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Follow up review – Ambulance Services in Wales



Follow-up review – Ambulance Services in Wales

I have prepared this report for presentation to the National Assembly under the Government of Wales Acts 1998 and 2006.

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National Assembly for Wales on 24 June 2008**



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Summary

- 1 In December 2006, the Auditor General for Wales (the Auditor General) published his report, *Ambulance Services in Wales*, which arose from an inquiry voted for by the National Assembly for Wales (the National Assembly). The report concluded that there were longstanding and severe problems throughout the Welsh Ambulance Services NHS Trust (the Trust) but that they could be resolved over time provided that various internal and external challenges were dealt with. The Trust Board's then draft modernisation plan, *Time to Make a Difference*, which was published in January 2007, set out a direction which addressed the key weaknesses identified. The original inquiry confirmed that the ambulance service's poor performance was more than a matter of not meeting targets, but also could have compromised patient care. The diagnosis of the reasons for such performance was that the ambulance service's very considerable strengths – including the quality of front-line staff, public goodwill and the emerging modernisation agenda – had been let down by weaknesses in all the key aspects of good business management.
- 2 The report contained 28 recommendations for improvement. In December 2007, the Minister for Health and Social Services invited the Chairman of the Trust, Stuart Fletcher, to carry out a review into:
 - the progress the Trust has made against the recommendations of the Wales Audit Office report;
 - the robustness of the Trust's five-year modernisation plan *Time to Make a Difference* and its ability to deliver the further improvements required of the service;
 - progress against the actions identified in the plan; and
 - the effectiveness of infection control and cleanliness in ambulance vehicles.
- 3 The Wales Audit Office has contributed to the Chairman's review by undertaking follow-up work into its original recommendations. The Chairman's report reflects our work. This report sets out in more detail our conclusions and the reasons for them, and includes a high level review of actions taken in respect of the Patient Care Service which did not form part of the Chairman's terms of reference. We considered whether the Trust is well placed to deliver the improvements required by the Wales Audit Office review and its modernisation plan.
- 4 Overall, although we found significant evidence of positive improvements within the Trust through the process of implementing the majority of the Auditor General's recommendations and actions in the modernisation plan, some difficult problems remain. We judge that these problems are only to be expected at this stage of a process of transformational change. In addition, there is a need to manage a series of future risks, including expectations to engender a wider recognition that it will take more time to



implement fully the modernisation plan and bring the Trust to a desired standard of performance.

Recommendations

While the Trust is in the process of implementing all of our recommendations (see Appendix 2), the Chairman's review group made some supplementary recommendations based on the findings of its follow-up work. We agree with the Chairman's recommendations and have included them below.

Performance

- 1 The Trust should build on its good work with acute trusts and Local Health Boards (LHBs) to develop robust plans to address excessive handover and turnaround times where there are particular problems and to ensure compliance with the new Welsh Assembly Government (the Assembly Government) 15 minute standard.
- 2 In monitoring performance, the Trust and its commissioners should also focus on:
 - the time taken to back up the initial response;
 - clinical indicators such as call to needle time;
 - improving benchmarking data to inform decision making;
 - patient transportation rates; and
 - improved specificity of call categorisation.

Strategy

- 3 The Trust should strengthen its strategic planning capacity and develop a clearer vision of the future delivery of ambulance services. As part of this, it should also develop a clear plan to improve relative performance in South East Wales, with a clear timetable for the realisation of its goals.
- 4 The Trust should review its communications strategy to increase awareness of the role, purpose and impact of the modernisation programme and its implementing department, so as to increase the sense of local ownership.
- 5 The Trust should work with NHS partners to:
 - develop a clearer understanding of the volume and nature of demand for unscheduled care services;
 - redesign service provision to meet that demand through alternative service models;
 - reduce pressure on accident and emergency departments through the development of new care pathways which minimise the number of patients taken there inappropriately; and
 - promote relevant training and education programmes to better equip staff to provide an enhanced range of clinical services that would allow them to treat and refer an increasing number of patients without transporting them to hospital.

Governance

- 6 The Trust should maintain its progress towards integrating clinical and corporate governance, embed and disseminate key policies and develop clinical governance structures to support new models of service consistent with the vision set out in the Assembly Government's strategy for unscheduled care, *Delivering Emergency Care Services (DECS)*.

Leadership

- 7 The Trust should further support the development of its executive and non-executive team to better equip it to meet the heavy demands upon it.

People and culture

- 8 The Trust should develop local champions of change to build management capacity at that level. Locality Ambulance Officers, Clinical Team Leaders and other key front-line staff will be crucial elements in this process.
- 9 The Trust must support staff through early recruitment of clinical team leaders, with a clear role and time allocation and management development programmes for those appointed.
- 10 Arrangements for performance appraisal and the identification of development needs must be put in place for all staff. The Trust should make this a priority and set a firm timetable for its achievement.
- 11 The Trust should develop a clear strategy to address issues of morale. It should set clear objectives for its executives, managers and supervisors to contribute to improved morale, as well as improving understanding of the modernisation programme. The ideas emerging from staff focus groups will inform the development of the programme.

Process

- 12 The Trust should build on good progress achieved in analysing demand, changing rosters and developing information systems, by developing detailed local analysis, reviewing allocation of resources between regions, refining demand analysis and developing new service models – particularly in meeting the unique needs of sparsely populated areas and learning lessons from adverse incidents. The engagement and participation of staff is crucial to this process.
- 13 The Trust should build on its early work concerning clinically driven, triage based call handling and despatch systems, taking advantage of the experience being gained in the commissioning of the new south east control at Vantage Point House.

Capacity, systems and infrastructure

- 14 The Trust should agree a clear capital development framework with the Assembly Government, supported by a rigorous benefits realisation framework linking capital investment with the delivery of performance improvement.
- 15 The Trust should develop a clear and detailed estates strategy, with a coherent approach to rationalisation, compliance with statutory duties, 'Make Ready' facilities and social deployment points.
- 16 The Trust should implement the advice appended to the Chairman's report regarding infection control and ensure that it benefits from playing a full part in the wider NHS Wales arrangements in this regard.



Part 1 - There is evidence of positive improvements in the Trust since December 2006

1.1 Our follow-up work identified a number of areas of improvement which the Trust has delivered since our original report of December 2006:

- general improvements in performance;
- the successfully managed integration of NHS Direct into the Trust;
- significant investment in new fleet and clinical equipment;
- the establishment of an entirely new executive team and improvements in governance; and
- systems and processes have been improved.

There have been general improvements in performance since December 2006 although some issues of equity and sustainability remain

1.2 The general improvements in performance which the Trust has delivered since December 2006 centre on the following areas:

- Category 'A' response performance has improved and there has been a generally upward trend in respect of ambulances backing up initial responses;
- GP urgent performance has been much improved through changes in the control

room and the early stages of developing the High Dependency Service (HDS);

- although the gap is closing, regional variations in performance remain;
- the transportation ratio for emergency incidents is falling although it remains much higher than the best performing English services; and
- concerns about the sustainability of the improved performance has arisen since September 2007 as hospital turnaround times have worsened.

Category 'A' response performance and the time taken for ambulance back-ups to arrive have improved

1.3 The Auditor General's report found that patient care could have been compromised by the Trust's consistent failure to provide sufficiently responsive emergency ambulance services, manifested by a failure to achieve performance targets. We repeated our analysis of performance against a number of key metrics, and updated it to take advantage of improvements in the Trust's information systems since our original review. The target with the highest profile relates to the Trust providing a response to 60 per cent of Category 'A' (immediately life threatening incidents) within eight minutes as a milestone to achieving a 75 per cent rate of responses within eight minutes. This target reflects the clinical need to reach those in life threatening situations in time to maximise their chances of survival.

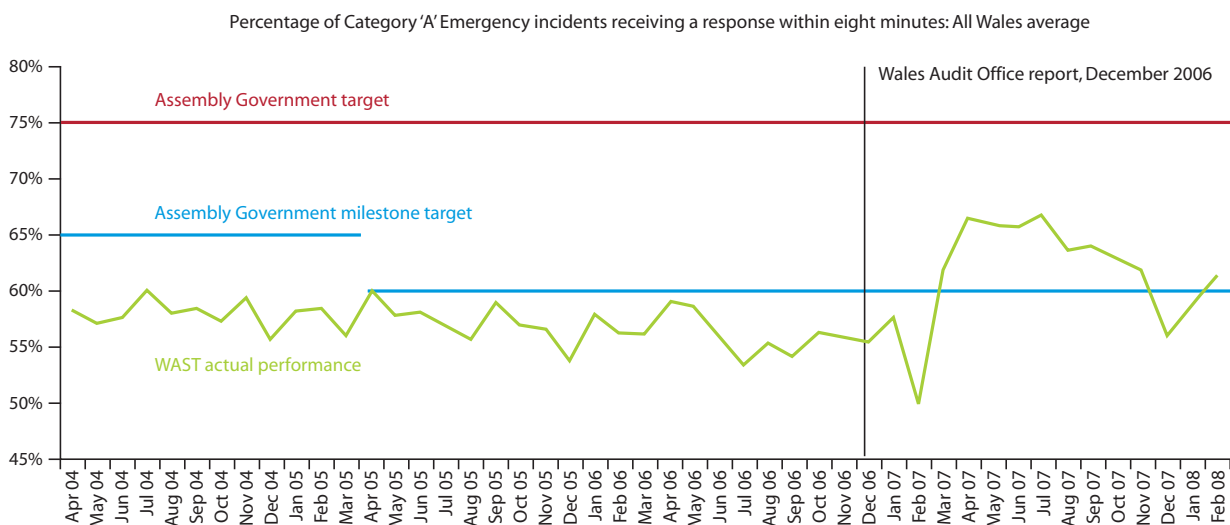
1.4 We found that performance has improved against the eight minute standard. The overall annual performance figure rose from 55.8 per cent in 2006/2007 to 62.3 per cent in 2007/2008. **Figure 1** shows that there was a steep improvement between February and April 2007 which was sustained until July, after which performance dropped below the Assembly Government’s 60 per cent target in December 2007 and January 2008. The drop in performance was affected by hospital turnaround times (paragraphs 1.27-1.34 and 2.47-2.49) but also about challenges facing the whole system of unscheduled care, such as flu and norovirus outbreaks, and problems arising at the ‘back door’ of hospitals in respect of the timely discharge of patients.

1.5 Performance has started to improve once again and was over 60 per cent in February 2008. Nevertheless, although the Trust has generally achieved the 60 per cent standard since our original report was published in December 2006, it is still some way from delivering the 75 per cent standard initially set

by the Assembly Government in 1999 and which applies to English ambulance services.

1.6 One of the primary drivers of the overall improvements in response time performance has been the development of new rosters and deployment which aims to match resources to anticipated demand more accurately. A key element of the Trust’s *Time to Make a Difference* strategy has been the increased use of Rapid Response Vehicles (RRVs), subject to a new RRV policy approved by the Board in January 2008. RRVs are single crewed vehicles that provide an initial response while an ambulance backs them up as a single-crewed car driver cannot transport a seriously ill patient to hospital. There has been public concern, mirrored by many of the staff who contributed to our focus groups, about adverse incidents when very seriously injured people have been waiting with an RRV for excessive periods of time for an ambulance to take them to specialist care in hospital.

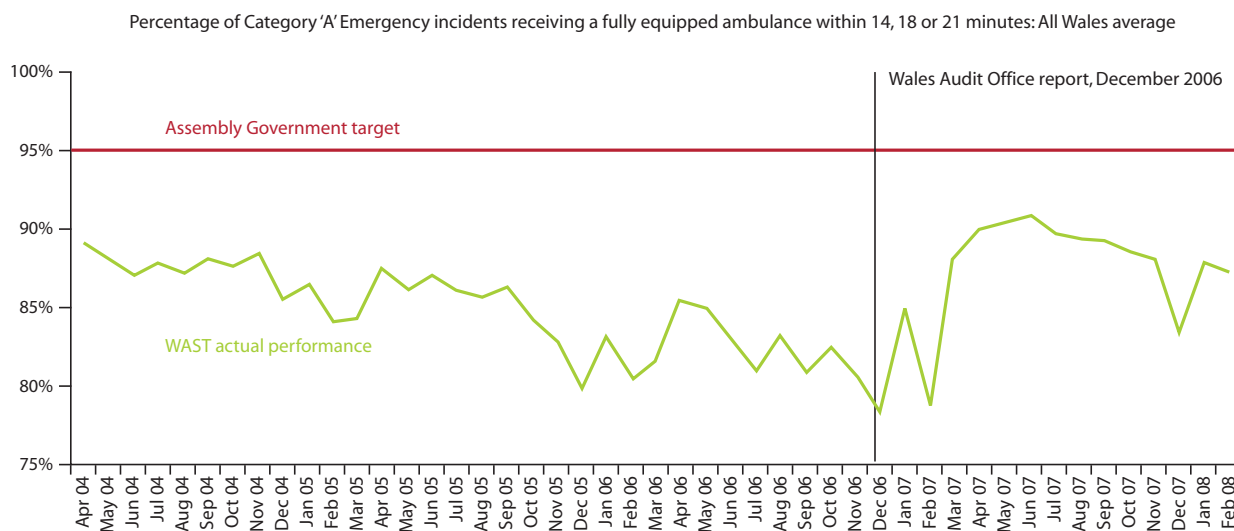
Figure 1: Performance has improved in respect of eight minute responses to Category ‘A’ calls



Source: Wales Audit Office analysis of Trust data



Figure 2: Percentage of Category 'A' emergency incidents receiving an ambulance response within the target time



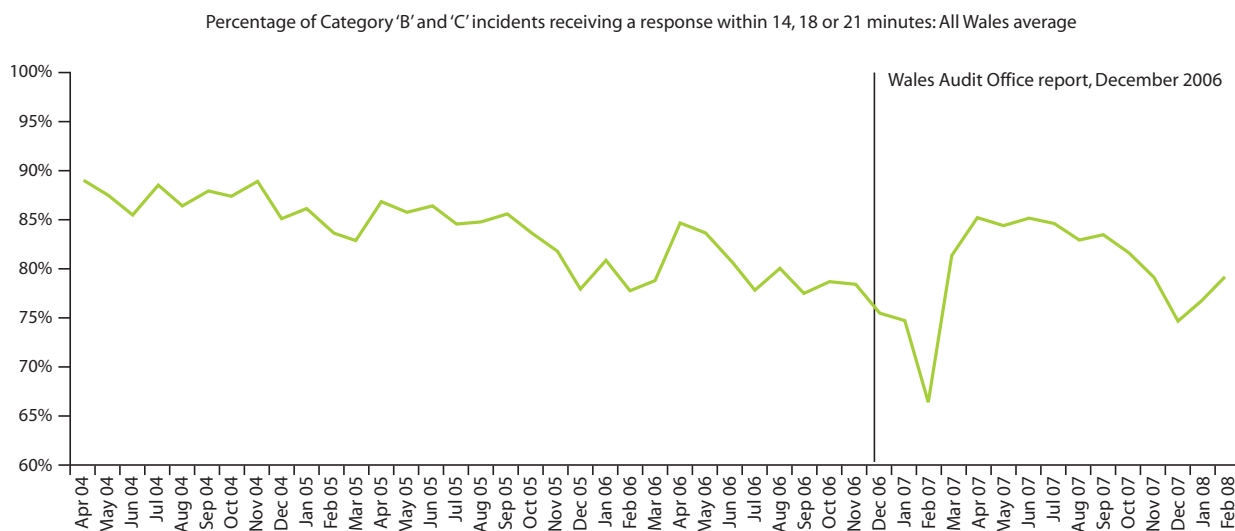
Source: Wales Audit Office analysis of Trust data

1.7 The Trust is subject to additional targets which measure the time it takes for a double-crewed ambulance to attend patients in urban, rural and sparsely populated areas. There are separate targets for both Category 'A' and Category 'B' calls. The degree of compliance with these targets provides a good measure of the extent to which the Trust backs up initial responses from RRVs or community first responders with a fully crewed ambulance to transport patients who need to be taken to hospital. **Figure 2** shows that compliance with the Category 'A' target for ambulance responses has improved by just under ten percentage points between December 2006 (78.5 per cent) and February 2008 (88 per cent).

1.8 Similarly, **Figure 3** shows that there has been a slight improvement in the rate of ambulance responses within target times for Category 'B' and 'C' calls since December 2006, although there has been an overall decline since April 2004.

1.9 As well as percentage compliance with particular time standards, we also analysed the actual time it took for ambulances to arrive where the Trust failed to meet its time targets. The Trust has delivered improved compliance with its targets to back up its initial response with a fully equipped ambulance to transport patients to hospital in the majority of LHB areas between 2006/2007 and 2007/2008. Most LHB areas improved their compliance with time targets for an ambulance back-up between 2006/2007 and 2007/2008. These improvements have been delivered in part because of the abolition of the so-called 'Directive 66' which allowed RRVs to decide whether or not they needed ambulance back-up. An ambulance back-up is now automatically despatched. Taken together, the overall and local improvements in the extent to which an ambulance arrives to back up an initial response within target times suggest that in most cases the use of initial responders, such as RRVs and community first responders, has not been at the expense of ambulances being available to transport patients to hospital.

Figure 3: Percentage of Category 'B' and 'C' incidents receiving an ambulance response within target times



Source: Wales Audit Office analysis of Trust data

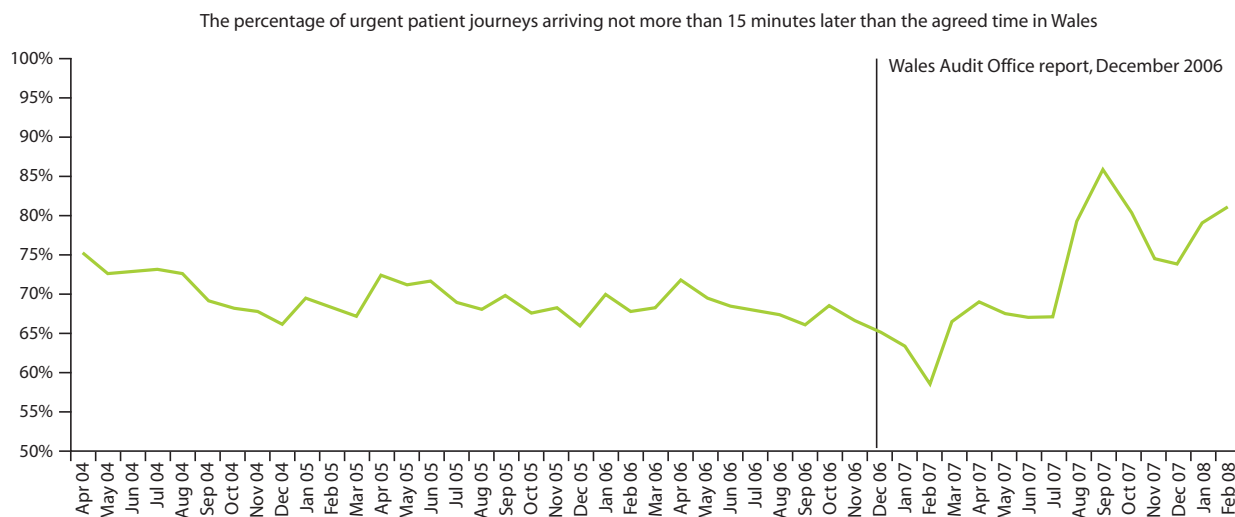
Figure 4: In the 2007/2008 financial year, the majority of calls received an ambulance response within half an hour but there is a much longer tail in the South East region

Category 'A' calls	30 minutes or under	30 to 50 minutes	Over 50 minutes
The Trust	121,214 (95.7%)	2,921 (3.4%)	791 (0.8%)
North	27,498 (99.2%)	175 (0.6%)	23 (0.001%)
Central and West	39,180 (96.1%)	816 (3.3%)	110 (0.6%)
South East	54,536 (93.8%)	1,930 (3.3%)	658 (1.3%)
All incidents			
The Trust	273,993 (94.7%)	10,678 (3.7%)	4,680 (1.4%)
North	70,187 (98.9%)	709 (1.0%)	73 (0.1%)
Central and West	89,913 (97.0%)	2,435 (2.6%)	431 (0.4%)
South East	113,893 (90.7%)	7,534 (6.0%)	4,176 (3.0%)

Source: Wales Audit Office analysis of Trust data



Figure 5: The percentage of GP urgent patients arriving at hospital no later than 15 minutes after the agreed time has improved since December 2006



Source: Wales Audit Office analysis of Trust data

1.10 Nevertheless, Figure 4 shows that in 2007/2008, while the vast majority of calls received a fully equipped ambulance to back up the initial response in half an hour or less, there is a longer tail in South East Wales, especially for Category 'B' and 'C' calls. 4,176 of the 4,680 incidents in Wales in 2007/2008, where it took over 50 minutes to provide an ambulance, took place in South East Wales. This is disproportionate to the region's share of the total number of incidents, which is just under 50 per cent. Overall, this analysis suggests that the Trust sends out a timely ambulance back-up to their initial responses on most occasions but that there is a small minority of calls, generally in South East Wales, for which there are excessive delays.

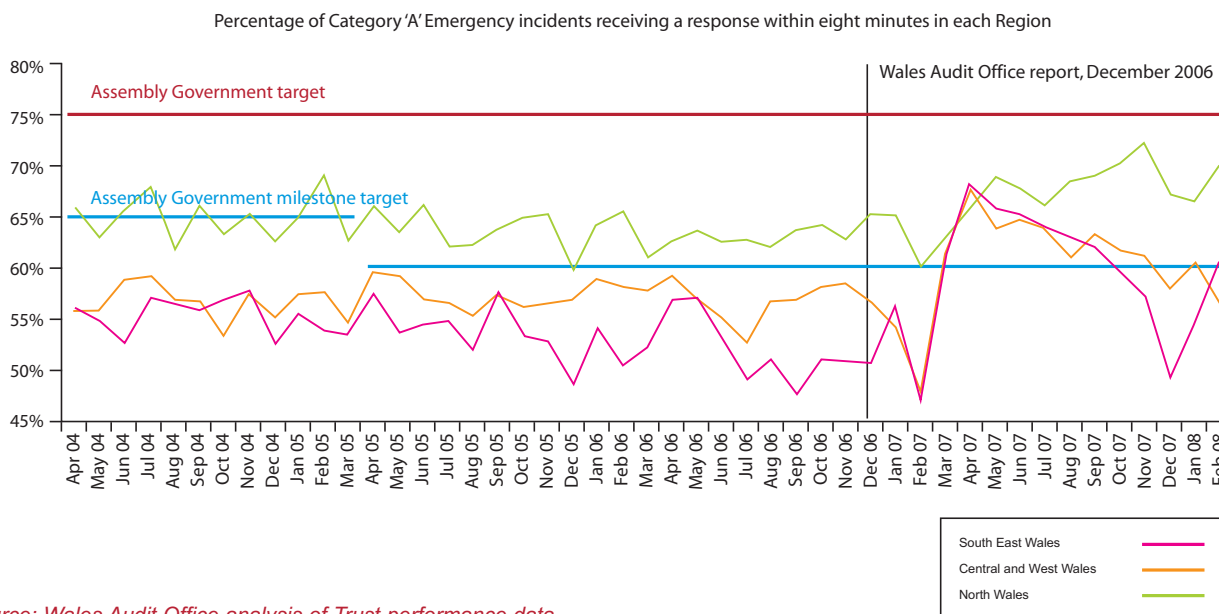
GP urgent performance has been much improved through changes in the control room and the High Dependency Service

1.11 Our original report found very poor compliance with the target that patients referred urgently by their GP should arrive at hospital no more than 15 minutes later than the agreed time. This target is important because these patients have been professionally assessed as having an urgent clinical need, yet at the time of the original review only 57 per cent of such patients were transported to hospital within target times in South East Wales, 75 per cent in Central and West Wales and 81 per cent in North Wales. Since then, Figure 5 shows that GP urgent performance has improved from 63 per cent in January 2007 to 81 per cent in February 2008.

