Performance Analysis

1) Overview

2015/16 was a pivotal year in the transformation of the Trust as the new commissioning arrangements became established and the new National Collaborative Commissioning and Quality Framework was implemented.

For this reason, the Welsh Government recognised that an approvable three-year Integrated Medium Term Plan (IMTP) for the organisation was unrealistic for 2015/16. Consequently, the organisation was asked to focus on producing a one-year plan. A one-year plan was produced, approved by Trust Board, endorsed by the Chief Ambulance Services Commissioner (CASC), the Chair of the Emergency Ambulance Services Committee (EASC) and the lead NHS Wales Chief Executive.

Key headlines in delivering the one-year plan were as follows:

- The launch of the pilot of the New Clinical Response Model on 1 October 2015.
- Being awarded the ‘hosting’ rights for the 111 Pathfinder project in Abertawe Bro Morgannwg University Health Board.
- NHS Wales agreement on a new service model for Non-Emergency Patient Transport Services (NEPTS).
- Construction of the brand new Ambulance and Fire Services Resource Centre (AFSRC) in Wrexham; completed in March, ready for opening in April 2016.
- Improvements in delivery against the national time-based performance targets.

2) Strategic Change and Drivers

a) Commissioning and Quality Delivery Framework (CQDF).

Emergency ambulance services are commissioned on a collaborative basis by the seven Local Health Boards through the Emergency Ambulance Committee (EASC) and the Chief Ambulance Services Commissioner (CASC), acting on their behalf.

2015/16 saw the introduction of the Commissioning and Quality Delivery Framework. The framework provides the mechanism to support the recommendations of the 2013 McClelland review and provides the accountability structures for commissioning and service provision.

The Trust has worked closely throughout 2015/16 with both the Chief Ambulance Services Commissioner (CASC) and the Emergency Ambulance Service Committee (EASC) to ensure the framework agreement translates into demonstrable service improvements for people in Wales who need and use the services.

The framework articulates a five-step Ambulance Care Pathway. This details the
steps within the delivery of emergency ambulance services within NHS Wales. The Ambulance Care Pathway encourages focus on the patient journey i.e. patient flow, and a whole systems approach.

The framework has set out a clear strategic aim to focus on a ‘shift left’ of patient flow along the pathway, where it is clinically appropriate and safe to do so, so that patients are better informed as to how to access the urgent and emergency care system, where appropriate they can receive telephone advice or be treated by a paramedic providing care and treatment ‘on scene’ or be taken to an emergency department or other services as and when appropriate.

Much progress has been made throughout 2015/16 in terms of strengthening the collaborative approach to commissioning. Some other headline achievements are the development, implementation and publication of the new Ambulance Quality Indicators (AQIs) which provide an increasingly granular and a transparent balanced way of understanding the services performance. The published AQI’s can be accessed through the EASC website following the link below:

Additionally support has been gained through the new framework and structures for the implementation of 14 proposed service change initiatives.

b) The Five Step Ambulance Care Pathway

Figure 1: Five-Step Ambulance Care Pathway

**STEP 1: Help Me to Choose** – increasing public and public services education about the service model and when it is appropriate to make a call to the service. This step includes the development of appropriate linkages between the Trust and the future 111 service, building on the success of NHS Direct Wales and its website as well as the secondary triage clinical desk.

**STEP 2: Answer my Call** – professional and timely answering of 999 calls and calls from Health Care Professional (HCP) by the Trust’s Clinical Contact Centres (CCCs). This step incorporates the provision of adequate time to assess a call in order to determine the best clinical response/assessment.

**STEP 3: Come to See Me** – This step focuses on how the Trust makes decisions about what resources to dispatch to assessed/prioritised calls. Broadly, the response options are as follows:
- Emergency Ambulances (EAs) and solo crewed Rapid Response Vehicles (RRV) and Community First Responders (CFR) will be allocated to RED calls, e.g. cardiac arrest or choking;
- Emergency Ambulances (EAs) will be deployed to AMBER calls where the patient requires transfer to hospital (e.g. heart attack or stroke);
- Solo crewed Rapid Response Vehicles (RRV) will be sent to AMBER calls where the likelihood is that, after assessment, the patient will be referred to another service e.g. GP Out of Hours. (see, treat and refer);
- Clinical Telephone Assessment (‘hear & treat’) offered to all other low acuity AMBER and GREEN calls; and
- Urgent Care Service crews (UCS) will be dispatched for low acuity GREEN patients who are assessed by HCPs as requiring admission to hospital.

**STEP 4: Give Me Treatment** – This step focuses on the development and delivery of a range of clinical care services able to offer a variety of treatment options. The selection of the most appropriate treatment will be supported by decision support tools e.g. Paramedic Pathfinder for ‘see & treat’; the Manchester Triage System and the Clinical Assessment System (for ‘hear & treat’). Treatment options will include the use of alternative care pathways allowing patients to be referred to primary and community care.

