INTERIM COLLABORATIVE COMMISSIONING AGREEMENT 2014/15

EASC – Emergency Ambulance Services Committee
("Commissioning Collaborative")
and
WAST - Welsh Ambulance Services NHS Trust
("Provider")

This Interim Collaborative Commissioning Agreement is entered on this day of_____2014 by and between:

1. **Emergency Ambulance Services Committee** ("Commissioning Collaborative"); and
2. **Welsh Ambulance Services NHS Trust** ("Provider").

Scope

The scope of services covered by this document are as follows:

- responses to emergency calls via 999;
- urgent hospital admission requests from general practitioners;
- high dependency and inter-hospital transfers;
- major incident response and urgent patient triage by telephone.

[As per the EASC (Wales) Directions 10 March 2014]

Purpose

This document is an agreement on key areas of service between NHS Wales Health Boards and WAST through the transitional year (2014/15) before full implementation of a new Commissioning & Clinical Quality Delivery Framework.

A separate Project Initiation Document (PID) has been *agreed* by EASJC for the production of a Commissioning & Clinical Quality Delivery Framework and it is expected that WAST will participate in its production during 2014/15 for implementation in 2015/16.

Principles

The Commissioning & Clinical Quality Delivery Framework will enable the philosophy of Prudent Healthcare and its associated principles to be applied.

An operational principle during 2014/15 is that any collaborative opportunities which may improve the efficiency and effectiveness of any parties to the agreement will be exploited.

Underpinning principles for this agreement is that all parties shall promote effective and efficient collaboration by acting in accordance with the principles of:

- Consistency;
- Reasonableness;
- Fairness;
- Transparency.

Background & Introduction

Prior to the production of this Interim Collaborative Commissioning Agreement for 2014/15 there has been limited formal processes in place to enable the production of a commissioning framework and any subsequent contractual type agreement between Health Boards and WAST.

The production of the Commissioning & Clinical Quality Delivery Framework for 2015/16, has been requested by the EASC and is being developed in collaboration with WAST.

Commissioning collaboratively aims to create the sense of operating within a non-competitive environment, behaving in a national (once for Wales) way to progress, share and develop ideas.

The objectives for each Section of the framework have been outlined within this document together with the interim arrangements for 2014/15 as a transitional year.

Part 1 – Care standards

Care standards must:

- be consistent with Prudent Healthcare;
- give assurance around quality and safety of service delivery;
- be evidence/best practice based;
- be aligned to an intelligent suite of clinically focussed outcome measures for the benefit of the public and patients;
- be understandable, realistic and achievable;
- be able to be performance measured / have clear metrics for measurement;
- be transparent.

For 2014/15 as a transitional year the standards will be those where existing performance measures apply and are as shown in the table within Appendix One (i).

- standards that apply across the key stages of an Ambulance Service Care Pathway (ASCP): ie the pathway of care for a "999" or "Urgent" call;

- standards which are under development for the future Commissioning & Clinical Quality Delivery Framework;
- standards for consideration during the development of the new framework.

Appendix One (ii) shows standards which are under development that relate to giving assurance that the correct infrastructure is in place to deliver effective and efficient services.

Part 2 – Activity

Activity requirements must:

- be consistent with Prudent Healthcare;
- be relevant to improving performance and outcomes;
- be measureable;
- be recorded, with information sources identifiable;
- provide clarity around demand and capacity;
- be able to be benchmarked between Health Boards – whenever comparable;
- be able to benchmarked with other Ambulance services – whenever comparable.

For 2014/15 as a transitional year the Activity will be related to:

- services within the scope of the responsibility of the EASJC;
- existing performance measures;
- new indicators announced by the Health Minister for the key treatment areas of cardiac arrest, strokes and fractured Neck of Femur (NoF).

The indicative types of activity forming the baseline for 2014/15 and to be considered for reporting in 2014/15 is as shown in Appendix Two, these will be finalised during **Quarter 1 (April to June) 2014/15** and will replace Appendix Two within this Heads of Agreement.

