of the move towards the implementation of the 111 service next year.

17. The **Betsi Cadwaladr UHB** Unscheduled Care Strategic Board and local Unscheduled Care groups' terms of reference include acute, community, social service and WAST partners. All groups review unscheduled care performance and explore potential improvement opportunities. A comprehensive action plan has been developed to address a number of issues that impact on ambulance performance.

18. The relationship between **Powys Teaching Health Board** and WAST is slightly different from other Health Boards in that Powys does not manage any acute care services and has no Accident and Emergency Departments. The Health Board manages 10 Community Hospital facilities, with 176 largely rehabilitation beds, and including four Community Hospital based Minor Injuries Units. The Health Board's Unscheduled Care Programme has a strategy of:

i. Keeping people healthy and living independently in their own homes and communities as much as possible, thus reducing inappropriate demand on more acute healthcare services, and

ii. Returning people back to their communities from acute care as quickly as safety allows, thus improving the flow through the healthcare system.

19. The Health Board has been reasonably successful in delivering this, reporting lower than Welsh average A&E attendances, emergency admissions per head of population and length of stay in acute care for emergency admissions and good rates of alternative use to both emergency ambulance and emergency care services.

20. The general level of performance against the traditional A8 target for Powys Health Board has generally been below 60%, however this figure tends to mask the impact of the rurality of the county and the dispersed nature of its population. For example, an analysis undertaken in June 2015 showed that although only 54% of A8 calls were reached within the required time, around 72% of those that were not were actually unreachable within the six minute drive time allowance because of where they lived. In effect this means that the Ambulance Services reached around 80% of those that could be reached within eight minutes.

21. The rurality of Powys, and the fact that there are few large centres of population (Welshpool is the largest town with a population of just under 13,000) means that many

Powys residents cannot be reached within eight minutes, irrespective of system performance or resource deployment. This is an important, if subtle nuance to consider when reviewing performance in Powys.

22. For these reasons, amongst others, Powys Teaching Health Board welcomes the revised performance measures and also strongly endorses the recent decision by WAST to develop outcome measures that include survival rates for those transported to hospital by emergency ambulance.

23. In a broader context, and given the issues noted above, it is important to stress that in a county such as Powys, road quality is a hugely important factor and developments such as those that have occurred in the Heads of the Valleys in recent years are warmly welcomed. Access to services via these roads, particularly during periods of adverse weather, is an important factor in ensuring that transportation times to and from acute centres are kept to a minimum.

24. Powys is fortunate in that most Ambulance Services staff based in Powys are residents of the county and understand the needs and anxieties of the local population. Concern has been expressed that as more specialist services provided by other Health Boards and Trusts move further away from our borders, through the current processes of consolidation and rationalisation, more ambulance time will be spent out of county.

25. A number of specific developments are being implemented or planned, as part of Powys teaching Health Board Unscheduled Care Improvement Action Plan, aimed at both reducing unnecessary demand of unscheduled care services and improving delivery performance, including ambulance service.

Conclusion 2: To maintain momentum and work towards a whole system approach to unscheduled care, all health boards must be fully engaged with the work of the Welsh Ambulance Services NHS Trust through the work of the Emergency Ambulance Services Committee on a national level, and directly with the Trust on a local level.

26. There has been progress towards a whole system approach to unscheduled care across Wales and all Health Boards have been fully engaged with the work of WAST. All seven Health Boards are represented on two key sub committees of the main EASC group:

i. The *Performance Delivery Group* is attended by the Chief Operating Officers/Directors of Operations from the seven Health Boards. Within this group, chaired by Chief Ambulance Services Commissioner, Commissioners and WAST considers current performance and advise EASC of a common position. The group will provide appropriate challenge regarding performance and agree corrective actions and escalation.

ii. The *Collaborative Commissioning Group* is attended by ambulance commissioning champions from each Health Board. These champions represent primary care, planning, commissioning and community care functions within Health Boards. This group manages, maintains and monitors the implementation and development of the National Collaborative Commissioning: Quality & Delivery Framework. It is chaired by the Chief Ambulance Services Commissioner.

27. At a local tactical level WAST and Health Board managers are engaged. The examples of local work below demonstrate in more detail the outputs of this engagement:

28. In **Hywel Dda UHB**, WAST are part of the Health Board's plans for any changes in service. Recently Hywel Dda UHB had to change the borders in order to reduce the medical intake at Withybush hospital and WAST were part of the planning and ongoing review. This can be clearly evidenced from the early engagement with WAST following the changes to women and children's services, and the commissioning of the dedicated vehicle based at Withybush, and more recently the temporary change to patient flows, due to staffing issues.

29. The collaborative working between WAST and Primary Care within Hywel Dda UHB supports conclusions 2 and 7 within the initial Committee inquiry report. Within Hywel Dda UHB they have worked collaboratively with WAST to develop an Unscheduled Care Team which has now morphed into the Primary Care Support Team. Practices across Wales are facing workforce challenges and in many areas are not able to meet patient demand for appointments/home visits. This could be argued would have a knock on effect to WAST with a potential increase for calls due to patients not being seen in a timely way and panic/concern setting in. Through the introduction of the Advanced Practitioners into one GP practice, patients are being seen by an appropriate Health Care Professional and 75% of requested home visits are being seen by an Advanced Practitioner in a more timely way after an initial telephone triage with a GP (working in accordance with WAST Call prioritisation e.g. Green 1,2,3). This enables the patients to be seen within their home and reduces their anxiety and need to call for an ambulance.

30. **Aneurin Bevan UHBs** Senior managers who liaise with WAST participate in national and local joint working to explore and share best practice and interpret this for patients. WAST managers are part of the Health Board's seasonal planning and local delivery plans in areas that will impact on WAST service. Examples of this are:
    i. Members of Seasonal Planning Board;
    ii. Members of Stroke Centralisation Board; and
    iii. Member of Urgent Care Transformation Board.

31. In **Cardiff & Vale UHB** monthly meetings are held between the Health Board's Chief Operating Officer and the ambulance commissioner to ensure that planning and operations are aligned. Where there are operational and planned changes that may affect, or improve, ambulance performance these are shared and discussed jointly, through the fortnightly joint operational meetings. Whole system implications of service change are duly considered.

32. In **Abertawe Bro Morgannwg UHB** monthly Unscheduled Care Delivery Meetings are chaired by the Chief Operating Officer with other members of the Executive Team, the WAST Head of Operations for Abertawe Bro Morgannwg UHB and senior clinical and operational managers. Local site based meetings involve operational colleagues from WAST as needed.

33. **Betsi Cadwaladr UHB** and WAST senior operational managers meet monthly to jointly plan and implement any changes in service. Recent changes managed in this way are

Paramedic Pathfinder and alternative conveyance projects aimed at reducing demand in the Emergency Departments. WAST managers are part of the Health Board's seasonal planning and local delivery plans in areas that will impact on WAST service. In addition, WAST are a member of any group within the Health Board where they discuss unscheduled care.

34. **Powys teaching Health Board** has a number of mechanisms for engaging with WAST on an ongoing basis. These include:
    i. Emergency Ambulance Service Committee: The EASC meetings are attended by the Director of Primary and Community Care, or Deputy, and the Health Board has contributed fully to the development of the Quality and Delivery Framework;
    ii. Strategic Planning: WAST colleagues are involved in the development of the Health Board's strategic plan and have contributed to a number of strategic planning workshops;
    iii. Unscheduled Care Board: WAST colleagues are full and active members of the Unscheduled Care Board, which is responsible for the development and delivery of a joint Seasonal Pressures Plan and an Unscheduled Care Improvement Action Plan;
    iv. Health Focus Groups: These provide an opportunity for the Health Board to engage with local communities on an ongoing basis. WAST has access to these arrangements via the Locality Teams on an ongoing basis and attend either to address issues of concern in the local community or to brief or inform local communities in relation to Ambulance Service changes;
    v. Specific Consultations: Where major changes are planned and consultation is required, WAST colleagues are included as appropriate;
    vi. Locality Management arrangements: Local links are strong between Health Board locality and WAST operational managers and this is reflected in the level of engagement in pathway development across the Health Board.

Conclusion 3: Agreement must be reached between the Welsh Ambulance Services NHS Trust, trades unions and staff at the earliest opportunity on revised staff rosters in those parts of Wales for which revised arrangements are not yet in place. The Welsh Ambulance Services NHS Trust must, working in partnership with trades unions and staff, put in place arrangements to review staff rosters at appropriate intervals to avoid future mismatches between staffing and anticipated demand.

35. In **Hywel Dda UHB** new rosters have been introduced from 14th September 2015. This will now follow the Local Development Plan process with roster reviews undertaken annually.

36. In **Aneurin Bevan UHB** the Health Board and WAST's local joint meeting's agenda covers the commissioning requirement and a joint action plan includes roster improvements and exploring ring fencing of certain staff and services that will allow protection of the emergency response crews. Examples of this are:
    i. Ring fencing hospital car service crews to convey health care professional requested admissions to the assessment areas in a timely manner and release the emergence crews to attend the 999 calls; and

ii. Joint job description development for ambulance liaison officers to meet both WAST and Health Board needs.

37. In **Cardiff and Vale UHB** local roster changes for ambulance service staff have been put in place by WAST in recent months.

38. **Betsi Cadwaladr UHB** and WAST local joint meeting's agenda covers the commissioning requirement particularly mismatches between staffing and anticipated demand.

Conclusion 4: The Welsh Ambulance Services NHS Trust must prioritise emergency ambulance services provision. Work is required to identify appropriate mechanisms for the provision of non-emergency patient transport services, and to disaggregate those services from the Trust in accordance with recommendation 2 of the McClelland Review. The Trust must establish a clear plan for the disaggregation, with identified timescales and costs. The Committee expects to receive an update on this plan before it follows up its inquiry later this year.

39. Significant work has been undertaken over the last year with WAST working with a range of statutory and non-statutory partners on developing a business case that sets outs a preferred option for the future provision of Non-Emergency Patient Transport Services (NEPTS) in Wales in the future. In October that business case was approved by the NEPTS Project Board, the Chief Ambulance Services Commissioner and Chief Executives of Health Boards and Trusts across Wales and, as a result, was submitted to Welsh Government.

40. The business case recommends that NEPTS remain managed by WAST but that WAST uses multiple providers to deliver the service. Specifically, it is proposed that local authorities, community transport providers and third sector organisations are used, in conjunction with WAST, as service providers.

41. The NEPT service will be completely disaggregated from the provision of the emergency ambulance service within WAST, with an entirely separate management structure. Following a full and detailed options appraisal which considered alternative models of delivery, including devolving the service to Health Boards, all stakeholders, including the Chief Executives of all Health Boards, WAST, Velindre NHS Trust and the Renal Clinical Network agreed that the alternatives represented neither value for money nor improved service delivery.

42. A new service specification has been developed by the health community commissioners which includes costing and timeframes for implementation. This new service specification also includes enhanced services for renal, end of life and oncology patients. At the time of writing, WAST and its partners are awaiting approval of the business case from the Welsh Government. In the interim, the information below summarises some of the initiatives that have been undertaken by Health Boards.

43. In **Aneurin Bevan UHB** the Health Board holds a separate contract with Patient Transport Service to deliver their discharge transport arrangements. Regular meetings occur between bed management and the Patient Transport Service to manage and adjust this

contract. The ring fencing of the health care professional admissions described above on page 6 also allows the emergency crews to be available for 999 calls.