**STEP 5: Take Me to Hospital** – Patients who require ongoing care and treatment will be transported to hospital or to alternative care settings (e.g. Minor Injury Unit or a primary/community care facility).

The 5 step pathway is part of the 10 step National Unscheduled Care Pathway being developed by the National Unscheduled Care Programme.

Figure 2: Unscheduled Care Pathway
c) Ambulance Quality Indicators (AQIs)

As part of the developing CQDF a set of Ambulance Quality Indicators (AQIs) that provide information on patient flow, performance and clinical indicators across the Five-Step Ambulance Care Pathway have been developed.

The new AQIs, developed in collaboration with the Trust are published each quarter. They were published for the first quarter of the clinical model (October –December 2015) on the 27 January 2016 by EASC on their website: Emergency Ambulance Services Committee | Ambulance Quality Indicators

Some of the Ambulance Quality indicators are still under development. Data for October 2015 to March 2016 has been provided at an all Wales level, but in the future data will also be presented at a Local Health Board level where possible.

The Ambulance Quality Indicator set will be reviewed each year and updated, based on feedback.

d) Core Requirements

The Ambulance Care Pathway is then underpinned by six enablers, which are referred to as Core Requirements (CR) within the CQDF; governance, patient experience and satisfaction, equity, clinical care, staffing and safety.

The Trust already reports on a range of enabling indicators but will work with the CASC during 2016/7 to develop indicators further against the core requirements.

A self-assessment against the Core Requirements was undertaken in December 2015 and reported to the Quality Assurance Improvement Panel (a sub-committee of EASC). It highlighted a number of areas where further focus was required and an action plan was developed and agreed. Much progress has been made against the action plan e.g. improvements to the risk management processes.

e) Core Requirements

The CQDF also provides a structured approach that enables discussion, agreement and evaluation of significant service change ideas that the Trust is considering.

Some 14 service change ideas during 2015/16 have been agreed with EASC and these, along with a summary of each, can be found in Appendix 1

3) The New Clinical Model.

On 01 October 2015 the Trust implemented a new clinical model, as a one year pilot. The new model provides a clinically appropriate focus to responses rather than a time based approach to emergency vehicle dispatch.

The new model introduces new ways in which callers to 999 are assessed to ensure they are receiving the most appropriate care and response to the suit their needs. The changes will clearly identify those patients who require an immediate life-saving response and those patients will receive the highest priority response in the fastest time
possible. An 8 minute target remains for these ‘RED’ calls. All other patients will receive an appropriate response based on their condition rather than a generic response based solely on a time standard; these changes should improve patient experience as well as improve patient flow.

The major changes in the model were to:

a) Emergency calls are categorised based on the clinical need of the patient.
b) Time-based targets are removed for all calls except the highest priority ‘RED’ calls;
c) Performance is measured by clinical achievement using clinical indicator data (measuring the quality of care the patient received) rather than time-based data alone.
d) Additional time is allowed for the service to assess what help is required rather than dispatching an ambulance to an address alone. This is for emergency calls other than the highest priority RED calls.

Figure 3: Clinical Response Model Pilot

<table>
<thead>
<tr>
<th>Call Type</th>
<th>EASC Definition</th>
<th>Example</th>
<th>Quality Indicator</th>
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</thead>
<tbody>
<tr>
<td>RED</td>
<td>Immediately life threatening calls such as cardiac arrest or choking. These calls will be subject to both clinical indicators such as Return of Spontaneous Circulation (ROSC) rates and a time based standard requiring a minimum attendance at 65% of these calls within 8 minutes.</td>
<td>Respiratory / cardiac arrest</td>
<td>8 minute response time within 65%, National target</td>
</tr>
<tr>
<td>AMBER</td>
<td>Serious but not immediately life threatening. These calls will include most medical and trauma cases such as chest pain and fractures. Amber calls will receive an emergency response. A response profile has been created to ensure that the most suitable clinical resource is dispatched to each amber call. This will include management via “hear &amp; treat” services over the telephone. Patient experience and clinical indicator data will be used to evaluate the effectiveness of the ambulance response to amber calls.</td>
<td>Cardiac chest pains / stroke</td>
<td>Compliance with care bundles for cardiac stroke and fractured neck of femur patients.</td>
</tr>
<tr>
<td>GREEN</td>
<td>999 calls received and categorised as green are neither serious or life threatening. Conditions such as ear ache or minor injuries are coded as green calls. Green calls are ideally suited to management via secondary telephone triage. Health Care Professionals (HCP) such as doctors, midwives or community hospitals often require an urgent transfer of a patient from low acuity care to a higher acuity facility. Theses transfers are coded as green calls and undertaken within a timeframe agreed with the requesting HCP.</td>
<td>Fainting - recovered and alert</td>
<td>Clinical outcomes and patient satisfaction for 999. Compliance with healthcare professional agreed admission timescales for HCP calls.</td>
</tr>
</tbody>
</table>