Part 3 – Resource Envelope

The Resource Envelope should include the direct or complementary services which impact upon the effective and efficient delivery of emergency ambulance services, by the identification of all opportunities from:

- the application of Prudent Healthcare principles;
- whole system resource regardless of resource-holder eg primary, community, secondary and ambulance;
- areas of perceived waste;
- areas of perceived variation;
- capital investment;
- alternative sources of funding to support innovative work to deliver transformational change, for example, Integrated Care Fund, Inverse Care Programme, Invest to Save, Social Enterprise funds.

For 2014/15 as a transitional year the Resource Envelope will be related to the annual income value to WAST from Health Boards for 2014/15 [including the £7.5m allocated by Health Boards during 2013/14]; and in particular the utilisation of WAST's staffing resources.

In relation to the WAST's utilisation of staffing resources health boards will require information in a form to be determined but to include inter alia:-

a) maximisation of Frontline Operational staff resources, that is, the substitution of overtime for permanent staff as indicated within WAST's draft Integrated Business Plan (IBP V11 – 28/3/14);

b) the recruitment plan for permanent Frontline Operational staff which has the right skill mix to deliver an effective and efficient clinical model of delivery;
c) the outcomes from a) above in relation to, for example:
    - sickness absence impact from recruitment and deployment of Frontline Operational staff resources;
    - overtime impact from recruitment and deployment of Frontline Operational staff resources;
d) the rota changes as a consequence of recruitment of Frontline Operational staff resources;
e) investment in the Clinical Contact Centre as also indicated within WAST's Integrated Business Plan (IBP V11 – 28/3/14).

WAST will produce for agreement of the EASJC a performance improvement plan which should be reflective and consistent with WAST's internal delivery plan and will include any new initiatives to be implemented as a consequence of the £7.5m investment, for example, the "batching" project. It should also explain how the £7.5m will unlock the potential for spending the £110m differently which will improve WAST capacity and capability to improve performance.

Specifically this plan will align with the content of WAST's Annual Delivery Plan (ADP) 2014/15 and be known as the WAST Performance Improvement Plan (PIP) 2014/15 for emergency ambulance services and is required to show for each quarter of 2014/15 the specific actions planned by WAST – for example the appointment and deployment of Urgent Care staff – plus, any new Models of Care, together with the associated improvement in performance – Category A and Handover – across Health Board areas. In addition, any enablers or dependencies by Health Boards to support its effective delivery need to be identified.

The PIP is to be produced by WAST before the end of **Quarter 1 2014/15**.

Part 4 – Models of care

Models of care:

- will be consistent with Prudent Healthcare;
- must be able:
    - to meet the clinical standards;
    - to meet the Evaluation criteria for the impact of the framework which is proposed as improving patient outcomes, improving patient experience and demonstrating Value for Money;
    - to support the delivery of new models of hospital care from NHS Wales Regional Reconfiguration Programmes;
    - to complement and support new developments in clinical practice;
    - to balance national expectations / standards with local responsiveness and need;
- must be joined up across the health system and link with other public services eg local authority, police;

- are underpinned by an acceptance that there may be different models of delivery across Health Boards dependent upon epidemiological, demographic or geographical factors.

For 2014/15 as a transitional year the Models of care – which are not at present defined – will be those which will be outlined within the ADP and detailed within the PIP required by the end of **Quarter 1 2014/15** for approval of the EASJC as identified in Section 3.

Part 5 – Operational arrangements

Operational arrangements must:

- be consistent with Prudent Healthcare;
- include who is accountable and responsible for what;
- provide clarity around who does what across all parts of health care system (operational working practices / protocols);
- clarify performance management arrangements to improve quality;
- identify how the *"money will flow from Health Boards as purchasers to the delivery organisation"* (Minister's statement July 2013).

For 2014/15 as a transitional year the Operational arrangements will be limited to:

- Accountabilities & Responsibilities: to be defined by the EASJC as part of formalising their own governance structure and clarifying accountabilities and responsibilities for Emergency Ambulance Services with for example Welsh Government, Welsh Audit Office and Health Inspectorate Wales.
- Operational Working Practices: any opportunities to improve operational performance from the identification of exemplar working practices, to be considered for early adoption across NHS Wales by the Task & Finish Collaborative Commissioning Project Delivery Group and recommended for approval to the EASJC.
- Performance Management: as outlined in Part 6.
- Finance: The basis of the financial agreement for WAST in 2014/15 is on a "block basis". The agreed financial value for 2014/15 payable to WAST from Health Boards and the detailed components of the financial agreement are shown in the Finance Schedule included as Appendix Three. Exclusions to this sum will be:
    - extant developments by individual Health Boards;
    - any Major Incident event(s) which will be subject to a separate pricing mechanism that will reflect actual additional costs incurred and an "open book" approach to verifying costs by the Commissioning Collaborative before payment is made.

