



<b>Reporting Committee</b>	<b>Emergency Ambulance Services Committee</b>
<b>Chaired by</b>	Chris Turner
<b>Lead Executive Directors</b>	Health Board Chief Executives
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<b>Date of last meeting</b>	12 July 2022

**Summary of key matters including achievements and progress considered by the Committee and any related decisions made.**

An electronic link to the papers considered by the EAS Joint Committee is provided via the following link: <https://easc.nhs.wales/the-committee/meetings-and-papers/july-2022/>. The minutes of the EASC meeting held on 10 May 2022 were approved.

**CHAIR'S REPORT**

Members noted:

- the recent meetings attended by the Chair including the Appraisal with the Minister for Health and Social Services on 30 May 2022. The Chair confirmed that it would require a collaborative effort working with the Committee, Welsh Ambulance Services NHS Trust (WAST) and health boards (HBs) to deliver the objectives relating to reductions in handover delays.
- the meeting with the Chief Ambulance Services Commissioner (CASC), WAST Chair and Chief Executive and WAST Sub-Committee Chairs on 1 July 2022. Both the Chair and Jason Killens reported that all present at the meeting felt this was a useful session with all able to share their concerns in relation to quality, safety and patient experience.
- the meeting with Judith Paget, Chairs and Chief Executives on 8 June 2022. Members were aware that the Chairs and Chief Executives had made a commitment to improve immediate release requests.

**'FOCUS ON' PERFORMANCE REPORT**

The significant challenge in the provision of timely ambulance services at present was noted and the actions being taken and opportunities to drive improvement were discussed in the Focus on session which included:

**Recent high-level outputs from the Performance Report**

- Red performance remained extremely challenging (at approximately 50%) with some variation noted
- Increasing median response times (approximately 7minutes 50seconds) and the implications in terms of the response for patients and outcomes
- Median response times for Amber 1 patients (over 2 hours)
- Increasing lost hours (baseline last October of approximately 74 minutes with current average handovers of approximately 2 hours)
- 4 hour waits for patients continue to be significant with in excess of 100 x10 hour plus waiting times.

## **EASC Action Plan**

It was noted that the EASC Team has been asked via the Welsh Government (WG) Integrated Quality, Planning and Delivery (IQPD) meeting to enhance the existing EASC Action Plan to provide one overall comprehensive plan with the focus on the improvement priorities and actions for the remainder of 2022-23.

The work undertaken, led by the CASC working with WAST and health board teams as part of the fortnightly handover improvement plan meetings, was noted including:

- the agreement of trajectories against the 25% reduction on the minutes lost per arrival and no handover delays over 4 hours
- the undertaking of an annual review at the end of September 2022 against the trajectories
- the number of core actions being undertaken across each health board
- an element of variation in some of the other actions being undertaken by health boards
- the impact that these actions would have on the trajectories and in ensuring the required progress was made.

The EASC Action Plan would continue to be developed to reflect the discussions with Chief Operating Officers (COOs) and WAST and reported via the existing EASC governance arrangements, via the NHS Wales Leadership Board and also through the WG IQPD process.

Members commented that:

- the weekly WAST Performance Dashboard (of management information) circulated by the EASC Team was very helpful and provided up to date live information that health board teams could relate to the previous week, month and 3 monthly trend
- information relating to immediate release was not as transparent and it was requested that it could be added to the dashboard as a weekly metric. It was agreed that the EASC Team would work with WAST to provide this information as soon as practicable. A live PowerBI dashboard for Immediate Release Directions (previously red release requests) would be available to all NHS Wales colleagues from week commencing 25 July 2022 as a screen in the current WAST health board view of the Operational Delivery Unit PowerBI data set
- the focus should be on the actions with the highest impact
- there was a need as individual Chief Executives to take responsibility for communicating decisions and agreements made to their respective Boards thus ensuring the required openness and transparency. This would ensure that Boards had oversight of the actions individual HBs were committed to and would ensure that Executives and Independent Members were clear on the actions being taken locally and nationally to improve system safety and the patient experience.
- The EASC Action Plan would be shared at the NHS Wales Leadership Board.

## **Handover Delays**

- An update was provided on the local fortnightly meetings being held between the CASC, COOs and WAST. This included the development of handover improvement plans for each health board, agreed trajectories for each organisation against the 25% reduction on the minutes lost per arrival and no handover delays over 4 hours, core actions being taken across the system and an element of variation in some of the other actions being undertaken.