- 1.12** The improvement in GP urgent performance has been achieved through a mixture of simple improvements in control processes and the early stages of developing a new HDS. Processes have been changed in control, where the Trust had previously been allocating GP urgent calls to crews with an insufficient lead time to collect the patient and drive them to the hospital by the agreed time.
- 1.13** More significantly, the Trust has ring-fenced resources for the GP urgent calls, rather than relying on the same crews that provide emergency responses to 999 calls. Consistent with the plans set out in *Time to Make a Difference*, the Trust is in the process of rolling out the new HDS where dedicated crews provide a service to GP urgent patients. The new HDS tier was introduced in the last quarter of 2007. HDS ambulances will be able to transport cases that have been predetermined, and can transport more than one patient at a time, leaving EMS vehicles to concentrate on serious life threatening calls. HDS staff will not be trained to the same level as Emergency Medical Services (EMS) personnel and will use vehicles of a lower specification. The intention is that they will be able to deal with a range of cases which are currently tying up emergency responders – particularly urgent cases requested by GPs.
- 1.14** The pace of progress in developing the HDS service has been slower than planned because it depends on releasing resources from within the EMS establishment. Each Region has been asked to evidence how they can release EMS resources from their rotas to allow the introduction of HDS crews and to review vehicles. Currently, work is ongoing in the Regions to undertake this exercise, and it will also form part of their Regional Business Plans. Each region has also been asked to prepare a business case for the staffing of HDS within their region. Work has commenced on the business case for staffing based on the regional analyses.
- 1.15** High Dependency Service crews have been introduced in some areas across the Trust. In North Wales, HDS was introduced in two areas: North East Wales and Caernarfon. In North East Wales, GP urgent performance remained fairly static. However, performance has improved in Caernarfon since the introduction of the HDS. The North East Wales pilot was opportunistic because of the changes in shift patterns but in Caernarfon was targeted because most of the GP urgent calls in North Wales came from this area. There has been an improvement in urgent performance, supported by a dedicated desk in control to deal only with urgent calls to the HDS. This has helped staff on the desk to get to know the GPs' staff and helps them to stream patients who do and do not need a paramedic. Some reports suggest that GPs are noticing an improvement in the quality and reliability of the urgent service. There are also fewer diversions to 999 calls from urgent calls, which tended to lead to sicker patients becoming increasingly high risk.
- 1.16** The development of the HDS has been slower than planned because technicians did not volunteer to join the service to the extent that the Trust anticipated. In South East Wales, problems reallocating resources from EMS rotas has meant that the HDS has been developed only at the regional level rather than in individual localities but has helped reduce the extent of previous regional variation.



Figure 6: Regional variation in compliance with the eight minute response time standard for Category 'A' calls (immediately life threatening incidents)



Source: Wales Audit Office analysis of Trust performance data

Although the gap is closing, regional variations in performance remain

1.17 Although the overall figures for ambulance responses show an improvement (Figure 1), these mask significant regional variations. Figure 6 shows that regional variations in performance against the eight minute standard persist. While performance has improved overall in each region since December 2006, performance has been falling consistently in the South East region since April 2007, while there has also been a drop in Central and West Wales. Since February 2007, there has been an upward trend in North Wales, which already had the highest levels of compliance with the eight minute standard. While addressing the pressures in South East Wales needs to be a major focus for the Trust, it should not lose sight of the downward trend in Central and West Wales, where there has been a sharp

reduction in compliance with the eight minute target for Category 'A' calls, which the Trust attributes to a deterioration in hospital turnaround times in Swansea.

Figure 7: Regional performance in responding to Category 'A' calls within eight minutes, 2006/2007 and 2007/2008

Region	2006/2007 (per cent)	2007/2008 (per cent)
North Wales	62.8	68.6
Central and West Wales	56.0	61.4
South East Wales	52.5	60.2
Total	55.8	62.3

Source: Wales Audit Office analysis of Trust data

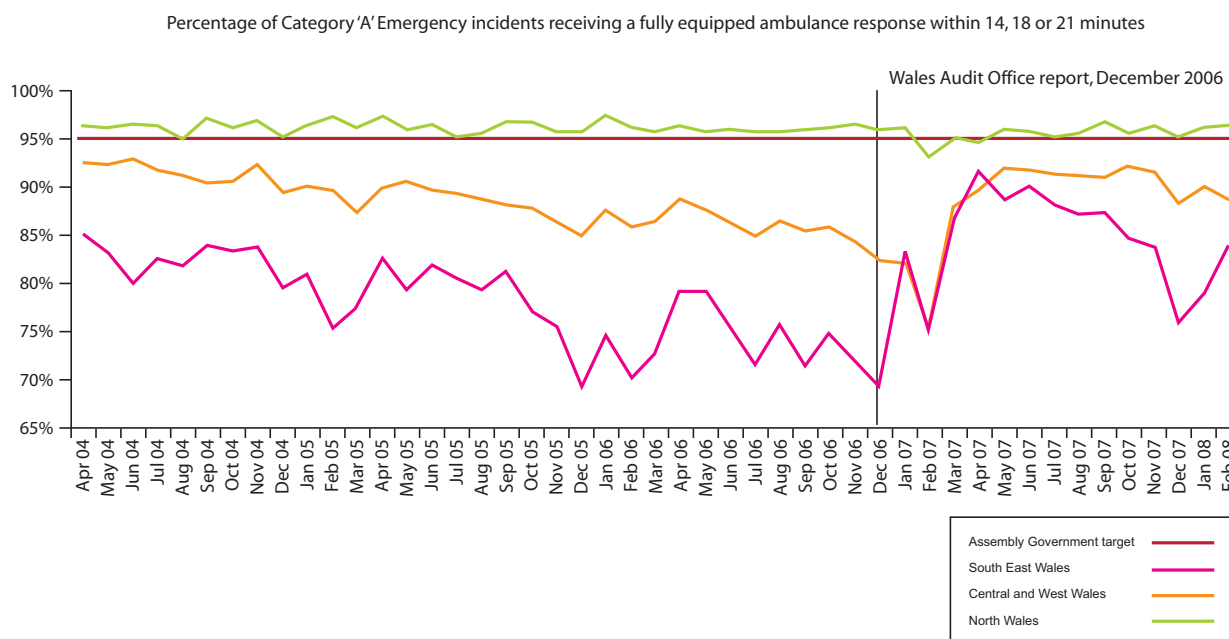
1.18 Figure 7 shows that North Wales was the best performing region in both 2006/2007 and 2007/2008, responding to 62.8 per cent of Category 'A' calls within eight minutes in 2006/2007 and 68.6 per cent in 2007/2008. The biggest regional improvement was seen in South East Wales where the proportion of Category 'A' calls receiving a response within eight minutes rose from 52.5 per cent in 2006/2007 to 60.2 per cent in 2007/2008. In Central and West, there was an improvement from 56.0 per cent to 61.4 per cent.

1.19 In addition, there have also been regional variations in the extent to which ambulances have been able to back up initial responses. Figure 8 shows that there has been a marked decrease in compliance with the target in South East Wales, where half of the Trust's activity takes place, although the long-term downward trend has started to reverse since December 2007. In contrast, North Wales has

remained generally compliant with the Assembly Government's target and Central and West Wales is showing a generally improving trend since February 2007.

1.20 Figure 9 shows that there is also a very significant gap between the regions in terms of the percentage of Category 'B' and 'C' incidents receiving a full ambulance response within response time standards. Performance has been relatively stable and the level of compliance relatively high in North Wales. There has been a steady improvement in performance in Central and West Wales but there was a significant decline in performance in South East Wales between April and December 2007 following a short period of improvement. This trend appears to be improving since December 2007 but there is still a very significant gap in performance between South East Wales and the Trust's other two regions.

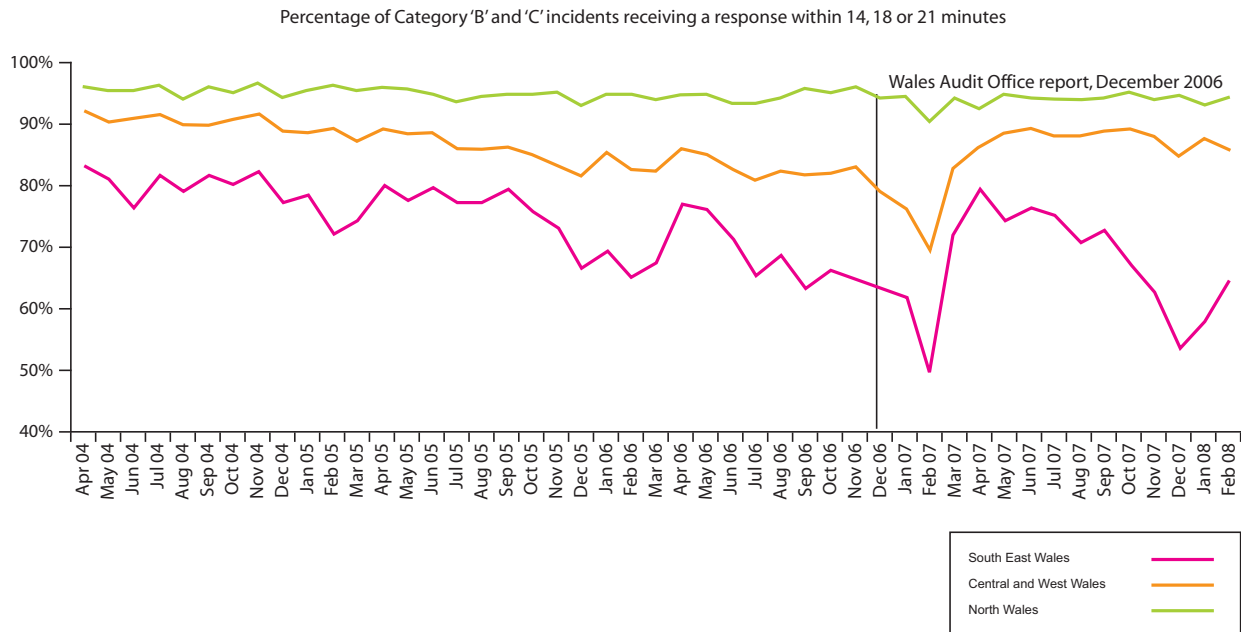
Figure 8: Regional variation in compliance with the target time for ambulance responses for Category 'A' calls



Source: Wales Audit Office analysis of Trust data

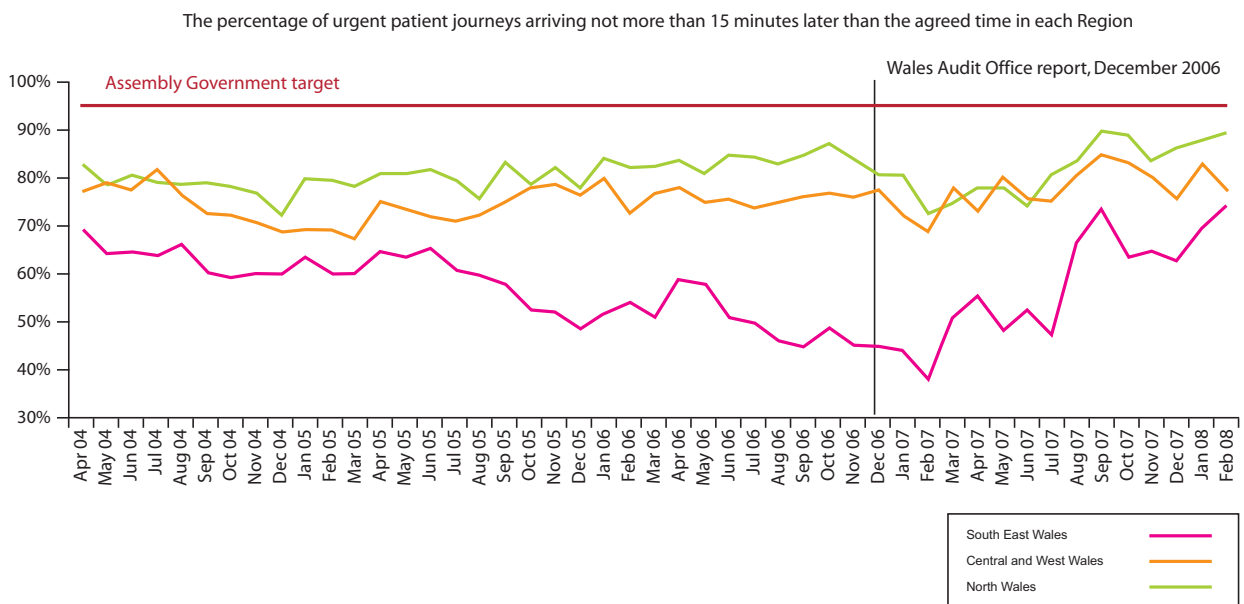


Figure 9: Regional variation in the percentage of Category 'B' and 'C' incidents receiving an ambulance response within time standards



Source: Wales Audit Office analysis of Trust data

Figure 10: A significant improvement in GP urgent performance in South East Wales has reduced the extent of regional variation



Source: Wales Audit Office analysis of Trust data

- 1.21** Figure 10 shows that while all three regions have improved their GP urgent performance, this has been particularly acute in South East Wales where compliance with the response time target has improved nearly twofold since the publication of our original report. This has reduced the previous extent of regional variation in GP urgent performance.
- 1.22** There has also been variation in performance between LHB areas although the extent of the variation is reducing. Figure 11 shows that the Trust has improved the overall number of LHB areas which were achieving 60 per cent performance since December 2006 and has also achieved some improvements in the number of areas achieving over 75 per cent. The improvement in 60 per cent compliance, the level of the new Ministerial target, was particularly marked until September 2007 but fell away after this time.
- 1.23** Our analysis of performance at LHB level also suggests that there have been improvements in performance across most individual LHB areas. Figure 12 shows that in two LHB areas, Monmouthshire and Powys, there was no month between March 2007 and February 2008 in which they achieved a response rate of 60 per cent within eight minutes for Category 'A' calls. This contrasts with our original report which identified that 12 localities failed to achieve 60 per cent in any month in 2005/2006. Conversely, Figure 12 shows that five localities did not fall below 60 per cent in any month between March 2007 and February 2008. The spread of performance is generally much better than it was at the time of our original report although there is more acute variation in monthly performance in some LHB areas, such as the Vale of Glamorgan, Bridgend, Anglesey, Torfaen, Cardiff and Carmarthenshire.

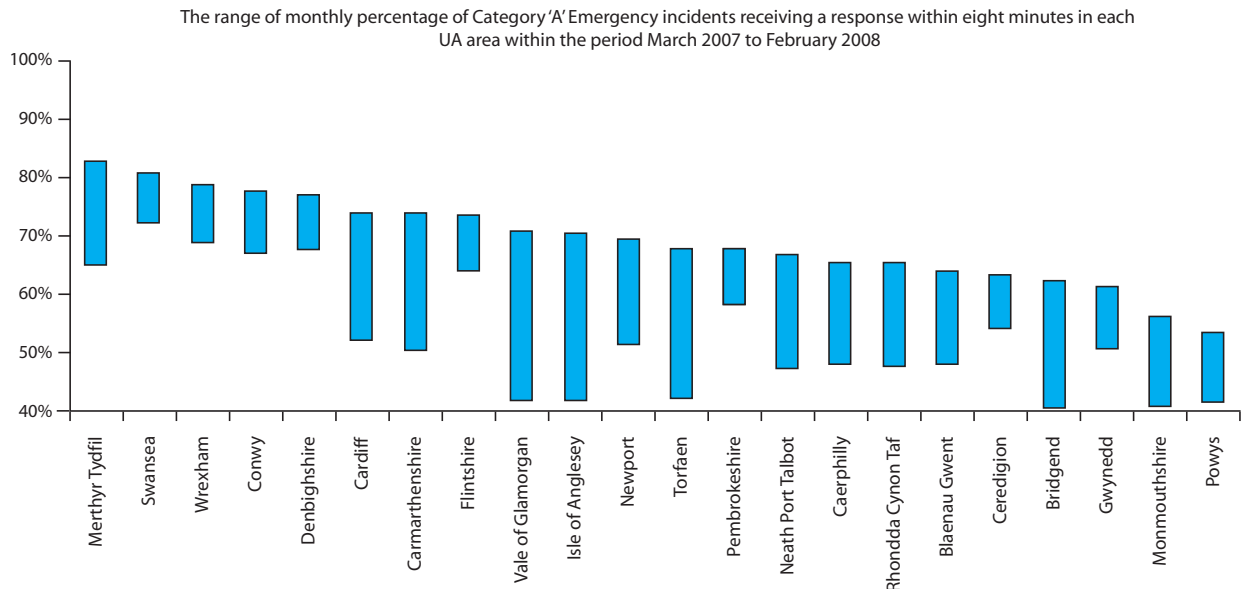
Figure 11: The number of LHB areas responding to Category 'A' calls within eight minutes

	LHB areas performing over 60 per cent	LHB areas performing over 75 per cent
December 2006	6	0
January 2006	9	0
February 2007	4	0
March 2007	12	0
April 2007	16	2
May 2007	16	3
June 2007	15	2
July 2007	14	2
August 2007	15	3
September 2007	15	4
October 2007	12	2
November 2007	12	5
December 2007	7	1
January 2008	8	2
February 2008	11	2

Source: Wales Audit Office analysis of Trust data

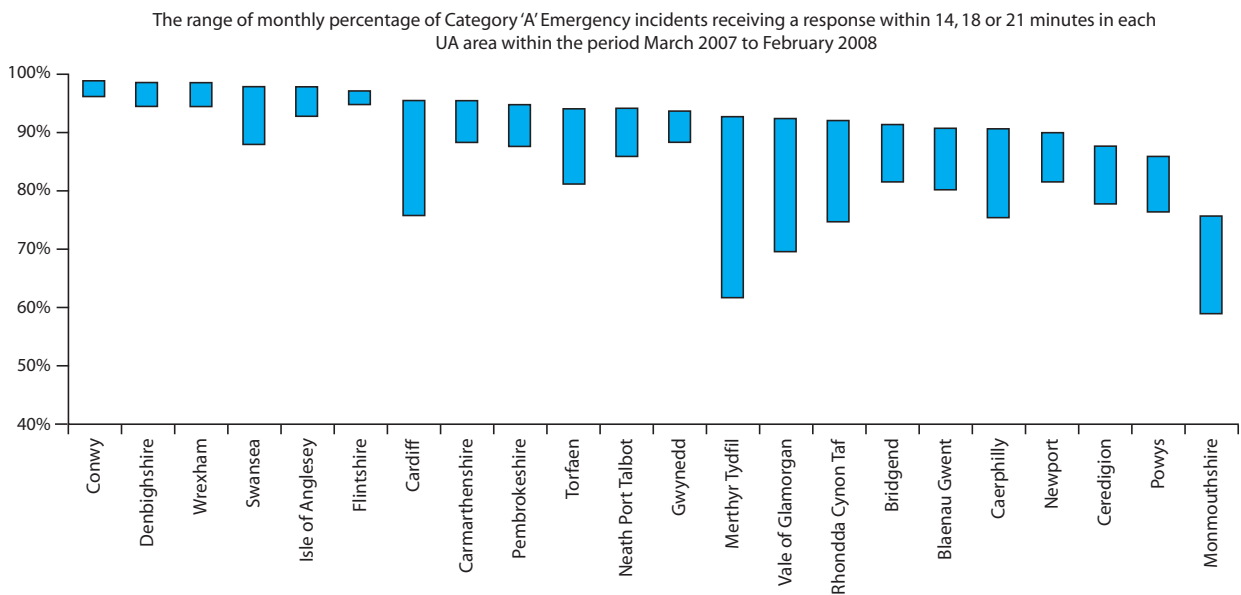


Figure 12: There was variation in the range of performance by LHB area for Category 'A' responses within eight minutes between March 2007 and February 2008



Source: Wales Audit Office analysis of Trust data

Figure 13: The variable range of monthly performance by LHB area in providing an ambulance within target times for Category 'A' calls



Source: Wales Audit Office analysis of Trust data

1.24 Similarly, **Figure 13** shows that there has been a levelling up of the range of performance by LHB area in providing a fully equipped ambulance within target times. However, the consistently poor performance in Monmouthshire remains a cause for concern, as does the extent of variation in performance in some LHB areas.

1.25 Our analysis of changes in response time performance by LHB area confirmed that there have been general improvements from

2006/2007 to 2007/2008. **Figure 14** shows that each LHB area in Wales improved its Category 'A' response time performance within eight minutes between 2006/2007 and 2007/2008, with an increase from five to 11 LHB areas achieving an annualised performance of 60 per cent or more. We have placed detailed information about performance in each LHB area on our website, www.wao.gov.uk.