44. In **Abertawe Bro Morgannwg UHB** the following initiatives have been taken forward:
    i. Taxi initiative: From the early part of this financial year WAST has utilised 89 taxis for the conveyance of appropriate patients to hospitals within ABMU Health Board, and therefore avoided the use of highly skilled ambulance crews. This uptake compares well with other UHB areas. ABMU Health Board are continuing to promote the use of the taxi initiative for any appropriate low acuity calls received;
    ii. A new pathway has been introduced for pre-hospital blood tests which means that these are now initiated by ambulance personnel, to reduce assessment times upon arrival at hospital. This initiative has also reduced the door to needle time of stroke patients by 30 – 40 minutes;
    iii. Alternative pathways in place for resolved epilepsy, resolved hypoglycaemia and falls patients, with 538 patients avoiding hospital conveyance as a consequence between April and September 2015;
    iv. A review of the access criteria to the Minor Injuries Unit at Neath Port Talbot hospital has recently been undertaken. Consequently the standard operating protocol is being rewritten and will be re-launched to ambulance personnel to maximise and increase the conveyance by ambulance of appropriate patients to this service;
    v. The Acute GP Unit (Singleton) pathfinder pilot has been implemented. The acute GP at Singleton has access to the ambulance stack and works directly with ambulance service attending supported targeted call selection of patients, and visiting these patients in their home setting. The aim is to support the patient at home or access other community support to maintain the patient at home, thereby avoiding the need for conveyance to hospital; and
    vi. The close liaison and working between the Health Board and WAST on the implementation of the new clinical response model.

45. **Betsi Cadwaladr UHB** holds a separate contract with Patient Transport Service to deliver their discharge transport arrangements. Regular meetings occur between the Health Board and WAST Patient Transport Service to manage and adjust this contract.

46. Following the recommendations of the McClelland Review, **Powys teaching Health Board** has been strongly represented within the NEPTS Board to identify and consider options for the future of NEPTS in Wales. The work to explore options for disaggregation have now been completed and a comprehensive business case has been drafted. The Board also took the opportunity to appraise other non-full disaggregation options that would allow a sustainable improvement to Emergency Medical Services performance. These have also been detailed within the case.

47. In **Hywel Dda UHB** this is ongoing as part NEPTS work stream. In **Cardiff & Vale UHB** the Health Board will continue to work with WAST in its intention to disaggregate emergency and non-emergency transport services.

Conclusion 5: The Emergency Ambulance Services Committee, the Welsh Ambulance Services NHS Trust and local health boards must work together to reduce the number of

hours lost as a result of patient handover delays. The new handover policy must be implemented consistently across Wales, and any issues identified in the follow up visits made by the chief executive-lead on unscheduled care must be resolved swiftly.

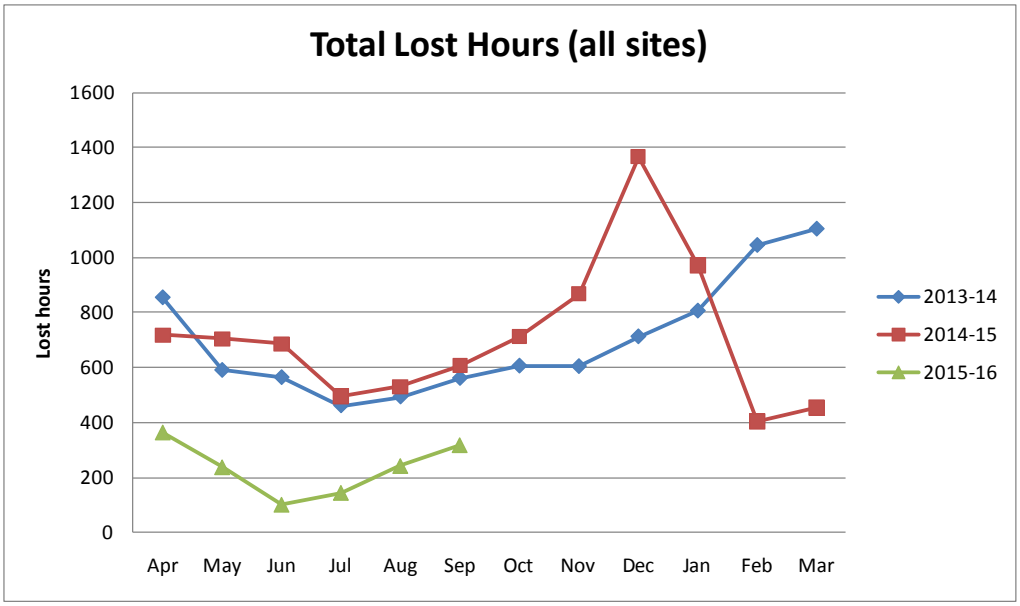
48. Ambulance handover delays have reduced in 2015 from the levels seen in 2014 but this continues to be an operational challenge in all but one Health Board area. **Cwm Taf UHB** continues to lead the way in managing ambulance handover. The national ambulance handover guidance issued in 2014 was not universally implemented across the seven Health Board areas.

49. In **Hywel Dda UHB** a key focus on lost hours is in place which is reviewed daily. Under times of high demand and handover delays, WAST deploy a senior manager alongside the Health Board to ensure ambulance handovers are expedited. The handover policy has been implemented and currently under review.

50. In **Aneurin Bevan UHB** the urgent care plan is designed to reduce the delays across the patient pathway to prevent exit block from Emergency Department that can lead to ambulance delays. An urgent care transformation board has been set up in the Health Board that addresses the urgent care pathway across all sectors. Examples have been provided previously of a pathway approach to managing patients flow. In addition Aneurin Bevan UHB:
    i. Ensures early assessment by a senior doctor: Emergency Department consultant or Advanced Clinical Practitioners taking calls directly from GPs and scheduling the unscheduled pathway for appropriate patients into dedicated slots;
    ii. Makes good use of short stay beds for Emergency Department appropriate patients;
    iii. Is improving communication with wards (use Vocera person to person calling system); and
    iv. Ensures use of fast track pathways effectively e.g. fractured hips and stroke.

51. Other local initiatives are the creation of an ambulance liaison post funded by the Health Board to be based at peak times in the Emergency Department and facilitate the handover of patients and release crews. This was initially run as a Plan-Do-Study-Act (PDSA) cycle and significantly reduced handover delays. The Health Board has also introduced the handover policy.

52. In **Cardiff & Vale UHB** handover delays and hospital lost hours have been placed as one of the highest priorities since December 2014. The Health Board has worked internally to improve its standard operating procedures, and with the Welsh Government Delivery Unit to revise its escalation procedures, particularly focused on minimising ambulance delays. The graph below shows the reduction in monthly ambulance lost hours for Cardiff and Vale UHB in 2015-16 in comparison to previous years. Year to date (April to September), this represents a 62% improvement over the same period last year and a 77% reduction since the highest peak of lost hours in December 2014.



53. In **Abertawe Bro Morgannwg UHB** compliance with national handover guidance has been reviewed with some improvement implemented to improve communication and handover, particularly for Red 1 calls. In addition, the Health Board played a major role in support of the implementation of the Emergency Medical Retrieval Transfer Service (EMRTS) in April 2015. Effective internal escalation is a key component of reducing hours lost through ambulance delays, and now includes risk based use of pre emptive transfers to wards to reduce congestion in Emergency Departments.

54. **Betsi Cadwaladr UHB's** key focus on lost hours is in place and is reviewed daily. Under times of high demand and handover delays, WAST deploy a senior manager alongside the Health Board to ensure ambulance handovers are expedited. The Health Board's unscheduled care improvement plan is designed to reduce the delays across the patient pathway to prevent exit block from Emergency Departments that can lead to ambulance delays. The handover policy is being implemented by the Health Board.

55. As **Powys teaching Health Board** does not provide Accident and Emergency Services, the Handover Policy issues have a limited direct impact. The Health Board has raised the potential implications of increased travel time to access specialist services further afield as services are rationalised, and it continues to support other Health Boards in their attempts to reduce handover delays at their own facilities.

Conclusion 6: The Chief Ambulance Services Commissioner, the Emergency Ambulance Services Committee and the Welsh Ambulance Services NHS Trust should urgently address the issue of ambulances being 'pulled away' from their areas. In doing so, they should seek to identify and learn from best practice across the UK. The 'return to footprint' pilot should be explored and evaluated on a wider basis as a priority.

56. The "Explorer" project is a joint initiative between WAST and **Cwm Taf UHB**. Explorer began in March 2015. The "Explorer" project ring-fences WAST resources based at stations within the UHB area for calls within the UHB area. Explorer was designed to resolve longstanding poor operational performance in the Cwm Taf area and the fact that Cwm Taf resources were often deployed to calls outside of the UHB area and therefore

not available for calls in their home area. As part of the "Explorer" project, resourcing in Cwm Taf was bolstered by some private provided additional ambulance crews. Over the course of the project operational performance has improved month on month. WAST and Cwm Taf UHB are currently evaluating the financial and clinical outcomes of the explorer model.

57. In **Aneurin Bevan UHB** the introduction of a protected response to care for 35 patients enabled a pilot of retaining crews in their footprint area in Cwm Taf UHB. The initial findings were good and the local WAST management team are planning to run a similar system in Aneurin Bevan UHB at the conclusion of some imminent recruitment.

58. **Cardiff & Vale UHB** has supported the ring fenced ambulance approach taken within neighbouring Health Boards. In particular, within the Cwm Taf UHB area. While the evidence suggests that this has been beneficial for the Cwm Taf UHB area, Cardiff & Vale UHB has been clear that this can only work if it is applied regionally and therefore would recommend that the approach should be implemented across neighbouring Health Boards.

59. In **Abertawe Bro Morgannwg UHB** recent developments in the role of Morriston Hospital as a regional centre has affected ambulance flows out of neighbouring areas, for example in relation to vascular emergencies. There are a number of clinical services which pull patients in from surrounding areas to ensure the best outcomes, and this needs to be taken into account in the planning and commissioning of services in the future.

60. **Betsi Cadwaladr UHB** is actively involved in the development of WAST commissioning through the Emergency Ambulance Services Committee and Collaborative Performance Delivery Group.

61. **Powys teaching Health Board** supports any action to limit the negative impact of vehicles "pulled away". The loss of ambulance capability to respond due to the effect of vehicles being off the patch is a concern. The Health Board is conscious of the fact that, as they border most other Health Boards in Wales and a number of Trusts in England, they are both losers and gainers in this respect, with vehicles from other areas also providing additional capacity to Powys when needed.

62. In **Hywel Dda UHB** this is currently under review as part of the integrated performance review process.

Conclusion 7: In providing unscheduled care, health boards and the Welsh Ambulance Services NHS Trust must take account of the patient's individual needs. Health boards and the Welsh Ambulance Services NHS Trust must ensure that assessment, care and treatment are provided in ways which meet the patient's individual needs, and help them achieve their optimum outcome. This should include appropriate use of assessment, care and treatment provided in the community, as well as hospital-based provision.

63. Through the collaborative commissioning process monthly data capture on 23 Ambulance Quality Indicators is recoded. A key metric is the referral of 999 patients to different parts

of NHS Wales. Referral rates remain largely static across Wales with around 61% of 999 callers being conveyed to an emergency department.

64. As shown below there are a number of local initiatives which are being developed. As described earlier in this submission, the National Collaborative Commissioning Quality and Delivery Framework has selected several work streams for roll out on a pan Wales basis.

65. In **Hywel Dda UHB**, through the collaboration with WAST, patients are seen in the community either at home or within General Practice. The role of the Advanced Paramedic Practitioner (APs) is aimed at visiting the lower acuity calls and there is recognition that there was overlap between these visits and those made by GPs. By working within General Practice, the Advance Practitioners are able to visit those patients before they become an emergency call and are treated where they feel most comfortable, usually at home as opposed to a hospital setting.

