

Cynulliad Cenedlaethol Cymru  
National Assembly for Wales

# Special Assurance Review of the Welsh Ambulance Services NHS Trust

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## **Chapter 1: Background**

1.1. Healthcare Inspectorate Wales (HIW) came into being on 1 April 2004. Its role is to undertake inspections and investigations of healthcare bodies in Wales. HIW aims to provide public assurance as to the efficiency, effectiveness and safety of NHS and independent healthcare services. In this role it has a responsibility to follow up past problems to ensure that these difficulties have been dealt with effectively in the best interests of the service, patients and the public<sup>1</sup>.

### **The Proposal for a Review of the Welsh Ambulance Services NHS Trust**

1.2. HIW was approached by the Welsh Ambulance Services NHS Trust (WAST) in mid-December 2005 with a request to carry out a formal review of its Patient Care Services (PCS) policies and operational procedures. This followed an incident in 2003 when a patient in South East Wales was transported to the wrong address and left there alone. The incident had tragic consequences and was investigated internally by the Trust and was also the subject of an external inquiry commissioned by the South East Wales Regional Office of the Welsh Assembly Government's Department of Health and Social Services. The Trust, together with Cardiff and Vale NHS Trust, was subsequently prosecuted by the Health and Safety Executive. Both Trusts pleaded guilty and were fined.

1.3. HIW agreed to carry out a review of WAST's revised PCS policies and procedures and the effectiveness of the changes that had been introduced since the incident in 2003. However, in the meantime, a further untoward incident occurred in South East Wales. While this did not, fortunately, have any serious or tragic consequences for the patient concerned, it raised a question about the adequacy of WAST's revised PCS policies and operational arrangements. Consequently, HIW announced its intention to

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<sup>1</sup> See Annex D for a full description of HIW's duties and responsibilities.

conduct a Special Assurance Review of the Trust as part of its 2006-07 review programme, to include PCS and a broader examination of clinical governance. During the period that the planning for the special exercise was being taken forward the then Interim Chief Executive of the Trust publicly raised a number of issues concerning the performance of the Trust. Among those matters was an estimate that up to 500 deaths per annum resulted from the inefficiency and less than optimal effectiveness of the Trust. In the light of these concerns HIW revised the terms of reference for its Review.

1.4. The final Terms of Reference and those under which this review was conducted were established as follows:

1. Evaluation and testing of mortality and response time data against recent allegations that 500 lives are lost each year as a result of current ambulance response times.
2. A review of the adequacy and effectiveness of the Trust's Patient Transport Services policies and procedures and how lessons learnt from the incident in 2003 have been implemented and monitored by the Trust.
3. Testing of the effectiveness of the Trust's incident reporting procedures and systems.
4. A review of the Trust's general clinical governance arrangements.

1.5. Chapter 2 of this report sets out the arrangements for the Review. Chapter 3 reports upon the overall clinical governance of the Trust including PCS and EMS. In so doing it covers matters relating to the adequacy and effectiveness of PCS policies and procedures and explores the effectiveness of the Trust's incident reporting systems. The evaluation and testing of mortality and response time data against recent allegations that 500 lives are lost each year is discussed in Chapter 4 and Chapter 5 addresses the matter of how lessons learnt from a specific incident have been implemented.

Recommendations are set out within the relevant chapters and brought together in the concluding chapter.

1.6. In parallel with HIW's Review and following debates conducted in the National Assembly for Wales, the Auditor General for Wales was invited to conduct an inquiry concerning WAST. The Inquiry and the HIW Review have progressed within similar time scales. The Inquiry team at the Wales Audit Office (WAO) and staff responsible for HIW's Review have worked together to reduce the amount of duplication in their work as much as possible. However, in order to provide a comprehensive account of the Trust and of its services in all its aspects this report touches upon some of the same areas as the Auditor General's Report.

## **The Trust**

### ***Organisation***

1.7. The Welsh Ambulance Services NHS Trust (WAST) was established by Statutory Instrument on 1 April 1998. It provides ambulance and related services to a resident population in Wales of 2.9 million, distributed across a total land area of 20,640 square kilometres. In addition WAST provides services to a large number of visitors to Wales, particularly during the summer months.

1.8. The Trust employs just under 2,500 people. Of this number, over 76% are employed at the operational level; 1,310 on emergency ambulance duties and 693 on non-emergency ambulance and health transport services.

1.9. The Trust operates from a large number of sites across Wales. These include more than 90 ambulance stations, four Control Centres where calls are received and responses dispatched, a National Training College and associated regional training centres, the Trust Headquarters, three Regional Offices and five vehicle maintenance workshops.

1.10. The Trust is managed by a Board comprising a Chairman, five Non-Executive Directors, appointed by the Welsh Assembly Government, and five Executive Directors. The Board is responsible for setting the policy and strategic direction of the Trust, for monitoring clinical and financial performance and for ensuring the achievement of objectives and a high standard of corporate governance and professional conduct.

1.11. Since April 2003 Health Commission Wales (HCW) has been responsible for the commissioning of Emergency Medical Services (EMS) for the whole of Wales, while the commissioning of PCS has remained a matter for individual NHS Trusts.

1.12. During 2005-2006, WAST dealt with 269,000 emergency incidents, 63,251 urgent journeys and transported 1,434,285 non-emergency patients to over 200 treatment centres throughout England and Wales.