The Trust is clear that the new model of care will deliver the following benefits:

- The sickest patient will always be treated first.
- The centrality of patient and public safety will maintained at all times.
- Patients will receive care which meets their clinical needs.
- Delivery of the best clinical outcome for each and every patient on every occasion and optimal patient experience.
- A reduction in overall clinical risk within the ambulance service model by offering a range of treatment options, once the patient’s need has been identified.
- Right skills, right place, right time.

EASC have commissioned an external, independent evaluation of the model which the Trust are proactively engaged with and which will be invaluable in testing the extent to which these benefits have been realised.
4) Strategic Change Programmes

The Trust's 2015/16 plan outlined a portfolio of strategic change which the organisation committed to deliver. The portfolio brought together five strategic change programmes; the Clinical Modernisation Programme, Non-Emergency Patient Transport Service Programme, Workforce and Organisational Development Improvement (WODI) Programme, Strategic Efficiency Programme and Community Engagement.

a) Clinical Modernisation.

The Clinical Modernisation Programme Board (CMPB) was established with a primary objective in 15/16 to deliver the New Clinical Model and ensure any changes were clinically-led and managed in a systematic way, starting with the identification of core clinical activity which could be standardised across Wales with appropriate supporting performance and clinical indicator information.

The Programme was divided into five key development project areas using the Five-step New Clinical Model, plus an identified Human Resource project to support these developments, each with underpinning work streams.

b) Non-Emergency Patient Transport Service.

At the request of the Minister for Health and Social Care a Non-Emergency Transport Service (NEPTS) Transformational Project was established in September 2014, the remit being to produce a Business Case recommending a way forward for NEPTS in Wales.

The project group considered previous reviews including the McClelland Review, 2013 and in October 2015 produced and submitted a business case which went through an internal and external review process prior to being submitted to Ministers on 30 October 2015.

The Business Case recommended a preferred model of service delivery; the Trust managing and co-ordinating all NEPTS in Wales using a mixed economy of providers. The main benefit outlined was enabling robust organisational arrangements and investment required to truly modernise and improve the quality and performance of NEPTS in Wales.

A recommendation was also put forward that NEPTS would be commissioned through EASC in the future, the main benefit of this development being to reduce the existing nine commissioning processes to one, significantly reducing organisational time, allowing this capacity to focus on and deliver the modernisation agenda. In addition, having a single Commissioner assists in the standardisation of NEPTS in Wales, whilst also ensuring any strategies are developed in such a way that they reflect local and national strategies.

A new Service Level Agreement (SLA) that contains generic service standards and requirements for Wales has been produced and agreed, thus ensuring NEPTS provision is delivered equitably across Wales.

Ministers agreed to the proposals set out in the Business Case and the Deputy Minister for Health published a written statement to Assembly Members announcing the decision in January 2016.
c) Workforce and Organisational Development Improvement (WODI).

The programme set out to deliver an ambitious programme of workforce, organisational design and improvement activity, aligned to existing strategy, to support the Trust to achieve its aspiration of becoming a high performing organisation and continuing its journey from ‘good’ to ‘great’.

The programme set out to deliver the following outcomes:

i) Rosters that are safe, sustainable and aligned to demand, and also ensure staff can utilise their full Continued Professional Development (CPD) hours to ensure they are appropriately skilled and able to deliver the highest quality patient care.

ii) A 2% point reduction of the cumulative rate of sickness absence across the Trust by 31 March 2016 and consequent reduction in variable pay expenditure.

iii) A streamlined recruitment process, reduced time to hire and a plan that ensured all vacancies were filled in a safe and timely manner and that staffing levels are safe and sustainable.

iv) Achievement of the Gold Corporate Health Standard.

v) The Trust as an Employer of Choice and ‘a great place to work’.

The programme made significant progress over the year, and delivered the following headlines:

- An operational workforce plan with agreed establishments and identified vacancies, and aligned recruitment and training plans.
- Successful recruitment campaigns throughout the year have significantly reduced the levels vacancies.
- A significant reduction in the time taken to hire staff with an average reduction by 60 days when comparing recruitment timescales in December 2015 / January 2016 with 12 months earlier.
- The reduction in sickness absence seen across the Trust in 2015/16 is a significant achievement and a positive story. WAST considers reducing sickness absence to be one of its top priorities and developed a comprehensive Sickness Action Plan to deliver the 1% target reduction set by Welsh Government and the 2% stretch internal target set by the Trust. This internal stretch target was an ambitious target, and good progress has been made towards its achievement; as sustained reduction in the cumulative rate of sickness absence from 8.17% (March 2015) to 6.94% in March 2016. Additionally a refreshed annual sickness action plan was produced which reflects learning and best practice from other organisations and ambulance services.
- A set of shared organisational behaviours, approved by the Board, and developed from listening to more than 800 staff, that will assist colleagues to do the right thing in the right way.
- Establishment of staff long service awards & recognition events.
- Improved partnership working relationships with staff representatives, including manager and staff representative development sessions #GoTogetherGoFar, lead representative development session, regular meetings with the Chief Executive and Director of Workforce & OD, and engagement in key strategic developments such as the People Programme, Clinical Modernisation Programme, NEPTS.
- Significant improvement in PADR rates from 10% to 60% during 2015/16.
- Review of the Clinical Team Leader role and proposed development programme to support CTLs to be the best they can be.
- An Executive Team development programme and development of Executive Team Charter.
• A review of the Advanced Paramedic Practitioner role and proposed progression framework.

Following changes to the assessment criteria of the Corporate Health Standard (CHS), it was recommended that the Trust allow more time to develop and embed its well-being framework and activities before seeking to be assessed for the Gold CHS. As a result, Gold status will be sought by the end of 2016.

d) Strategic Efficiency Programme.

The Strategic Efficiency Programme constituted a number of work streams which collectively laid the foundations for work in future years in terms of realising efficiencies and supporting the organisation to become more efficient. Delivery of this programme included work streams set out below.

i) Points of Presence: A baseline review of the organisation’s current estate (excluding ambulance stations). This work identified a number of opportunities to progress and these are now woven into this plan.

ii) Administration Review: A baseline review was successfully completed regarding the organisation’s administrative function. Proposals to carry out a full review of administrative and corporate functions will be developed through 2016/17 and will form part of our plans for year 2.

iii) CCC re-configuration: During 15/16, this work stream was disaggregated from the strategic efficiency programme. This was done in light of the in-year decision regarding the 111 Pathfinder project and a dedicated strategic programme to modernise the CCCs was developed.

e) Community Engagement.

This project set out to develop a Community Engagement Strategy and implementation plan that was citizen-centred, to enable the Trust to interact with all stakeholders and promote community ownership of the service. The project delivered a full scale engagement scoping exercise that mapped the levels of reported engagement activities across the Trust and the regions. A ‘living’ database showing levels of community engagement/activity is also ‘live’.

The community engagement database has the potential to evolve further and its use broadened. The specification outlined for the database will provide evidence of engagement undertaken and for what purpose. With further development it would be able to highlight where engagement activities will need to be strengthened in order to make certain that engagement activities are representative of all.

The system has the potential to be advocated as a pan Wales system to ensure that learning is shared across other health organisations. This will support the principles of prudent healthcare and co-production.

5) Emergency Medical Services and Urgent Care Services Performance

Due to the changes in the clinical model the way the Trust measures performance reporting has changed from 01 October 2015 onwards. It is therefore important to note that some performance information pre October and post October are not comparable unless indicated. Some performance measures are therefore divided between the first and second half of the year. Presentation of the data also differs with the latter half of the year presenting data against the five steps of the ambulance care pathway.
Average performance for responses to serious and life threatening calls (Category A calls) was 53.2% for 2014/15. Recognising that this was below the expected national target of 65% the Trust made the improvement of operational performance a key priority in 2015/16.

As well as improving performance demand for the service has been on an increasing trend, putting additional pressure on the service.

Comparing 2014/15 with 2015/16; there were 666,589 valid calls, of which there were 454,356 total verified incidents within the year 2015/16 in comparison to 578,634 valid calls and 441,126 verified incidents in 2014/15. (Verified incidents are the number of calls to the service that are confirmed as incidents and are not duplicate calls for the same incident).

For 2015/16 there was an increase of 13,230 verified incidents or an increase of 3% over the course of the year.


From April to July there was a month on month improvement for Category A calls (serious and life threatening calls) but there was a slight reduction in performance in August and September, correlating with periods of higher demand, usually attributed to the numbers of tourists visiting.

Overall however the average performance to Category A calls improved between April and September 2015 averaging at 59.7% within 8 minutes, 65.1% within 9 minutes and 69.8% within 10 minutes. The 8 minute performance is demonstrated by month in Figure 4 below. Variation between Local Health Board (LHB) areas varied from 52.3% to 64.6%.

The year to date performance at the end of September 2015 for Category C (patients who do not require an immediate or urgent response by “blue light,” and who may be suitable for an alternative response to an emergency ambulance) face to face assessment responses within 30 minutes was 72.4% against a target of 90%. Variation between LHBs ranged from 63.9% to 79.5%.