66. Working collaboratively with WAST from a primary care perspective has enabled the following benefits:
    i. Increased capacity for GPs in the practice as the APs undertake over 75% of the home visits;
    ii. Patients arriving at the practice are triaged and either signposted or treated by the AP that day rather than being turned away;
    iii. Patients are given an appointment with an appropriate healthcare professional thereby supporting the diversification of the workforce;
    iv. Professionals building better working relationships where there have previously been tensions between GPs and WAST staff;
    v. Rapid activation of the APs skills in a way not currently possible within WAST;
    vi. Positive feedback from patients; and
    vii. Positive feedback and engagement with the Community Health Council.

67. Community pathways are in place to avoid hospital attendance and admission. Further work is underway to expand these. The current pathways are being utilised; Advance Practitioners are working across organisational boundaries to support appropriate care within both primary and secondary care.

68. **Aneurin Bevan UHB** and WAST have collaborated on a number of initiatives that will allow crews to be released rapidly from their Emergency Departments and assessment areas to prevent the conveyance of patients unnecessarily through redirecting them into a more appropriate pathway. Examples of these include:
    i. Physicians' response unit where an Emergency Department consultant is deployed with a paramedic to patients that can potentially be treated at the scene and not conveyed;
    ii. Joint pathway for non-injured falls patients that allows ambulance staff to hand over to another professional who can meet their needs at home;
    iii. An Ambulance Liaison Officer at the acute Emergency Departments to facilitate handover and release of crews;
    iv. Working with nursing homes to encourage end of life anticipatory care plans;

v. Identify, and care plan for, 'frequent flyers' which often impact on a number of services;
vi. Paramedic practitioners minor procedure training (wound glue);
vii. Alcohol treatment centre; and
viii. Internal diverts between departments in escalation.

69. **Cardiff & Vale UHB** supports the development of 'upstream' alternatives to conveyance to hospital. It has been proactive in the development of alternative pathways, for example, the development of a direct assess mental health pathway. The Mental Health Crisis Pathway was initially piloted in the Cardiff and Vale UHB area. This pathway allows ambulance crews to refer patients known to the crisis team directly to a Mental Health professional rather than conveying them to the emergency department. This pilot has been running for one year. 164 patients were referred to the pathway. 132 of these cases resulted in a management plan which did not require the patient to travel to Emergency Departments. Patients were referred to community based care or taken directly to a Mental Health unit. This is a prudent and clinically effective pathway making good use of an existing service. This pathway has been selected for roll out on a pan-Wales basis. A community communications hub approach has been successfully implemented in the Vale Local Authority area and is being replicated through a single contact point in Cardiff Local Authority.

70. **Betsi Cadwaladr UHB** and WAST have collaborated on a number of initiatives that will allow crews to be released rapidly from their Emergency Departments and assessment areas. This will prevent the conveyance of patients unnecessarily by redirecting them into a more appropriate pathway. Some of the initiatives include:
i. The Paramedic Pathfinder has been rolled out to ensure patients are treated in the most appropriate setting through formal pathways;
ii. Minor Injury Units are utilised by WAST for appropriate patients;
iii. Treatment Escalation plans for palliative care patients in care homes are being piloted and will be rolled out across North Wales once evaluated;
iv. Through the collaboration with WAST, patients are being seen in the community either at home or within General Practice. The role of the Advanced Paramedic Practitioner has been introduced to provide visits for the lower acuity calls as an alternative to admission wherever possible.
v. An Ambulance Liaison Officer at the acute Emergency Departments to facilitate handover and release of crews; and
vi. Community pathways are in place to avoid hospital attendance and admission. Further work is underway to expand these.

71. In **Powys teaching Health Board** their approach to unscheduled care is based on ensuring that people receive the level of care appropriate for their needs and the Unscheduled Care Improvement Plan contains a number of improvement actions that have been mapped to the WAST "5 Step Pathway".

Conclusion 8: Ambulance services in the medium and longer term must be high performing, and aligned to demand. Therefore health boards, the Emergency Ambulance Services Committee and the Welsh Ambulance Services NHS Trust should undertake robust and effective forward planning which takes anticipated demographic changes into account.

72. Through the Integrated Medium Term Planning process Health Board plans are increasingly including developments that link WAST and Health Board activities to design services based on need.

73. In **Aneurin Bevan UHB** demand and capacity planning has been used to introduce a more bespoke response to ambulance demand. A Plan-Do-Study-Act (PDSA) cycle was run last winter to provide an alternative response to 999 crews to non-injured falls patients. The PDSA failed to reach the expected volume of patients to make it a cost effective approach. A review of current data has indicated that this service may be more appropriately targeted at two areas of the borough which will reduce travel time, increase potential to attend more calls and prevent inappropriate conveyance. A high percentage of emergency calls in Aneurin Bevan are related to falls and this adjusted PDSA will be run in the next few months. The areas chosen have the higher demand and also are currently the lower performing areas within the Health Board.

74. **Cardiff & Vale UHB** is acutely aware of the need for medium and longer term planning aligned to predicted demand. The changing demographic and expected population growth in Cardiff features predominantly in such plans. This includes work undertaken on the geography and impact of anticipated housing and estates growth, and the need for local community infrastructure in terms of health, wellbeing and access to primary and social care services.

75. **Abertawe Bro Morgannwg UHB** is actively involved in the development of WAST commissioning through the Emergency Ambulance Services Committee and Collaborative Performance Delivery Group and is also planning to be the pathfinder site for 111 in 2016 which will be a lever to remodel the whole unscheduled care system and consequent patient flows.

76. **Betsi Cadwaladr UHB** works closely with WAST colleagues on commissioning and planning of service change when they anticipate changes in terms of demand and demography.

77. In **Powys teaching Health Board** WAST colleagues have been involved in the Health Board's strategic planning activities including demand and capacity modelling. This involvement will continue in both a planning context and as changes to service models start to be delivered, in line with the engagement arrangements noted in Conclusion 2 above.

Conclusion

78. Health Boards are commissioners of primary, community, secondary and tertiary care services. As providers, their own services are firmly placed in the primary and community setting, reflecting both planned and urgent primary and community care service delivery. The Health Board's relationship with the WAST, as its primary provider of out of hospital emergency care, is a crucial one.

79. Health Boards are committed to continuing to work closely with WAST to ensure that the services provided to their residents are of the highest quality, appropriate to need and equitably applied, and also that the systems and processes in place within Health Boards positively support improved Ambulance Service performance.

80. The National Collaborative Commissioning Quality and Delivery Framework and 5 step Ambulance Service Care Pathway is an innovative model which allows Health Boards and the ambulance service to work together to deliver joined up services.

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Follow-up inquiry into the performance of Ambulance Services in Wales / Ymchwiliad dilynol i berfformiad Gwasanaethau Ambiwlans Cymru
Evidence from Welsh Ambulance Services NHS Trust – PAS(F)06 / Tystiolaeth gan Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru – PAS(F)06

Welsh Ambulance Services NHS Trust: Submission to National Assembly for Wales Health and Social Care Committee: Follow-Up Inquiry into Ambulance Services, December 3, 2015

Introduction

1. The Welsh Ambulance Services NHS Trust welcomes the opportunity to submit evidence to the National Assembly for Wales' Health and Social Care Committee in support of its follow-up inquiry into ambulance services in Wales.

2. In the nine months since the original inquiry, the Welsh Ambulance Service has made significant progress in redefining its purpose as a clinical service at the forefront of pre-hospital emergency care and clinical transport.

3. The piloting of a new clinical response model from October 1, 2015, which places the quality and clinical appropriateness of care above an often arbitrary time target, except in the most urgent of cases, represents a significant opportunity for the ambulance service.

4. The new model ensures that high quality, clinical care is the focus of its work, and that the anomalies, and sometimes perverse consequences of chasing a time target are resolved.

5. In setting out the Trust's evidence for Committee, we are mindful of addressing the conclusions of the initial Inquiry in March 2015, while also being keen to ensure that Committee members have a sense of the significant progress made by the Welsh Ambulance Service since that time.

6. Similarly, it is hoped that the commitment of the Trust Board in supporting an ambitious programme of change, which will deliver long term and sustainable improvement to ambulances services in Wales, is recognised.

7. The support of WAST's partners has been important in the organisation's improvement journey, including staff and trade unions, health boards, the Emergency Ambulance Services Committee (EASC), the Chief Ambulance Services Commissioner and Welsh Government.

8. Detailed below is the Trust's response to the recommendations of Committee's initial inquiry. Additional information has been included which it is hoped will be of interest to Members and will enable Committee to understand fully the significant improvement journey underway at the Welsh Ambulance Service as it establishes itself as a critical component in the unscheduled and scheduled care systems across Wales.

Strategic Context

9. The strategic context within which the Welsh Ambulance Service operates has changed considerably in recent years.

10. Rising demand for services, a function both of an ageing population and increasing numbers of people living with long term conditions and/or multiple co-morbidities, coupled with increased public expectation, have presented the Welsh Ambulance Service with a number of performance challenges.

11. In addition, pressures on the wider unscheduled care system across Wales have had an inevitable contributory effect on the performance and efficiency of the ambulance service.

12. The role of the ambulance service has moved on considerably in recent years. The focus is now very firmly on the delivery of a clinical service, at the front line of pre-hospital emergency care, through to the delivery of appropriate care to the chronically and terminally ill who use the Trust's Patient Care Service to attend outpatient services.

13. This is a significant departure from the traditional model of the ambulance service as simply a transport provider and has necessitated significant investment in staff training and development to upskill staff (it is likely that paramedicine will become a degree-entry based profession in the future), as well as investment in clinical equipment and fleet.

14. Arguably more significant has been the need for the organisation itself to adapt to this changing role by developing a more professional, patient-focused culture where the needs of the patient are paramount and the ability and confidence of staff to undertake more clinically autonomous roles are recognised and supported.

15. The progress which has been made so far in 2015/16 in sharpening the Welsh Ambulance Service's clinical credentials reflects this redefinition process. These include:

    - the introduction of the Digi-Pen across WAST to record patient records digitally and in real time, allowing for better recording and interrogation of data in support of WAST's clinical indicator work
    - the introduction of the Clinical Desk (see paragraph 83)
    - the development of alternative care pathways in conjunction with health boards
    - the introduction of Paramedic Pathfinder as a clinical decision-making support tool (see paragraph 90)
    - the new clinical response model, which reflects clinical evidence

16. In a similar vein, it has been important to foster better and more constructive relationships with other elements of the healthcare system, for example GPs and health boards, in order to work collaboratively as a single team particularly in terms

of the wider unscheduled care system, and in developing alternatives to hospital admission, which are better for patients and make best use of the available clinical expertise.

17. Significantly, ambulance service performance in Wales improved incrementally across Wales during the first half of 2015 and, in September 2015, stood at 58.3%, up from 42.6% in December 2014 (see Conclusion 1 below).

18. The piloting of a new Clinical Response Model (CRM) by the Welsh Ambulance Service from October 1, 2015 recognises the importance of clinical indicators as a measure of quality, rather than exclusively time-based targets.

19. The contribution of the Health and Social Care Committee, following its initial inquiry into the performance of ambulance services, in creating an environment which facilitated change, together with the support and courage of Welsh Government in responding to clinical evidence, have been important factors in enabling the CRM pilot.

20. For those conditions where time is a significant factor, for example cardiac or respiratory arrest, the new model allows for a rapid response by an appropriately skilled clinician. In these circumstances, which the majority of people would recognise as being life-threatening, speed of response and clinical indicators are both used to measure performance.