Figure 14: Changes in Category 'A' eight minute response time performance between 2006/2007 and 2007/2008 by LHB area

LHB area	2006/2007 per cent Category 'A' calls responded to within eight minutes	2007/2008 per cent Category 'A' calls responded to within eight minutes	Percentage improvement in Category 'A' response time performance within eight minutes between 2006/2007 and 2007/2008
Merthyr Tydfil	59.9%	76.2%	16.3%
Blaenau Gwent	42.9%	58.5%	15.6%
Isle of Anglesey	50.1%	64.6%	14.5%
Swansea	65.5%	76.5%	11.0%
Rhondda Cynon Taf	50.5%	60.1%	9.6%
Torfaen	46.4%	55.9%	9.5%
Caerphilly	49.6%	56.9%	7.3%
Wrexham	66.1%	73.1%	7.0%
Monmouthshire	42.8%	49.1%	6.3%
Cardiff	58.1%	64.2%	6.1%
Bridgend	44.8%	50.7%	5.9%
Vale Of Glamorgan	51.3%	57.1%	5.8%
Conwy	70.0%	74.5%	4.5%



LHB area	2006/2007 per cent Category 'A' calls responded to within eight minutes	2007/2008 per cent Category 'A' calls responded to within eight minutes	Percentage improvement in Category 'A' response time performance within eight minutes between 2006/2007 and 2007/2008
Ceredigion	54.5%	58.8%	4.3%
Gwynedd	52.9%	57.1%	4.2%
Denbighshire	68.2%	72.0%	3.8%
Neath Port Talbot	54.8%	58.6%	3.8%
Flintshire	64.1%	67.8%	3.7%
Powys	43.9%	47.1%	3.2%
Pembrokeshire	59.1%	61.8%	2.7%
Carmarthenshire	55.9%	58.4%	2.5%
Newport	58.0%	60.0%	2.0%

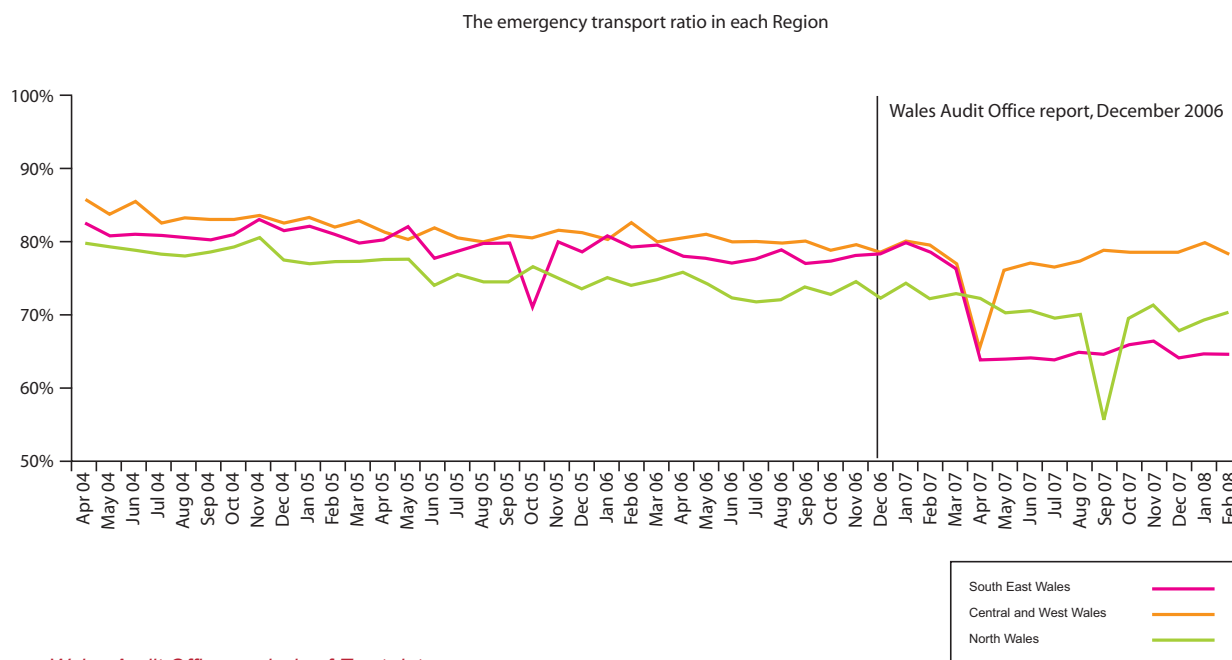
Source: Wales Audit Office analysis of Trust data

There has been improvement by reducing the proportion of patients transported to hospital, although the ratio remains higher than the best performing English services

1.26 Our original report identified the importance of minimising the number of attendances at scene that lead to the patient being transported to hospital when this was not clinically necessary. This has potential benefits not only for the Trust but also for the whole system of unscheduled care, for example by reducing the pressures on accident and emergency departments. The use of 'see and refer' and 'see and treat' approaches through the development of enhanced clinical skills among paramedics has significant potential to improve clinical services provided to patients, manage

demand more effectively and make more effective use of the clinical skills of the Trust's staff. A useful measure of progress is the percentage of patients transported to hospital. It suggested that the Trust had a relatively high number of patient journeys per emergency incident compared with English ambulance services. **Figure 15** shows that there has been an overall reduction in the emergency transport ratio, which has reduced from around 80 per cent to an average closer to 75 per cent since December 2006. It is particularly encouraging that the most pronounced downward trend has taken place in the South East region, which accounts for 44 per cent of the Trust's EMS workload and most significant challenges in terms of response time performance.

Figure 15: There has been a downward trend in the emergency transport ratio since December 2006, particularly in South East Wales



Source: Wales Audit Office analysis of Trust data

Concerns about the sustainability of the improved performance have arisen since September 2007 as ambulance turnaround times at hospitals have worsened

1.27 The extent of excessive ambulance turnaround times at hospital, especially in the South East region has been high and has contributed to the Trust’s problems sustaining improvements in response time performance. Since October 2007, the Trust has experienced significant pressures at hospital emergency units in terms of turnaround times. The Trust’s analysis suggests that since April 2007, the extent of excessive turnarounds (measured as over 50 minutes) has increased beyond expected variation. In the summer of 2007, the extent of excessive delays mirrored the levels usually seen during the winter months. It is also worth noting that a 50 minute turnaround is a conservative measure of an excessive turnaround: the new

Ministerial handover target for 2008/2009 requires the handover of patients within 15 minutes of the ambulance arriving at accident and emergency. In October 2007, there were single days when there were over 80 individual delays of 50 minutes or more.

1.28 We analysed ambulance turnaround times at hospitals over the year from February 2007 to February 2008. We found that over half of hospital turnarounds – 56 per cent of all Category ‘A’ patient journeys – involved a turnaround longer than 20 minutes, while seven per cent of all Category ‘A’ patient journeys involved a turnaround longer than 50 minutes.

1.29 The time lost by ambulances through hospital turnarounds in excess of 20 minutes rose by 13 per cent between 2006/2007 and 2007/2008, equating to 40,868 lost unit hours of ambulance cover across the 2007/2008



Figure 16: Lost hours arising from turnaround times in excess of 20 and 50 minutes generally increased month on month between 2006/2007 and 2007/2008 (all categories of call)

Lost hours in excess of 20 minutes – change per month between 2006/2007 and 2007/2008 (Bold = increase)					Lost hours in excess of 50 minutes – change per month between 2006/2007 and 2007/2008 (Bold = increase)				
	Central and West Wales	North Wales	South East Wales	Total for the Trust		Central and West Wales	North Wales	South East Wales	Total for the Trust
April	13	55	87	154	April	-12	18	-48	-4
May	74	2	162	235	May	30	-17	-70	-5
June	37	164	590	794	June	-7	25	200	21
July	-20	60	602	642	July	-16	6	268	25
August	-2	116	515	635	August	-14	28	174	18
September	61	49	381	490	September	29	-3	150	17
October	115	83	797	992	October	35	3	353	39
November	153	127	596	874	November	32	21	272	32
December	194	154	251	595	December	29	22	71	11
January	139	68	-54	149	January	26	10	-76	-4
February	-273	-64	-632	-978	February	-211	-8	-374	-59
March	14	65	61	133	March	-39	13	30	0

Source: Wales Audit Office analysis of Trust data

year, of which 8,618 lost unit hours related to turnarounds longer than 50 minutes. The lost hours over 20 minutes represent only a small proportion, around 4.5 per cent, of the hours of ambulance cover produced by the Trust each year but this is a level sufficiently significant to affect performance. The impact is higher in the South East, where turnarounds of 20 minutes or longer represent eight per cent of unit hours and turnarounds of over 50 minutes are equivalent to two per cent of unit hours. In particular months, such as February 2007, deterioration in turnaround times appears to have been linked with a drop in Category 'A' performance. **Figure 16** shows that the lost hours arising from turnaround times in excess of 20 and 50 minutes increased comparing the same months in 2006/2007 and 2007/2008, particularly in South East Wales.

- 1.30** The majority of the long delays took place in two hospitals, the University Hospital of Wales, Cardiff, and the Royal Gwent Hospital, Newport. 14,800 unit hours were lost in the year between February 2007 and February 2008 in these two hospitals because of turnarounds of 20 minutes or longer, of which 3,850 unit hours were lost as a result of turnaround times in excess of 50 minutes. There were also long delays in the Nevill Hall Hospital in Abergavenny and the Prince Charles Hospital in Merthyr Tydfil. There have been increasing problems with long turnaround times at Morriston Hospital in Swansea. Turnaround times in excess of 50 minutes are rare in the North Wales region.
- 1.31** Although over a longer period, there is not a strong correlation between speed of response and lost hours through excessive turnarounds, the Trust's analysis suggests a correlation between excessive (over 50 minute) turnarounds and the drop in

compliance with the eight minute response time standard for immediately life threatening (Category 'A') calls since October 2007. On some days, there were as many as four or five ambulances simultaneously delayed at the University Hospital of Wales, Cardiff. This makes it very difficult to provide a safe level of cover, involves misuse of specialist paramedic resources and is a symptom of wider problems across the whole system of unscheduled care.

- 1.32** The long turnaround times have negative impacts for the patients being cared for by the Trust, but also for those patients who require an ambulance to transport them to hospital. **Box 1** provides examples of the individual cases affected on one day in October when pressures were especially high.
- 1.33** More seriously for front line staff, these problems have adversely affected their day to day working experience. Being delayed for long periods in an accident and emergency department is far from satisfactory for ambulance crews, and can lead to significant shift overruns where a long handover takes place towards the end of a shift. In addition, the delays can also cause problems for RRV drivers if they experience occasional very long waits between providing an initial response and back-up arriving from an ambulance crew at times when several crews are stuck at an accident and emergency department. While the vast majority of ambulances provide back-up within target times (paragraphs 1.6-1.10), a single incident, where an RRV driver is left with a seriously ill patient and their carers for an inappropriate time, will have a lasting impact on that member of staff. This has also compromised perceptions of the effectiveness and safety of RRVs – while most RRVs are backed up within target times and performance has



Box 1: The impact of excessive turnaround times in South East Wales on individual patients on Thursday 4 October 2007

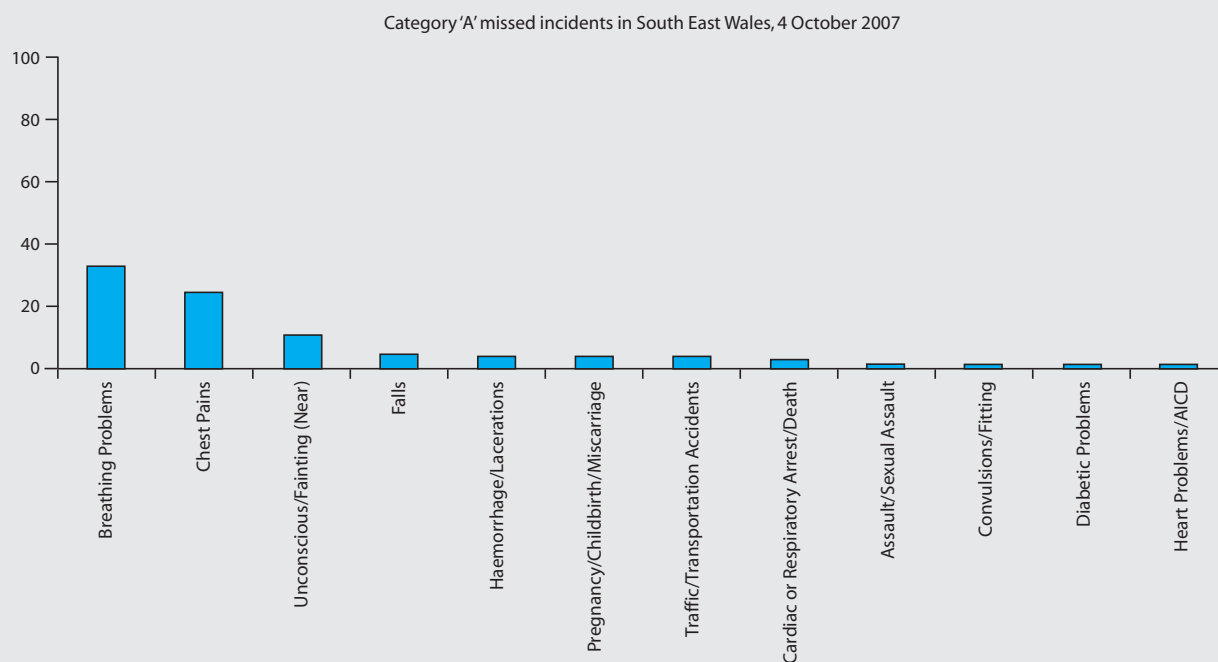
There was heavy demand across the whole system of unscheduled care on 4 October 2007. There was a steady level of demand – between 25 and 40 incidents per hour – between 9am and 5pm. At the same time, hospital delays began to build up from the early morning to the extent that by midday, there were 30 cases with extended delays at hospitals in the South East. By 1pm the Trust had over 90 vehicles committed to incidents in the region.

Patients with an ambulance crew at accident and emergency on 4 October 2007:

- Patient A with chest pain – 2 hours 28 minutes with a crew at 01:30
- Patient B with stroke – 2 hours 13 minutes with a crew at 09:33
- Patient C with chest pain – 1 hour 52 minutes with a crew at 18:50
- Patient D with breathing problems – 1 hour 46 minutes with a crew at 20:46

Category 'A' calls for which the Trust was unable to respond within eight minutes in the South East Wales region on 4 October 2007:

Three patients classified as being in cardiac arrest at the time of the call could not receive an emergency response within eight minutes because all other resources were committed to existing calls or were waiting to hand patients over at accident and emergency departments. On this day, there were another 84 Category 'A' calls in the region for which the Trust was unable to provide a response within eight minutes. Nearly half of these were breathing problems or chest pains.



Such pressures also affect the provision of ambulances to back up initial responses with transportation to hospital, as well as the provision of acceptable service levels to patients classified as urgent by their GPs. This can negatively affect RRV drivers or community responders when they are left with a Category 'A' patient without transportation to hospital where this is required.

Source: Trust paper to the Minister for Health and Social Services, October 2007

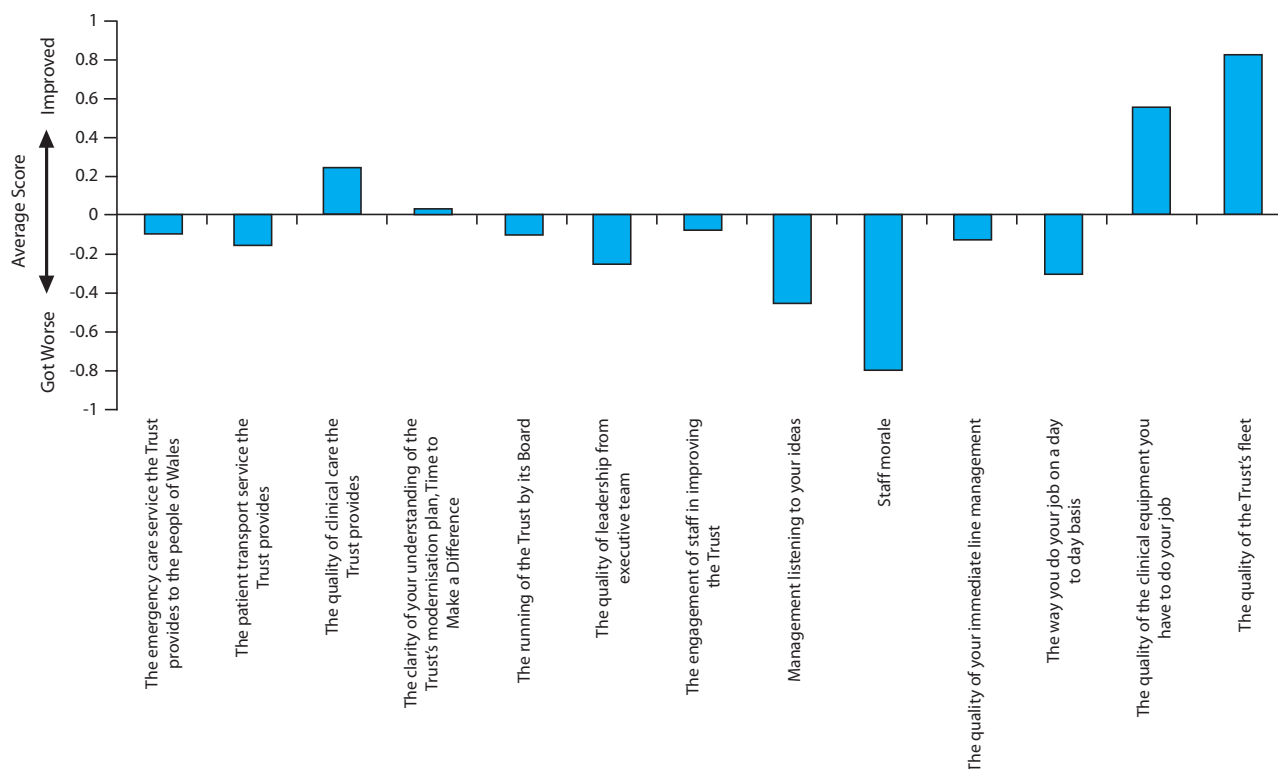
improved since December 2006, some excessive delays remain for which long turnaround times are a contributory factor.

1.34 The impact of turnaround times has also affected the effectiveness of the new rosters that have been implemented. The extent of turnarounds at hospitals in excess of 50 minutes has affected the adequacy of cover as regional crews have been unable to provide cover in accordance with the rotas that reflect the demand analysis.

The integration of NHS Direct into the Trust has been well managed, with further opportunities to enhance clinical focus

1.35 On 1 April 2007, NHS Direct Wales was absorbed into the Trust. This involved the absorption into the Trust of all the NHS Direct staff and the assimilation of two very different cultures, one predominantly an emergency service culture, the other a clinically focused culture among its nurses. We understand that the integration of NHS Direct and the ambulance service is unique in the United

Figure 17: Overview of the views of those attending our focus groups on individual improvement areas



Source: Staff Focus Groups 2008



Kingdom. The former NHS Direct part of the organisation has been absorbed into a new Unscheduled Care Directorate.

1.36 We found that the integration of NHS Direct into the Trust has been effectively managed. Morale remains higher among staff in the Unscheduled Care Directorate, when the results of the recent staff survey are compared with those from the Trust's traditional workforce. **Figure 17** shows that our analysis of the views of those attending our focus groups identified that of 13 areas for improvement identified in our previous report, the quality of clinical care provided by the Trust was one of only three which participants believed to have improved. One of the other areas which participants perceived to have improved was the quality of clinical equipment available to help them to do their job.

1.37 There is evidence that the development of the new Unscheduled Care Directorate has helped to take initial steps to address many of the weaknesses in Clinical Governance identified in the reports of the Auditor General and Healthcare Inspectorate Wales in late 2006 and early 2007. These reports highlighted concerns about poor resourcing of clinical leadership and the fact that although Clinical Governance had been developed, it was not an integral part of managerial processes.

1.38 The creation of the Unscheduled Care Directorate has given the Trust a full-time Clinical Director with executive status on the Board. This provides significantly increased senior capacity to deal with clinical matters in comparison with the part-time role played by the previous Medical Director. Although the Trust does not have a designated Medical Director, the Director of Unscheduled Care is supported by two medical advisors, one a GP with significant out-of-hours experience, the

other an accident and emergency consultant. The Trust has developed a Clinical Advisory Group to provide clinical leadership for the Trust.

1.39 The Unscheduled Care Directorate has made progress in a number of key areas:

- A new Clinical Governance structure is being developed and is expected to be launched in April or May; this will provide separate clinical and corporate governance but is seen by the Director of Unscheduled Care as a crucial first step towards the development of genuinely integrated governance within the Trust. There have also been improvements to the support and monitoring systems used by the Clinical Governance committee through:
 - the introduction of clinical effectiveness leads in each region;
 - the development of a clinical effectiveness strategy;
 - the development of clinical performance indicators; and
 - the formation of the adverse incidents projects group.
- The previous training team has now been rebranded as an education and development team and has been moved from the HR department to form part of the Unscheduled Care Department; this reflects the increasingly advanced clinical education and training for paramedics and development of specialist paramedic roles able to assess and refer and see and treat. This will be supported by a move towards higher education provision in partnership with the University of Wales, Swansea and with reference to the Health Professions Council. The Trust is focussing more

strongly on clinical issues and has appointed a specialist paramedic, with a view to the post being at Consultant level, pending Healthcare Inspectorate Wales approval.

- The Trust has improved its call to need times for pre-hospital thrombolysis with 91 per cent of eligible or appropriate patients receiving pre-hospital thrombolysis within 60 minutes of the call in 2007/2008 against a 70 per cent target.
- The Trust has increased clinical capacity within the control room, which is one of the potential advantages of the integration of NHS Direct. Initially, the Trust used GPs in control on a temporary basis to help it to get through a highly pressurised period but has now piloted 'clinical desks' in control rooms which are staffed by nurses rather than GPs and have helped the Trust reduce the number of times an unnecessary ambulance response is provided to Category 'C' calls which could access a more appropriate element of the unscheduled care system (**Case Study A**).
- The Unscheduled Care Directorate has been developing basic frameworks to support Clinical Governance and address basic gaps in policy through the ongoing development and sign-off of policies for:
 - discharge of care;
 - professional scope of practice;
 - complaints;
 - children's welfare;
 - Protection of Vulnerable Adults (POVA);
 - Mental Health;

- Integrated care; and
- Medicines management.

- There have been a number of developments in respect of Public and Patient Involvement (PPI), including the establishment of a PPI committee, a review of the PPI strategy, a feedback facility on the website, patient surveys, a multi-lingual phrasebook for frontline staff and a new communication strategy.
- New approaches to dealing with complaints and adverse incidents have been developed, although the slow progress in establishing the Clinical Team Leader role (paragraphs 2.38-2.39) may reduce the impact of these approaches in the short-term.

1.40 Despite this positive progress, a number of challenges and opportunities remain in developing further the clinical focus of the Trust through the maturing Unscheduled Care Directorate:

- There are risks around the Trust's capacity to develop and embed Clinical Governance, both at the centre in terms of policy development but at locality level because of the absence of Clinical Team Leaders (paragraphs 2.38-2.39) and as the Trust and the staff side seek to ensure that adequate time is available to the Clinical Team Leaders to discharge their duties.
- The development of the Vantage Point House control centre and regional headquarters, in which NHS Direct, Gwent out-of-hours and ambulance control staff will be co-located, provides a significant opportunity to develop a model of an integrated unscheduled care call centre which can more accurately manage



Case Study A: Development of Clinical Desks to improve the triage of emergency calls

Time to Make a Difference recognises that not all patients who dial 999 need a full emergency response from the ambulance service and states that the Trust will develop a system to assess patients' needs and broker their access to appropriate urgent clinical care. A specific objective states the intention to provide a telephone-based assessment and signposting service for Category 'C' calls.