Any existing initiatives currently funded individually, or collectively, by Health Boards which are in excess of the sum detailed in the Finance Schedule. To be identified by Health Boards during **Quarter 1 2014/15** and highlighted within an updated Finance Schedule.

Any existing initiatives which are currently under discussion by Health Boards either individually or collectively with WAST regarding service change are to be identified and collated by the Collaborative Commissioning Project Delivery Group during **Quarter 1 2014/15**.

Part 6 – Reviewing performance

The reviewing of performance needs to:

- be consistent with Prudent Healthcare;
- apply across all parts of the healthcare system;
- include measurements which cover infrastructure measures, process measures and outcome measures and enable trend analysis;
- ensure any improvement measures have an agreed action plan including timeframe for delivery.

There will be a collaborative (joint Health Board & WAST) quality and performance approach during 2014/15, which will enable:-

a) regular performance reporting to the EASJC;
b) regular performance reporting across all Health Boards and WAST;
c) opportunities for preventive action and/or adoption of exemplar practices to be identified;
d) a review and revision if necessary to the current WAST Balanced Scorecard as shown in Appendix Four.

In advance of the review and revision referenced in d) above, WAST will provide on the **15th day of each month** the Balanced Scorecard and the supporting data used to calculate the performance measures therein, to the Head of Performance & Information (Welsh Health Specialist Services Committee) who will be responsible for collating and distributing the information.

To support delivery of both the production of the commissioning framework and the new performance management arrangements, WAST will identify by **16th May** and make available from the **1st June**, the Clinical Leadership of 1 WTE of a dedicated senior paramedic who can perform an "intelligent customer function".

The Collaborative Commissioning Project Delivery Group will determine during **Quarter 1 2014/15** the performance reporting and monitoring arrangements for 2014/15 which they will recommend to the EASJC. These will be reflective of interim arrangements for 2014/15 as a transitional year before the establishment of the new commissioning framework for 2015/16. It will need to consider ad-hoc / day to day requests and issues; regular reporting and developmental requirements.

In addition, during the year there will be an expectation to develop specific emergency ambulance services performance information which fit with any development of integrated data sets to support system wide improvements.

Part 7 – Evaluation

The Evaluation of the impact from the commissioning model must:

- meet Prudent Healthcare expectations;
- be based upon:
  - outcome measurements which are readily available with the current baseline position identifiable;
  - criteria which should also be used when assessing proposed Models of care;
- evidence of improvement in for example service delivery and patient outcomes, which are: transparent; robust; used to show trends and promote continuous improvement; able to give assurance around quality and safety.

For 2014/15 as a transitional year, the Evaluation work to be conducted will inform the new commissioning framework and will be focussed upon the following:-

1. The outcomes and potential benefits of the new indicators for Cardiac, Stroke and Fractured NoF.
2. The outcomes of WAST initiatives to de detailed within their PIP (Performance Improvement Plan) as referenced in Parts 3 and 4.
3. The production of the new commissioning framework including for example processes; relationships and developmental needs.

During **Quarter 1 2014/15** the Collaborative Commissioning Project Delivery Group will identify potential collaborators such as Public Health Wales and academic and improvement organisations for supporting the development of the criteria, methodology and responsibility for conducting these evaluations.