The year to date notification to handover rates at the end of September 2015 was
62.2% with an average of 3005 hours being lost per month to handovers. The month by month notification to handover rate is demonstrated in Figure 5 below.

**Figure 5: Notification to Handover April to September 2015**

![Graph showing notification to handover rate month by month](image)

i) **October 2015 – March 2016: New Clinical Model; the 5 Steps.**

Performance under the new 5 step model is integrated across the pathway and therefore includes some performance metrics for NHS Direct Wales. Performance for some of the key metrics are outlined below:

**Step 1: Help Me Choose**

- Between October 2015 and March 2016 there were 2,096,988 unique website visits to NHS Direct. Measuring the number of visits to the NHS Direct Wales website helps to identify periods of high demand and examine links to call volumes to both NHS Direct Wales and the Clinical Contact Centres. There were 173,023 calls to NHS Direct during this period. Figure 6 below demonstrates how the number of calls has increased in 2015/16 compared to the same period in 2014/15.

**Figure 6: Calls to NHS Direct Wales**

![Graph showing call volumes](image)

- The top reason for calling NHS Direct was for dental problems (17,751 calls or 10% of calls). Identifying the top ten reasons for calling NHS Direct Wales helps identify the topics for advice that NHS Direct Wales need to be able to
provide. It also helps to inform where there may be areas of unmet need to determine service development priorities. The top 10 reasons for calls to NHS Direct Wales for the period are provided in Figure 7 below.

**Figure 7: NHS Direct Wales Top 10 Calls by Reason**

- Frequent callers are defined as people who call the Trust via the 999 system five times or more in a month. On average frequent callers accounted for 3.56% of incidents during the period. Identifying frequent calls helps the Trust managed the needs of these groups of patients, many of which are vulnerable or have complex needs that may not be being met. Frequent caller needs are being managed via multi-disciplinary teams including primary, secondary care and local authorities to better manage the needs of the patients whilst also ensuring that the ambulance service is used appropriately.

**Step 2: Answer My Call**

- 245,474 emergency 999 calls were answered plus an additional 58,003 calls from health care professionals during the period of the new clinical response model. This is demonstrated in Figure 8 below.

**Figure 8: 999 Calls**

- 30,899 of these calls were in relation to falls.
- 12,146 calls were ended following telephone assessment and advice (‘hear and treat’). Hear and treat is a telephone clinical advice service that callers
who do not have serious or life threatening conditions received from the Trust. This may mean that an ambulance response may not necessarily be sent immediately. Patients may be given more appropriate healthcare advice based on an assessment by the clinician over the phone, they may be give advice, referred to another service for treatment or be advised to make their own way to hospital where safe and appropriate. ‘Hear and treat’ is provided by NHS Direct and the clinical desk. The clinical desk was a service development initiative implemented at the end of 2014/15.

**Step 3: Come to See Me**

- There were 10,958 RED incidents resulting in an emergency response between October and March.
- On average 68.8% were responded to within 8 minutes, above the national target of 65%, as seen in Figure 9 below. RED calls are immediately life threatening so it is important to also review against the distribution of performance. Median response times are therefore also reported on a monthly basis. These ranged from 5 minutes and 13 seconds to 6 minutes and 15 seconds.

![Figure 9 Red Response Performance: New Clinical Model](image)

- There were 131,706 AMBER incidents resulting in an emergency response in the period. AMBER calls are serious but not life threatening.
- There were 25,158 GREEN incidents resulting in a response between October and March. GREEN calls are 999 calls received that are considered neither serious nor life threatening.
- Figure 10 below demonstrates the category of call as a percentage of the total calls responded to, compared with the percentage of RED calls responded to within 8 minutes,
Step 4: Give Me Treatment
(note: some clinical indicators collected throughout the year)

Treatment given by ambulance clinicians before a patient reaches hospital is a major factor in their chances of survival and recovery. Ambulance clinicians use packages of care, assessment and treatment known as care bundles for certain conditions.

- 95.8% of suspected stroke patients were documented as receiving the appropriate stroke care bundle for the year.
- 85% of older people who had fallen and had a suspected fracture of the hip/femur who were documented as receiving analgesia was 85% across the year.
- 66.4% of acute coronary syndrome patients were documented as receiving the appropriate care bundle between October and March.
- In December 2015 a new clinical indicator for patients suffering cardiac arrest with a return of spontaneous circulation (ROSC) was introduced.

Step 5: Take Me to Hospital

- On average 70.4% of patients who called 999 were conveyed to hospital between October and March, a total of 138,468. The month by month figures for this period can be seen in Figure 11 below.
NHS Wales guidance is that the handover of care of patients from an ambulance crew to hospital staff should be within 15 minutes. Across Wales 53.3% of patients were handed over to the hospital within 15 minutes. The handover of care within 15 minutes is important as taking more than 15 minutes means the patient remains in the ambulance and the ambulance is not available to respond to other calls. Between October and March a total of 34,856 hours were lost to delays in handover; an average of 5,807 per month but ranging from 3,600 in December to 8,445 in March. The month by month figures for this period can be seen in Figure 12 below.