Academic research has suggested Category 'C' calls can be safely transferred to NHS Direct nurses for advice whilst being acceptable to patients as an alternative to the traditional ambulance response. Ambulance trusts in England do not routinely respond to Category 'C' calls and Scotland is also piloting alternative responses to such incidents.

In late 2007, the Trust set up a three-month pilot study to test the effectiveness of clinical desks in ensuring patients receive the right treatment, at the right place by the right person. Desks were set up in the Carmarthen and Mamhilad control centres and were staffed by paramedics and experienced NHS Direct nurses.

The primary role of the desks was to intercept specific Category 'C' calls where a full ambulance response was inappropriate. During periods of high activity it was decided to extend the desk's work to cover certain Category 'B' calls.

Calls were initially triaged through the automated Medical Priority Dispatch System (AMPDS) and an ambulance was dispatched immediately. If the patient met certain criteria, the call was then diverted to the clinical desk which was empowered to stand down the ambulance under certain circumstances.

The nurses used their experience as well as decision support software to agree an appropriate clinical response with the patient, caller and operational paramedic. The response could be a continued blue light ambulance response or alternatives such as non-ambulance transportation to an Accident and Emergency department, the caller being advised to contact their GP, GP out-of-hours service or pharmacist, or the nurses could provide information for the patient to care for themselves.

The results from the pilot showed that for Category 'C' and 'B' calls, the ambulance dispatched at the start of the call could frequently be stood down due to the work of the clinical desk. In Carmarthen, 19 per cent of the 468 Category 'C' calls and 28 per cent of the 54 Category 'B' calls transferred to the desk resulted in the ambulance being stood down. In Mamhilad, 40 per cent of the 309 Category 'C' calls and 40 per cent of the 60 Category 'B' calls involved the ambulance being stood down.

The Trust's evaluation of the pilot concluded that the clinical desk should be given time to triage patients before dispatching an ambulance because they were frequently unable to complete their triage due to the ambulance's proximity to the patient. The evaluation also suggested that the clinical desk could become involved in a wider range of conditions.

Source: *The Trust, An Interim Report on the Clinical Desk Pilot Study. 15 February 2008*

demand and better ensure that patients access the right level of service to meet their needs, rather than an over-reliance on unnecessary double-crewed ambulance responses for some patients.

- Beyond Vantage Point House, there is scope to develop more effective control processes to derive the full benefits of linking ambulance control and NHS Direct nursing staff; drawing on their expertise, the Trust hopes to develop more specificity in its triage, especially of the lower acuity Category 'C' calls to minimise the inappropriate provision of ambulance responses where they are not needed, and

Category 'A' responses where there is no clinical need for a response within eight minutes (with the associated risks of responders driving on blue lights as well as the opportunity costs for other Category 'A' calls that genuinely need an eight minute response). More specific triage and the development of more effective pathways through the whole system of unscheduled care has significant potential in the crucial area of demand management, which can help the Trust direct its limited resources most appropriately to those patients who most need an emergency ambulance response, while ensuring that other patients receive an appropriate response.

- While new policies have been developed in a number of areas, the Trust has historically experienced problems ensuring that policies are implemented effectively. The Director of Unscheduled Care is aware of the need to look carefully at the problematic areas of staff engagement and communications to ensure that the policies are embedded within day-to-day working practices.
- The ongoing development and expansion of the paramedic profession, through the establishment of a clearer professional scope of practice and more advanced clinical skills, has considerable potential to improve the Trust's capacity to develop innovative solutions to service provision, particularly in rural areas. It also provides the scope for the Trust to play an increasing role within the whole system of unscheduled care to relieve some of the pressures currently affecting particular parts of that system, such as emergency ambulance responses and accident and emergency departments.
- In playing a leading role in the development of unscheduled care services, consistent with the Assembly Government's *DECS* strategy, there will be a need to balance potentially competing demands in terms of developing innovative service models and maintaining patient safety and effective Clinical Governance.

There has been significant expenditure on new fleet and clinical equipment, which the majority of staff have received positively

1.41 Our original report identified the poor quality of fleet management, the lack of a national fleet manager and a failure to deliver value for money in the procurement of new vehicles. The Trust has clearly made significant progress in improving its fleet and has spent £23.1 million on new vehicles as part of *Time to Make a Difference*, with Assembly Government support. A national fleet manager has been appointed and led the project which procured and rolled out 119 new EMS vehicles. A further 32 EMS vehicles have now been built and commissioned, giving a total of 151 new ambulances on the road. In addition, 51 RRVs have been built and are in service, seven major incident vehicles are being built, together with two driver training vehicles and three vehicles are being converted to carry out a mobile command and control function. The Vehicle Clinical Equipment Working Group (VCEWG) has met to ensure that all vehicles and equipment being procured meet the Trust's operational needs.

1.42 In parallel with this, there have been improvements to workshop and maintenance capacity and the fleet care computer system has been updated to improve the quality of management information. Other developments include the provision of air compressors at all stations, development of road traffic working groups, improved workshop turnaround times and the appointment of a national equipment manager.



1.43 Staff have clearly been impressed by the quality of the new vehicles. Of the 13 areas for improvement which our focus groups of staff addressed, the quality of the Trust's fleet was consistently cited as the most significant improvement perceived by staff. eighty-two per cent of those attending the sessions recognised the improvements, with some seeing beyond EMS vehicles to highlight the positive developments in respect of PCS and RRVs. Despite these very positive views of improvements in fleet, staff did identify some areas for improvement:

- implementation of the planned 'Make Ready' stations to prepare vehicles more effectively (paragraphs 2.54-2.55);
- greater involvement of front-line staff with the fleet department to discuss day-to-day issues as well as longer-term procurement strategy;
- improvements in servicing and the resolution of problems with vehicles;
- improving hygiene levels on vehicles;
- maintaining the improvement in the fleet through a robust replacement programme; and
- consideration of the need to vary the fleet to deal with particular road and climatic conditions.

1.44 The other area in which staff attending our focus groups perceived particular improvement since December 2006 was the quality of clinical equipment available to do their job. Sixty-three per cent of staff attending our focus groups felt that clinical equipment had improved. They highlighted four areas in particular:

- lifting and handling equipment;
- new clinical equipment on EMS vehicles which has supported a better range of treatment options;
- access to IT provision; and
- provision of mobile telephones on EMS vehicles which has supported improved clinical care.

1.45 Although making further improvements in clinical equipment was not a major priority of staff attending our focus groups, they did identify a number of further potential solutions:

- there is a need to improve access to supplies through next day delivery and locally based delegated supplies processes;
- older equipment needs updating, with more emphasis placed on the use of clinical IT equipment on board vehicles, such as electronic patient records; and
- there is a need to make more equipment available so that all vehicles are fully equipped, with training packages being made available to support staff on the use of equipment.

Although staff still have concerns about leadership, the Trust has an almost entirely new executive team and improved governance

- 1.46** There have been very significant changes in the Trust's governance arrangements. Although there has been continuity of non-executive members of the Board, the composition of the executive team has changed fundamentally since December 2006, with only one member of the executive management group remaining in post. Although this was perhaps inevitable given the extent of the change programme implied by our original report and *Time to Make a Difference*, it is clear that there is further work to do to develop the cohesion of what is an entirely new executive team.
- 1.47** Staff attending our focus groups expressed concerns about the leadership of the Trust. There was a general view that the quality of leadership from the executive team had either stayed the same or deteriorated with the exception of staff in North Wales where staff had generally more positive views.
- 1.48** Assembling an entirely new executive team has been time consuming in terms of recruitment and induction. The new executives bring with them considerable experience of ambulance services and unscheduled care more generally. The independent academic advisor recognised the capability of the senior team in his report to the Chairman's Review Group. However, there remain some gaps – the new Regional Director for South East Wales is due to join the Trust on 1 May 2008 (paragraphs 2.13-2.14) and the Trust's Director of Human Resources recently left the Trust and took with her considerable knowledge of the Trust and its history. The Trust has not appointed a substantive replacement HR Director but an interim HR Director is currently on secondment from Gwent Healthcare NHS Trust.
- 1.49** The Trust's Chief Executive recognised that the morale of the management team has fluctuated over time and it has taken time to mould a cohesive team without continuity of membership and with people joining the team from a wide variety of backgrounds. The team appears to be operating more cohesively than it was but the Trust would now benefit from investing more in further development of the executive team.
- 1.50** Our original report identified that the Trust had over-centralised and recommended greater devolution to the regions with a more strategic approach from Trust headquarters. We found that the Trust had made good progress in this respect, creating new Regional Director posts, two of which have been filled, and creating strengthened regional management structures. This has included delegating financial budgets to regional level for the first time, which should improve accountability and the flexibility of the regions to respond more effectively to local circumstances. Nevertheless, the independent academic advisor's report highlighted the need to allow the Regional Directors to exercise increasing autonomy in terms of sub-regional planning.
- 1.51** There have been improvements in governance by the Trust Board, recognised by a recent external review by the National Leadership and Innovation Agency in Healthcare's Governance in Health (GIH) project. The review found that the Trust is working to establish a strong, well developed governance and accountability framework, supported by clear definition of roles and



responsibilities, policies and procedures. Committees have been reviewed and are now chaired exclusively by non-executives. There is a board development programme to support non-executives and an experienced Corporate Secretary has been appointed to advise the Board. The GIH review found that strong and focused leadership is contributing to the establishment and continuing development of a Board with a good skills mix and a maturing outlook.

1.52 The GIH review found senior staff to be enthusiastic and energetic about meeting the significant challenges that the organisation faces. There is strong leadership which is helping to develop a strong and united Board. This internal progress needs to be reflected externally to build strong and meaningful relationships with partners and stakeholders.

1.53 In moving forward, the GIH review identified a number of issues that will need to be addressed to continue the positive progress made in terms of leadership and governance, particularly around the capacity of Board members to support the extremely challenging agenda facing the Trust:

- public and political expectation is very high, and the Board needs to engage carefully with its range of stakeholders to ensure realistic expectations;
- there is a danger that the speed of change may exceed the capacity of officers and non-executives to manage it properly;
- engagement of key local stakeholders such as the Assembly Government's Regional Offices, LHBs, Trusts and Primary Care providers needed to support new models of care;
- cascading the good work at Board level through all levels of the organisation;

- implementing new governance, complaints and PPI frameworks and embedding a risk culture;
- keeping the workforce engaged in the changed models of care and ensuring robust workforce planning is in place to deliver a modernised workforce;
- maintaining sustainable and positive relationships with the voluntary sector; and
- continuing its strong organisational development focus.

Systems and processes have been improved

Procurement systems are being strengthened although it is too soon to draw firm conclusions about their effectiveness

1.54 Our original report identified serious deficiencies in capital procurement processes which led to significant wasted money. The Trust has taken a series of actions to set up more robust systems to address these problems. On 1 April 2007, the Trust's procurement function transferred to the North Wales Business Services Partnership (BSP) which oversees the Trust's procurement processes under a Service Level Agreement. The BSP becomes involved at an early stage of the procurement process and is actively involved in the project management, overseeing the development of output specifications and developing the evaluation criteria and methodology. The BSP has developed consistent template documentation across North Wales, for example for scoring specifications. It has put in place internal guidance notes setting out how procurements are to be undertaken.

1.55 The BSP ensures that professional standards are applied and compliance with competition regulations. The BSP has a named lead officer for the Trust and the arrangements within the BSP appear to be operating effectively. We reviewed documentation for a sample of capital procurements. Although we found that the process for these procurements appeared robust at their current stage of progress, it is too soon to draw firm conclusions about the effectiveness of these procurements in the absence of a robust benefits realisation framework.

The Trust is improving its business and capital planning processes

1.56 Good progress has been made by the Trust in addressing the Auditor General's report recommendations in respect of capital procurement, which focused on strengthening capital planning through a more strategic approach. The Trust has developed and agreed a basic 10-year capital programme that sets out when capital expenditure will be needed to meet operational requirements. This has been 'approved' by the Assembly Government. It is split between expenditure to modernise the service and maintenance/replacement expenditure.

1.57 The Trust also used all of its capital allocations in 2006/2007 and 2007/2008, which suggests improved capital planning processes and less reliance on rushing capital expenditure at year-end than was the case at the time of our previous report. Where the Assembly Government has made additional monies available at short notice, the Trust has been better placed to respond as it had already developed business cases which were ready to be actioned if additional funds became available. This enabled the Trust to purchase additional medical equipment at short notice in February 2007.

1.58 The Trust recognised the need to formulate more robust business planning processes both for procurements and for major internal projects. It established a Programme Management Department (PMD) in July 2007 which aims to ensure that all modernisation projects (both involving capital procurement and internal projects) follow a robust process. Individual service departments are responsible for identifying the business need and producing business plans setting out the delivery options. The PMD then applies a PRINCE2 methodology to the process and appoints a PMD project manager. Each project has an executive director as the nominated project sponsor. All projects are signed off by a Programme Board comprising project directors and executive directors.

Financial management processes are stronger although benchmarking information needs refinement

1.59 We examined a sample of the Trust's financial information and discussed the development of financial management systems with Trust staff and the Assembly Government's Regional Office and Health Commission Wales. We found that financial planning and management systems were improving, supported by stronger links to *Time to Make a Difference*. We also concluded that the Trust has generally addressed our recommendations in respect of financial and business planning.

1.60 Although the Trust faces significant financial challenges (see paragraphs 3.1-3.10), we found that its systems should put it in a stronger position to address those challenges. Although the Trust has not delivered its statutory target to break even, it has operated within agreed deficit levels for the last two financial years. In 2006/2007, its outturn deficit of £6.3 million was lower than the



£6.4 million deficit agreed with the Assembly Government. For 2007/2008, the Trust is on track to achieve a year-end deficit of £1.8 million which is £0.5 million lower than the £2.3 million deficit agreed with the Assembly Government, having delivered £12 million savings through various efficiency schemes that formed part of the Strategic Change and Efficiency Plan (SCEP) for 2007/2008.

- 1.61** The Trust has also improved its budgeting processes. It has delegated financial budgets to regional and locality levels and has based budgets on the Trust's demand analysis at local level, with a view to ensuring that resources are allocated according to demand rather than historical patterns of supply. The EMS budgets are based around the number of unit hours produced (paragraphs 1.67-1.70), based on the assumption of producing 97 per cent of unit hours required and a rate of absence of 26.82 per cent to reflect leave, sickness, training and trade union activities. The budget is built on the number of regular hours (rosters plus relief) and overtime hours needed, which means that localities can deliver their financial budgets if they ensure that they produce 97 per cent of unit hours and remain within the target for absence rates.
- 1.62** This exercise has led to the development of the new rosters. In future the rosters will be derived from the new rostering software, PROMIS, which will allow for more robust information about how rosters are designed and delivered.
- 1.63** It is also very positive that the Trust has engaged in benchmarking activity with ambulance services elsewhere in the UK. This benchmarking work is developing and has the potential to play an important role in

informing future management and commissioning decisions. However, we found that some of the benchmarking data were insufficiently robust to enable meaningful comparisons to be made at this stage. However, this does not detract from the potential to continue to improve the quality of the data and to use it to develop a more sophisticated understanding of the Trust, its services and cost base.

There has been a significant improvement in the performance management systems and information in most parts of the Trust

- 1.64** Our original report highlighted significant weaknesses in the performance information collected by the Trust and the associated performance management systems, and recommended that the Trust review its performance information requirements and develop appropriate management information systems. The report also highlighted the need to improve performance management systems.
- 1.65** We found positive evidence that these recommendations had been addressed. We concluded that there has been a significant improvement in the quality, depth and accuracy of information available in most parts of the Trust. The Trust now has an executive director with responsibility for Information and Communications Technology and has developed a health informatics team with very significantly enhanced capacity in comparison to the time of our original review. At the time of our initial review, the Trust had a lot of data available, but had little information. Our follow-up work found that information was being used much more widely and proactively to inform the management of the Trust's operations.

1.66 The Trust has implemented, or is in the process of implementing, a wide range of new information systems to provide much more robust information about the services it provides:

- The PROMIS rostering system has been largely implemented, and will go live firstly in North Wales and then across all three regions. PROMIS will link to control and could link to ESR to provide an automated workforce management system.
- A new command and control system (MIS) has been implemented which includes a meal break module.
- Real time performance information in respect of response times is now provided on screens in Trust reception areas and on the Intranet.
- A pilot is underway in South East Wales where community responders use mobile data terminals to provide much more robust response time information.
- Signals From Noise, a performance management system, has been rolled out throughout the Trust's regions.
- A Status Plan Management System has been procured but is not yet operational because it requires tools on ambulance vehicles, such as Automatic Vehicle Locating Systems (AVLS), to make the status plan management system work effectively. AVLS and satellite navigation are available only in South East Wales.
- Enhanced Information System for Emergency Calls (EISEC) has now been implemented in all three regional controls and helps take seconds off the call cycle.

1.67 One of the fundamental conclusions of the original review was that the Trust had failed to match demand and supply effectively. The Trust has undertaken a major demand analysis, using average peaks of demand to predict where ambulances will be required. The methodology follows a well-known approach used in many English and North American ambulance services. The results are used to inform resource allocation, and assist dialogue, and allow discretion to meet local needs. The Trust adds information to enable it to accommodate additional demand likely to arise from known major events such as the Royal Welsh Show. Working together with the independent academic advisor to the Chairman, we reviewed the principles on which the methodology is based and the methodology itself. We concluded that both were soundly based. There is, however, a need for demand profiling to be better communicated to and discussed with personnel at local levels, and this should be a priority for Regional Directors.

1.68 Based on the demand analysis, the Trust has reviewed rosters and has changed them in the vast majority of localities to better match the demand analysis (in one locality in south east Wales, the Trust has not been able to agree new rosters, while in another the new rosters have only been implemented very recently). The Trust has sought to provide additional resources for initial responses by using additional RRVs. The number of incidents for which RRVs provide an initial response has more than doubled since December 2006: by March 2008, RRVs responded to just under one in three Category 'A' incidents and to just under one in five Category 'B' incidents.



- 1.69** The Trust has also set a target that the proportion of incidents where a community responder provides an initial response should increase from two per cent to five per cent, which is particularly important in rural and sparsely populated areas where it can be extremely challenging to provide sufficient ambulance cover to meet the eight minute initial response standard on a consistent basis. While these are positive improvements, there have been a small number of specific cases where there have been problems backing up these initial responses with fully crewed ambulances to transport patients to hospital (paragraph 1.10).
- 1.70** The Trust has implemented new regional Resource Management Centres to manage the production and distribution of unit hours (hours of cover provided by double-crewed ambulances or RRVs) of EMS cover to meet the requirements of the demand analysis. This process is now closely linked with the Trust's budgeting systems and reflects the greater devolution to the regions. There is some evidence that the Resource Management Centres are improving the production and distribution of response resources and ambulances to meet predicted demand, although capacity pressures and process weaknesses mean that much more needs to be done to deliver further improvements in this crucial area for the Trust.
- 1.71** It is important to note that while significant progress has been made in improving the performance information available to the Trust, the quality and robustness of that information will improve with time, particularly in creating a warehouse of data from which to predict demand and build rosters that optimally supply resources to meet predicted demand.
- 1.72** A linked priority for the Trust is the development of much more robust systems in its control rooms, where our original review identified a number of weaknesses. The Trust is addressing these weaknesses and has achieved some of the improvements in performance by changing processes in control. There have also been some changes in the areas covered by the various control rooms. For example, in March 2008 Bridgend moved from the control of Church Village to Carmarthen, so that it was controlled by its own region. Early performance information suggests an eight per cent improvement in Category 'A' performance by Bridgend vehicles and more appropriate utilisation of those vehicles. This may suggest that Bridgend crews were previously being displaced to help support performance in the South East region.
- 1.73** The development of the new Vantage Point House single control room and headquarters for the South East Wales region (paragraph 1.40) has significant potential to improve the efficiency and effectiveness of the Trust's control in south east Wales and to develop richer data warehouses of information to understand and predict demand for unscheduled care services which could be used across the unscheduled care system.
- 1.74** The Trust has also introduced a much more robust approach to performance management, building in part on the improved quality of management information. The Trust has introduced in most areas a four level performance management system where issues escalate through the levels if improvements are not delivered, based on the effective use of the management information that is available to the Trust, and statistical techniques to identify where variations in performance go beyond normal levels of variation. The idea of the performance

management approach is to empower staff to take action at the lowest level and to escalate only those insoluble issues where improvements are not forthcoming. The Trust uses an 'ABC' (Authority, Beneficial, Compliant) approach to allow staff and managers to identify when they can take decisions.

1.76 Operational staff attending our focus groups expressed some unease about the existence and cost of the PMD at a time of intense workload pressures. This signals the need for the Trust to communicate more effectively with all staff about the PMD and to strive to develop more coherent links between the regions and the PMD.

Project management disciplines have been introduced to the Trust

1.75 The Trust has also made good progress by introducing robust programme and project management arrangements, both of which were found to be weak in our previous review. Robust project management capacity is a key requirement of any organisation seeking to deliver a wholesale programme of transformational change. The Trust has established a dedicated Programme Management Department (PMD) to oversee the implementation of *Time to Make a Difference*. The implementation of the *Time to Make a Difference* programme is following the 'Managing Successful Programmes' approach, and the majority of PMD staff are PRINCE2 qualified. While there is scope to improve further the work of the department and, in particular, its links with operational staff in the regions, overall, the introduction of rigorous project management and recruitment of a skilled team of project managers is of benefit to the Trust when it is seeking to manage a programme composed of a large number of inter-related projects. An independent academic contribution to this review concluded that although the Trust formulated a best practice approach to programme management of *Time to Make a Difference*, it missed opportunities to engage managers in the field at an early stage.



Part 2 - Some difficult problems remain, which we judge are only to be expected at this stage of a process of transformational change

Significant challenges still need to be addressed in South East Wales, where progress has been slower than expected

Performance and morale in South East Wales are symptoms of slow progress and remaining challenges

- 2.1** Our original report highlighted the much lower levels of performance in the South East region. Whilst there is some evidence that the difference in performance between the regions is reducing, performance in South East Wales remains relatively low, which is of particular concern given that the region delivers just under half, 44 per cent, of the Trust's EMS workload.
- 2.2** When he gave evidence to the National Assembly's Audit Committee, the Trust's Chief Executive said that there was no obvious reason why the region should have lower levels of performance than the other two regions and, indeed, that it should be easier to produce good performance in the South East than in the other two regions¹. The Trust Chief Executive ascribed the variable performance principally to differences in the quality of leadership in the three regions. Consequently, it is disappointing that morale in South East Wales appears to be lower than in the other two regions and also that the

Trust has experienced considerable difficulty making a substantive appointment to the Regional Director position in South East Wales. Our overall conclusion, which the Chief Executive recognised, is that progress in South East Wales has been slower than we would have expected. This will need to be a key priority in the coming months.