Signed on behalf of the Commissioning Collaborative

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[Mr Bob Hudson Lead CEO]

Date

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Signed on behalf of the Provider

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[Mr Elwyn Price-Morris, CEO WAST]

Date

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Care standards – Presented across Ambulance Service Care Pathway (ASCP)

Standards in **bold** are applicable for 2014/15
Standards in *italics* are under development for the new commissioning framework

Ref.	Standard	Performance Measures*	Opportunities for consideration
Area	**A- Supporting the appropriate use of 999 / urgent ambulance services**		
1	*WAST must maximise the use of LHBs available existing alternative pathways to minimise the use of the ambulance service as a first response*		
2	*WAST must provide the public with appropriate access to high quality advice, support and care*		
Area	**B- Ensuring appropriate access**		
3	**WAST must answer all 999 calls promptly**	• **95% of 999 calls answered within 6 seconds**	• Should we agree a standard for answering urgent calls which may reflect an "whole system approach"?
Area	**C- Ensuring appropriate response to call**		
4	*WAST must ensure procedure in place to identify life threatening conditions with minimum delay*		
5	**WAST must ensure an emergency response is dispatched with minimum delay to immediate life threatening calls**	• **a minimum of 65% of responses arrive within 8 minutes**	• Should we have parity & consistency with the reporting of the 75% NHS England target? • Should Wales have a national requirement for "truly life threatening conditions" eg Cardiac Arrest, CPR in progress 4 minutes?
6	**WAST must ensure an appropriate response is dispatched with minimum delay to serious, non-life threatening calls**	• **95% of Face to Face assessments in 30 minutes**	• Could existing LHB services respond to some calls?
7	*WAST must ensure an appropriate response to non serious, non-life threatening calls – "signposting" to the correct care option within NHS Wales ("hear & direct")*		• Enhanced role for ambulance service to enable correct care option for citizen?
8	**WAST should ensure all appropriate non-life threatening calls are diverted to "hear and treat"**	• **95% of immediate telephone assessments are transferred within 10 minutes** **call back of 95% of callers requiring clinical triage in 10 minutes**	

9	***WAST must ensure there is in-vehicle technology and systems to*** *ensure the ambulance response arrives at the correct location of the incident by the most appropriate route*		
10	*WAST must ensure that where dispatch is required, the correct type of ambulance vehicle (ie correctly staffed) to provide patient care is deployed*		Development of ambulance service workforce to reflect patient need eg an Urgent Care Service?
Area D - Provision of treatment or intervention by the right person, in the right place at the right time			
11	**WAST must ensure via telephone assessment, "hear & treat" is the first choice intervention whenever clinically safe and appropriate**	• **call back of 95% of callers requiring clinical triage in 10 minutes** • **immediate telephone triage calls to be closed with no transport required**	
12	*WAST must ensure see, treat & referral is the second choice intervention whenever clinically safe and appropriate*	• *Face to Face triage to be closed with no transport required*	• Should link to Standard 1 and 7 above?
13	*WAST must only convey patients to hospital where no alternative eg community-care or other care-professional is safe or available to meet the care needs of the patient*		• Should link to Standard 1 above?
14	*WAST must undertake clinical interventions at scene within the scope of practice of the attending clinician*		• Should link to Standard 10?
15	**WAST must ensure all interventions adhere to best practice eg JRCALC**	• **% of Acute Coronary Syndrome patients who are documented as receiving appropriate STEMI care bundle** • **% of patients who receive pre hospital thrombolysis within 60 minutes** • **% of stroke patients who are documented as receiving appropriate care bundle** • **% of older people who have fallen and have suspected fracture of hip / femur who are documented as received analgesia**	• Should offer numerous opportunities for focus on clinical quality, safety and patient outcomes rather than time-based process targets?

Area	E- Ensuring safe and effective care transition		
16	*WAST must ensure conveyance by EMS is only undertaken when the patient condition requires ALS intervention/monitoring on route to hospital*		• Should link to Standard 10? • May require ALS first responder and BLS transport?
17	*WAST must ensure that all patient information is passed to the receiving clinician in an appropriate format*		• Should there be electronic data transfer? • Should ambulance service have access to LHB patient records as per Out of Hours services?
18	*WAST must ensure that all vehicles are replenished and disinfected after handover of care with the minimum delay*		• Should correlate with Infrastructure Standards?
19	*WAST must ensure there is clear and accessible information available to patients where they are discharged at scene eg a head injury advice card*		• Should improve safety of decision making at scene?
20	*WAST must ensure that they promote and protect the welfare and safety of Patients at all times*		

***Current Performance Measures**

Care standards – Key Infrastructure Requirements
(Under development for the new commissioning framework)

