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 Emergency Ambulance Services Committee – PAS(F)04 / Tystiolaeth gan Bwyllgor Gwasanaethau Ambiwlans Brys – PAS(F)04

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

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.

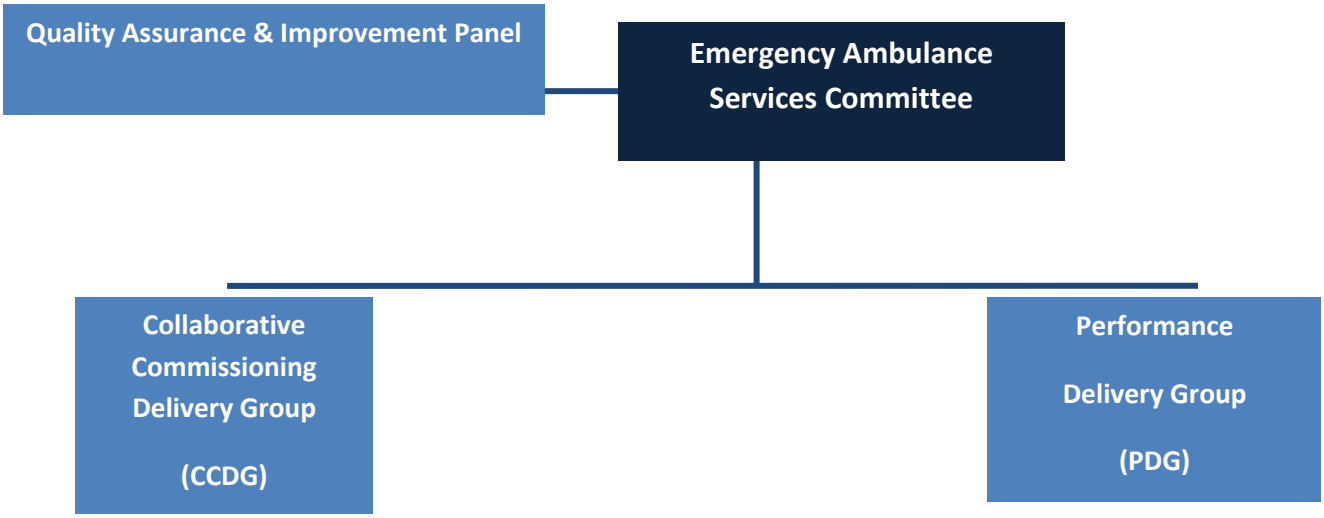
14. All seven Health Boards are engaged with EASC. EASC is provided in line with the Emergency Ambulance Services Committee (Wales) Regulations 2014. These regulations require that "*seven Local Health Boards in Wales work jointly to exercise functions relating to the planning and securing of emergency 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.

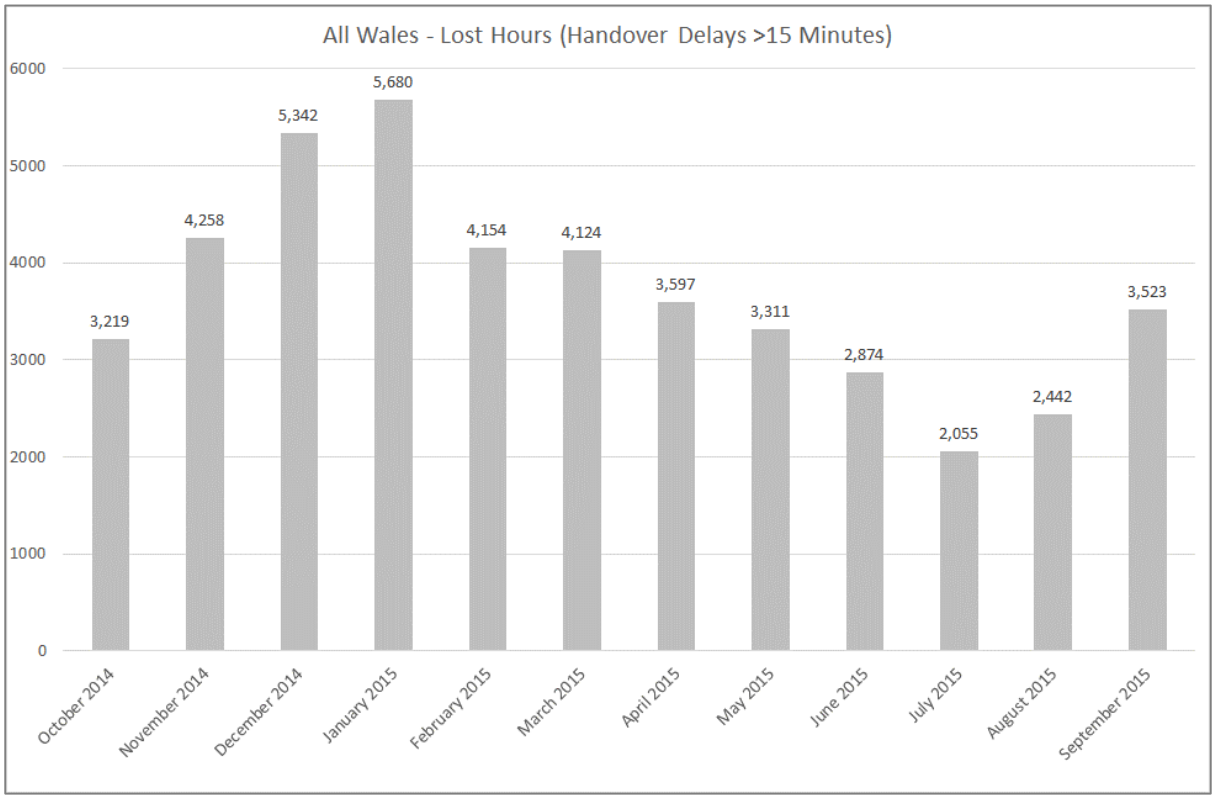
c. The *Collaborative Commissioning Group* is attended by ambulance commissioning champions from each Health Board. These champions represent primary care, planning, commissioning and community care functions within Health Boards. This group manages, maintains & monitors the implementation and development 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
Fax/ffacs: [redacted]
Email/ebost: [redacted]

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