21. Where the condition of the patient is such that their life is not in immediate danger, the new model allows for an appropriate clinical response which may or may not result in conveyance to hospital, dependent on the condition of the patient. Performance in these cases will be measured not in the speed of response, but in the appropriateness of the care provided linked to relevant clinical indicators.

22. Indeed, with improved clinical training, enhanced clinical decision-support tools (for example Paramedic Pathfinder – see paragraph 90) and the development of more community-based care pathways, for example in mental health, it is anticipated that, as the new model matures, and the associated care pathways are secured across Wales, the core role of the ambulance service, and the way it responds to demand, will alter considerably, creating a more sustainable and clinically appropriate platform for the future.

23. Similarly, as the clinical role of the ambulance service becomes more widely acknowledged, and the skills of its staff better recognised, it is to be hoped that the way in which the service is viewed and used will also shift, resulting in better use of resources and, importantly, better outcomes for patients.

24. The piloting of the new model is something which is garnering global interest. There is a real sense in the feedback WAST is receiving from ambulance services and their staff across the world, particularly via social media, that the ambulance community

is willing the Welsh Ambulance Service to be successful in its implementation, reflecting, as it does, both clinical evidence and patient need.

25. The formation of the Emergency Ambulance Services Committee (EASC), and the creation of the post of Chief Ambulance Services Commissioner (CASC) in response to the 2013 McClelland Review, have assisted considerably in supporting the Trust's development, improving the system and creating clearer lines of accountability.

26. While it is fair to say that the commissioning arrangements continue to mature, there has been considerable progress since March in forging effective and collaborative relationships with the Commissioner and, through EASC, WAST's health board partners. The development of the CAREMORE commissioning framework has provided clear structure, standards and accountabilities for the Welsh Ambulance Service, but recognises the roles of all elements of the unscheduled care system in supporting performance improvement and better experience for patients.

Findings of Initial Inquiry into Performance of the Welsh Ambulance Service

27. Detailed below is the Welsh Ambulance Service's response to Committee's request for an update on progress against each of the conclusions of the initial inquiry into ambulance performance. This response is intended to inform Members and to provide a basis for discussion at Committee on December 3.

Conclusion 1:
The Emergency Ambulance Services Committee, the Welsh Ambulance Services NHS Trust and local health boards must work together urgently to improve emergency ambulance response times and optimise patient outcomes. Performance measures must be clinically appropriate and take sufficient account of patient outcomes. Therefore the work announced by the Minister for Health and Social Services to review ambulance response measures should be rapid, clinically-led, informed by best practice and designed to enable benchmarking across the UK where possible.

28. The subject of emergency ambulance response times has been contentious for some time. While it is fully acknowledged that, for a relatively small cohort of patients, time is of the absolute essence, for example those patients in cardiac or respiratory arrest, for the majority of patients, evidence suggests that a time-based response based around the eight minute model does not deliver any clinical benefit.

29. During the course of the 2015 calendar year, performance by the Welsh Ambulance Service improved steadily to July 2015, with slight dips in performance in August and September, illustrated in the following graph (Figure 1) and accompanying data chart (Figure 2).

Figure 1: All Wales A8% Performance May 2014 – September 2015: Performance Graph

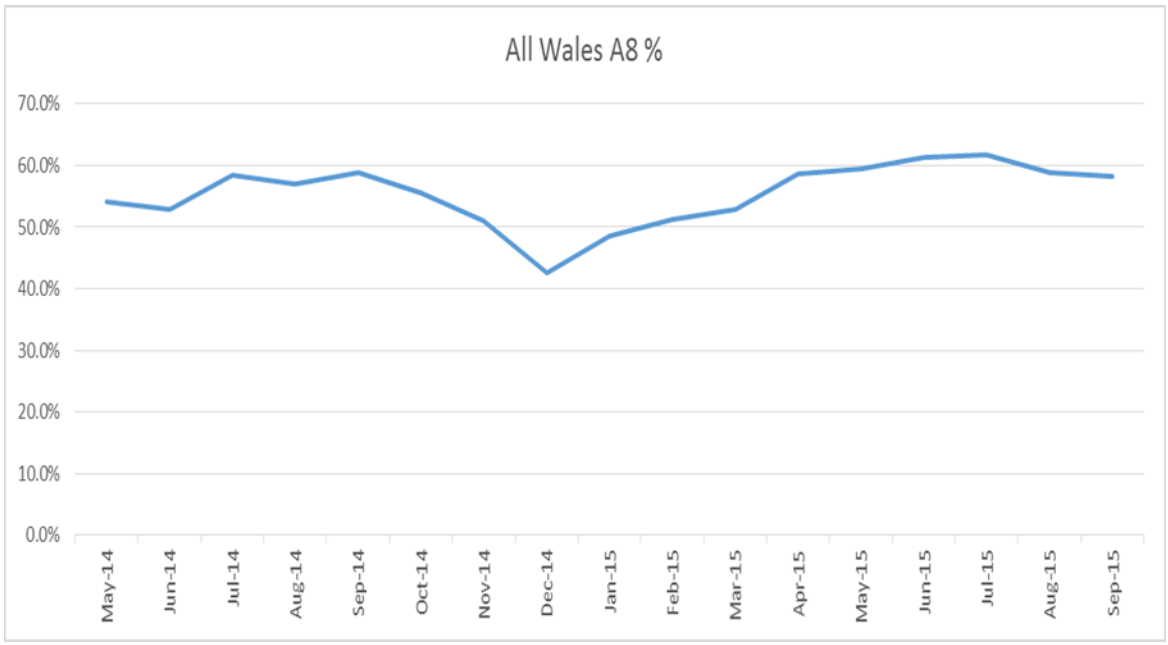


Figure 2: A8% Performance May 2014 - September 2015

Month Year	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
A8 %	54.1%	53.0%	58.3%	56.9%	58.9%	55.5%	51.0%	42.6%	48.5%	51.2%	52.9%	58.7%	59.4%	61.4%	61.7%	58.8%	58.3%

30. The piloting of a new clinical response model for 12 months from October 1, 2015 reflects clinical advice and evidence that the use of an out-dated, time-based target is not a good measure of performance, clinical care or patient outcome.

31. The development of the new response model has been undertaken very much on a collaborative basis between the ambulance service, health boards and the Commissioner, working together to develop the new “Five Step Model”.

32. This places much more emphasis on the early part of the patient pathway by helping people to “choose well” and ensuring that, if patients do call 999, their call is triaged appropriately to ensure they receive the right clinical response, which may not always result in an ambulance being deployed but could, for example, mean a referral to NHS Direct Wales, GP out-of-hours services or another community-based service.

Figure 3: Five-Step Model

33. Under this new model of care, there are three categories of calls: Red, Amber, and Green. The Red calls are still measured as an eight minute response, as these are calls where there is a potentially imminent danger of death (e.g. cardiac arrest), and there is compelling evidence to support a rapid response to such critically ill / injured patients.

34. The Amber calls still require a blue light response, but the emphasis is more on ensuring that patients receive appropriate, evidence-based clinical care once the ambulance crews arrive at their side. Clinical indicators for the Amber calls include compliance with the pre-hospital care bundles for stroke, fractured neck of femur and myocardial infarction.

35. The Green calls are the least serious category and, although ambulance crews still respond to some of these calls, patients within this category can often be treated or cared for by other health providers. A good example of this alternative care is where NHS Direct Wales receives direct referrals of Green calls and provides expert nurse advisor telephony advice and assessment.

36. Health boards continue to have a significant role in supporting effective delivery of the new clinical response model. This includes minimising handover delays, thus releasing emergency vehicles promptly; working with WAST to develop, or facilitate access to, alternative care pathways for patients who would be more appropriately cared for by a community-based service and in supporting effective communication with staff, patients and the public, increasing understanding and helping to reduce inappropriate demand on ambulance resources.

37. Wales' relatively small size, and its integrated healthcare system, provides the Welsh Ambulance Service with a powerful opportunity to link data across the unscheduled care system as part of its approach to benchmarking within the new response model pilot. Work is underway with Welsh Government on the potential sharing of data across the system which would give a wider view of individual patient indicators and outcomes, for example, ambulance response, time in A&E, length of stay in hospital, procedures and outcome.

38. In addition, the Trust is currently reviewing its Integrated Performance Report (which is considered by the Trust Board at its public meetings and published on the Trust's website) to ensure its contents reflect the clinically-led basis of the response model.

Conclusion 2

To maintain momentum and work towards a whole system approach to unscheduled care, all health boards must be fully engaged with the work of the Welsh Ambulance Services NHS Trust through the work of the Emergency Ambulance Services Committee on a national level, and directly with the Trust on a local level.

Health boards must take due account of the impact on the Welsh Ambulance Services NHS Trust when developing new services or considering making changes to existing services. Health boards must also ensure that the Welsh Ambulance Services NHS Trust is involved in discussions at a sufficiently early stage to enable it to give proper consideration to the impact on its services.

39. From a Welsh Ambulance Service perspective, the maturing commissioning arrangements with EASC, the positive relationship with the Chief Ambulance Services Commissioner and good working relationships between health board and WAST staff across Wales, at both managerial and operational levels, represent a positive step forward.

40. This change is recognised by healthcare partners and commissioners, which has resulted in a more collaborative approach to commissioning and an improving relationship between WAST and other partners in the unscheduled care system, including in primary care.

41. The Welsh Ambulance Service expects to play a full part in the wider NHS service change agenda and is working closely with health boards to develop and understand the impacts of service change proposals in Wales.

42. The Trust's plan for 2016-17 is being developed through a frontline engagement exercise within the organisation and the development of Local Delivery Plans. A key requirement for LDP development is that, wherever appropriate, they are developed and agreed with health board partners. Examples of this include where pathways are being developed at an LHB level or where service changes are proposed.

43. Directors of Planning across NHS Wales are leading strategic discussion to ensure alignment of plans at a number of key stages in the planning process.

44. WAST is engaged in a number of strategic change programmes that will have an impact on its services. Examples include the major trauma network development as part of the NHS Wales Collaborative and, more recently, the maternity change consultation in north Wales. The impact on WAST services of the various options under consideration will be picked up as part of the appraisal exercise, with WAST in its role as a key partner in the process.

45. The demand and capacity modelling tool Optima Predict, referred to under Conclusion 8, will further support the strategic planning agenda in WAST and support scenario testing options for service change across NHS Wales

46. WAST is also working closely with the Mid Wales Healthcare Collaborative and is providing strategic leadership to two elements of the Collaborative's work, namely, transport and access and communications and engagement, as well as being represented at the Collaborative Board by the Chair and Chief Executive.

Conclusion 3:
Agreement must be reached between the Welsh Ambulance Services NHS Trust, trades unions and staff at the earliest opportunity on revised staff rosters in those parts of Wales for which revised arrangements are not yet in place. The Welsh Ambulance Services NHS Trust must, working in partnership with trades unions and staff, put in place arrangements to review staff rosters at appropriate intervals to avoid future mismatches between staffing and anticipated demand.

47. The workforce agenda is of critical significance for the Welsh Ambulance Service and one on which the organisation has made substantial progress in the last 12 months. Relationships with Trades Unions have improved considerably and there is more visible and effective partnership working across the organisation, recognising that there remains some way to go to ensure that this partnership approach is embedded uniformly across the Trust.

48. Clearly, the effective planning and staffing of rosters is critical to ensuring that the ambulance service is able to meet demand. It is equally important that those rosters are reviewed regularly to ensure that they remain fit for purpose and keep pace with changes in demand and/or staffing levels.

49. The approach adopted by WAST to reviewing EMS rosters has been developed in partnership and can be used for ongoing roster planning. The majority of rosters across Wales have been reviewed and implemented with, at the time of writing, five out of seven health board areas having implemented revised rosters.