Governance

- *WAST must meet all regulatory requirements eg Health & Safety, COSHH*
- *WAST must ensure Patients needs in respect of race, sex, sexual orientation, disability, age, religion or belief, gender reassignment are identified and addressed*
- *WAST must ensure the promotion of equality and diversity is part of the staff induction programme and mandatory training programme*
- *WAST must ensure there are effective internal systems and processes in place to assure patients, commissioners and other stakeholders, that they are providing patient focussed high quality, evidence based care and treatment*
- *WAST must ensure the views of service users and patients are sought and actively used to inform service improvement and development*

Safeguarding

- *WAST must ensure they promote and protect the welfare and safety of patients at all times*
- *WAST must ensure there is clear and accessible information available to patients and staff detailing how they can raise concerns about abuse/potential/perceived abuse*

Workforce

- *WAST must ensure employees are appropriately recruited, trained, qualified and competent for the work they undertake*
- *WAST must ensure its clinical staff are led, supervised and supported by an effective model of clinical leadership*

Resources

- *WAST must ensure they service, maintain and store all medical and diagnostic equipment in line with manufactures recommendations and legal requirements*
- *WAST must ensure its vehicle fleet is modern, reliable, safe and effectively configured to deliver the Ambulance Service Care Pathway (ASCP)*
- *WAST must ensure its estate is effectively configured to support staff in their role of delivering the*
- *Ambulance Service Care Pathway (ASCP)*

Activity Schedule (Indicative)

[To be completed & replaced by Health Boards & WAST via Collaborative Commissioning Project Delivery Group during 1st Quarter 2014/15]

Activity in relation to services within the scope of the responsibility of the EASC, to include by Health Board area the 2013/14 outturn for:

- **responses to emergency calls via 999**
- **urgent hospital admission requests from general practitioners**
- **high dependency and inter-hospital transfers**
- **urgent patient triage by telephone**

Relevant activity to calculate existing performance measures ie numerator & denominator if applicable, by Health Board area the outturn for 2013/14 for the measures, as follows:

- **95% of 999 calls answered within 6 seconds**
- **a minimum of 65% of responses arrive within 8 minutes**
- **95% of Face to Face assessments in 30 minutes**
- **95% of immediate telephone assessments are transferred within 10 minutes**
- **call back of 95% of callers requiring clinical triage in 10 minutes**
- **immediate telephone triage calls to be closed with no transport required**

Relevant activity ie numerator & denominator if applicable to enable new indicators for the key treatment areas of cardiac arrest, strokes and fractured Neck of Femur (NoF) to be calculated as follows:

- **% of Acute Coronary Syndrome patients who are documented as receiving appropriate STEMI care bundle**
- **% of patients who receive pre hospital thrombolysis within 60 minutes**
- **% of stroke patients who are documented as receiving appropriate care bundle**
- **% of older people who have fallen and have suspected fracture of hip / femur who are documented as received analgesia**

Plus, other activity considerations which may be supportive of new indicators as follows:

- **Cardiac**
  - Chest pain calls
  - Calls requiring ALS response
  - Diagnosis of STEMI calls
  - 12 lead ECG
  - STEMI care bundle used
  - Conveyances to Cath lab
  - Conveyances to ED
  - Thrombolysis numbers
  - Number of Primary Coronary Interventions (PCIs)
  - Number of rescue PCI
  - Conveyances to nearest available facility with reason
  - Conveyances to most appropriate facility
- **Stroke**
  - Suspected stroke calls
  - Use of FAST via telephone advice pre-arrival
  - FAST assessment Face to face
  - Positive FAST tests
  - Negative FAST tests
- **Fractured NoF**
  - Face to face assessments
  - Suspected #NOFs
  - Immobilisations
  - Analgesia – basic to advanced
  - Destination ED
  - Destination Orthopaedic Ward
  - Source of admissions eg home, care home, etc
  - Conveyance rates to Orthopaedic dept

Finance Schedule

Payments

Payments against this agreement will be made on the first working day of each month and will be for one twelfth of the annual sum via Welsh Health Specialised Services Committee on behalf of the EASC.

Adjustments to payments to account for changes in the agreement or performance variation will be subject to individual agreement. The default position will be:

- In year variation – agreed variations will be adjusted to the monthly payments over the remaining months of the financial year.
- Performance variation – performance variation payments will normally be made in month 1 or month 2 of the following financial year depending on receipt of financial performance information for the year.