Members noted a number of core actions to avoid conveyance including:

- the advanced paramedic practitioner and its navigator role (SBUHB)
- the need to explore the impact on the number of conveyances into emergency departments (EDs) and continuing to link in with flow centres, community hubs and primary care clusters to maximise the opportunities
- the potential for WAST access to urgent primary care centres
- the increased use of 111
- the likely impact of same day emergency care services (SDEC) following the immediate success of the Hywel Dda UHB pilot, although the likely staffing challenges were noted
- 111 press 2 for Mental Health (MH) and its likely impact due to the number of MH calls to WAST.

It was agreed that the next version of the EASC Action Plan would focus on the increasing number of long wait handovers.

The principle of the importance of immediate red release was agreed, there was a concern about its viability at the present time. A proposal for maximising the impact of this was therefore made relating to compliance (of immediate release) when approaching the 4-hour deadline and the significant impact that this could have in terms of freeing up ambulance resources. Members noted that this would require the right conversation at the time between the hospital and ambulance control to ensure risks are balanced in the moment.

Members noted issues relating to the lack of social care input (and ambulance services) and a proposal was made to consider the inclusion of a social care practitioner in the WAST control room to ensure that the social care requirements were identified to avoid ambulance conveyance to EDs; this could also be extended to provide an advice line for care homes. Other opportunities, such as having a national maternity line, would be explored further with the WAST Team, COOs and the EASC Management Group as appropriate.

### **Red Demand and Variation**

- Variation in terms of red performance was noted and an acceptance that this variation needed to be reduced.
- It was agreed that further work would be undertaken with Optima with a view to facilitating a presentation at a future meeting of the Committee to broaden colleagues understanding of the drivers of variation in red performance.

### **Performance Reporting**

- Members noted exciting work relating to the linking of system wide data with Digital Health Care Wales which described and tracked the patient's journey through the system and how this could present opportunities for improving the design of services.
- Members noted that the most important aspect currently being looked at was the application of the WAST Clinical Safety Plan, in particular understanding the impact of higher levels of CSP on patients waiting in the community. The risk and harm that patients could be exposed to, and also quantifying the impact of the non-attendance of an ambulance, would be areas to be focused on next.

- Members queried whether there was any evidence to suggest that escalation of the WAST CSP impacted on the numbers of patients attending ED by their own means; and also, the impact that this had on those waiting outside in an ambulance. Members noted that progress was slow as this was a complex and extensive data set and work to retrospectively track patients following 'can't send' and other touch points with health services were expected to provide clarity in relation to levels of harm and the impact of prioritisation.

Members were asked to note that the two commitments (25% reduction on the minutes lost per arrival and no handover delays over 4 hours) had been referred to by the Minister for Health and Social Services as part of the update on the Six Goals for Urgent and Emergency Care Programme on the 19 May 2022 and were the subject of recommendations by the Health and Social Care Committee in their recent report on Hospital discharge and its impact on patient flow through hospitals.

Members noted the information contained within the latest version of the Ambulance Service Quality Indicators (April & May 2022) and are available at this link <https://easc.nhs.wales/asi/> .

Following discussion, Members **RESOLVED** to:

- **NOTE** the content of the report.
- **NOTE** the Ambulance Services Quality Indicators
- **ENDORSE** the EASC Action Plan
- **ENDORSE** the handover improvement trajectories
- **NOTE** the performance reporting information submissions.

## **QUALITY AND SAFETY REPORT**

The Quality and Safety Report provided Members with an update on quality and safety matters for commissioned services. The following areas were highlighted:

- the work of the Healthcare Improvement Wales (HIW) Task & Finish Group established to coordinate and lead the work in response to the recommendations made as part of the HIW Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover
- progress of the NHS Wales Delivery Unit on Appendix B Task & Finish Group which will be established to review the process related to serious incident joint investigation framework; working between WAST and health board and make recommendations for improvement
- the general growth in the demand and focus on quality and safety issues closely linked to the deteriorating performance position.

Members **RESOLVED** to:

- **NOTE** the content of the report
- **NOTE** the impact of deteriorating performance and the resulting challenges in commissioning the provision of safe, effective and timely emergency ambulance services
- **NOTE** the provision of Quality and Safety Reports relating to commissioned services at all future meetings.