50. As a result of the new roster arrangements, hours have been released to support staff CPD activity. In turn, this supports the ambulance service's drive to develop its staff and ensure they have the appropriate skills to care for patients appropriately and safely.

51. Rosters in the Aneurin Bevan University Health Board area have been prepared and are awaiting internal approval by the relevant Project Board. Subject to such approval, it is anticipated that those rosters will be implemented by the end of March 2016.

52. Currently, any further review of rosters in the Cwm Taf University Health Board area is in abeyance pending the outcome of the Cwm Taf Explorer project and further discussion with the LHB and Commissioners. This will be reviewed in 2016.

53. In terms of future reviews of rosters, WAST is committed to exploring how best to optimise its performance and will continue to identify further options through workshops and benchmarking with other ambulance services.

54. Notably, the Clinical Response Model pilot presents an opportunity to generate data and intelligence to inform future staffing requirements and this is being considered as part of the overall evaluation of the model and its impacts.

55. Similarly, WAST is developing a comprehensive and integrated workforce plan which will bring together workforce and financial modelling to set out the likely shape of the future workforce, which will assist in planning, recruitment and rostering.

56. As outlined in Conclusion 8, WAST has procured a system called Optima Predict, which will also support the determination of future workforce needs.

Conclusion 4:
The Welsh Ambulance Services NHS Trust must prioritise emergency ambulance services provision. Work is required to identify appropriate mechanisms for the provision of non-emergency patient transport services, and to disaggregate those services from the Trust in accordance with recommendation 2 of the McClelland Review. The Trust must establish a clear plan for the disaggregation, with identified timescales and costs. The Committee expects to receive an update on this plan before it follows up its inquiry later this year.

57. Significant work has been undertaken over the last year, working with a range of statutory and non-statutory partners, including Health Boards (commissioners of services), local government representatives, clinical networks, patients and the Community Transport Association (CTA) on developing a business case that sets outs a preferred option for the future provision of Non-Emergency Patient Transport Services (NEPTS) in Wales in the future.

58. In October, that business case was approved by the NEPTS Project Board, the Chief Ambulance Services Commissioner and Chief Executives of Health Boards and Trusts across Wales and, as a result, was submitted to Welsh Government.

59. The business case recommends that Non-Emergency Patient Transport Services remain managed by the Welsh Ambulance Service (WAST) but that WAST uses multiple providers to deliver the service. Specifically, it is proposed that local authorities and third sector organisations are used, in conjunction with WAST, as service providers.

60. The NEPT service will be completely disaggregated from the provision of the emergency ambulance service within WAST, with an entirely separate management structure. Following a full and detailed options appraisal which considered alternative models of delivery, including devolving the service to local health boards, all stakeholders, including the Chief Executives of all health boards, WAST, Velindre NHS Trust and the Renal Clinical Network agreed that the preferred option represented the best solution and would secure improved patient experience.

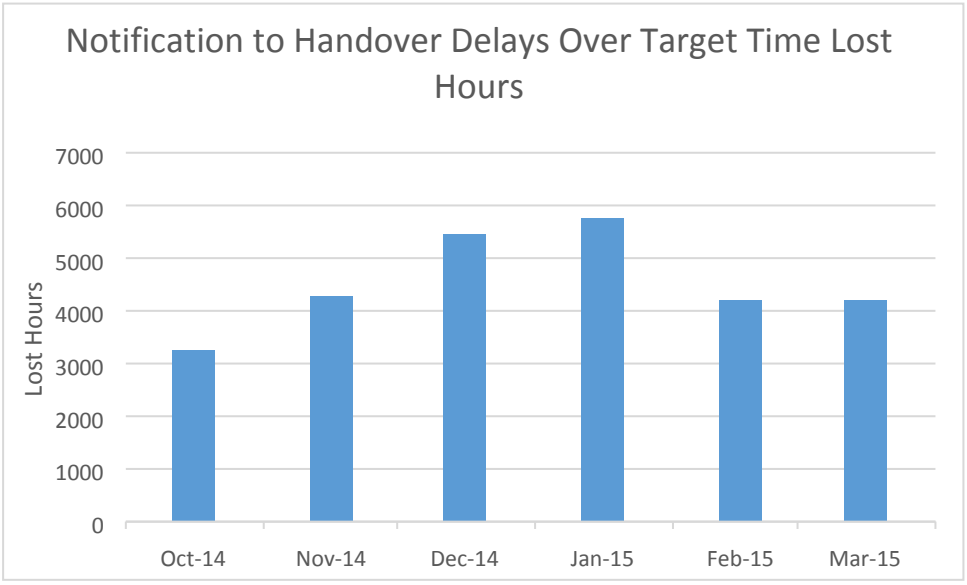
61. A new service specification has been developed by the health community commissioners which includes costing and timeframes for implementation. This new service specification also includes enhanced services for renal, end of life and oncology patients.

62. At the time of writing, WAST and its partners are awaiting approval of the business case from Welsh Government.

Conclusion 5:
The Emergency Ambulance Services Committee, the Welsh Ambulance Services NHS Trust and local health boards must work together to reduce the number of hours lost as a result of patient handover delays. The new handover policy must be implemented consistently across Wales, and any issues identified in the follow up visits made by the chief executive-lead on unscheduled care must be resolved swiftly.

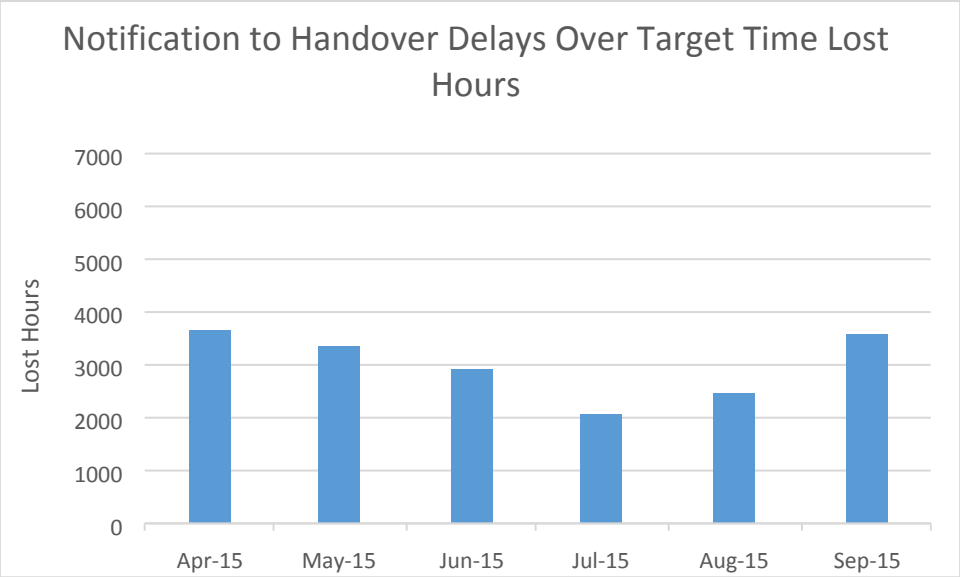
63. Committee will recall that, at the time of its original inquiry, handover guidance had very recently (February 2015) been issued to the NHS in Wales by Welsh Government in a bid to support efficient and safe handover of patients from ambulance crews to receiving hospital staff. This came in the wake of some significant handover delays during the winter of 2014/15. A total of 27,136.71 hours were lost between October 2014 and March 2015.

Figure 4: Notification to Handover Delays Over Target Time: October 2014 – March 2015



64. The Welsh Ambulance Service has been working closely with health boards and Welsh Government to ensure handover delays are kept to a minimum and, during the spring and summer period this year, there was a discernible improvement in ambulance handover. A total of 18,033.99 hours were lost between April 2015 and September 2015, a 33.5% reduction on the previous six months.

Figure 5: Notification to Handover Delays Over Target Time: April 2015 – September 2015



65. It is fair to say that there has been some variation in the implementation of, and adherence to the handover policy across Wales. Challenges in handover times have re-emerged in recent months and this is now placing additional strain on the Welsh Ambulance Service.

66. Given the importance of prompt handover, both for patients, crews and the wider ambulance service, a system of daily dialogue and conference calls between WAST and health boards has been instituted at all levels of management, including at Director level, to manage situations and resolve issues.

67. In addition, WAST is providing dedicated discharge vehicles through its Patient Care Services arm and, in some areas, is supporting HALOs (Hospital Ambulance Liaison Officers) to ease the flow of patients through the system.

68. Despite these efforts, problems are more persistent in some health board areas, for example Abertawe Bro Morgannwg UHB and Betsi Cadwaladr UHB, and concerted effort is going into resolving these challenges, including support from the Welsh Government's Delivery Unit, prior to the onset of winter proper when, historically, demand for services is at its peak.

69. It is important to note that, as a rough guide, losing 1000 hours equates to around 100 shifts of 10 hours in duration being lost to the Welsh Ambulance Service.

Conclusion 6:
The Chief Ambulance Services Commissioner, the Emergency Ambulance Services Committee and the Welsh Ambulance Services NHS Trust should urgently address the issue of ambulances being 'pulled away' from their areas. In doing so, they should seek to identify and learn from best practice across the UK.
The 'return to footprint' pilot should be explored and evaluated on a wider basis as a priority.

70. The Cwm Taf Explorer was introduced in March 2015 to trial a new way of working that “ring fences” ambulance resources to their own area. This does not mean that ambulances do not leave their home area; for example, they may need to convey a patient to a centre of clinical excellence outside Cwm Taf. However, what is important is that those resources then return to Cwm Taf to serve local patients, rather than being called to incidents outside the area, resulting in depleted ambulance resources in the local community.

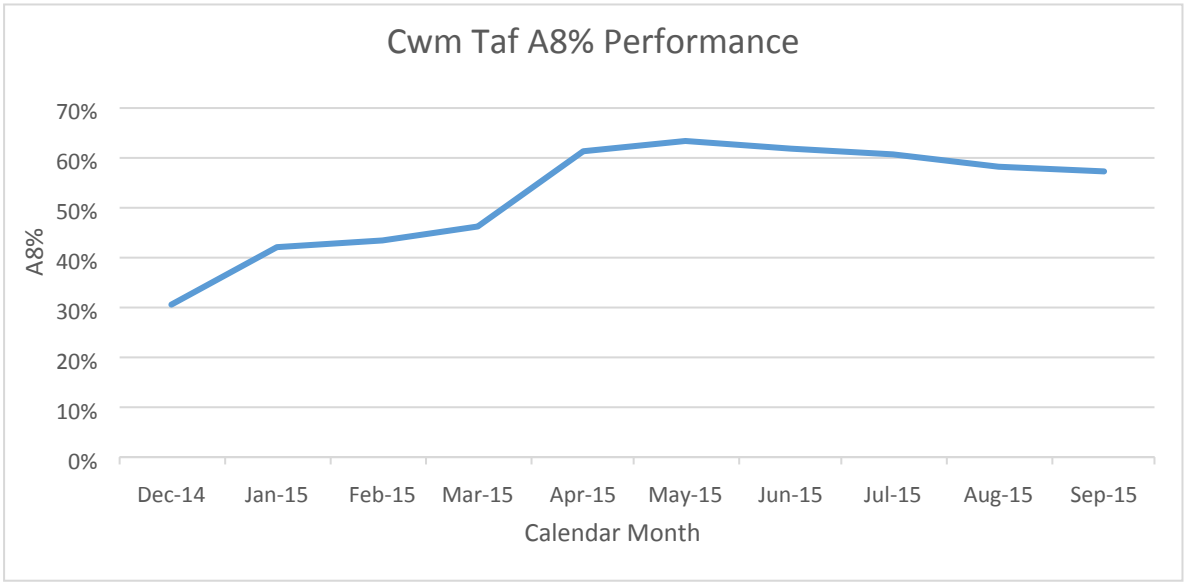
71. It is important to note that, in the case of Red calls (in the new model since October 1; previously Red 1 calls), where there is an immediate threat to life, ambulances from Cwm Taf can be sent outside their area where they represent the nearest available resource.