- 2.3** Our focus group results suggested that staff in South East Wales had stronger negative views about a number of aspects of the Trust's progress compared with staff in other regions. The softer qualitative data from the focus groups suggested that staff in South East Wales had very strong concerns about the current position and that they were extremely frustrated by a number of factors. The level of frustration among staff and their representatives in South East Wales will need to be addressed in order for the Trust to ensure that staff re-engage with the Trust and sign up to the modernisation plan.
- 2.4** Staff in South East Wales expressed more negative views about corporate improvement areas². Although the recent staff survey did not enable analysis by Trust region, the free text comments included explicit comments raising concern about the quality of management in the South East region, which reflected some of the comments made at our focus group in the region.

¹ National Assembly for Wales Audit Committee, Ambulance Services in Wales, Committee Report (2) 02-07, paragraph 19.

² Clarity of understanding of *Time to Make a Difference*; the running of the Trust by its Board; the quality of leadership from the executive team; and the engagement of staff in improving the Trust.

Pressure on staff, difficulties with new ways of working and problems appointing a Regional Director have contributed to the problems in the region

2.5 There are three main themes which appear to have influenced the position in respect of staff morale:

- there has been significant operational pressure in the region, mainly as a result of excessive hospital turnaround times;
- there have been difficulties between staff and management over new ways of working; and
- the Trust has experienced difficulties appointing a substantive Regional Director.

2.6 Our interviews, focus groups and data analysis provided evidence that staff in the South East region have been under particularly intense pressure in recent months and that morale is a significant issue in that region. Given the volume of work delivered in the region and the stronger perception in South East Wales that things had got worse in terms of staff understanding of the modernisation plan, it is particularly important that staff in South East Wales are signed up to the modernisation agenda and that their morale improves.

2.7 Long turnaround times and a consequent loss of capacity have affected performance in South East Wales. South East Wales accounted for between two thirds and three quarters of hours lost as a result of turnarounds in excess of 20 and 50 minutes in 2006/2007 and 2007/2008, which is disproportionate to the region's 44 per cent share of the workload. Staff attending our focus groups perceived strongly a shortfall of resources to meet demand. Although there

are clearly problems in the region's ability to match supply and demand, the development of the new Vantage Point House control centre (paragraph 1.40) has significant potential to improve systems and manage the heavy demand within the region more effectively. In addition, two benchmarking exercises have suggested that the region is under-staffed in terms of control, and a business case has recently been submitted to increase the resources in control in South East Wales.

2.8 There have been particular problems in South East Wales over some of the Trust's modernisation actions to achieve a closer match between supply and demand. In South East Wales, the Trust has had greater problems changing rosters in line with its demand analysis, compounded by problems complying with the demand analysis because of excessive turnaround times at hospitals. In one locality, the new rosters have only recently been implemented, while in Rhondda Cynon Taf, the Trust is still operating 10 year old rosters because there have been major problems agreeing new rosters.

2.9 Generally, there has been particular resistance to roster changes to increase the level of relief from 25 per cent to 33 per cent of unit hours – the provision of planned additional capacity within rosters to reduce reliance on overtime to cover absence. The Trust has reduced its overtime expenditure from £8.5 million in 2006/2007 to £7.9 million in 2007/2008. There had been variable approaches to relief in the ten localities in South East Wales.

2.10 Another very contentious issue has been changes to the provision of meal breaks where the Trust's previous inclusive policy did not comply with the Agenda for Change



agreement that one of the two meal breaks should be unpaid while the other would be covered as part of the twelve hour shift. Negotiating the new meal break policy in South East Wales has taken a considerable amount of time and there is still only an interim policy and bridging agreement. We were told that staff have cited special dietary requirements and the fact that they did not carry cash as reasons why they needed to return to their base stations for meal breaks. Such reasons suggest a resistance to change as the often very long travel times to return to stations would significantly compromise capacity and could therefore damage service quality. The interim Regional Director has now asked those with genuinely special dietary requirements to provide a letter from their GP so that this could be placed on their personal file and to ensure that control were aware of, and able to meet, any special needs.

- 2.11** The difficulties arising from the concerns of staff in South East Wales about changes in working practices culminated in December 2007 with an unofficial overtime ban for one month, from the middle of December to the middle of January 2008. This arose from concerns about meal breaks and the availability of leave over Christmas, a time when the Trust historically experienced difficulties granting leave because of seasonal pressures and levels of demand. Staff decided to spend more time with their families over this period and so declined overtime. The Trust's plan to increase relief from 25 per cent to 33 per cent will help to mitigate the risk of relying on overtime if the Trust is able to agree this increased level of relief with the staff side.
- 2.12** Taken together, these problems reflect the strong view of staff in South East Wales that there are insufficient resources in the region

to meet demand. The Trust would benefit from reviewing the allocation and distribution of resources in South East Wales, taking account of the impact performance improvements which might be expected if hospital turnaround times were reduced to acceptable levels.

- 2.13** There has also been a lack of continuity of senior management in South East Wales, where the Trust has experienced difficulties recruiting a substantive Regional Director. Time was lost during an appointment process in which an offer to one candidate had to be withdrawn, and the Trust is now awaiting the arrival on 1 May 2008 of the substantive new Regional Director who is joining the Trust from the Scottish Ambulance Service. His appointment provides an opportunity for a fresh start in the region and concerted action to address the problems in the region, but the delay in the appointment has been a major impediment to necessary change in the region.
- 2.14** The South East Wales Regional Director role was undertaken by the Director of Ambulance Services between April and July 2007. Between July 2007 and 31 March 2008, the post has been covered on an interim basis from within the existing regional management team. The interim Regional Director has been supported by some additional capacity provided by a consultant who recently joined the Trust to provide some input in terms of managing external relationships in the context of planning strategies to support implementation of the Assembly Government's *DECS* strategy. Another symptom of problems of leadership and engagement within the region is the fact that when the new Clinical Team Leader posts were advertised, only five of the 30 existing supervisors expressed an interest.

There is scope to develop further the change programme and its management

The Trust recognises the importance of addressing staff morale, which many staff consider to have worsened

2.15 Notwithstanding the particular problems in the South East, staff morale is a fundamental challenge that still confronts all regions of the Trust. The results of the recent staff survey revealed that staff have negative views of the current position. On every issue, the Trust fell below the NHS Wales average (which is taken as a baseline). Additionally, on most issues, the Trust had the lowest score in NHS Wales, with very marked differences between the Trust and the next worst NHS

organisation. **Box 2** describes some of the key findings from the survey which were identified in an internal briefing on the staff survey results.

2.16 These negative perceptions were reinforced by the results of our focus groups of staff. These focus groups identified an overwhelming perception that morale was a very serious problem and that Trust management needs to listen to and engage with staff who remain very committed to the service. Overall, the focus groups identified that staff felt that staff morale was the improvement area that had deteriorated the most since December 2006. The negative perception about staff morale was twice as strong as the next most negative area (management listening to the ideas of staff).

Box 2: The Trust's analysis of the recent staff survey identified a number of areas for detailed focus

On one of the key elements of employee engagement, 38 per cent of staff responded positively when asked 'considering everything I am satisfied with this organisation as a place to work', compared with an NHS Wales average of 57 per cent.

Looking at change management, 12 per cent of staff believed that change is handled well in the Trust (compared with an All Wales average of 33 per cent).

In relation to line management honesty, 38 per cent of staff stated that they believed that their line manager was honest and open with them against an NHS Wales average of 62 per cent.

Examining communication, 18 per cent of staff stated that they were kept well informed about what is happening in the Trust (against NHS Wales 40 per cent). Additionally, 12 per cent of staff believed that senior managers within the Trust are open and honest in their communication with staff (compared with 41 per cent across Wales). Further, nine per cent of staff believed that communication between managers and staff is effective (against 31 per cent across Wales).

When looking at listening to staff, 13 per cent of staff reported that they believed that their ideas or suggestions would be listened to (against 37 per cent in the NHS in Wales). Further, 15 per cent of staff reported that they were happy with the opportunities that they have to make suggestions against an All Wales average of 40 per cent.

In relation to Performance Review and Appraisal, 19 per cent of staff said that their performance had been reviewed in the last 12 months (against 37 per cent across Wales), with 14 per cent stating that they had a Personal Development Plan in place (against 36 per cent in Wales). Sixteen per cent of staff believed that poor performance is dealt with effectively (against 31 per cent across Wales), with 18 per cent stating that they had sufficient opportunities to improve their skills to do their current role (against 49 per cent in Wales).

Examining Recognition, 18 per cent of staff were satisfied with the recognition they receive for doing a good job (compared with 44 per cent across Wales). Additionally, 16 per cent of staff feel valued for what they can offer the organisation (against 39 per cent in Wales).

When looking at reporting of incidents and challenging practices, 15 per cent of staff felt safe to challenge the way things are done (against 34 per cent in Wales). Additionally, 48 per cent of staff did not report incidents of violence and aggression against them (against 63 per cent in Wales) because 59 per cent of them did not feel that anything would happen.

Source: Trust briefing for the executive team on the staff survey results, January 2008



2.17 While we would expect there to be negative views among staff at an early stage of what is a comprehensive and ambitious change process, the Trust needs to focus strongly on addressing this negativity which is detrimental not only to the delivery of day-to-day business but also to the longer-term programme of strategic change. The Trust is entirely reliant on its workforce, which remains its major strength, but needs to find better ways to engage and communicate with it.

2.18 Our focus group identified a number of areas of concern which the Trust should address in respect of staff morale:

- staff identified workload pressures and a lack of respect from management in listening to their ideas as the worst aspects of working for the Trust;
- perceptions of a blame culture and bullying of staff;
- the fact that many staff see the Trust as being driven by response time targets rather than clinical performance; this contrasts with the ethos of *Time to Make a Difference* and does not reflect the clinical importance of reaching genuinely life threatening incidents within eight minutes; and
- a feeling of empty promises and a perception that staff views are not taken on board.

The Trust's problems with communication are reflected by the very disappointing take up of a CD-ROM explaining *Time to Make a Difference*

2.19 The Trust produced an interactive CD-ROM explaining *Time to Make a Difference* and invited staff to watch the CD-ROM, with a flat screen TV available through a prize draw for those participating. This approach mirrored

that taken in Merseyside Regional Ambulance Service by the Trust's current Chief Executive. While 70 per cent of staff in Merseyside took up the CD-ROM, only 30 per cent of Trust staff used the CD-ROM in Wales. This may reflect apathy and disengagement of staff, who seem to be somewhat alienated from the change programme.

2.20 This is reflected by problems of internal communication. The Trust has made significant improvements in its approach to internal communications. The Chief Executive has led a series of initiatives aimed at widening contact with staff, including meetings and road shows, the introduction of station champions and listening lunches, held at different locations with an open invitation to local staff. There are also Communication Days where Board members see for themselves operational locations and activities. An 'Ask the Chief Executive' database provides a further opportunity for staff access. More generally, the Chief Executive has made significant personal efforts to communicate directly with staff on a face-to-face basis. Although the Trust is seeking to transmit corporate messages, staff do not always appear to be receiving them. This reflects a level of apathy but also weaknesses in immediate line management and the availability of change agents at local level.

Some staff remain hostile to some of the key changes the Trust is seeking to make to working practices

2.21 Some staff remain hostile to a number of the key changes the Trust is seeking to make. There has been significant resistance to the introduction of the exclusive second meal break in accordance with the national Agenda for Change agreement.

2.22 Staff have also expressed concerns about the new dynamic deployment approach, where they often spend time in their vehicles at strategic deployment points. Although staff were involved in designing the cabs in the new ambulances to make them more comfortable, with much more space and television available and using ergonomic design principles, staff do not all like sitting in their cabs at the side of the road when they could be in an ambulance station which is often nearby. Nevertheless, the Trust's deployment plans reflect the fact that activation time and proximity to strategic points on the road network can make a significant difference to the speed of response and thus the quality of clinical care to those in life-threatening situations.

2.23 There is also resistance to the Trust's proposal to increase the level of relief in the new rosters and in a small number of localities there have been significant problems agreeing the new rosters. The Trust favours moving towards eight hour shifts to avoid the problems associated with meal breaks, to improve flexibility and reduce pressures on staff from long shifts but staff and their representatives generally do not favour any move away from 12 hour shifts.

There is a need for greater clarity about how the Trust will deliver what is expected from *Time to Make a Difference*

2.24 *Time to Make a Difference* is an ambitious programme of change which has a five year timeframe. Given the historically low base from which the Trust is trying to build, there has inevitably been a period of rapid activity and change during the first 18 months of implementation. The Programme Management Department has co-ordinated the management of *Time to Make a*

Difference projects and has introduced professional project management disciplines to the Trust. However, although staff consider their understanding of the modernisation plan to have improved and generally appear to support the direction, there is a lower level of understanding of how the Trust is going to deliver *Time to Make a Difference*.

2.25 The independent academic advising the Trust's Chairman concluded that the *Time to Make a Difference* projects have stretched the Trust's capacity as it seeks, in a relatively short time, to turn the organisation around. He also concluded that it is not surprising that many Trust staff sense that the organisation is doing better, but they are feeling worse and that this is not unusual in turnaround situations.

2.26 Similarly, a consistent theme emerging from our work, which the Trust itself has recognised, was a feeling that the Trust needed to prioritise projects within the *Time to Make a Difference* programme and to adopt a more strategic approach to implementation. There are real concerns about capacity within the Trust, not only management capacity to support the basics of running the organisation but also change management capacity to deliver the strategic change programme. Consequently, the Trust is seeking to take stock of the various projects, prioritise them and to seek to combine as many of the projects as possible into larger projects that can more easily be aligned with strategic objectives. In this way, the Trust is seeking to reduce 73 projects to 40 which will also help to mitigate the impact of perceived burdens of the project management requirements set down by the Programme Management Department.



- 2.27** There are also issues about ownership and capacity which affect the change programme. In an immature organisation, there is an inevitable conflict between central drive to make necessary change and local ownership. The evidence suggests that the Trust should take steps to increase the ownership of change projects at a more local level, not least to counter a perception that the PMD knows more about managing projects than managing ambulance services. Increased local ownership, supported by the robust project management disciplines provided by the PMD, could help reduce the sense of front-line staff being ‘done to’ and should be supported by clearer communication about why changes are being made. The Trust’s progress in devolving power to the regions will help achieve this rebalancing but there would also be benefits of the PMD reviewing its interaction with the operational side of the Trust.
- 2.28** The conclusions of the independent academic advisor to the Chairman’s review support this analysis. He identified the need to:
- make *Time to Make a Difference* project networks more inclusive and representative of knowledge from all levels of the Trust;
 - involve Regional Directors increasingly in constructing an active membership in *Time to Make a Difference* project networks;
 - make investment in management at local levels to deliver *Time to Make a Difference* on the ground, supported by more robust and consistent arrangements in relation to authority and autonomy; and
 - bring together the work of the various project group networks to avoid wasted opportunities for synergies, and potentially less efficient and effective activities.
- 2.29** In addition, the Trust may need to review its capacity to deliver all of the *Time to Make a Difference* projects, in terms of timescales and people. The review of timescales may require a rescheduling of projects to achieve a slightly sharper focus and to ensure that the Trust can deliver effectively without risking burn-out of staff in headquarters and also in the regions. A short period of reflection to reprioritise and, if necessary, reschedule may help to improve the robustness of the plans to implement *Time to Make a Difference*.
- 2.30** In respect of capability, there are doubts about whether there is an adequate number of staff locally who have the skills to act as leaders of change in their locality and team. The slow progress with the recruitment of Clinical Team Leaders and management development (paragraphs 2.38-2.39) has contributed to this problem, but in refocusing on these areas the Trust should take the opportunity to embed local staff to act as catalysts for changes required by *Time to Make a Difference*. The Trust’s Chief Executive recognises the need to do more to identify local champions for change.
- 2.31** The other capability gap, which the Assembly Government’s Regional Office has identified within its performance management of the Trust, is a lack of strategic planning capacity, at least in the short-term. This may contribute to a focus on delivering *Time to Make a Difference* projects which is so strong that it obscures the ongoing strategic monitoring and thinking to refocus the programme and communicate the big picture to staff. There is little doubt that the levels of expectation and external pressure, which lead to considerable ‘fire fighting’ by senior managers, exacerbate this. In 2007/2008, the Trust spent £1.28 million on external consultants, 48 per cent higher than in 2006/2007, to support implementation of *Time to Make a Difference*:

while this short-term use of consultants is unsurprising given the Trust's problems of management capacity, the Trust is aware of the need to balance increased capacity with the risk that the use of consultants could reduce the ownership of change by Trust staff and reinforce a perception of being 'done to'.

- 2.32** Whilst the PMD has introduced a rigour to business planning, the PMD only deals with modernisation projects. This creates a false distinction because the same level of rigour should be applied to all significant projects regardless of whether they have the label of 'modernisation'. There is an inherent danger of having two distinct business planning and project management processes operating within the Trust, which risks missing links between 'operational' and 'modernisation' projects.

The Trust now needs to make rapid progress to improve the quality of immediate line management, while management capacity remains a significant concern

There needs to be rapid progress on management development

- 2.33** Our previous report highlighted poor management capacity at all levels, with confusion about roles and responsibilities, and little management development³. The National Assembly's Audit Committee concluded that there had been basic failures of management and leadership throughout the organisation, which manifested themselves in poor people management,

cultural problems and a longstanding failure to translate strategies into action⁴. Both reports recommended that the Trust establish management development programmes with a particular focus on the quality of immediate line management.

- 2.34** While management capacity has been addressed to some extent through changes at executive level and the introduction of project and programme management skills through the development of the PMD, there has been disappointingly little progress on developing the quality of immediate line management. The Trust has recognised that it has not implemented a management development programme, which has perpetuated the historically low levels of investment in developing middle and line management. Staff attending our focus groups identified the need to improve the quality of their immediate line management. Problems with line management are compounded by the lack of training and development for managers and the workload pressures which affect many of the Trust's managers. The Trust recognises these findings, which were also supported by the independent academic advisor to the Chairman, who highlighted progress on human resources and training as huge risks to the delivery of *Time to Make a Difference*. The report of the independent academic advising the Chairman's review highlighted the potential 'lynchpin' role of the Locality Ambulance Officer, and the need to invest at this level.

- 2.35** The recent staff survey identified a number of problems with management, including:
- a strong perception of a culture of bullying, with 75 per cent of respondents indicating that they had been bullied, harassed or

³ Auditor General for Wales, *Ambulance Services in Wales*, paragraphs 2.93-2.133.

⁴ National Assembly for Wales Audit Committee, *Ambulance Services in Wales*, Committee Report (2) 02-07.



discriminated against in the previous twelve months and generally that it took the form of excessive criticism;

- only 18 per cent of staff responding to the recent survey were satisfied with the recognition they received for doing a good job;
- staff generally perceived managers not to be honest and open, with many staff feeling unsafe to challenge their managers; and
- staff feel poorly informed about the Trust's direction of travel and believe that change is poorly managed.

2.36 Staff attending our focus groups identified similar key areas which need to be addressed in terms of line management:

- a culture in some localities where managers do not listen to staff and a perception of a bullying culture;
- lack of time to carry out management roles, such as Clinical Team Leaders and Locality Ambulance Officers, and lack of appropriate training for managers;
- too much focus on bureaucratic issues such as sickness levels and performance targets, rather than the management and development of staff;
- staff in management posts who are not necessarily suitable for the role and too many middle managers; and
- inconsistent messages from managers because they are not kept up to date on changes within the Trust.

2.37 Box 3 summarises the principal ideas provided by Trust staff attending our focus group.

Box 3: Potential solutions to improving the quality of immediate line management

- Give managers appropriate training, sufficient time to undertake the role, encouragement to manage and engage with staff and the ability to act upon their decisions.
- Develop a clear progression structure for staff into management roles and a recognised management structure.
- Encourage managers to communicate upwards on all issues, both positive and negative.
- Provide more management support on the road.
- Effective implementation of the Clinical Team Leaders, supported with sufficient time and training to undertake the role.
- Ensure resources are available to meet the demands placed on the staff.

Source: Staff Focus Groups 2008 conducted by the Wales Audit Office

The development of the Clinical Team Leader role has been slow

2.38 While the Trust has signed off its new management structure, it has been slow to enact important parts of it. Most significant is the time it has taken to put in place the Clinical Team Leader role. This role is a key element of day-to-day supervision and will involve the appointment of staff to provide clinical supervision, mentoring and support with a direct clinical reporting line to clinical operations. Although Clinical Team Leaders will report to Locality Ambulance Officers, their relationship with Clinical Operations will sit outside the direct management line between operational staff and their Locality Ambulance Officer. The purpose of the role is to establish robust arrangements to improve clinical quality, and support learning and professional development.

2.39 While Clinical Team Leaders are in place in North Wales, only ten of the existing supervisors applied for the Clinical Team Leader role in South East and Central and West Wales. There has been poor communication about the purpose and nature of the role. Consequently, the Trust has re-advertised the Clinical Team Leader role in South East and Central and West Wales and is having to open up a new dialogue with staff about the role to encourage greater interest. The Trust is confident that it can now make rapid progress to establish the Clinical Team Leader role as it has now agreed the job description with the staff side.

The Trust has not made progress in appraising the performance of its staff

2.40 Linked with the slow progress on management development, the Trust has made little progress with the performance appraisal of its staff, despite recommendations in the reports of both the Auditor General and National Assembly's Audit Committee. While performance management of the organisation has improved significantly, performance management of individual members of staff has not. The recent staff survey showed that only 19 per cent of respondents had received a performance appraisal in the last 12 months (Box 2). We asked 40 of the participants in our focus groups whether they had received a performance appraisal in the last 12 months but only two of them had.

2.41 The delay in implementing an appraisal and personal development system is a very major weakness which links to the problems appointing Clinical Team Leaders. Appraisals and personal development review arrangements will follow from the appointment of Clinical Team Leaders and an action plan is in place. Progress implementing the Knowledge and Skills Framework under

Agenda for Change has been slow to date, although the Trust is now confident that it is has gained momentum and is better placed to introduce appraisals and personal development reviews than it was. Implementation needs to be a key priority as the process of setting objectives, reviewing performance and providing personal development activity to support learning and continuous improvement is central to the achievement of change within the Trust. The lack of performance management systems for individual members of staff remains a key barrier in terms of implementing *Time to Make a Difference*.

There is a need to ensure that new processes reduce sickness and promote a better work-life balance for staff

2.42 Our original report highlighted the high rates of sickness absence in the Trust and recommended that the Trust refocus on applying its sickness absence management policies in a robust and consistent fashion, and to speed up benefits realisation in respect of the electronic staff record system.

2.43 As part of our all-Wales mandated good practice work, the Trust's auditors, KPMG, undertook a light touch review of the current status of the Trust in respect of sickness absence management. Generally, the overall conclusion of the review supports the views of the Trust that it has put in place arrangements that are robust and consistent with good practice. However, there are clearly other cultural and managerial issues that are contributing to the high sickness rates.