## **PROVIDER ISSUES**

Jason Killens, Chief Executive at the Welsh Ambulance Services NHS Trust (WAST) gave an overview of key matters including:

- the seasonal forecasting and modelling undertaken by WAST as a matter of routine and the concerning modelled results
- WAST had updated its tactical Performance Improvement Plan with specific action for the summer months
- WAST was currently at escalation level 3 (maximum 4)
- in the last 3 months, 33 patient safety incidents had been shared with health boards as part of the joint investigation framework (known as Appendix B).
- lost hours in relation to handover delays for May totalled 22,080 hours (18% of WAST's total capacity or 25% of total conveying capacity)
- WAST has recently introduced a new Managing Attendance Plan with seven work-streams and improvement trajectories. The Plan was being reported to the Executive Management Team every two weeks
- Post-production Lost Hours (PPLHs) amounting to 5,835 hours were lost in May-22 for a range of reasons e.g. vehicle defect, trauma stand down, police interview, etc. Members noted these could not be viewed as areas for potential efficiencies.
- detailed the significant programme of work relating to the Non-Emergency Patient Transport Service (NEPTS) including to further assess the benefits of the all Wales business case and the transfers of work from HBs. Members noted that a roster review to maximise efficiency would be undertaken with implementation expected in 2023-24.

Members noted that the 4-stage process to develop rosters had been completed, with the new rosters implemented from September 2022 starting with Hywel Dda University Health Board. It was confirmed that the roster review roll-out would continue as follows:

- Cardiff and Vale UHB in late September
- Swansea Bay UHB in early October
- Aneurin Bevan UHB during mid-October
- Cwm Taf Morgannwg UHB in late October
- Betsi Cadwaladr UHB in early November and
- Powys mid-November 2022.

Members noted that each health board would benefit from growth in terms of total numbers of staff and a commitment was made to ensure that there would be no reduction in emergency ambulance cover in West Wales. However, there would be changes in the mix of the fleet including less single staffed cars and an increase in double staffed resources. It was agreed that more information would be provided by WAST on a health board by health board basis.

Stephen Harray updated Members in relation to the ongoing work WAST to ensure the required progress was made against key elements of work within the report including:

- the roster review programme equated to approximately 70 additional WTEs
- supporting the constructive discussions with the staff side representatives regarding working practices – it was noted that indicative timescales would be helpful and would be provided in the next report
- the improvement trajectories for sickness as part of the new Managing Attendance Plan

- the role that first responders could take to supplement ambulance services, although not at the expense of the core ambulance service.

### **Immediate red release**

The Immediate Release Protocol developed by WAST was considered and discussed with a view to agreeing the next steps. It was noted that the protocol had been considered by Chief Operating Officers and set out the national process relating to Red and Amber 1 immediate release requirements.

A conversation was held on the implications of classifying each episode where an immediate release direction was declined as a 'never event' (this was specific terminology used within the Welsh Health Circular WHC / 2018 / 12

<https://gov.wales/sites/default/files/publications/2019-07/never-events-list-2018-and-assurance-review-process.pdf> which did not include immediate release of ambulances). It was agreed that the protocol needed to emphasise the requirement to improve and enhance the escalation process; all were keen not to over complicate the process and there was agreement that WAST would amend the language used and circulate a further version. Once received, Members recognised that each organisation would be responsible for taking the revised protocol through their local governance processes.

Members **RESOLVED** to:

- **NOTE** the WAST Provider Report
- **NOTE** the actions required for the immediate red release protocol.

### **CHIEF AMBULANCE SERVICES COMMISSIONER'S (CASC) REPORT**

Stephen Harray presented the report and highlighted the following:

- Emergency Medical Retrieval and Transfer Service (EMRTS Cymru) and the Wales Air Ambulance Charity had undertaken a strategic review of the service and confirmed that the existing model of four aircraft would be retained for the population of Wales. Members noted that a strategic review of air bases was also being considered in order to maximise coverage. It was noted that this could impact on the location of the existing bases in North Wales. Jason Killens suggested that there could be opportunities to explore efficiencies in co-locating services for EMRTS and WAST and agreed to make contact to discuss potential options
- Temporary funding (£3m non-recurrent funding) for additional ambulance capacity had been secured from Welsh Government to fund additional front-line staff (approximately 100 additional staff members) to support WAST services during these unprecedented system wide pressures. The progress of recruitment, utilisation and impact would be reported via the EASC Management Group and an update on progress provided at the next Committee meeting.