72. In addition, the introduction of the Cwm Taf Explorer has resulted in calls categorised as “Green 3” healthcare professional (HCP) calls, i.e. calls from a clinical professional (e.g. a GP) requesting conveyance for a patient, being managed separately, with discrete resources allocated to them in order to reduce pressure on the emergency ambulance service.

73. The Explorer project has also encompassed, in conjunction with Cwm Taf University Health Board, a shared programme of public education and communication to develop understanding of the project and appropriate use of both the ambulance service and the wider unscheduled care system.

74. Significant non recurrent investment has been made in the Cwm Taf Explorer and performance has seen considerable improvement. In December 2014, performance in Cwm Taf stood at 30.6%. By September, this had risen to 57.3%, an increase of 26.7%.

Figure 6: A8% Performance in the Cwm Taf UHB Area: December 2014 – September 2015



75. While ring-fencing appears, on the face of it, to be an attractive option for wider implementation, the dynamics are complex and there are consequences elsewhere in the system which need to be balanced. It is by no means a "one size fits all" solution to performance improvement.

76. The ring-fencing experience in Cwm Taf is providing some interesting learning for the organisation and, where appropriate, we are transferring good practice to other parts of Wales, for example, rolling out a similar approach to the management of HCP (healthcare professional) calls to the Aneurin Bevan and Abertawe Bro Morgannwg University Health Board areas.

77. The Cwm Taf Explorer approach will continue to be reviewed through the Clinical Response Model pilot.

78. In terms of learning from experience across the UK, ambulance trusts elsewhere in the country do not routinely ring fence resources to particular areas, although they do have procedures in place to allow for areas being left without any cover.

79. All ambulance trusts recognise the importance of returning resources to their localities as promptly as possible when they have cause to travel out-of-area. The key to doing this lies more in the efficiency of the home organisation and the wider unscheduled care system than it does in a ring-fencing approach.

80. The priority of the Welsh Ambulance Service is to deliver a clinically safe and effective service to all areas of Wales. The ring fencing of resources has to be viewed in the broader context of our continued improvements in performance, the new clinical model, increased recruitment and improved productivity and efficiency.

Conclusion 7:
In providing unscheduled care, health boards and the Welsh Ambulance Services NHS Trust must take account of the patient's individual needs. Health boards and the Welsh Ambulance Services NHS Trust must ensure that assessment, care and treatment are provided in ways which meet the patient's individual needs, and help them achieve their optimum outcome. This should include appropriate use of assessment, care and treatment provided in the community, as well as hospital-based provision.

81. The new clinical response model, which is being piloted from October 1, is predicated on the importance of sending the most appropriate resource and clinical professional to meet patient need, based on accurate triage of the call received.

82. Call handlers now have up to 120 seconds to triage a call to ensure the nature of the patient's condition is fully understood prior to dispatch (the "dispatch on disposition"), which allows for more accurate categorisation of calls and thus dispatch (or not) of the most appropriate resource.

83. In some low acuity cases, or where further clinical triage is required, calls can be passed either to NHS Direct Wales for advice from a nurse advisor (in the case of the former), or passed to the Welsh Ambulance Service's "clinical desk" for further advice.

84. Hear and Treat is a method of determining patient need following initial telephone contact with the ambulance service. WAST's Hear & Treat Telephone Triage and Advice (TTA) model is based on the Manchester Triage System (MTS) tools and is called MTS TTA. The aim of the model is to ensure patients are directed toward the most appropriate point of care for their health and social care needs and to provide telephone advice and support to patients, carers and relatives, along with other health and social care professionals who have contacted the ambulance service.

85. Nurses and paramedics are able to provide a pan Wales, holistic approach to patient care and early intervention to improve the patient experience in line with the principles of Prudent Healthcare. They also provide clinical support and leadership to the non-clinicians who perform a wide variety of roles and functions within the Clinical Contact Centre.

86. The outcomes of our clinical desk to-date show a steady increase in the number of patients being advised to make alternative arrangements to access an appropriate place of care, an increase in the number of patients being advised to see an alternative primary care provider rather than go to Emergency Departments and an increase in the number of patients to whom self-care advice is provided. This allows the clinician to identify higher priority calls more efficiently and ensure the right resource is sent in the right timeframe.

87. In September 2015, WAST's Clinical Desk triaged 2088 calls. This involved providing clinical advice to patients and making decisions around upgrading and downgrading of the ambulance service response, dependent on the clinical need of the patients.

88. In 439 cases, no emergency ambulance resource was sent to the patient, with the patients either being discharged/referred, advised to make their own way to hospital or having a taxi provided via a clinician on the desk.

89. In September the percentage of calls resolved by hear and treat was 4.32% (of more than 38,000 calls). While the numbers are steadily increasing, WAST is currently looking at ways of improving the streaming of calls direct to the desk to optimise its impact.

90. In order to support paramedics in determining which unscheduled care patients require transfer to Emergency Department care, and those who can safely be cared for in the community or at home, the Welsh Ambulance Service has implemented a new face to face triage model called Paramedic Pathfinder for all paramedics across Wales.

91. The Paramedic Pathfinder triage model is suitable for all categories of medical and traumatic emergencies, but excludes patients with immediately life threatening problems, those on End of Life Pathways and patients with acute mental health needs.

92. Specifically designed to support paramedic decision-making, Paramedic Pathfinder places patients into one of four triage outcome categories, all of which aim to ensure patients are directed to the most appropriate point of care. These triage outcomes include emergency care, primary care, community care pathways and self-care pathways for resolved conditions i.e. resolved hypoglycaemia and epilepsy.

93. Paramedics are developed to administer the pathfinder tools through a self-directed, open learning module which utilises a case study based approach. This is then followed by a period of consolidation training facilitated by an approved Paramedic Pathfinder trainer/facilitator.

94. The efficacy of the Paramedic Pathfinder is predicated on the availability of alternative pathways being available for paramedics to utilise. The initial implementation of the Paramedic Pathfinder provides the foundations for the Trust to undertake future work with health and social care to develop community care pathways to assist paramedics in deciding the most appropriate care for patients who frequently present, and/or are already known to the system.

95. In addition, WAST is working closely with health boards on either the provision of, or access to existing, alternative care pathways, which allow paramedics to refer patients to other community-based services that can deal more appropriately with their healthcare need or by-pass the need for patients to be admitted directly to Emergency Departments, for example the direct admission of patients with an acute mental health need to mental health facilities in Cardiff.

Conclusion 8:
Ambulance services in the medium and longer term must be high performing, and aligned to demand. Therefore health boards, the Emergency Ambulance Services Committee and the Welsh Ambulance Services NHS Trust should undertake robust and effective forward planning which takes anticipated demographic changes into account.

96. WAST is working with EASC to develop collaboratively an approach to demand and capacity modelling. WAST has also procured a system called Optima Predict which is currently being implemented. Optima Predict is an interactive strategic planning solution for emergency services that provides a platform that enables effective planning and the simulation of resource requirements.

97. Optima will enable WAST to evaluate the impact of demand growth on performance, for example, the impact of housing developments; changes to response targets; changes to healthcare systems e.g. a hospital no longer accepting cardiac patients, a

new hospital, a hospital closure ; how changes to the resource mix impact on performance etc.

98. Optima will be particularly useful for modelling the impact of changes resulting from the South Wales Programme and other service change programmes across Wales, but it clearly has a wider use for WAST in terms of modelling changes in demand and supply and their impact on performance.

Closing Observations

99. While the Trust recognises that the Welsh Ambulance Service has a significant way to go on its improvement journey, there is no doubt that it is in a fundamentally different place from 12 months ago.

100. Its industrial relations have improved, its reputation with the public, stakeholders and, importantly, its staff, is on an upward trajectory and there is a renewed sense of optimism and “can-do” within the organisation.

101. There has been significant performance improvement since December 2014, but WAST recognises that this is fragile and showing signs of inconsistency. The Trust is committed to addressing this robustly, working closely with EASC, the Chief Ambulance Services Commissioner and partners across the healthcare community.

102. What is important now is that confidence in the organisation’s ability to improve further is maintained and supported, and that the efforts of its employees in securing such improvements for people in Wales are acknowledged and welcomed.

Ends/November 2015

Eitem 6.1

Cofnodion cryno – Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:

Ystafell Bwyllgora 3 – Senedd

Dyddiad: Dydd Iau,

19 Tachwedd 2015

Amser: 09.20 – 11.35

Gellir gwylio'r cyfarfod ar Senedd TV yn:

http://senedd.tv/cy/3324

Yn bresennol

Categori	Enwau
Aelodau'r Cynulliad:	Alun Davies AC John Griffiths AC Altaf Hussain AC Elin Jones AC Darren Millar AC Lynne Neagle AC (Cadeirydd dros dro) Gwyn R Price AC Joyce Watson AC (yn lle David Rees AC) Lindsay Whittle AC Kirsty Williams AC
Staff y Pwyllgor:	Llinos Madeley (Clerc) Catherine Hunt (Ail Glerc) Sian Giddins (Dirprwy Glerc)

	Gareth Howells (Cynghorydd Cyfreithiol) Amy Clifton (Ymchwilydd) Philippa Watkins (Ymchwilydd)

Trawsgrifiad

Gweld trawsgrifiad o'r cyfarfod.

1 Cynnig o dan Reol Sefydlog 17.22 i ethol Cadeirydd dros dro

1.1 Oherwydd bod David Rees, Cadeirydd y Pwyllgor wedi anfon ei ymddiheuriadau, gofynnodd y Clerc am enwebiadau ar gyfer ethol Cadeirydd dros dro yn unol â Rheol Sefydlog 17.22. Enwebodd Elin Jones, gyda chefnogaeth Gwyn Price, Lynne Neagle, ac fe'i hetholwyd.

2 Cyflwyniad, ymddiheuriadau a dirprwyon

2.1 Roedd Joyce Watson yn dirprwyo ar ran David Rees.

3 Papurau i'w nodi

3.1 Cofnodion y cyfarfod ar 11 Tachwedd 2015

3.1a Nododd y Pwyllgor y cofnodion.

3.2 Bil Iechyd y Cyhoedd (Cymru): gwybodaeth ychwanegol gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

3.2a Nododd y Pwyllgor y wybodaeth ychwanegol.

4 Cynnig o dan Reol Sefydlog 17.42(vi) i benderfynu gwahardd y cyhoedd o weddill y cyfarfod

4.1 Derbyniwyd y cynnig.

5 Bil Lefelau Diogel Staff Nyrsio (Cymru): trafodaeth am drefn ystyried trafodion Cyfnod 2

1.1 Cytunodd y Pwyllgor ar y drefn o ystyried trafodion Cyfnod 2 Bil Lefelau Diogel Staff Nyrsio (Cymru).

6 Bil Cymru drafft: trafod y canfyddiadau

6.1 Trafododd y Pwyllgor lythyr drafft i'r Pwyllgor Materion Cyfansoddiadol a Deddfwriaethol a chytuno arno.

7 Bil Iechyd y Cyhoedd (Cymru): trafod yr adroddiad drafft

7.1 Trafododd y Pwyllgor yr adroddiad drafft. Cytunodd y Pwyllgor i drafod yr adroddiad drafft eto yn ei gyfarfod ar 25 Tachwedd 2015.