2.44 While the Trust has set out an action plan designed to help achieve a reduction in sickness absence to six per cent in 2007/2008, the latest figures show that the Trust will not achieve the 2007/2008 target. Achieving the Assembly Government's 4.2 per



cent target for 2008/2009 is extremely ambitious and probably unrealistic. Although the KPMG report noted that some positive figures were provided to the Human Resources Committee in August 2007, subsequent analysis suggests higher rates of absence for the same period – a rate of 6.5 per cent for August 2007. Average monthly sickness rates reported for April 2007 to February 2008 were around seven per cent, based on the latest data (compared with 7.23 per cent for 2006/2007). It is important that the Trust does not draw conclusions about its sickness absence rates, nor report data internally, without being confident that all sickness for each period has been recorded on the Electronic Staff Record system (or that the figures are at the very least identified as subject to change).

- 2.45** There was a sharp peak in the Trust's overall rate of sickness absence in December 2007 and January 2008, coinciding with problems with emergency response time performance. While it would be difficult to establish a causal relationship, there appears to be some correlation: figures provided by the Trust for 2006/2007 show the highest rate of absence, 7.99 per cent, in February 2007 when there was also a significant dip in Category 'A' performance.
- 2.46** Overall, long-term sickness absence accounts for 72 per cent of total sickness reported to date for 2007/2008 (up slightly from the 68 per cent figure we reported for 2005/2006). The peak in December 2007 relates to short-term absence as long term absence was only 57 per cent of all absence in that month. The peak was particularly prominent in South East Wales but also in Central and West Wales which reported significantly higher sickness rates than South East Wales for 2007/2008 as a whole due to high overall absence among technicians. Paramedic absence was highest in South East Wales,

peaking at almost 11 per cent in January 2008. The rising sickness rate is symptomatic of issues around morale and engagement, such as the difficulties taking annual leave because of informal local management decisions (this is not a Trust policy). The difficulties taking leave are bound into pressure to deliver performance targets. Staff can only carry forward five days' leave but have 33 basic days' leave plus around seven to eight days per person carried forward from the Agenda for Change assimilation delays. Work life balance remains a significant issue for the Trust's staff.

The Trust has attempted to address turnaround times at hospital and their negative consequences

- 2.47** Overall, excessive turnaround times reflect a system-wide problem which not only has significant negative effects on the performance of the ambulance service but also reflects wider problems at its interface with accident and emergency. While a significant element of the solution, as set out in *Time to Make a Difference* and the Assembly Government's *DECS* strategy, is to manage demand much more effectively by reducing unnecessary transportation of patients to accident and emergency departments by creating new models of service, the Trust and its partners urgently need to address the systemic and cultural issues that tolerate such excessive turnaround times. This will also need action from outside the Trust, in particular for acute trusts to change a culture where it is seen as acceptable for scarce paramedic and ambulance resources to be delayed in accident and emergency departments, at the expense of those people not yet in hospital but who require an emergency ambulance

service. The existence of signs in some accident and emergency departments saying 'paramedics wait here' is indicative of the cultural weaknesses in the system as it currently operates.

2.48 The Trust has worked hard to address the problems of turnaround times, which has absorbed considerable managerial capacity, particularly in South East Wales. Reducing turnaround times is not a central element of *Time to Make a Difference* which means that the time spent tackling this issue has inevitably compromised capacity to implement the modernisation programme as well as operational performance. In respect of turnaround times, the Trust has:

- Focused its efforts on improving the information to support the management of hospital turnaround times, providing information to over 40 individuals and organisations about hospital turnaround times; this includes the implementation of a new version of the Trust's Medical Priority Despatch System (AMPDS) which has improved specificity by reducing the number of calls inappropriately prioritised as Category 'A' and which are automatically transported to an accident and emergency department.
- Raised the issue with its external governance partners in the Assembly Government and Health Commission Wales, with Chief Executives of NHS Trusts and LHBs.
- Worked closely with the acute trusts where the turnaround problems have been most severe, including placing paramedic supervisors and managers in accident and emergency departments to assist in the co-ordination and management of patients on ambulance vehicles.

- Ambulance control has sought to co-ordinate the picking-up of GP urgent patients only where there is a hospital bed available to receive them, working closely with the patient and their GP to monitor their condition. The Trust has also taken part in a programme of direct admissions to wards where this is appropriate and can help relieve pressure on accident and emergency departments and speed up admission processes.
- Introduced a duty doctor pilot in March 2007 during a period of intense pressures, which helped to develop alternative pathways for the management of Category 'C' calls, which is now being taken forward through the clinical desk pilot ([Case Study A](#)).
- Contributed to the development of an NHS emergency care lead role, which is now being undertaken by the Assembly Government's South East Wales Regional Office on behalf of health communities to develop a whole system approach to the co-ordination of emergency and unscheduled care across Wales.
- In partnership with Cardiff and Vale, Gwent Healthcare and the former Swansea NHS Trusts, commissioned consultants to undertake a study to better understand the underlying causes of extended hospital delays in South Wales and how these might be addressed.

2.49 It is encouraging that as a result of the keen interest taken by the Minister for Health and Social Services in the problem of excessive turnaround times, and the ongoing efforts of the Trust to work with its partners, that there has been a much stronger focus on addressing excessive turnaround times since October 2007. The Minister has set a target in



the Annual Operating Framework for 2008/2009 that NHS organisations will achieve a handover⁵ of patients from an emergency ambulance to accident and emergency (in a major A&E department) within 15 minutes. This will require robust measurement systems but should provide partners from both the ambulance Trust and acute trusts with a strong incentive to improve the efficiency with which patients are handed over. More efficient handovers should in turn improve the availability and quality of ambulance services to those who need them outside accident and emergency departments, and consequently lead to improved performance. The issue of handover times is one that the Wales Audit Office might address in the coming year through an audit of the new arrangements, robustness of measurement systems for handover times, and to track improvements in the ambulance capacity currently lost as a result of long handover times.

The Trust needs to develop a detailed estates strategy to support *Time to Make a Difference*

- 2.50** Our original report highlighted problems with the Trust's estate and recommended that the Trust should benchmark its estates function to ensure that it had sufficient capacity and develop a clear estates strategy that is consistent with its modernisation plan.
- 2.51** The Trust has improved its estates management capacity by creating three regional estates manager positions, although one of the post-holders has recently resigned. More significantly, the Trust now has an

executive with a specific estates and ICT portfolio. The Trust has not yet developed a detailed estates strategy although it has developed a Strategic Outline Case which will form the basis of the detailed strategy. Given the potential volume of capital projects if the Trust secures the capital funding to progress them, there may be a need to reassess the resources and skills in the estates department to deliver the programme of capital works.

- 2.52** We previously reported that the Trust had secured Major Risk Framework funding from the Assembly Government to help address the major estates risks relating to the Health and Safety Executive (HSE) Improvement Notice which covered 19 of the Trust's sites. The Improvement Notice has subsequently been discharged although in the meantime the HSE has issued an additional Improvement Notice in respect of asbestos, but we understand that this relates to management systems rather than actual physical works. This Notice is still current but we understand that the Trust expects to have discharged it by the end of May 2008. Although the Trust has discharged the main HSE Improvement Notice, a recent resurvey of its estate revealed a considerable backlog of essential maintenance. The Trust estimates that the cost of this basic backlog maintenance is £13.3 million.
- 2.53** The Trust is developing a Strategic Outline Case for estates which will be submitted to the Assembly Government for approval. In developing its estates strategy, the Trust needs to clarify its emerging vision to improve its estate. There are issues about rationalising surplus estate, and the Strategic Outline Plan provides an outline vision of how the estate will be developed to support the modernisation plan which will need to be

⁵ The handover period starts from when the A&E staff are notified by the ambulance crew that a patient has arrived and needs to be seen within the A&E Department, and ends when the patient has been transferred into the clinical care of A&E staff and the ambulance crew are free to return to the ambulance. The Trust was previously subject to a 'turnaround' target which stated that there should be no waits of more than 20 minutes in handing patients over to accident and emergency departments (15 minutes for patient handover plus five minutes to return to and mobilise the ambulance).

supported by more detailed plans. Despite this, some progress has already been made through specific projects such as the ongoing project to create a new control centre and regional headquarters at Vantage Point House in Cwmbran (paragraph 1.40), which the Trust informed us remains on time and on budget.

2.54 One of the main elements of the vision for the Trust's estate encapsulated in *Time to Make a Difference* was the development of a number of 'Make Ready' stations which would prepare, service, clean and restock ambulance vehicles so that they were ready for crews. The need to progress the Make Ready concept was cited by a number of staff attending our focus groups when asked for potential solutions to improving the Trust's fleet and improving the way they worked on a day-to-day basis.

2.55 However, there remains a need to discuss how to deliver the 'Make Ready' vision. The Strategic Outline Case provides a preferred option based around 'Make Ready' stations and larger ambulance resource centres in Cardiff, Wrexham and Swansea, with 35 disposals identified in the context of a wider rationalisation of the estate.

2.56 In addition, the estates strategy will need to address the estates implications of the modernisation of the Trust's service models in line with the Assembly Government's *DECS* strategy. The opportunities to improve collaboration with other providers of unscheduled care services and the development of new ways of integrating services provided by EMS and the Unscheduled Care Directorate (including the former NHS Direct operation), are likely to imply strategic change in the Trust's estate and will be dealt with as individual business cases are developed.

2.57 Further, collaboration on estates issues with partners from outside the NHS, such as Fire and Rescue Authorities and Police, has delivered benefits and may affect the need for the Trust to maintain its own buildings. For example, the Trust temporarily accommodated staff from its Blackweir Station in the Central Fire Station in Cardiff which delivered benefits in terms of alignment between the services and the quality of facilities offered. Throughout Wales, the Trust benefits from using fire stations as social deployment points where crews can use toilet facilities, kitchens and social areas.

2.58 Such developments are particularly relevant because staff attending our focus groups told us that they did not like spending time in their cabs at strategic deployment points as part of the Trust's new dynamic deployment approach. Staff can spend up to an hour in their cabs before control moves them to a station or deployment point with facilities. The Trust regards dynamic deployment as an absolute requirement of its drive to improve performance. While it would clearly be a significant retrograde step if crews reverted to travelling long distances between calls to their home station, which is often inappropriately located in terms of providing timely responses to meet predicted demand, the Trust's plans to provide strategic deployment points using the facilities of partner organisations could help to balance the wishes of staff with the demands of the service. Consequently, the Trust has recently asked its Regional Directors to investigate potential social deployment points to increase their number.



The Trust needs to further enhance the effectiveness with which it matches supply and demand

Staff remain concerned about whether supply and demand have been adequately matched

- 2.59** While there is evidence that the Trust has set up better information systems, resource management processes and new rosters, there are still some concerns about whether current supply adequately matches demand for ambulance services. These relate to concerns about the extent to which the new rosters match supply and demand effectively, and wider issues about the management of demand to improve the specificity with which resources are targeted.
- 2.60** When we asked staff attending our focus groups about the Emergency Medical Service (EMS) that the Trust provides, there were mixed views, with 35 per cent of staff saying that the service had improved, particularly around response times. However, 44 per cent of staff felt that the EMS service had deteriorated. Staff with negative views cited problems with hospital turnaround times; lack of appropriate care pathways; a perception that the use of RRVs sought to stop the clock rather than provide a more effective service for the patient which the performance data do not support; and insufficient focus on outcomes.
- 2.61** Our focus groups revealed a particularly strong feeling that there was a lack of staff to cover the basic shift patterns, which compounded problems responding in some rural areas. There was also a feeling, particularly in South East Wales, that EMS had not grown in step with demographic

growth. In terms of demand management, staff felt that there had been no proactive campaign from the Trust to minimise demand by informing and educating the public, leading to inappropriate use of the EMS by some members of the public.

- 2.62** Potential solutions identified by staff to improve the emergency care services that the Trust provides are outlined in **Box 4** and are consistent with actions already being taken to implement *Time to Make a Difference*.

The Trust and its commissioners need to understand better the balance of resources across its regions

- 2.63** The workload pressures cited by front-line staff suggest that there may be further scope to improve the balance of supply and demand further. One area of concern is the balance between providing geographical coverage and providing sufficient resources in areas of high volume activity. Our original analysis of the resources available to the Trust suggested that there was sufficient revenue to provide adequate cover but that the resources may not yet have been optimally matched with demand. The Trust's own benchmarking activities suggest its level of resources is not a constraint relative to other services. While the Trust has improved its processes, there may still be scope to review how resources are deployed.
- 2.64** The perceived pressures in some parts of South East Wales suggest that there may be a need to consider whether the Trust is producing enough unit hours of cover in that Region, linked with the potential that the Trust could be producing too many unit hours of cover in other regions. There may also be scope to redeploy resources within the region to provide better levels of cover in some areas. Such an analysis may also identify

Box 4: Potential solutions to improving the Emergency Care Service that the Trust provides

- Invest in manpower and increase the staffing levels within the Emergency Care Service in line with the demand placed on the service.
- Introduce alternative care pathways, supported by the development of a Clinical Desk in each control and enhanced staff within the service, such as Advanced Practitioners who can 'see and treat' the patient rather than just transport them to hospital, using RRVs to 'treat and refer' non emergency calls or investing in doctors.
- Implement better systems to prioritise '999' calls and performance manage the control.
- Focus on patient care and not on targets.
- Encourage the Assembly Government to take a whole systems approach to tackling hospital turnarounds and bed management.
- Educate the public and GPs to stop the misuse of the service and recognise what the service is really there for.

Source: Wales Audit Office Focus Groups of Trust staff, March 2008

scope to reallocate resources between the Trust's regions. Clearly, such an exercise would also need to focus on:

- the need to provide geographical cover in areas with lower volumes of activity;
- the impact of developing new models of response in some rural areas and the need for ambulance back-up;
- the impact on supply if the currently excessive turnaround times at some hospitals in South East Wales reduces as a result of the new Ministerial target; and
- the need to discuss openly with staff any concerns about the level of cover in their locality and to learn from any adverse incidents.

The Trust plans to improve the specificity with which it allocates resources to calls

2.65 As well as looking at the current configuration of resources, the Trust can also do more to improve its processes so that resources are used more effectively. The way that the Trust collects information from 999 callers determines the type of response despatched. There is considerable scope to categorise calls more effectively, so that the Trust does not despatch ambulances driving on their blue lights to calls which do not require them.

2.66 Consequently, the need to match supply and demand goes deeper than simply providing resources to meet the number of calls. The Trust and its partners need to do more to ensure that they understand the nature of the demand and provide the appropriate level of service for that demand. At the moment, the unscheduled care system tends to default to providing services in the most complex and expensive parts of the system. Recent benchmarking showed that in 2006/2007 the Trust categorised a significantly higher number of calls – around 50 per cent – as Category 'A' than 11 other UK services, all of which categorised between 24 and 39 per cent of calls as Category 'A'. The Trust could target its resources more effectively, reduce clinical risks and risks to staff and the public from driving unnecessarily on blue lights seeking to respond within eight minutes and improve its ability to respond to genuinely life-threatening Category 'A' incidents within eight minutes if its call categorisation were more sophisticated and specific. It is important to recognise the clinical risks inherent in sending ambulances to calls without a genuine clinical need.



2.67 The Trust is well aware of this opportunity and has developed links with the North East England Ambulance Service, which has the lowest percentage of Category 'A' calls of the services involved in the benchmarking exercise. The Trust has already reduced the percentage of Category 'A' calls from 50 per cent to 40 per cent but intends to bring this down to a figure of less than 30 per cent. The North East service is using a new software package to assess calls and despatch resources, which the Trust is considering for Wales.

2.68 Staff working in control expressed concern about their working environment within the recent staff survey. The Trust is undertaking considerable work to improve its control function by making its clinical triage processes more robust. The new model of control which is being set up at Vantage Point House, with NHS Direct nurses and ambulance control staff co-located, supported by clinical desks (paragraph 1.40 and **Case Study A**), offers significant scope to triage calls more effectively. The Trust has reintroduced Category 'C' calls and is discussing with the Assembly Government response time standards that should be applied to Category 'C' calls. The Assembly Government told us that the Trust has been advised that there is no absolute requirement to send an ambulance to every 999 call where the presenting conditions do not require their attendance. Using experienced NHS Direct nurses in control should help the Trust to be more specific in categorising calls and to provide telephone advice or referral to a more appropriate service rather than despatching an ambulance response when it is not really needed. This ties up valuable resources, tends to lead to patients being transported to accident and emergency

departments when they do not need to go there, and generally contributes to the 'locking up' of the unscheduled care system, as characterised by the excessive turnaround times at some hospitals.

Part 3 - There is a need to manage a series of future risks to support a wider recognition that it will take more time to implement fully the modernisation plan and deliver an acceptable standard of performance

The Trust needs to achieve greater clarity about a number of financial risks which could affect implementation of the modernisation plan

- 3.1** Although we have found no evidence to contradict the conclusion of our previous review that the Trust had sufficient financial resources, there are challenges that could affect the financial viability of the Trust's future plans.
- 3.2** The Trust has been subject to a SCEP which sets out how it will deliver efficiencies year-on-year, and which is now known as a financial recovery plan. The Trust has delivered the required £12 million savings under its SCEP in 2007/2008 with the level of required savings increasing to £17 million in 2008/2009 and £23 million in 2009/2010.
- 3.3** However, the Trust's future assumptions include ongoing support with capital charges. While the Assembly Government has provided £4.5 million capital charge support in 2007/2008, this may not continue and represents an ongoing financial risk for the Trust and Assembly Government. Given the relatively high capital charges arising from the short life cycle of the Trust's vehicle assets, this is a key assumption. The withdrawal of capital charge support could significantly affect the overall financial viability of the Trust's plans.
- 3.4** The Trust's main commissioner, Health Commission Wales, has deferred the Trust's contribution to its own financial recovery until 2009/2010 but the level of the cost improvement targets – £2 million in 2009/2010 and £5 million in 2010/2011 – could significantly affect the modernisation programme.
- 3.5** There are also financial pressures associated with the new locality based minimum performance standards that the Assembly Government has set the Trust from 1 April 2008. The targets require the Trust to respond to 60 per cent of Category 'A' calls within eight minutes in each of the 22 LHB areas every month.
- 3.6** The Trust is currently negotiating the additional cost of the new targets with Health Commission Wales but the initial indications are that there could be a shortfall of up to £6 million between any additional funding that might be made available by Health Commission Wales and the £9.4 million which the Trust estimates it will cost to deliver minimum standards of performance in each locality every month. This will require the Trust to examine very carefully the scope for efficiencies and will provide a very strong incentive to improve the specificity with which the Trust's control function is able to categorise calls.



- 3.7** The National Assembly's Audit Committee expressed concern about the viability of the Trust's plans to sell additional unscheduled care services to LHBs using 'surplus' hours of paramedic cover at a time of significant financial pressures. Although the original plans have been scaled down and the SCEP for 2007/2008 includes no plans to realise income in this way, the Trust's current plans still assume the realisation of £0.5 million additional income from other NHS bodies. The proposed reconfiguration of LHBs and the ongoing development of plans to support delivery of the Assembly Government's *DECS* strategy may affect the viability of realising this income.
- 3.8** A broader challenge in the context of *DECS* is the management of financial flows to support the reshaping of the unscheduled care system. There is not yet a robust system to manage the implications and financial flows arising from changes in service models. For example, if the Trust provides additional advanced paramedic services in the community which can reduce the number of patients transported to accident and emergency departments, it is not yet clear through which mechanism the financial flows will move to support the new model of service provision. Similarly, if the Trust is successful in improving the specificity of its call categorisation, develops new models of service such as 'see and treat', 'treat and refer' and 'hear and treat', it is not yet clear how the financial flows (there would be some additional costs and some financial savings) would be managed across the whole system. In the light of possible reconfiguration of commissioning of unscheduled care services, both as a result of the consultation on the future shape of LHBs and the Aylward review of Health Commission Wales, the Assembly Government needs to identify how the financial flows arising from *DECS* will be measured and managed.
- 3.9** There is also uncertainty about funding the costs of the Ambulance Radio Re-Procurement Project (ARRP). The Assembly Government has agreed £45 million revenue funding for the airwave (the 'cloud') over the next 10 years as part of a lease agreement. However, the equipment needed on the cabs, such as satellite navigation and mobile data terminals to receive the airwave is part of a separate negotiation. At the time of our fieldwork in March 2008, the Trust was preparing its 'equipment business justification case' for submission to the Assembly Government. The cost of the equipment for ambulance cabs is currently in the Trust and Assembly Government's capital plan but the Trust has applied for revenue funding to be provided on the same basis as the airwave so that risks are managed by the supplier rather than the Trust bearing these additional financial risks. The Assembly Government is considering whether some of the funding currently in the capital plans can be transferred to revenue funding.
- 3.10** The Trust could also face financial risks arising from the potential loss of PCS contracts. With the merger of Trusts, there is a smaller number of contracts. We are aware that some Trusts remain dissatisfied with the level of service they receive from PCS. With fewer contracts of a higher value, the Trust faces additional financial risk, and higher costs for remaining contracts, if it loses any of its PCS contracts with the acute trusts.

There is a need for a clear, medium-term capital plan and benefits realisation process to support *Time to Make a Difference*

- 3.11** As well as addressing revenue risks, the implementation of the modernisation plan would benefit from a clearer long-term capital plan. Although the Trust's capital planning has improved, there are currently a number of uncertainties about the nature and level of capital expenditure to support implementation of *Time to Make a Difference*. The resolution of the uncertainty requires some development of the Trust's current strategic plans as well as greater clarity about the level of capital investment from the Assembly Government.
- 3.12** There has been significant development of ICT since the time of the original review but further expenditure is likely to be needed to bring the Trust up to the level of ICT available to many English ambulance services. In particular, there is a need to make satellite navigation and mobile data terminals more widely available within the Trust. There is also a need to make AVLS and the new CAD system available throughout the Trust's regions to ensure that the control room functions in accordance with the latest industry standards. The Trust is also developing a business case for in-cab technology to automate the provision of meal breaks and to help control know the exact location of crews.
- 3.13** Given the slow progress in developing the Trust's estates strategy (paragraphs 2.50-2.58), and the need for the Trust to establish a clearer view about which premises it requires to support its strategy, there is a need to identify clearly the capital finance

implications of the development of the Trust's estate. The draft Strategic Outline Case highlights a need for £33 million capital investment over the next six years to develop ambulance resource centres and 'Make Ready' stations, although this is not offset by potential capital receipts arising from disposals.

- 3.14** The PMD requires business cases to include detailed benefit realisation criteria and a process has been put in place to hold benefit realisation workshops. However, this is still in its early stages and so we were unable to review at this stage the effectiveness of the newly established process. Nevertheless, given the scale of the *Time to Make a Difference* projects and the current and projected level of capital expenditure, the Trust will need to monitor carefully the effectiveness of its approach to benefits realisation. In particular, it is likely that commissioners and the Assembly Government will expect to see explicit links between capital expenditure and performance improvements, not only in business cases but also in hard evidence of the delivery of these benefits.