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

### **EMERGENCY AMBULANCE SERVICES COMMISSIONING FRAMEWORK**

Members noted that the approach taken in the development of the Framework had been adapted to provide clarity on the commissioning of core services alongside services considered to be 'transformational,' but optional, within the commissioning arrangements.

Members received a draft of the Framework as an appendix to the report and it included the high-level expectations of the ambulance service and proposed the opportunity to develop local Integrated Commissioning Action Plans (ICAPs). The process would involve more joint working with WAST and health boards to develop plans at a local level. Members noted the process would also provide the foundation for development of the Commissioning Intentions for emergency ambulance services.

In addition to recognising opportunities for national transformation, the local ICAPs would capture the local transformation programmes and their implications for ambulance services, identifying opportunities and developing and tracking resource requirements for delivery. The key principles and content of the draft Framework were endorsed, it was confirmed that the existing Framework would remain extant until the final version was presented and approved.

Following discussion Members **RESOLVED** to:

- **NOTE** the progress made in developing the new Emergency Ambulance Services Commissioning Framework
- **ENDORSE** the content of the Framework and the ongoing plans for development.

### **EASC COMMISSIONING UPDATE**

Members noted that formal confirmation was awaited from Welsh Government regarding the status of the EASC Integrated Medium Term Plan and that a quarterly update with regard progress made against the IMTP would be provided at the next meeting. An update against the Commissioning Intentions (Emergency Ambulance Services, Non-Emergency Patient Transport Services and Emergency Medical Retrieval and Transfer Services) would be provided to EASC Management Group at the August meeting.

### **FINANCE REPORT**

The EASC Finance Report was received and the purpose of the report was to set out the estimated financial position for EASC for the 2<sup>nd</sup> month of 2022/23 together with any corrective action required. No corrective action was required.

### **EASC SUB GROUPS**

The confirmed minutes from the following EASC sub-groups were **APPROVED**:

- Chair's Summary EASC Management Group – 16 June 2022
- EASC Management Group – 21 April 2022
- NEPTS Delivery Assurance Group – 3 May 2022
- EMRTS Delivery Assurance Group – 29 March 2022.

### **EASC GOVERNANCE INCLUDING THE RISK REGISTER**

The report on EASC Governance was received. Governance documentation is available at <https://easc.nhs.wales/the-committee/governance/>

Members **RESOLVED** to:

- **ENDORSE** the risk register
- **NOTE** the progress with the actions to complete the requirements of the EASC Standing Orders
- **APPROVE** the EMRTS DAG Annual Report 2021-2022
- **APPROVE** the EASC Communications and Engagement Plan
- **APPROVE** the EASC Assurance Framework

- **APPROVE** the completion of the Internal Audit on EASC Governance
- **NOTE** the information within the EASC Key Organisational Contacts.

### Key risks and issues/matters of concern and any mitigating actions

- Red and amber performance
- Handover delays (and the development of handover improvement plans in HBs with trajectories)
- Community care capacity

### Matters requiring Board level consideration

- Consider and oversee the implications of the commitment made at the meeting with Judith Paget by Chairs and Chief Executives improve immediate release requests on 8 June 2022.
- To acknowledge the significant risks for patients in relation to handover delays and the need for health boards to implement the local handover improvement plan and identified trajectories) for every emergency department against the 25% reduction on the minutes lost per arrival and no handover delays over 4 hours
- Note that a live PowerBI dashboard for Immediate Release Directions (previously red release requests) would be available to all NHS Wales colleagues from week commencing 25 July 2022 as a screen in the current WAST health board view of the Operational Delivery Unit PowerBI data set
- Note the roll out of roster reviews for each area before the end of November 2022
- From the Performance Report
  - Red performance remains extremely challenging (at approximately 50%)
  - Increasing median response times (approximately 7minutes 50seconds) and the implications in terms of the response for patients and outcomes
  - Median response times for Amber 1 patients (over 2 hours)
  - Increasing lost hours (baseline last October of approximately 74 minutes with current average handovers of approximately 2 hours)
  - 4 hour waits for patients continue to be significant with in excess of 100 x10 hour plus waiting times.

### Forward Work Programme

Considered and agreed by the Committee.

Committee minutes submitted	Yes	✓	No	
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<b>Date of next meeting</b>	<b>6 September 2022</b>
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