8 Bil Iechyd y Cyhoedd (Cymru): trafod yr adroddiad drafft

8.1 Cwblhaodd y Pwyllgor ei fusnes ar gyfer 19 Tachwedd cyn yr egwyl ginio.

Cofnodion cryno – Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:

Ystafell Bwyllgora 3 – Senedd

Dyddiad: Dydd Mercher,

25 Tachwedd 2015

Amser: 09.00 – 12.12

Gellir gwylio'r cyfarfod ar Senedd TV yn:

http://senedd.tv/cy/3321

Yn bresennol

Categori	Enwau
Aelodau'r Cynulliad:	David Rees AC (Cadeirydd) Peter Black AC (yn lle Kirsty Williams AC ar gyfer eitemau 1 a 2) Alun Davies AC John Griffiths AC Altaf Hussain AC Elin Jones AC Darren Millar AC Lynne Neagle AC Gwyn R Price AC Lindsay Whittle AC Kirsty Williams AC (ar gyfer eitemau 3 a 4)
Tystion:	Kirsty Williams AC

	Philippa Watkins Lisa Salkeld, Comisiwn Cynulliad Cenedlaethol Cymru Mark Drakeford AC, Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol Helen Whyley, Llywodraeth Cymru Rhian Williams, Llywodraeth Cymru
Staff y Pwyllgor:	Llinos Madeley (Clerc) Gareth Howells (Cynghorydd Cyfreithiol) Catherine Hunt (Ail Glerc) Sian Giddins (Dirprwy Glerc) Gwyn Griffiths (Cynghorydd Cyfreithiol) Amy Clifton (Ymchwilydd) Philippa Watkins (Ymchwilydd)

Trawsgrifiad

Gweld trawsgrifiad o'r cyfarfod.

1 Cyflwyniad, ymddiheuriadau a dirprwyon

1.1 Ni chafwyd unrhyw ymddiheuriadau.

1.2 Dirprwyodd Peter Black ar ran Kirsty Williams ar gyfer yr eitemau'n ymwneud â'r Bil Lefelau Diogel Staff Nyrsio (Cymru).

2 Y Bil Lefelau Diogel Staff Nyrsio (Cymru): Cyfnod 2 - Trafod y gwelliannau

2.1 Datganodd Lynne Neagle y buddiant perthnasol a ganlyn o dan Reol Sefydlog 17.24A:

- Mae un o'i pherthnasau teuluol agos yn byw ar ward iechyd meddwl i gleifion mewnol ar hyn o bryd

2.2 Yn unol â Rheol Sefydlog 26.21, gwaredodd y Pwyllgor y gwelliannau a ganlyn i'r Bil:

Gwelliant 28 (Mark Drakeford)

O blaid	Yn erbyn	Ymatal
Alun Davies	Altaf Hussain	Peter Black
John Griffiths	Darren Millar	
Elin Jones		
Lynne Neagle		
Gwyn R Price		
David Rees		
Lindsay Whittle		
Derbyniwyd gwelliant 28.		

Gwelliant 29A (Darren Millar)

O blaid	Yn erbyn	Ymatal
Peter Black	Alun Davies	
Altaf Hussain	John Griffiths	
Elin Jones	Lynne Neagle	
Darren Millar	Gwyn R Price	
Lindsay Whittle	David Rees	
Gan fod y bleidlais yn gyfartal, defnyddiodd y Cadeirydd ei bleidlais fwrw yn negyddol (yn unol â Rheol Sefydlog 6.20(ii)). Felly, gwrthodwyd gwelliant 29A.		

Gwelliant 29B (Darren Millar)

O blaid	Yn erbyn	Ymatal
Peter Black	Alun Davies	
Altaf Hussain	John Griffiths	
Elin Jones	Lynne Neagle	
Darren Millar	Gwyn R Price	
Lindsay Whittle	David Rees	
Gan fod y bleidlais yn gyfartal, defnyddiodd y Cadeirydd ei bleidlais fwrw yn negyddol (yn unol â Rheol Sefydlog 6.20(ii)). Felly, gwrthodwyd gwelliant 29B.		

Gwelliant 29C (Darren Millar)

O blaid	Yn erbyn	Ymatal
Altaf Hussain	Peter Black	
Darren Millar	Alun Davies	
	John Griffiths	
	Elin Jones	
	Lynne Neagle	
	Gwyn R Price	
	David Rees	
	Lindsay Whittle	
Gwrthodwyd gwelliant 29C.		

Gwelliant 29D (Darren Millar)

O blaid	**Yn erbyn**	**Ymatal**
Peter Black	Alun Davies	
Altaf Hussain	John Griffiths	
Elin Jones	Lynne Neagle	
Darren Millar	Gwyn R Price	
Lindsay Whittle	David Rees	
Gan fod y bleidlais yn gyfartal, defnyddiodd y Cadeirydd ei bleidlais fwrw yn negyddol (yn unol â Rheol Sefydlog 6.20(ii)). Felly, gwrthodwyd gwelliant 29D.		

Gwaredwyd **gwelliannau 29E, 29F, 29G, 29H a 29I (Darren Millar)** gyda'i gilydd.

O blaid	**Yn erbyn**	**Ymatal**
Peter Black	Alun Davies	
Altaf Hussain	John Griffiths	
Elin Jones	Lynne Neagle	
Darren Millar	Gwyn R Price	
Lindsay Whittle	David Rees	
Gan fod y bleidlais yn gyfartal, defnyddiodd y Cadeirydd ei bleidlais fwrw yn negyddol (yn unol â Rheol Sefydlog 6.20(ii)). Felly, gwrthodwyd gwelliannau 29E, 29F, 29G, 29H a 29I.		

Gwelliant 29J (Darren Millar)

O blaid	Yn erbyn	Ymatal
Altaf Hussain	Peter Black	
Elin Jones	Alun Davies	
Darren Millar	John Griffiths	
Lindsay Whittle	Lynne Neagle	
	Gwyn R Price	
	David Rees	
Gwrthodwyd gwelliant 29J.		

Gwelliant 29Z (Elin Jones)

O blaid	Yn erbyn	Ymatal
Altaf Hussain	Peter Black	
Elin Jones	Alun Davies	
Darren Millar	John Griffiths	
Lindsay Whittle	Lynne Neagle	
	Gwyn R Price	
	David Rees	
Gwrthodwyd gwelliant 29Z.		

Gwelliant 29AA (Elin Jones)

O blaid	Yn erbyn	Ymatal
Altaf Hussain	Peter Black	
Elin Jones	Alun Davies	
Darren Millar	John Griffiths	
Lindsay Whittle	Lynne Neagle	
	Gwyn R Price	
	David Rees	
Gwrthodwyd gwelliant 29AA.		

Gwelliant 29AB (Elin Jones)

O blaid	Yn erbyn	Ymatal
Altaf Hussain	Peter Black	
Elin Jones	Alun Davies	
Darren Millar	John Griffiths	
Lindsay Whittle	Lynne Neagle	
	Gwyn R Price	
	David Rees	
Gwrthodwyd gwelliant 29AB.		

Gwelliant 29AC (Elin Jones)

O blaid	Yn erbyn	Ymatal
Altaf Hussain	Peter Black	
Elin Jones	Alun Davies	
Darren Millar	John Griffiths	
Lindsay Whittle	Lynne Neagle	
	Gwyn R Price	
	David Rees	
Gwrthodwyd gwelliant 29AC.		

Gwelliant 29AD (Elin Jones)

O blaid	Yn erbyn	Ymatal
Altaf Hussain	Peter Black	
Elin Jones	Alun Davies	
Darren Millar	John Griffiths	
Lindsay Whittle	Lynne Neagle	
	Gwyn R Price	
	David Rees	
Gwrthodwyd gwelliant 29AD.		

Gwaredwyd **gwelliannau 29K, 29L, 29M, 29N a 29O (Darren Millar)** gyda'i gilydd.

O blaid	**Yn erbyn**	**Ymatal**
Peter Black	Alun Davies	
Altaf Hussain	John Griffiths	
Elin Jones	Lynne Neagle	
Darren Millar	Gwyn R Price	
Lindsay Whittle	David Rees	
Gan fod y bleidlais yn gyfartal, defnyddiodd y Cadeirydd ei bleidlais fwrw yn negyddol (yn unol â Rheol Sefydlog 6.20(ii)). Felly, gwrthodwyd gwelliannau 29K, 29L, 29M, 29N a 29O.		

Gwelliant 29P (Darren Millar)

O blaid	**Yn erbyn**	**Ymatal**
Peter Black	Alun Davies	
Altaf Hussain	John Griffiths	
Elin Jones	Lynne Neagle	
Darren Millar	Gwyn R Price	
Lindsay Whittle	David Rees	
Gan fod y bleidlais yn gyfartal, defnyddiodd y Cadeirydd ei bleidlais fwrw yn negyddol (yn unol â Rheol Sefydlog 6.20(ii)). Felly, gwrthodwyd gwelliant 29P.		

Derbyniwyd **gwelliant 29Q (Darren Millar)** yn unol â Rheol Sefydlog 17.34(i).

Gwelliant 29R (Darren Millar)

O blaid	Yn erbyn	Ymatal
Peter Black	Alun Davies	
Altaf Hussain	John Griffiths	
Elin Jones	Lynne Neagle	
Darren Millar	Gwyn R Price	
Lindsay Whittle	David Rees	
Gan fod y bleidlais yn gyfartal, defnyddiodd y Cadeirydd ei bleidlais fwrw yn negyddol (yn unol â Rheol Sefydlog 6.20(ii)). Felly, gwrthodwyd gwelliant 29R.		

Gwelliant 29S (Darren Millar)

O blaid	Yn erbyn	Ymatal
Peter Black	Alun Davies	
Altaf Hussain	John Griffiths	
Elin Jones	Lynne Neagle	
Darren Millar	Gwyn R Price	
Lindsay Whittle	David Rees	
Gan fod y bleidlais yn gyfartal, defnyddiodd y Cadeirydd ei bleidlais fwrw yn negyddol (yn unol â Rheol Sefydlog 6.20(ii)). Felly, gwrthodwyd gwelliant 29S.		

Gwelliant 29T (Darren Millar)

O blaid	Yn erbyn	Ymatal
Altaf Hussain	Peter Black	
Elin Jones	Alun Davies	
Darren Millar	John Griffiths	
Lindsay Whittle	Lynne Neagle	
	Gwyn R Price	
	David Rees	
Gwrthodwyd gwelliant 29T.		

Gwelliant 29U (Darren Millar)

O blaid	Yn erbyn	Ymatal
Altaf Hussain	Peter Black	
Elin Jones	Alun Davies	
Darren Millar	John Griffiths	
Lindsay Whittle	Lynne Neagle	
	Gwyn R Price	
	David Rees	
Gwrthodwyd gwelliant 29U.		

Gwelliant 29V (Darren Millar)

O blaid	Yn erbyn	Ymatal
Peter Black	Alun Davies	
Altaf Hussain	John Griffiths	
Elin Jones	Lynne Neagle	
Darren Millar	Gwyn R Price	
Lindsay Whittle	David Rees	
Gan fod y bleidlais yn gyfartal, defnyddiodd y Cadeirydd ei bleidlais fwrw yn negyddol (yn unol â Rheol Sefydlog 6.20(ii)). Felly, gwrthodwyd gwelliant 29V.		

Gwelliant 29W (Darren Millar)

O blaid	Yn erbyn	Ymatal
Altaf Hussain	Peter Black	
Darren Millar	Alun Davies	
	John Griffiths	
	Elin Jones	
	Lynne Neagle	
	Gwyn R Price	
	David Rees	
	Lindsay Whittle	
Gwrthodwyd gwelliant 29W.		