The Trust needs to manage expectations so that there is a wider recognition that it takes time to make a difference and reach an acceptable standard of performance

- 3.15** *Time to Make a Difference* is a five year modernisation programme. A recurrent theme in our fieldwork was that it will take time to deliver the programme and that it is too early to identify whether or not it has been effective. The Trust's Chief Executive and executive team highlighted the extent of external



scrutiny of the Trust and the fact that this 'fire-fighting' can reduce the managerial capacity available within the Trust to support change. While it is understandable that there is considerable public, political and media interest in the Trust, it is important that the energies of those in a position to improve the Trust can be focused as far as possible on positive steps to change the organisation.

3.16 Inevitably, some of the changes made to date have not yet translated into specific improvements in the level of performance and have certainly not led to improved staff morale. Consequently, there is scope for the Trust to provide a clear exposition of the milestones which stakeholders can expect it to deliver over the lifetime of *Time to Make a Difference*, drawing on the targets agreed with Health Commission Wales and the Assembly Government as well as the Trust's emerging benefits realisation framework.

3.17 Consequently, the management of, and communication with, key stakeholders is a vital part of modernisation. While the Trust has a key stakeholder plan and has improved its communications function, it would be beneficial if the Trust increased its stakeholder briefings, both through written and face-to-face media. A more proactive approach to communicating about *Time to Make a Difference* with key stakeholders, such as Assembly Members, the public and other NHS partners, could reduce the amount of time the Trust spent fire-fighting. It appears that the extent of communication with stakeholders may have diminished – based on the conduct of this review, we believe that reopening such channels of communication might yield valuable ideas and suggestions for improvement as well as improving the realism of stakeholder expectations.

There are whole systems opportunities which the Trust and its partners will need to address

3.18 Many of the most significant opportunities to improve the performance of the Trust require joint action with partners across the whole system. In particular, the Trust will need to:

- work with partners to develop more effective responses to the problems of excessive turnaround times at hospitals and deliver the new Ministerial handover targets;
- develop a clearer understanding of the volume and nature of demand for unscheduled care services;
- redesign service provision to meet that demand through more appropriate services provided in the right place and at the right time; the development of such service models has considerable potential to reduce the volume of traditional ambulance services provided and to increase the volume of new services offered, such as community paramedic services, see and treat, hear and treat, assess and refer and contributing to GP out-of-hours services;
- reduce pressure on accident and emergency departments through the development of new care pathways which minimise the number of patients inappropriately taken to accident and emergency when their needs could be met by another type of service;
- achieving greater benefits from the integration of NHS Direct into the Trust, particularly in the control room where

nurse triage has significant potential to support improved specificity of call categorisation, and a more clinically-driven approach to determining the nature of the Trust's response to the calls it receives;

- rapidly developing education and development programmes to equip the Trust's staff with the clinical skills and supervision to establish the enhanced range of unscheduled care services needed to deliver the Assembly Government's *DECS* vision, treating or referring an increasing proportion of patients without the need to transport them to hospital while improving response times in rural areas; and
- making the most of opportunities to improve the operation of the whole system of unscheduled care which might arise from the implementation of *DECS*.

The new locality targets for Category 'A' response time performance intend to improve equity but may create perverse incentives and reduce value for money

3.19 From 1 April 2008, the Trust is required to respond within eight minutes to 60 per cent of all Category 'A' calls in each LHB area every month. Such locality targets are unique in the United Kingdom and have the laudable intention of improving equity through uniform standards for each part of Wales rather than overall performance targets based on average performance across Wales. While the new target has commendable objectives, we believe that there are some risks inherent in the way the target has been set, which will require careful management.

3.20 Given the low monthly volume of Category 'A' calls in many localities, there is a risk that the targets may lead to a configuration of services which is not cost-effective. The targets could create a perverse incentive to move resources from some of the areas with a high volume of calls towards areas with lower call volumes, which could actually bring performance down in some areas to enable the Trust to achieve the locality target every month in rural areas. In some localities where there are low call volumes, missing a small number of calls each day is likely to lead to failure to achieve the target.

3.21 In supporting the important concept of equitable service levels in each area, there may be more value in focusing attention on localities with relatively low performance. This could help to identify the key barriers to better performance and opportunities to invest in improving performance, either through the provision of more traditional ambulance services or by developing new models of service. Such alternative models of service have considerable potential to improve compliance with response time standards, for example the development of Community Paramedic Officers and community first responders in rural areas. Alternatively, the targets may prove more reliable if compliance is measured over larger geographical areas or over a longer timeframe in order to improve the reliability of the statistics where there are low volumes.



Appendix 1 - Methodology

- 1 This report is the result of the Wales Audit Office's contribution to the Trust Chairman's review, which the Minister for Health and Social Care invited him to lead. The terms of reference were:
 - the progress the Trust has made against the recommendations of the Wales Audit Office Report on Ambulance Services in Wales published in December 2006;
 - the robustness of the Trust's five year modernisation plan *Time to Make a Difference* and its ability to deliver the further improvements required of the service;
 - progress against the actions identified in the plan; and
 - the effectiveness of infection control and cleanliness in ambulance vehicles.
- 2 Our contribution was based upon a self-assessment of progress against the Auditor General's recommendations provided by the Trust and the reports on progress against the recommendations of the National Assembly's Audit Committee, provided by the Assembly Government's Compliance Office.
- 3 To validate this information, we reviewed documentary, financial and performance information. We undertook:
 - a documentary review of the supporting evidence;
 - a detailed analysis of performance data which both updated the analyses contained in our original report but also expanded the depth of the analysis as a result of the Trust's significantly improved information systems; and
 - an analysis of financial information and performance.
- 4 We drew heavily on and spoke to the team that conducted the review of governance carried out by the National Leadership and Innovation Agency for Healthcare's Governance in Health team on behalf of the Assembly Government.
- 5 We also spoke to KPMG, who are the Trust's external auditors, working on behalf of the Auditor General, and drew on their recent report on sickness absence management.
- 6 We interviewed all members of the Trust's executive team. We also interviewed officials from Health Commission Wales and the Assembly Government's Department for Health and Social Care and North Wales Regional Office.
- 7 We conducted one focus group of staff in each region, with a separate session for the staff side and the Locality Ambulance Officers. This used the same computerised system that we used in conducting our original review in 2006, which facilitates anonymous participation and discussion. The focus groups addressed the following questions:

- Have things got better overall since the Auditor General's review in 2006?
 - What is the best and worst aspect of the organisation?
 - What still needs to be done?
 - What is the important thing that the Trust needs to improve, and how could improvements be achieved?
- 8** The Trust arranged the staff who attended. Overall, 64 staff took part in the focus groups, broken down as follows:

Breakdown of staff at focus groups

Staff group	Number	Percentage
Central Services/ Headquarters	10	15.6
Emergency Medical Services	20	31.3
Patient Care Services	4	6.3
NHS Direct	3	4.7
Other	3	4.7
Locality Ambulance Officers	13	20.3
Staff side representatives	11	17.2

- 9** We have provided the Chairman and Chief Executive of the Trust with our report analysing the findings of the focus groups. This report included each of the 491 suggestions for improvement provided by staff taking part in the focus groups.
- 10** We participated in the Chairman's Reference Group and drew on the findings of members of the Review Group. We worked especially closely with Professor Morton Warner, the independent academic advisor to the Review. We were very grateful to Dave Galligan of UNISON, who was part of the Review Group, for his advice on the design of the focus groups.



Appendix 2 - Schedule of actions taken in response to the National Assembly's Audit Committee and Auditor General's recommendations

Wales Audit Office recommendation	Associated Audit Committee recommendation	Wales Audit Office findings on progress
<p>1. The Trust has generally failed to achieve its 60 per cent response time target for Category 'A' calls, which is a significantly lower milestone towards achieving the same target as applies in England, whilst Wales categorises Category 'A' slightly differently than England. The Trust's detailed business planning should set out how the Trust will deliver and then maintain 75 per cent performance across Wales and how it will achieve a step change in performance in rural areas. At the same time, the Trust should develop a robust, accurate and balanced system of measuring and reporting ambulance service performance that covers key aspects such as:</p> <ul style="list-style-type: none"> a clinical quality; b measures of progress in transporting fewer patients to hospital; c patient and stakeholder satisfaction; d staff morale and cultural change; e finance and resources; and f PCS performance. 		<p>Trust-wide performance has improved but progress in South East Wales has been slower.</p> <ul style="list-style-type: none"> ■ Improvements in performance against the eight minute target for Category 'A' calls rising from 56 per cent in 2006/2007 to 62.3 per cent in 2007/2008. There is still significant regional variation with a recent downward trend in South East and Central and West. ■ In terms of the response times of fully crewed ambulances, regardless of whether a rapid response vehicle has been deployed, performance has improved from 78.5 per cent of Category 'A' calls in December 2006 where fully crewed ambulances responded within their area-specific target times to 88 per cent in February 2008. However, regional variations persist with a long-term decrease in performance in South East which has recently begun to reverse, stable performance in North Wales and general improvement in Central and West since February 2007. ■ Since December 2006 there has been a small improvement in performance of responses to Category 'B' and 'C' calls within area-specific targets. There has been stable performance in North Wales, a steady improvement in Central and West and a significant decrease in performance in South East. ■ Performance in relation to GP urgent calls has also improved in all three regions, rising overall from 63 per cent arriving at hospital no later than 15 minutes after agreed time in January 2007 to 81 per cent in February 2008. ■ Transportation rate – the percentage of patients transported to hospital is declining in all three regions. <p>Systems for measuring performance have improved</p> <ul style="list-style-type: none"> ■ Information collection and monitoring has improved through the work of the health informatics team and introduction of several new information systems. ■ The Trust continues to develop its systems to collect clinical information, such as pre-hospital thrombolysis. ■ Measurement of PCS performance should improve through the CLERIC ICT system. The Trust is developing KPIs which will eventually be superseded by CLERIC-derived KPIs.

Wales Audit Office recommendation	Associated Audit Committee recommendation	Wales Audit Office findings on progress
<p>2. There are significant problems with access to emergency medical services, as shown by performance data and the significant concerns expressed to the team by members of the public. There have been particular problems with response times in some rural areas. The Trust should conduct a review that leads to the development of regional strategies, consistent with the national plan. These strategies should take account of specific local circumstances, service developments and the need to deliver significant performance improvements and more equitable access. The regional plans should also analyse new models of service that might significantly improve performance in rural areas, as well as the need to maintain cover by double crewed ambulances.</p>		<p>Imbalance persists in supply and demand within the regions</p> <ul style="list-style-type: none"> ■ The Trust has recently produced regional plans for delivery of targets in under performing areas for the Assembly Government's Regional Office. ■ The Trust has developed Resource Management Centres in each region to develop rosters to meet demand analyses. ■ The pressures in the South East may suggest a need to review the balance of supply and demand across the Trust. ■ Although Category 'A' response time performance has improved in all LHBs, there are still particular problems with relatively low levels of performance in particular LHBs.
<p>3. The time ambulances spend at A&E departments handing over patients and then presenting themselves for the next call remains a significant drain on capacity. A monitoring system is in place to measure the length of time ambulances remain at A&E departments. The Trust should take a much more proactive role in tackling poor turnaround times and monitoring real time delays that occur.</p>		<p>The trust has taken a proactive approach to addressing the problems of poor turnaround times although the problem remains particularly acute in the South East</p> <ul style="list-style-type: none"> ■ Excessive turnaround times (over 50 minutes) have increased since April 2007. ■ Problems have impacted on patients and on the day-to-day work of staff. ■ A large amount of managerial capacity has been used to address this problem, to the detriment of other managerial tasks/projects. ■ Specific measures include: improved information on turnaround times, raising the issue with external governance partners, targeted work with acute trusts where problems are worst, and employing consultants to investigate the issue. ■ The Trust has fully recognised the urgent need to work with partner organisations to remove the systemic problems that cause poor turnarounds and to meet the Assembly Government's new 15 minutes target for handing over patients (2008/2009 Annual Operating Framework).



Wales Audit Office recommendation	Associated Audit Committee recommendation	Wales Audit Office findings on progress
<p>4. The Trust has over-centralised to the extent that the regions have not been empowered to develop appropriate services and to tackle the challenges they face. Headquarters was too operationally focused and consistently failed to deliver strategic change. Internal communication has been a weakness. The Trust Board and headquarters should focus on longer-term strategic development and the performance management of operations, while the managers in the regions should be empowered to develop and deliver the Trust's services to patients. To enable the Board to achieve this necessary level of strategic leadership, it should undergo a programme of Board development. There should be much clearer accountability for results delivered through the performance management system. A communications strategy should support the positive development of the Trust's culture.</p>		<p>The Trust has made good progress in empowering the regions</p> <ul style="list-style-type: none"> ■ New Regional Director posts have been set up with dedicated support, although problems appointing a Regional Director in the South East have contributed to difficulties in that region. ■ Budgets have been delegated to region and locality levels, built on the demand analysis. ■ Management of PCS has become more regionalised, coming under the remit of the new Regional Directors. There is a PCS modernisation group in each region. ■ Regional resource management centres have been put in place. <p>The Trust has developed its performance management and governance arrangements</p> <ul style="list-style-type: none"> ■ A recent review by the NLIAH Governance in Health team was positive about the Trust's governance which appears much improved. There has been considerable activity to develop the working of the Trust Board. ■ The Trust has largely rolled out a new system to manage its performance which is based on delegating decision making to the lowest level possible but escalating matters where problems cannot be solved, supported by much improved measurement and information systems. <p>The Trust has developed a new communications strategy</p> <ul style="list-style-type: none"> ■ A new communications strategy has been drafted and includes plans to improve internal and external communications, and specifically aims to publicise <i>Time to Make a Difference</i>.

Wales Audit Office recommendation	Associated Audit Committee recommendation	Wales Audit Office findings on progress
<p>5. The public needs to be informed about how a modern ambulance service works and why the changes in the draft modernisation plan are necessary. The public, particularly in rural areas, can help ambulance staff to provide a better service. In the context of <i>DECS</i>, the Assembly Government should develop a patient information campaign to:</p> <ul style="list-style-type: none"> a explain changes in unscheduled care services, including ambulance services and their changing role; and b highlight ways in which the public could help the ambulance service deliver a prompt and appropriate response, such as by knowing when and how to call the service, what information they need to provide and how it will be used. 		<p>The Trust has developed its approach to PPI but still needs to inform the public about developments within the trust and in the ways in which they can assist service delivery</p> <ul style="list-style-type: none"> ■ There have also been improvements to the support and monitoring systems used by the Clinical Governance committee through: <ul style="list-style-type: none"> - the introduction of clinical effectiveness leads in each region; - the development of a clinical effectiveness strategy; - the development of clinical performance indicators; and - the formation of the adverse incidents projects group. ■ The Governance in Health (GIH) report commented that less progress has been made in PPI than in other areas of the Trust. ■ There remains considerable public interest in the Trust and there is a continued need for a more proactive approach to communicating with the public about <i>Time to Make a Difference</i>. ■ The Engagement and Communication Workstream established under <i>DECS</i> will look at the issue of PPI.



Wales Audit Office recommendation	Associated Audit Committee recommendation	Wales Audit Office findings on progress
<p>6. The Trust transports a relatively high proportion of people to hospital, despite evidence that a significant proportion of calls could be treated more appropriately without being transported to hospital. This exacerbates pressures on A&E departments, ties up crews unnecessarily and means that patients do not access the most appropriate care. In implementing its modernisation strategy, the Trust should, with the Assembly Government where appropriate, develop alternative response interventions including:</p> <ul style="list-style-type: none"> a developing roles, staff and protocols to allow hear and treat and see and treat approaches that avoid transporting patients to hospital unnecessarily; b expand the number of staff who have had additional education and training to make clinically safe decisions not to convey the patient; c re-introducing Category 'C' calls and protocols that allow the service to refuse to attend patients where the caller has had a telephone consultation and it is not clinically appropriate to attend; d monitoring the percentage of patients transported to hospital; e developing referral protocols with NHS Direct and GP out-of-hours services to ensure that patients access the care most appropriate to their clinical needs; f expanding successful initiatives such as the field hospitals, set up in Swansea and Cardiff at busy times, that provide appropriate responses to demand for unscheduled care; and g working with health partners, develop alternative care pathways that provide appropriate routes through the unscheduled care system and increase the clinical role of the ambulance service as a front-line provider of mobile primary and diagnostic healthcare. 		<p>The proportion of patients transported to hospital has reduced</p> <ul style="list-style-type: none"> ■ Transportation rate – the percentage of patients transported to hospital is declining in all three regions. <p>The Trust is focusing more on higher education to extend roles for staff</p> <ul style="list-style-type: none"> ■ The training team has been rebranded as the Education and Development Team. This has moved from the HR department to the Unscheduled Care Directorate. ■ There is a general move towards higher education provision through work with the University of Wales, Swansea. <p>The Trust has piloted a clinical desk to triage Category 'C' calls using NHS Direct nurses</p> <ul style="list-style-type: none"> ■ The Trust has successfully piloted clinical desks to assess the effectiveness of NHS Direct nurses taking calls to ensure Category 'C' callers receive the most appropriate response within the unscheduled care system. <p>Working with health partners to provide alternative care pathways for unscheduled care</p> <ul style="list-style-type: none"> ■ The Trust has worked with health partners, especially in South East Wales, to address turnaround times; and ■ The Trust is working with health partners to develop alternative care pathways but there is a need to minimise the risks posed by a lack of clarity around the financial flows that will arise from the changes to the whole system that may arise from the Assembly Government's <i>DECS</i> strategy.

Wales Audit Office recommendation	Associated Audit Committee recommendation	Wales Audit Office findings on progress
<p>7. The ongoing secondary care reviews will lead to a reconfiguration of services that could significantly affect the ambulance service. The Regional Planning Fora should ensure that the secondary care reviews include a consideration of the impact of any changes on the ambulance service. In particular, there is a need to consider the impact of reconfigured services on demand for the air ambulance service.</p>		<p>Outside the scope of the review.</p>
<p>8. There have been historical weaknesses in internal governance concerning the Trust Board, some of which have been addressed in recent months. There is a particular need to develop greater clarity of the Board's role, responsibility and decision making. The Trust should review the roles and responsibilities of Board members to ensure that non-executives are much more actively involved in the Trust, for example through regional non-executive roles. There should also be more robust performance management arrangements for non-executive members of the Board. The Trust Board should also clarify which decisions the Board should take and to communicate more clearly with staff the decisions taken at each Board meeting.</p>		<p>There has been significant improvement in the Trust's governance arrangements</p> <ul style="list-style-type: none"> ■ There have been significant changes to the Trust's executive team, with only one member remaining in post since December 2006. ■ The composition of non-executives has remained largely unchanged. ■ A recent review by the NLIAH Governance in Health team was positive about the Trust's governance which appears much improved. There has been considerable activity to develop the working of the Trust Board.
<p>9. Although national commissioning is a strength, its role in performance managing the contractual delivery of the emergency service has been insufficiently co-ordinated with performance management of the Ambulance Trust as an organisation by the Assembly Government and there was insufficient input from local health communities. As the DECS strategy evolves, the Assembly Government should maintain national commissioning but seek to develop regional consortia of LHBs to inform it about the local needs that should inform the commissioning of unscheduled care services, of which ambulance services are a key element. In respect of PCS, the Trust should develop more integrated commissioning of transport services with social services and Mental Health services.</p>		<p>The ongoing reviews of Health Commission Wales and recent Assembly Government consultation on the future of LHBs may provide an opportunity to develop new approaches to the commissioning of emergency ambulance services.</p> <p>The Assembly Government's North Wales Regional Office has involved the other Regional Offices more closely in performance management.</p>



Wales Audit Office recommendation	Associated Audit Committee recommendation	Wales Audit Office findings on progress
<p>10. The Trust has experienced a very difficult period, including significant external scrutiny. The Trust has experienced problems in the past implementing strategies. Now that it has developed a plan to move the service forward, the Assembly Government should provide the Trust with the space to work towards implementing its plan as quickly as possible with a minimum of distraction, particularly over the next 12 months.</p>		<p>The Assembly Government has sought to balance support with performance management to ensure that the Trust delivers necessary improvements.</p>
<p>11. Management capacity has been poor at all levels, with confusion about roles and responsibilities, and little management development. The Trust should assess management capacity urgently and ensure that its leadership has sufficient skills at all levels to manage the organisation effectively. The Trust should develop a leadership and management development programme that is linked to the performance and appraisal system and addresses skills shortages. It should also link the workforce planning processes, which seeks to identify future skill needs, as the organisation moves to more modern working practices. There should be a particular focus on:</p> <ul style="list-style-type: none"> a change, programme and project management skills; b valuing staff, engaging with them and acting upon their suggestions where considered appropriate; and c investigating the potential of team leadership to improve management capacity at local level, particularly through managers having named team members; and changing the management structure to provide the capacity and skills to deliver change and to manage the organisation effectively on a day-to-day and longer-term strategic basis. 	<p>We recommend that the Trust develops a long-term management development programme to address these deep-rooted issues at all levels, with a particular focus on immediate line managers. The programme should cover setting personal objectives, conducting personal development reviews and performance management issues. It should also include as core managerial competencies project and programme management. (Audit Committee recommendation iii).</p>	<p>Considerable scope remains to improve management capabilities and capacity</p> <ul style="list-style-type: none"> ■ There have been improvements in relation to the introduction of project and programme management skills. ■ There is no management development programme and concerns remain about the quality of line management. ■ The staff survey and focus groups highlighted problems with management style: a perception of a bullying culture, a lack of openness and honesty from managers and poor provision of information on the direction of travel for the organisation. ■ The new Clinical Team Leader role has a key role in improving clinical supervision and support and forms part of the planned management structure. However, progress in establishing the Clinical Team Leader role has been slow to date.

Wales Audit Office recommendation	Associated Audit Committee recommendation	Wales Audit Office findings on progress
<p>12. There have been problems with the organisational culture and a lack of clinical leadership, partly because the Trust has not had a full-time clinical director. The Trust needs to change its culture and become a reflective, learning organisation that learns from adverse incidents and focuses on clinical issues rather than transport. To develop a more clinical focus, it should move towards full-time clinical leadership. It should also take account of the views of its service users and stakeholders in order to improve consistently the quality of care it provides.</p>		<p>The development of an Unscheduled Care Directorate has contributed to improved clinical governance arrangements</p> <ul style="list-style-type: none"> ■ a full time Clinical Director has been appointed supported by two medical advisors; ■ the Trust has developed a Clinical Advisory Group; ■ a new clinical governance structure is being developed including regional clinical effectiveness leads, the development of a clinical effectiveness strategy, the introduction of clinical performance indicators and the introduction of an adverse incidents project group; ■ the integration of NHS Direct Wales with the Trust has served to increase the clinical capacity in the control room; and ■ clinical governance has been strengthened by the development of policies for discharge of care, professional scope of practice, complaints, children’s welfare, Protection of Vulnerable Adults, Mental Health, integrated care and medicines management.