6) NHS Direct Wales

Calls to NHS Direct have increased by 8.9% in 2015/16 compared to 2014/15; a total of 327,695 calls were made during 2015/16. Figure 13 demonstrates the number of calls received each month in 2015/16 compared to the 2014/15 data, highlighting the variance between the two periods.
There were 4,031,292 web visits during the course of the year.

Overall 5.9% of calls resulted in a 999 call for an ambulance. 44% of calls were directed away from the unscheduled care system.

For 97.8% of the highest priority calls triage was commenced within 20 minutes.

7) **Non-Emergency Patients Transport Service (Patient Care Services)**

Non-Emergency Patients Transport Services (Patient Care Services) provides a service taking patients to outpatient and planned appointments.

During the course of the year 816,097 journeys were made. This has reduced by 3.3% in comparison with the previous year.

There have been some improvements on the three key indicators for NEPTS this year in comparison with last year:

i) 66.0% of all patients arrived within 30 minutes either side of their appointment time compared with 64.1% last year.

ii) 63.9% of all patients being discharged or transferred were picked up within 60 minutes of their ready time compared to 63.2%

iii) 85.8% of outpatients were picked up within 60 minutes of their ready time.

Figures 14, 15 and 16 demonstrate the month by month performance of the above three key indicators for 2015/16.
Figure 14: PCS Patient Arrival Performance

% of PCS patients arriving within 30 mins either side of their appointment time

- April 2015: 65%
- May 2015: 65%
- June 2015: 64%
- July 2015: 66%
- August 2015: 66%
- September 2015: 67%
- October 2015: 67%
- November 2015: 66%
- December 2015: 66%
- January 2016: 66%
- February 2016: 66%
- March 2016: 65%

Target: 70%

Figure 15: PCS Discharge/Transfer Performance

% of PCS discharge / transfer patients picked up within 60 minutes of ready time

- April 2015: 62%
- May 2015: 60%
- June 2015: 68%
- July 2015: 68%
- August 2015: 67%
- September 2015: 67%
- October 2015: 64%
- November 2015: 59%
- December 2015: 59%
- January 2016: 60%
- February 2016: 66%
- March 2016: 66%

Target: 70%

Figure 16: PCS Outpatient Performance

% of PCS outpatients picked up within 60 minutes of ready time

- April 2015: 86%
- May 2015: 84%
- June 2015: 84%
- July 2015: 86%
- August 2015: 86%
- September 2015: 87%
- October 2015: 87%
- November 2015: 86%
- December 2015: 86%
- January 2016: 86%
- February 2016: 86%
- March 2016: 86%

Target: 70%
8) Further Performance Information

For further detailed performance information please follow the links below to access the Welsh Ambulance Services NHS Trusts Integrated Performance Reports (IPR):

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<th>Data Period</th>
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<td>Trust Board Papers Jul-15</td>
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<td>3.2a</td>
<td>Trust Board Papers</td>
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</table>

9) Wales4Africa

The Welsh Ambulance Service has been supporting the charity Partnerships Overseas Networking Trust (PONT) since 2009, working with the Ugandan community of Mbale to tackle poverty and improve access to basic health care.

The Trust has continued to support the scheme throughout the year and it has continued to go from strength to strength.

The relationship between the Trust and PONT was cemented on 14 September 2015 by the renewal of the Memorandum of Understanding (MoU) between the 2 organisations. The MoU was signed on behalf of the Trust by Tracy Myhill, CEO and on behalf of PONT by Apollo Mwyeni (PONT Uganda). This MoU demonstrates the Trust’s continued support and commitment towards the work of the charity and towards those who volunteer their time to help.

The service has now completed more than 20,000 journeys since its launch in December 2010. It operates through a system of volunteer Village Health Teams, these workers make an initial triage of patients and call for the ambulance if they feel it is appropriate. The service operates on a 24/7 basis with a committed group of health workers and drivers who help to make the service successful. Approximately 65% of patients transported are maternity or obstetric related, the remainder is made up of children and adults with other illnesses and injuries.

WAST staff are planning their next visit in November 2016 to carry out further training with the village health teams and also some monitoring and evaluation work.