Gwelliant 29X (Darren Millar)

O blaid	**Yn erbyn**	**Ymatal**
Altaf Hussain	Peter Black	
Elin Jones	Alun Davies	
Darren Millar	John Griffiths	
Lindsay Whittle	Lynne Neagle	
	Gwyn R Price	
	David Rees	
Gwrthodwyd gwelliant 29X.		

Gwelliant 29Y (Darren Millar)

O blaid	**Yn erbyn**	**Ymatal**
Altaf Hussain	Peter Black	
Elin Jones	Alun Davies	
Darren Millar	John Griffiths	
Lindsay Whittle	Lynne Neagle	
	Gwyn R Price	
	David Rees	
Gwrthodwyd gwelliant 29Y.		

Ni chynigiwyd **gwelliant 29AE (Elin Jones)**.

Gwelliant 29 (Mark Drakeford)

O blaid	**Yn erbyn**	**Ymatal**
Alun Davies	Altaf Hussain	Peter Black
John Griffiths	Elin Jones	
Lynne Neagle	Darren Millar	
Gwyn R Price	Lindsay Whittle	
David Rees		
Derbyniwyd gwelliant 29.		

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **1 (Darren Millar)**.

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **20 (Elin Jones)**.

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **2 (Darren Millar)**.

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **21 (Elin Jones)**.

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **3 (Darren Millar)**.

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **4 (Darren Millar)**.

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **22 (Elin Jones)**.

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **23 (Elin Jones)**.

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **24 (Elin Jones)**.

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **5 (Darren Millar)**.

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **6 (Darren Millar)**.

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **7 (Darren Millar)**.

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **8 (Darren Millar)**.

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **9 (Darren Millar)**.

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **10 (Darren Millar)**.

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **11 (Darren Millar)**.

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **12 (Darren Millar)**.

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **25 (Elin Jones)**.

Gan fod **gwelliant 29W (Darren Millar)** wedi'i wrthod, methodd gwelliant **30A (Darren Millar).**

Gan fod **gwelliant 29X (Darren Millar)** wedi'i wrthod, methodd gwelliant **30B (Darren Millar).**

Derbyniwyd **gwelliant 30 (Mark Drakeford)** yn unol â Rheol Sefydlog 17.34(i).

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **13 (Darren Millar)**.

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **14 (Darren Millar)**.

Gwelliant 31A (Darren Millar)

O blaid	**Yn erbyn**	**Ymatal**
Peter Black	Alun Davies	
Altaf Hussain	John Griffiths	
Elin Jones	Lynne Neagle	
Darren Millar	Gwyn R Price	
Lindsay Whittle	David Rees	
Gan fod y bleidlais yn gyfartal, defnyddiodd y Cadeirydd ei bleidlais fwrw yn negyddol (yn unol â Rheol Sefydlog 6.20(ii)). Felly, gwrthodwyd gwelliant 31A.		

Derbyniwyd **gwelliant 31 (Mark Drakeford)** yn unol â Rheol Sefydlog 17.34(i).

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **15 (Darren Millar)**.

Gan fod **gwelliant 29 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **16 (Darren Millar)**.

Gwelliant 36 (Darren Millar)

O blaid	Yn erbyn	Ymatal
Altaf Hussain	Peter Black	
Darren Millar	Alun Davies	
	John Griffiths	
	Elin Jones	
	Lynne Neagle	
	Gwyn R Price	
	David Rees	
	Lindsay Whittle	
Gwrthodwyd gwelliant 36.		

Gwelliant 37 (Darren Millar)

O blaid	Yn erbyn	Ymatal
Altaf Hussain	Peter Black	
Darren Millar	Alun Davies	
	John Griffiths	
	Elin Jones	
	Lynne Neagle	
	Gwyn R Price	
	David Rees	
	Lindsay Whittle	
Gwrthodwyd gwelliant 37.		

Gwelliant 32 (Mark Drakeford)

O blaid	**Yn erbyn**	**Ymatal**
Alun Davies	Altaf Hussain	Peter Black
John Griffiths	Elin Jones	
Lynne Neagle	Darren Millar	
Gwyn R Price	Lindsay Whittle	
David Rees		
Derbyniwyd gwelliant 32.		

Gan fod **gwelliant 32 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliannau **17 a 18 (Darren Millar)**.

Ni chynigiwyd **gwelliant 19 (Darren Millar)**.

Derbyniwyd **gwelliant 33 (Mark Drakeford)** yn unol â Rheol Sefydlog 17.34(i).

Derbyniwyd **gwelliant 34 (Mark Drakeford)** yn unol â Rheol Sefydlog 17.34(i).

Gwelliant 35 (Mark Drakeford)

O blaid	**Yn erbyn**	**Ymatal**
Alun Davies	Altaf Hussain	Peter Black
John Griffiths	Elin Jones	
Lynne Neagle	Darren Millar	
Gwyn R Price	Lindsay Whittle	
David Rees		
Derbyniwyd gwelliant 35.		

Gwelliant 27 (Mark Drakeford)

O blaid	**Yn erbyn**	**Ymatal**
Alun Davies	Altaf Hussain	Peter Black
John Griffiths	Elin Jones	
Lynne Neagle	Darren Millar	
Gwyn R Price	Lindsay Whittle	
David Rees		
Derbyniwyd gwelliant 27.		

Derbyniwyd **gwelliant 38 (Mark Drakeford)** yn unol â Rheol Sefydlog 17.34(i).

Gan fod **gwelliant 38 (Mark Drakeford)** wedi'i dderbyn, methodd gwelliant **39 (Elin Jones)**.

2.3 Barnwyd bod holl adrannau'r Bil wedi'u derbyn gan y Pwyllgor.

3 Cynnig o dan Reol Sefydlog 17.42(vi) i benderfynu gwahardd y cyhoedd o weddill y cyfarfod hwn

3.1 Derbyniwyd y cynnig.

4 Bil Iechyd y Cyhoedd (Cymru): trafod yr adroddiad drafft

4.1 Trafododd y Pwyllgor yr adroddiad drafft ar Gyfnod 1 Bil Iechyd y Cyhoedd (Cymru), gan gytuno arno yn amodol ar rai mân newidiadau.

4.2 Cytunodd y Pwyllgor i gyhoeddi ei adroddiad Cyfnod 1 ar egwyddorion cyffredinol Bil Iechyd y Cyhoedd (Cymru) ddydd Llun 30 Tachwedd. Er bod hyn yn hwyrach na'r terfyn amser y cytunwyd arno gan y Pwyllgor Busnes, sef 27 Tachwedd, nododd y Pwyllgor Iechyd a Gofal Cymdeithasol na fydd y penderfyniad hwn yn effeithio ar:

- amseriad y ddadl ar Gyfnod 1 y Bil yn y Cyfarfod Llawn, y bwriedir ei chynnal ar 8 Rhagfyr ar hyn o bryd;
- terfynau amser cyfnodau diwygio dilynol y Bil, os bydd y Cynulliad yn derbyn yr egwyddorion cyffredinol.

Ann Jones AC, Cadeirydd y Pwyllgor Plant, Pobl Ifanc ac Addysg
Christine Chapman AC, Cadeirydd y Pwyllgor Cymunedau, Cydraddoldeb a Llywodraeth Leol
William Graham AC, Cadeirydd y Pwyllgor Menter a Busnes
Alun Ffred Jones AC, Cadeirydd y Pwyllgor Amgylchedd a Chynaliadwyedd
David Rees AC, Cadeirydd y Pwyllgor Iechyd a Gofal Cymdeithasol

17 Tachwedd 2015

Annwyl Gadeiryddion y Pwyllgorau

Etifeddiaeth y Pwyllgor Cyllid – proses y Gyllideb a chraffu ariannol ar ddeddfwriaeth

Fel rhan o drafodaethau'r Pwyllgor Cyllid ar ei etifeddiaeth, mae'r Pwyllgor yn ystyried y trefniadau ar gyfer craffu ar y gyllideb ac yn edrych ar graffu ariannol ar filiau, gan gynnwys effaith rôl y Pwyllgor.

Fel y gwyddoch, bydd gweithdrefnau cyllidebol yn newid yn ystod y Cynulliad nesaf. Fodd bynnag, mae'r Pwyllgor yn awyddus i glywed eich barn am effeithiolrwydd y dull cyffredinol o graffu ar y gyllideb yn y Cynulliad hwn. Mae gan yr Aelodau ddiddordeb mewn clywed pa mor llwyddiannus rydych yn credu y bu eich pwyllgor o ran cyfrannu at y broses, i ba raddau y mae rhanddeiliaid yn ymgysylltu â chraffu ar y gyllideb a pha mor briodol yw'r amserlenni ar gyfer y broses, yn enwedig y rhai a ragnodir mewn Rheolau Sefydlog.

Mae'r Pwyllgor hefyd yn awyddus i glywed eich barn am effeithiolrwydd craffu ariannol ar ddeddfwriaeth, gan gynnwys sut y mae eich pwyllgorau chi wedi integreiddio'r gwaith o graffu ariannol wrth ystyried deddfwriaeth a pha mor ddefnyddiol y bu canlyniadau ystyriaeth y Pwyllgor Cyllid o filiau wrth i'ch pwyllgor chi ymgymryd â'i waith craffu.

Edrychaf ymlaen at dderbyn eich ymateb a buaswn yn ddiolchgar am hyn erbyn 8 Ionawr 2016.

Yn gywir

Jocelyn Davies

Cadeirydd

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Deisebau

National Assembly for Wales
Petitions Committee

David Rees AM
Chair, Health and Social Care Committee
Tŷ Hywel
Cardiff Bay
CF99 1NA

16 November 2015

Dear David

Petition P-04-532 Improving Specialised Neuromuscular Services in Wales

The Petitions Committee has been considering the following petition from Muscular Dystrophy Campaign since February 2014.

> *We call on the National Assembly for Wales to urge the Welsh Government to ensure that Health Boards implement the investment proposed by the Welsh Neuromuscular Network Vision Document for improving specialised neuromuscular services in Wales.*
>
> ***Additional Information:***
>
> *The Welsh Neuromuscular Network is recommending the following priority developments: 1. Increase in Family Care Advisors and support. 2. Specialist adult neuromuscular physiotherapists. 3. Appointment of consultant in adult neuromuscular disease. 4. Increase in clinical psychology. 5. An equipment budget to enable minor purchases and lease arrangements.*

During our meeting of 6 October, the Committee agreed to write to you to ask whether the Health and Social Care Committee could consider the issues raised by the petition as part of your consideration of the Committee's forward work programme.

More detailed information on this petition, including correspondence and agreed actions are available at:
http://www.senedd.assembly.wales/mgIssueHistoryHome.aspx?IId=8838

Cynulliad Cenedlaethol Cymru
Bae Caerdydd, Caerdydd, CF99 1NA
SeneddDeisebau@cynulliad.cymru
www.cynulliad.cymru/SeneddDeisebau
0300 200 6565

National Assembly for Wales
Cardiff Bay, Cardiff, CF99 1NA
SeneddPetitions@assembly.wales
www.assembly.wales/SeneddPetitions
0300 200 6565

Please forward your response to the Committee Clerking team at *SeneddPetitions@assembly.wales*. They will also be able to provide you with any further information, should you require it.

Yours sincerely

William Powell AC/AM
Cadeirydd/ Chair

Mae cyfyngiadau ar y ddogfen hon

Mae cyfyngiadau ar y ddogfen hon

Mae cyfyngiadau ar y ddogfen hon

Mae cyfyngiadau ar y ddogfen hon