Wales Audit Office recommendation	Associated Audit Committee recommendation	Wales Audit Office findings on progress
<p>13. The Trust has failed to develop robust performance management processes, with key staff lacking objectives and performance appraisals, and significant confusion about roles and responsibilities. Along with a review of the organisation structure and programme of Board development, the Trust should urgently develop an integrated performance management system that:</p> <ul style="list-style-type: none"> a incorporates an effective business planning process that translates the Trust's strategy into specific operational business plans, linked to financial planning and service delivery processes; b ensures appropriate and timely monitoring and reporting of performance to enable decisions, action and intervention to take place at the appropriate time and at the appropriate organisational level; c incorporates an effective performance management, and personal development system for all employees where employees have personal targets and objectives that are derived from the strategy and business plan and assessed at least annually through a formal appraisal process; d gives all executives clear and measurable personal objectives which are cascaded from the strategy/business plan; e strengthens accountability and challenge within managerial and Board arrangements to deliver improvement; and f ensures there is timely reporting to the Board of progress against key strategic and operational objectives. 	<p>We recommend that the Trust develops a long-term management development programme to address these deep-rooted issues at all levels, with a particular focus on immediate line managers. The programme should cover setting personal objectives, conducting personal development reviews and performance management issues. It should also include as core managerial competencies project and programme management. (Audit Committee recommendation iii).</p>	<p>The Trust has not made good progress in developing robust appraisal mechanisms although corporate performance management has improved</p> <ul style="list-style-type: none"> ■ the Trust has developed performance management systems for the organisation but has not yet translated this into individual staff performance appraisal arrangements: only 19 per cent of staff responding to the staff survey had received a performance appraisal in the past year; ■ delays in introducing Clinical Team Leaders have contributed to the ongoing absence of performance appraisals; ■ performance information has improved through the development of ICT systems and the GIH review; and ■ the GIH report noted the lengths to which executives had gone to provide Board members with an appropriate level of information to enable sound and justifiable decisions to be made. <p>Business planning processes have improved</p> <ul style="list-style-type: none"> ■ the introduction of the Programme Management Department (PMD) in July 2007 aimed to ensure that all modernisation projects follow a robust business planning process; ■ individual departments identify the business need and produce business plans and the PMD then applies a PRINCE2 methodology and appoints a project manager; and ■ each project has a nominated executive director as the project sponsor and all projects are signed off by a Programme Board.

Wales Audit Office recommendation	Associated Audit Committee recommendation	Wales Audit Office findings on progress
<p>14. Despite some recent progress, levels of sickness absence remain high and compromise operational efficiency. Following Agenda for Change, sickness absence is likely to present even greater direct costs to the Trust. Although basic principles of policy and approach are in place, application has been inconsistent and sickness rates have increased since April 2005. The Trust should refocus on applying its sickness absence management policies in a robust and consistent fashion, and to speed up benefits realisation in respect of the electronic staff record system, in areas such as manager self-service for sickness reporting and direct access to sickness records.</p>		<p>The Trust has put in place arrangements to manage sickness absence that are consistent with good practice but cultural and managerial issues are contributing to continued problems with absence rates</p> <ul style="list-style-type: none"> ■ the Trust has an action plan to reduce sickness absence rates to six per cent; ■ average monthly sickness rates between April 2007 and February 2008 were approximately seven per cent; and ■ peaks in absence coincide with problems in emergency response times.
<p>15. Developing new service models will require the Trust to develop new capacity and skills. Workforce planning has been an historical weakness. The Trust should produce a detailed workforce plan that includes objectives and timescales, and takes account of enhanced paramedic roles and the modernisation plan, as well as the capabilities of existing staff to move into new roles.</p>		<p>Workforce planning remains a weakness</p> <ul style="list-style-type: none"> ■ the Trust is working with NLIH to produce a workforce plan; and ■ the GIH report said there is a need to keep the workforce engaged in the changed models of care and ensure robust workforce planning is in place to deliver a modernised workforce.
<p>16. In common with many other ambulance services, Agenda for Change has been implemented at significant cost to the Trust without yet deriving any modernisation benefits. Meal breaks remain a drain on capacity and the Trust is currently operating an inclusive meal break policy which appears to conflict with the national Agenda for Change agreement. The Trust now needs to work closely with staff and their representatives to deliver rapid benefits from the implementation of Agenda for Change. In particular, the Trust should urgently resolve the meal break issue to ensure compliance with the national agreement on Agenda for Change and that meal breaks do not compromise capacity through crews driving long distances back to base stations.</p>		<p>Changes to the provision of meal breaks remain contentious with only an interim policy and bridging policy in place</p> <ul style="list-style-type: none"> ■ the Trust's previous inclusive policy did not comply with the Agenda for Change agreement that one of the two meal breaks should be unpaid while the other would be covered as part of the 12 hours shift; ■ negotiations around the new policy have been time-consuming and only an interim policy and bridging policy have been agreed; and ■ staff in some areas remain resistant to the new arrangements whereby capacity is not lost through returning to stations for meal breaks.



Wales Audit Office recommendation	Associated Audit Committee recommendation	Wales Audit Office findings on progress
<p>17. There are significant problems with job satisfaction, stress and sickness in control centres, which deliver a vital function within an ambulance service. There are also inconsistencies between the gazetteers in use in the various control rooms, which lead to data quality problems and can lead to problems identifying the source and location of calls. The Trust should:</p> <ul style="list-style-type: none"> a develop a clear strategy to develop the control function, provide appropriate technology and a suitable working environment, listening carefully to the views of staff on improving the control function; b include in its strategy proposals for linking control and NHS Direct if the proposed merger proceeds, and systems to allow local service provision to be taken into account in telephone assessment and referral where this is the most appropriate pathway; and c urgently resolve the inconsistencies in gazetteers used in control rooms so that there are compatible gazetteers in all control rooms in Wales. 		<p>There have been improvements to control room function but scope remains to derive full benefits from the integration of NHS Direct and to develop more effective unscheduled care pathways</p> <ul style="list-style-type: none"> ■ Vantage Point House provides a significant opportunity to develop a model of an integrated unscheduled care call centre. ■ Scope remains to develop more effective control processes to derive the full benefits of integrating NHS Direct and the Trust, particularly by improving the specificity of call categorisation and reducing the proportion of Category 'A' calls relative to English services which have lower proportions than the Trust. ■ The development of more effective pathways through the unscheduled care system would improve demand management. ■ The implementation of the CLERIC ICT system should enable the trust to move from 24 PCS control centres to three, one in each region. It should also facilitate a move to electronic mapping and improved scheduling, rostering and record keeping through a single patient master index rather than the multiple records currently maintained for each patient. ■ There have been some changes in the areas controlled by the various control rooms. In March 2008 Bridgend moved from the control of Church Village to the control of Carmarthenshire, so that it was controlled by its own region. Early performance information suggests a significant improvement in performance. ■ Staff working in control expressed considerable concern about their working environment within the recent staff survey. ■ The integration of NHS Direct staff into the Trust has increased clinical capacity within the control room. ■ A clinical desk pilot has been carried out that involved nurses diverting Category 'C' and 'B' calls to the most appropriate unscheduled care service.

Wales Audit Office recommendation	Associated Audit Committee recommendation	Wales Audit Office findings on progress
<p>18. Staff do not feel valued or listened to by Trust managers, despite the evidence that they are very strongly valued by the public of Wales. The Trust should communicate more regularly and directly with individual employees, as well as with the Trade Unions. Management development should address the need to recognise and praise staff and to ensure that all employees realise that the Trust recognises their contribution and commitment.</p>		<p>Addressing low staff morale remains a fundamental challenge</p> <ul style="list-style-type: none"> ■ Staff in the South East were more negative about the Trust's progress than in other regions. The trust needs to address the level of frustration amongst staff in this region. ■ The staff survey showed that the trust fell below the NHS Wales average on every issue. ■ Focus group evidence revealed an overwhelming perception that low staff morale was a serious problem. Few staff felt they received adequate recognition from their work. <p>The Trust has made improvements to its internal communications but staff do not appear to be receiving the messages</p> <ul style="list-style-type: none"> ■ only 30 per cent of staff used a CD-ROM giving details of <i>Time to Make a Difference</i>; and ■ there has been a series of initiatives aimed at improving contact with staff including the introduction of station champions, listening lunches, communication days, Ask the Chief Executive sessions and improved face-to-face contact between Chief Executive and staff.
<p>19. There has been a failure to monitor or manage PCS costs and performance, with five different systems in operation, none of which is fit for purpose. The Trust should urgently:</p> <ol style="list-style-type: none"> a review contracts to establish the service that their PCS clients want and develop common core standards of service; b develop a standardised PCS management system; c establish appropriate management arrangements that ensure proper accountability for service management and delivery; and d develop accurate costing information to ensure that the service operates within its income levels and is competitive. 	<p>The Trust should address the serious problems with patient care services over the next year in particular by developing new management systems, service standards and staff development processes that are fit for purpose and consistent throughout Wales. (Audit Committee recommendation viii).</p>	<p>The Trust has begun to improve its Patient Care Services although there is still much work to be done</p> <ul style="list-style-type: none"> ■ some acute trusts remain concerned about the quality of PCS services; ■ the reduction in the number of acute trusts through reconfiguration presents a risk of the Trust losing PCS contracts; ■ management capacity within PCS has been improved. PCS is managed at a regional level by the Regional Directors and regional PCS modernisation groups have been established; ■ a PCS project board has been established to oversee the regional implementation of the PCS change programme; and ■ the Trust has procured a new PCS ICT system and is developing PCS KPIs.



Wales Audit Office recommendation	Associated Audit Committee recommendation	Wales Audit Office findings on progress
<p>20. Rosters, both for EMS and PCS, do not take account of demand, which has compromised service quality. The current rosters provide more capacity than is required overall, but not enough capacity at peak times. In some areas, rosters are eight years old and do not reflect recent changes in the demand profile or the context in which the ambulance service provides services. PCS rosters tend to focus on the hours of 8am to 4.30pm and therefore do not support the needs of the NHS or its patients. The Trust should urgently review its rosters and undertake fundamental changes to ensure that services are arranged around the needs of patients.</p>	<p>We recommend that the Trust should establish as soon as possible new rosters and shift patterns, with a particular focus on achieving a more appropriate match between supply and demand in the South East Wales region. (Audit Committee recommendation vii).</p>	<p>The Trust has used the results of its major demand analysis to inform the design of new rosters but there is resistance to change in South East Wales</p> <ul style="list-style-type: none"> ■ The Trust has carried out major demand analysis and this information has been used when designing new rosters. ■ There is a need to finalise changes to one locality's roster in South East Wales. There has been resistance to roster changes in some areas. ■ Generally, there has been resistance to roster changes to increase the level of relief from 25 per cent to 33 per cent of unit hours. ■ There is scope to review the new rosters. ■ New rostering software (PROMIS), which will first go live in North Wales, will result in the use of more robust information when designing rosters.
<p>21. Problems in procurement have led to significant wasted money and the acquisition of assets that have compromised the Trust's ability to perform, although there have been some recent improvements in process. The Trust should designate an executive with responsibility for all procurement. It should also actively liaise with other ambulance services in the UK to learn from their procurement and to avoid duplication. The Trust should also bring in external procurement expertise for the highest-risk procurements to support the restoration of confidence and rigour in its procurement function. Procurement plans should be explicitly linked to national strategy and modernisation plans, and any investment, capital or revenue.</p>		<p>Procurement systems are being revised but it is too early to draw firm conclusions about their effectiveness</p> <ul style="list-style-type: none"> ■ the Trust now has a service level agreement with the North Wales Business Services Partnership (BSP) through a Service Level Agreement to oversee its procurement processes; ■ the BSP has a named lead officer for the Trust and the arrangements within the BSP appear to be operating effectively; and ■ the Wales Audit Office reviewed documentation for a sample of capital procurements and found that the process for these procurements appeared robust at their current stage of progress although it is too soon to comment on outcomes.

Wales Audit Office recommendation	Associated Audit Committee recommendation	Wales Audit Office findings on progress
<p>22. The Trust has experienced significant problems with the buildings that make up its estate. It is subject to an ongoing HSE improvement notice and has not invested sufficiently, either in maintenance or the estates function, to develop a strategic approach to the estate and to meet statutory obligations. The Trust should benchmark its estate function with a view to providing sufficient capacity to meet the challenging estates agenda. Drawing on previous reviews, the Trust should develop a clear estates strategy that is consistent with the modernisation plan.</p>		<p>The Trust has not developed an overall estates strategy</p> <ul style="list-style-type: none"> ■ The Trust has not yet developed a detailed estates strategy. ■ The Trust has created three regional estates manager positions although one of the post-holders has recently resigned. ■ The Trust now has an executive with a specific estates and ICT portfolio. ■ A recent resurvey of the Trust's estate revealed a considerable backlog of essential maintenance. The Trust estimates that the cost of this basic backlog maintenance as £15 million. ■ The Trust is developing a Strategic Outline Case for estates which will be submitted to the Assembly Government for approval. In developing its Strategic Outline Case and estates strategy, the Trust needs to clarify its emerging vision to improve its estate.
<p>23. Although there have been recent improvements, the Trust has had significant weaknesses in terms of the performance information collected and performance management systems. In particular, the information has been retrospective and does not provide 'real time' management information to enable managers to make decisions at the appropriate time. The Trust should review its performance information requirements and develop appropriate Management Information Systems that:</p> <ol style="list-style-type: none"> a provide real-time performance information about the delivery of their modernisation strategy; b capture the right information that the Trust needs to manage its various services (EMS, PCS, HR, Fleet, Estates etc); c are derived from the strategy and business and financial planning processes; d enable the Trust to carry out sophisticated demand modelling, both temporal and geographical; e are consistent across the regions to ensure that the Trust not only has regional management and performance information but also has a corporate overview; and f provide reports at timely intervals for both managers and the Board, and which are part of the performance management regime. 		<p>Performance management systems and information have improved</p> <ul style="list-style-type: none"> ■ there is now an executive director for ICT; ■ a health informatics team has been developed; ■ new information systems have been introduced including PROMIS rostering software, a new command and control system, real time response time information on the intranet, and the Signals From Noise performance management system; ■ three new regional resource centres have been developed and there is some evidence that these centres are improving the production and distribution of resources to meet demand; and ■ the Trust has introduced a four-level performance management system where issues escalate through the tiers if improvements fail to be delivered.



Wales Audit Office recommendation	Associated Audit Committee recommendation	Wales Audit Office findings on progress
<p>24. Although there have been a number of adverse incidents in which the other emergency services have transported emergency patients to hospital due to unacceptably long response times, there are no established systems to share learning from these incidents. Through the Joint Emergency Services Group, the Trust should develop a protocol to learn from serious incidents involving transportation of emergency patients by the police and fire services.</p>		<p>Communication with other emergency services needs improving</p> <p>In its response to the Chairman's review, the Joint Emergency Services Group, a voluntary forum of serving Chief Officers to promote emergency services co-operation in Wales, acknowledged initial improvements within the Trust following the Auditor General's report. However, it has pointed to continuing concerns about joint working arrangements, both strategic and operational which need to be addressed. Further discussions have been initiated and the Review Group has identified this as a key priority.</p>
<p>25. There are concerns about the adequacy of clinical information available to the Trust. The Trust should identify and implement an audit process for key clinical areas which will produce reliable information about the outcomes of patient care, and should use the adverse incident reporting arrangements already established by the Assembly Government.</p>		<p>A new clinical governance structure is being developed including regional clinical effectiveness leads, the development of a clinical effectiveness strategy, the introduction of clinical performance indicators and the introduction of an adverse incidents project group.</p>
<p>26. The Trust appears to have sufficient overall revenue and staff resources, although there are questions about the efficiency with which resources are used and people deployed. However, there is little costing or benchmarking information to help the Trust assess how capacity might be used more effectively. The Trust, using its developing information on unit hour utilisation, should carry out more detailed work to cost services. Taking account of its modernisation planning and the development of the SCEP for 2007/2008, it should also review the way it uses its capacity to improve efficiency, building in safeguards to avoid any 'levelling down' of performance.</p>		<p>There are still concerns from staff about the extent to which supply and demand have been matched</p> <ul style="list-style-type: none"> ■ Focus groups revealed that staff feel there is a lack of staff to cover the basic shift pattern. There was a particular concern that changes to the coverage in South East Wales had not matched demographic growth. ■ The Trust may need to consider whether it has enough staff resources (unit hours) in the South East region. ■ The Trust has engaged in benchmarking activity with other UK ambulance services but some of the benchmarking data is insufficiently robust to enable meaningful comparisons at this stage of its development.

Wales Audit Office recommendation	Associated Audit Committee recommendation	Wales Audit Office findings on progress
<p>27. The Trust has consistently met its statutory financial targets over recent years but there is evidence that it has not done so in a sustainable way, including a draft SCEP that predicts a £6.6 million deficit for 2006/2007. There is evidence that the service is adequately revenue funded and efficiencies can eventually result from modernisation and matching resources to demand, but that this will require capital investment, particularly to develop a modern and integrated communications infrastructure. Working with the Assembly Government and Health Commission Wales the Trust should develop robust business cases for all capital investments, including performance gains and revenue savings over a reasonable and achievable timescale. The Assembly Government and Health Commission Wales should rigorously assess these business cases using the Gateway Review, or similarly robust process to ensure their fitness for purpose and explicit link to the overall strategy.</p>	<p>We recommend that the Trust establish robust capital planning, management and governance arrangements to ensure that capital is used effectively but with appropriate levels of control. The Assembly Government should use the results of its review of procurement to disseminate to the wider NHS the lessons of procurement by the Trust. (Audit Committee recommendation vi).</p>	<p>Financial management processes have been strengthened</p> <ul style="list-style-type: none"> ■ our review of financial information suggests that the Trust has generally addressed the Auditor General's recommendations; ■ the Trust has not met its statutory break even target but has operated within agreed deficits for the last two financial years; and ■ financial budgets have been delegated to the regions. <p>The Trust has made good progress in improving capital planning processes</p> <ul style="list-style-type: none"> ■ the Trust has agreed a 10-year capital programme that has been approved by the Assembly Government; and ■ the Trust has used all of its capital allocations in 2006/2007 and 2007/2008 which suggests less reliance on rushing capital expenditure at the end of the financial year. <p>Dissemination of lessons learned</p> <p>For major capital schemes, each business case submitted to the Assembly Government will set out the procurement strategy and programme management arrangements which will be looked at as part of the scrutiny process. The Assembly Government will identify and discuss the lessons learned within the PricewaterhouseCoopers audit report on the previous ambulance report, and disseminate to the wider NHS.</p>
<p>28. Fleet management has been poor with no national fleet manager and evidence that current arrangements are not delivering value for money, particularly the recent ambulance purchase. A new fleet manager has recently been recruited. The Trust should conduct a fundamental review of its fleet needs and methods of delivery in the context of modernisation plan. The review should produce a clear decision on how best to use the recently-purchased ambulances.</p>		<p>Staff have welcomed the Trust's significant investment in new fleet</p> <ul style="list-style-type: none"> ■ The Trust has invested £23.1 million in new vehicles and 151 additional vehicles are on the road. ■ A national fleet manager has been recruited. ■ The Vehicle Clinical Equipment Working Group meets to ensure procurement of fleet and equipment is effective. ■ Staff said in the focus groups that they are impressed by the quality of the new vehicles. Eighty-two per cent of staff at focus groups recognised improvements in the fleet.



Recommendations of the National Assembly’s Audit Committee not covered in the Auditor General’s report

Audit Committee recommendation	Wales Audit Office findings on progress
<p>1. We recommend that the Assembly Government disseminate the lessons learned from the failures of governance, performance and financial management within the Trust and includes within its review clear guidance about the minimum frequency with which Boards should meet.</p>	<p>The Governance in Health Project is nearing completion of its programme of governance reviews of individual Trusts and LHBs across Wales. As part of this programme, the Project Team have taken on board and disseminated the lessons coming out of the Wales Audit Office report, and have worked with Boards to consider their role and effectiveness. This has included the conduct and frequency of Board meetings.</p> <p>The Governance in Health team has reviewed governance in the Trust and its report was generally positive about the progress that has been made.</p> <p>In tandem the Assembly Government is commencing a programme of training and development to enhance the skills and knowledge of board members and audit committees. Both these pieces of work are informed by both the lessons learnt from the Wales Audit Office report into Ambulance Services in Wales, as well as experiences from elsewhere.</p>
<p>2. We recommend that the Assembly Government consider the feasibility of introducing the concept of memoranda of understanding between trusts and the Assembly Government to formalise day-to-day working relationships. Such arrangements would facilitate more decisive action when an organisation is clearly failing. Whatever tools are in place, decisions to use them need to be taken promptly. We recommend that the Assembly Government should review its intervention and performance management procedures to learn from the failure to address known problems sufficiently quickly in this case.</p>	<p>Performance management by the Assembly Government’s North Wales Regional Office has been strengthened this year, with monthly reviews against the Annual Operating Framework and Strategic Change and Efficiency Programme and the involvement of the other two Regional Offices in performance management. There are also quarterly meetings on clinical governance and serious incidents and there are also overall quarterly reviews involving the Regional Office and the Trust regional directors in the three regions. The Regional Office has been testing out this more regional approach and has tried different ways to look at both regional and national issues.</p> <p>The Assembly Government has indicated that it is exploring the concept of a memorandum of understanding with NHS organisations. It has also indicated that its Director of Service Delivery and Performance Management took up post during October 2007. Intervention and performance management arrangements continue to be developed.</p>
<p>4. We recommend that the Assembly Government conduct a review of the lessons to be learned from the rapid turnover of leaders within the Trust, amends its own procedures in the light of this review and disseminates guidance to all Boards to avoid a recurrence of such a situation in other NHS bodies.</p>	<p>The Assembly Government has indicated that appointments were made by the Trust and not the Assembly Government, but that there will be a review of Assembly Government procedures associated with short-term appointments and if needed further guidance will be given to the NHS in Wales.</p> <p>The National Leadership and Innovation Agency for Healthcare has developed a draft Gold Standard Chief Executive Appointment Process document which is currently being finalised. It will be issued following final approval.</p>
<p>5. In the context of the <i>DECS</i> strategy and changes to the commissioning of unscheduled care services, we recommend that the Assembly Government monitors extremely closely the delivery of the proposed savings, particularly the process of the Trust seeking to sell additional unscheduled care services to LHBs at a time of significant financial pressures.</p>	<p>The proposal to sell unscheduled care services to the LHBs, which was included in a draft SCEP, was not included in the final agreed version for 2007/2008. However, the proposal to sell unscheduled care is still being pursued and whilst no income has been planned or realised in 2007/2008, future financial plans to achieve the SCEP do include £0.5 million income from other NHS bodies. The proposed reconfiguration of LHBs and the ongoing development of plans to support delivery of the Assembly Government’s <i>DECS</i> strategy may affect the viability of realising this income.</p>