Also work has been underway to launch the ‘Pennies from Heaven’ scheme due in April 2016 to support the work of the charity; this simple scheme allows the contributor to donate the pennies on the end of their pay to the charity each month.
More details are available on our website and the dedicated website for the project http://pont-mbale.org.uk/main/
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<th>Service Change Idea</th>
<th>Summary</th>
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<td>1</td>
<td>111 Pathfinder</td>
<td>The aim is for the 111 service to become a trusted, easy to use resource for urgent advice and clinical assessment which integrates the current contact services within NHSDW together with GPOOHs call handling and nurse triage services across Wales.</td>
</tr>
<tr>
<td>2</td>
<td>Digi-Pen</td>
<td>Digi-pens to record patient care records. Enables much greater focus on reporting and improving clinical outcome, in particular, the reporting of 10 clinical indicators (with further sub-indicators) compared the previous four. A key project related to the New Clinical Model.</td>
</tr>
<tr>
<td>3</td>
<td>Community First Responders</td>
<td>The effective deployment and utilization of first responders e.g. community first responders or uniformed first responders, through a single management team for Wales.</td>
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<td>4</td>
<td>Mental Health Pathway</td>
<td>To improve the quality and clinical appropriateness of care provided to mental health patients by involving a mental health professional at the earliest opportunity. This is done via a phone call between the Paramedic on scene and a crisis team worker. A decision can then be made as to the most appropriate course of action. The options are: direct admission to a mental health facility, for the patient to stay at home for follow up from G.P or mental health services, For the patient to be taken to the ED</td>
</tr>
<tr>
<td>5</td>
<td>Health Care Professionals (HCP)</td>
<td>A dedicated HCP calls service desk within the CCC function designed to manage the UCS provision and plan admissions with hospitals from HCP non-emergency calls, who are requesting transport for patients within an agreed timeframe of 1 to 4 hours (HCP GREEN 3 calls). Additional dedicated UCS resource to exclusively manage this demand.</td>
</tr>
<tr>
<td>6</td>
<td>Clinical Pathway Appraisal and Approval Group</td>
<td>Ensuring any clinical innovation or alternative pathway of care is based on patient need, has a current or emerging evidence base and has an associated clinical audit and evaluation plan to assess its effects on patients and the overall service delivery in term of patient flow and clinical outcomes.</td>
</tr>
<tr>
<td>7</td>
<td>Paramedic Pathfinder</td>
<td>Training costs associated with the development and roll out of a reductive triage model for paramedics to better enable them to conduct face to face triage of patients when they arrive at scene, using a flow chart of presenting signs and symptoms, to determine the most appropriate clinical pathway for the patient’s needs e.g. community care, self-care or patient specific pathways to, which should also help reduce conveyance rates to A&amp;E</td>
</tr>
<tr>
<td>8</td>
<td>Frequent Callers</td>
<td>A pan-Wales manager to ensure a standardised approach to improving clinical outcomes and reducing ambulance activations to 999 calls for frequent callers, working partnership with other health providers, the Police and social care.</td>
</tr>
<tr>
<td>9</td>
<td>Resuscitation Rapid Response</td>
<td>Initiative set up as part of the cardiac arrest survival plan. 3RU team set up to support and lead resuscitation efforts at cardiac arrest/peri</td>
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<tr>
<td>Unit</td>
<td>Description</td>
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<tr>
<td>10.</td>
<td>GP/Paramedic Out of Hours&lt;br&gt;The initiative was to provide the concept and potential benefits of Advanced Paramedic Practitioners and Training Advanced Paramedic Practitioners supporting GPOOHs with home visits. Based on best practice and much quoted report from Everden et al in 2003 that Band 5 Paramedics “can handle most of the likely GPOOHs home visits.”</td>
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<tr>
<td>11.</td>
<td>Clinical Model&lt;br&gt;The New Clinical Model 1 year pilot was driven by clinicians and the new 2015 Policy is clinically led. It recognises that getting to patients with life threatening symptoms requires an 8 minute emergency response (or less) and the organisation will continue to be performance measured against this. It also recognises that for the majority of callers, an 8 minute emergency response will not impact on the patient’s outcome. This model allows call takers up to two minutes extra time to identify the patient’s need and to send, or refer to, a clinically appropriate care provider e.g. an APP, refer to Hear &amp; Treat/Direct, refer to GP, take the patient to the right hospital or facility. This model also monitors and measures the clinical care provided to the patient on scene.</td>
<td></td>
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<tr>
<td>12.</td>
<td>Transformation of CCC&lt;br&gt;CCCs are the lynchpin to the EMS service. The effectiveness of them is a key determinant of the effectiveness of the rest of our service. They are integral to STEPS 2 and 3, Answer my Call and Come to See Me. The modernisation of CCCs (including the new Computer Aided Dispatch system) has been identified as a priority for the 2016/17 IMTP; however, there are a number of immediate actions that have been undertaken to mitigate identified risks around the CCC, staffing structure and ICT pending the new CAD and restructure.</td>