Contract Sum Payable – 2014/15 Financial Year

The initial contract sum is set out in the table below and will be amended following any subsequent in year agreement.

Core Baseline	£'000
Revenue	86,123
Capital Charges	12,264
Welsh Government Pass Through Allocations	
Air Ambulance	597
ARRP	2,770
In YearAdjustments	
VERS (adjustments to be agreed in year)	-
Re-basing to Flat Cash	1,250
Agreed Transformation Plan	7,500
Neo-natal transport baseline	199
TOTAL CONTRACT SUM 2014/15	110,703

Location Variation

Any additional local variations from individual health boards will be notified as in year variations.

Current [2013/14] WAST Balanced Scorecard

KPI Monitoring Scorecard - All Wales

Monthly Executive Key Performance Scorecard 2013/2014

Section	Ref	Description	Target
Outcomes	O03	% of patients who received pre-hospital thrombolysis within 60 minutes	70.0%
	O04	% of Acute Coronary Syndrome patients who are documented as receiving appropriate STEMI care bundle	100.0%
	O06	% of stroke patients who are documented as receiving appropriate stroke care bundle	-
	O07	% of older people who have fallen and have suspected fracture of hip / femur who are documented as receiving analgesia	100.0%
	O08	% of older people who have fallen and have suspected fracture of hip / femur admitted to an appropriate hospital within 60 minutes	100.0%
	O10	Number of EMS complaints	-
	O11	Number of PCS complaints	-
	O13	Number of adverse incidents (EMS & PCS)	-
	O14	Number of safeguarding children referrals	-
	O15	% of written safeguarding children referrals submitted within the standard of 2 working days	100.0%
	O16	Number of POVA referrals	-
	O17	% of written POVA referrals submitted within the standard of 2 working days	100.0%
Process	P02	EMS call abandonment rate (primary line only)	2.5%
	P03	% of 999 calls answered within 6 seconds	95.0%
	P04	% of 999 calls where pickup time to location verification was within 30 seconds	75.0%
	P05	% of Incidents where chief complaint identified within 30 seconds of location verification	50.0%
	P06	% Calls categorised as Category A	30.0%
	P10	% Response rate to Category C calls planned clinical telephone assessment within 10 minutes	90.0%
	P11	% of 999 calls where the time from location verification to allocation was within 30 seconds	65.0%
	P13	% of Cardiac arrest calls provided with a defibrillator response within 4 minutes	52.0%
	P14	% of Responses to Category A calls within 8 minutes	70.0%
	P15	% CFR contribution to Category A performance	5.0%
	P16	% Incidents treated at scene with no transport required	20.0%
	P17	% Patients referred to alternative provider	8.0%
	P18	% Conveyance rate to A&E department	60.0%
	P19	% Notification to handover within 15 minutes	95.0%
	P21	% Handover to clear within 15 minutes	100.0%
	P22	% of PCS patients arriving within 30 mins either side of their appointment time	70.0%
	P23	% of PCS discharge / transfer patients picked up within 60 minutes of ready time	70.0%
	P24	% of PCS outpatients picked up within 60 minutes of ready time	70.0%
	P26	% of Requested transporting vehicles arriving within 19 minutes of request for backup	95.0%
	P27	% of Category C planned face to face assessment responses within 30 minutes	95.0%
	P28	% of Card 35 incidents (pre-planned admission requests from HCPs) where response was within the pre-arranged time	95.0%
Learning and Improvement and Support Services	L02	% of planned training delivered	90.0%
	L03	% sickness absence	5.6%
	L04	% overtime (EMS)	5.0%
	L05	% of EMS relief capacity	-
	L07	Number of violence and aggression incidents reported by staff	-
	L08	Number of injuries reported by staff	-
	L09	Number of grievances	-
Value for Money	V01	Actual expenditure YTD as % of budget expenditure YTD	-
	V02	Actual Trust surplus/deficit YTD - £000	-
	V03	Actual savings YTD as % of planned savings YTD	-
	V04	YTD % of non-NHS creditor invoices paid within 30 days of receipt of invoice	-

Meets Defined Target | **Just Below Defined Target** | **Not Meeting Defined Target** | **Data Not Currently Available**