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<tr>
<td>13.</td>
<td>Overtime/Private Providers&lt;br&gt;The initiative aims to boost WAST’s capacity to respond to demand through increased unit hours production delivered through either incentivized overtime 7 days a week or the use of private providers.</td>
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<tr>
<td>14.</td>
<td>Cwm Taf Explorer&lt;br&gt;To improve the ambulance response times for immediately life threatening calls for patients in Cwm Taf. The initiative includes: 1) the delivery of a shared programme of public education to ensure residents of Cwm Taf understand the full range of services available 2) a communication strategy to support the work of Explorer 3) the commencement of the development of a clinical culture that encourages and supports clinicians to operate fully within their scope of practice 4) the geographic ring fencing of emergency ambulance resources within the boundaries of Cwm Taf 5) The implementation of a system to appropriately convey patients where the request originates from our HealthCare Professional colleagues (HCP) within the appropriate timescale</td>
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</tr>
<tr>
<td>Outcome 1: I feel well informed and supported to take responsibility for my health and manage my own health</td>
<td>P06</td>
<td>% Incidents of patient treated with no request required</td>
</tr>
<tr>
<td></td>
<td>P07</td>
<td>% Patients referred to alternate provider</td>
</tr>
<tr>
<td></td>
<td>P08</td>
<td>% Conveyance calls to A&amp;E department</td>
</tr>
<tr>
<td>Outcome 2: I am protected from harm whilst I am in your care</td>
<td>L08</td>
<td>Number of complaints</td>
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<tr>
<td></td>
<td>G06</td>
<td>Number of complaints</td>
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<tr>
<td></td>
<td>G07</td>
<td>Number of complaints</td>
</tr>
<tr>
<td>Outcome 3: I am treated with dignity and respect</td>
<td>L07</td>
<td>Number of incidents of violence and aggression</td>
</tr>
<tr>
<td>Outcome 4: I receive the right care and support at the right time, in the right place, from the right person (effective management)</td>
<td>C06</td>
<td>% of stroke patients who are documented as receiving appropriate stroke care bundle</td>
</tr>
<tr>
<td></td>
<td>C07</td>
<td>% of older people who have falls and have suspected fracture of hip/lower who are documented as receiving analgesia</td>
</tr>
<tr>
<td></td>
<td>P09</td>
<td>% Notification to handicap within 15 minutes</td>
</tr>
<tr>
<td>Outcome 5: I receive the best access to services based on clinical needs and equity</td>
<td>P02</td>
<td>EMS call re-attendance calls (primary only)</td>
</tr>
<tr>
<td></td>
<td>P05</td>
<td>% Calls categorised as NED</td>
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<tr>
<td></td>
<td>P10</td>
<td>% Response rates to GP out-of-hours phone calls within 5 minutes</td>
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<td></td>
<td>P14</td>
<td>% of Requests to GP calls within 5 minutes</td>
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<td></td>
<td>P20</td>
<td>% of Requested non-responder vehicles arriving within 15 minutes</td>
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<tr>
<td></td>
<td>P27</td>
<td>% of Green Card 35 Incidents to Face To Face Assessment Responses Within 30 minutes</td>
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<td>P28</td>
<td>% of CAS 35 Incidents to Face To Face Assessment Responses Within 30 minutes</td>
</tr>
<tr>
<td>Outcome 6: I am treated as an individual</td>
<td>P22</td>
<td>% of CAS patients arriving within 15 minutes of their appointment time</td>
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<tr>
<td></td>
<td>P22</td>
<td>% of CAS patients arriving within 60 minutes of their appointment time</td>
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<tr>
<td></td>
<td>P23</td>
<td>% of CAS patients arriving within 30 minutes of their appointment time</td>
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<tr>
<td></td>
<td>P24</td>
<td>% of CAS patients arriving within 60 minutes of their appointment time</td>
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<tr>
<td></td>
<td>L02</td>
<td>% of patients treated at home</td>
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<tr>
<td></td>
<td>L04</td>
<td>% of women screened</td>
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<tr>
<td></td>
<td>L05</td>
<td>% of referrals to others</td>
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<tr>
<td></td>
<td>L09</td>
<td>% of referrals</td>
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<tr>
<td></td>
<td>P10x</td>
<td>% of referrals to NED for performance</td>
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<tr>
<td></td>
<td>P10y</td>
<td>% of referrals to ANGER for performance</td>
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<tr>
<td></td>
<td>P10z</td>
<td>% of referrals to ORP for performance</td>
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<tr>
<td></td>
<td>P21</td>
<td>% of referrals to other within 60 minutes</td>
</tr>
<tr>
<td></td>
<td>V01</td>
<td>Actual expenditure YTD as % of budget expenditure YTD</td>
</tr>
<tr>
<td></td>
<td>V02</td>
<td>Actual Trust expenditure YTD - £000</td>
</tr>
</tbody>
</table>