### ***Recent History***

1.13. Following a period of annual leave in November 2005 the then Chief Executive of the Trust was unable to return to duty as a result of ill health. While initially the Deputy Chief Executive took on the role of Acting Chief Executive, it was decided that other arrangements should be made for the role of Accountable Officer and steps were taken to appoint an Interim Chief Executive. This led to a period of four months (March to July 2006) during which two successive Interim Chief Executives were responsible for the Trust.

1.14. In addition the term of office of the Chairman of the Trust came to an end on 31 March 2006 and a new Chairman took up position on 1 April.

1.15. The difficulties which any organisation would experience as a result of numerous changes in key personnel and the resultant uncertainty in the leadership of the organisation were compounded by difficulties elsewhere in

WAST's management structure. A number of senior and middle management positions had been unfilled or had been filled through the secondment of staff from other roles within WAST. Long term sickness had affected a number of these posts.

1.16. The appointment of the new Chairman of the Trust together with the appointment of a new Chief Executive designate in August 2006, whose appointment became substantive on 1 October 2006, has marked a watershed for the Trust. A modernisation plan has been produced, which we have drawn attention to throughout this report, and we found that there is a general sense of optimism for the future amongst staff working for the Trust.



## Chapter 2: Arrangements for the Review

### Review Design

2.1. The review process was designed to ensure that HIW could engage with a wide range of WAST staff. The significant differences between the regions in the topography of Wales and the reflection of that in the regional organisation of WAST were key considerations. In addition HIW collaborated with the Auditor General's Inquiry into WAST, drawing upon some of its work as well as providing inputs to the Inquiry, thereby reducing to an extent duplication of work which may have placed additional burdens upon WAST. Where the Auditor General's Report has provided detailed background information or provided specific analysis of issues, HIW has not sought to repeat that detail in this report.

2.2. Having initially called for and conducted a review of key documents from WAST, HIW undertook formal interviews over a period of nine days in September and October 2006. Interviews took place at the Trust Headquarters in St Asaph and at the Regional Headquarters for Central and West Region at Cefn Coed Hospital, Cockett, near Swansea and South East Wales at Mamhilad. Forty-one staff and Board members were formally interviewed. In addition, HIW visited five NHS Trust hospital Accident & Emergency (A&E) departments and five out-patient departments, where hospital staff were interviewed about their Trust's experience of WAST. Patients or patients' representatives were also interviewed.

2.3. In parallel with formal interviews, HIW reviewers visited 35 ambulance stations over the course of 16 days. Visits were made in each of the three Regions of the Trust and to at least one ambulance station in each of the counties of Wales. During the visits, reviewers were able to observe the work of WAST by travelling in EMS and PCS vehicles as they responded to emergency calls or transported patients to outpatient clinics. In the course of

the observation visits, reviewers were able to discuss more informally the experience of WAST staff and that of patients. In total, reviewers travelled on 43 PCS and 16 EMS vehicles and during the course of the observation visits spoke to 109 crew members. They also took the opportunity to talk to other ambulance station staff on their visits.

## Chapter 3: Clinical Governance in the Ambulance Trust

3.1. A general aim of this Review was to ensure that clinical governance arrangements across WAST:

- comply with guidance within Welsh Health Circular (2003) 69 *Annual Clinical Governance Reports 1<sup>st</sup> April 2002 to 31<sup>st</sup> March 2003 And Future Requirements* and Welsh Health Circular (2005) 040 *Clinical Governance Reporting Arrangements*;
- lead to continuous improvement of services to patients;
- engender a culture of quality and learning; and
- safeguard the safety of patients and staff.

3.2. More particularly the Review set out to establish the extent to which the necessary recommendations identified by the former Commission for Health Improvement (CHI) had been addressed. The key recommendations by CHI were:

1. *The Trust must take action to address and implement a broader vision of clinical governance across the organisation. The Trust needs to set out its strategic direction for clinical governance and must underpin this with strategies for all areas of clinical governance. This must include routine consultation with all grades of staff, patients and partners to ensure that clinical governance is fully integrated across the organisation.*
2. *The Trust should reconfigure its clinical governance committees and structures to ensure they are fully integrated with the operational management structure ensuring clarity of accountabilities for clinical governance at all levels of the organisation.*

3. *The Trust needs to set up a programme of education to help staff from board level down to ensure that clinical governance is fully integrated and understood throughout the trust.*
4. *The Trust should review the amount of dedicated time for clinical leadership at a strategic level.*
5. *The Trust must take urgent action to broaden its strategic approach to clinical risk management, ensuring the risk register captures the actual clinical risks inherent in its day to day operations and that these are rigorously monitored.*
6. *The Trust needs to increase its use of clinical and non clinical information and to develop routine and exception reporting to ensure that policies are implemented and that there is informed change.*
7. *The Trust must promote a culture of openness where clinical governance activities lead to monitoring, dissemination and learning throughout the organisation.*

3.3. The following areas of clinical governance were reviewed by HIW:

- The patients' experience;
- Patient and public involvement;
- Use of information;
- Processes for quality improvement;
- Staff focus; and
- Leadership, strategy and planning.

3.4. The remainder of this chapter addresses each of these areas in turn, referencing the CHI recommendations as appropriate.

## **Public and Patient Involvement**

3.5. The Trust produced a Public and Patient Involvement (PPI) Strategy in April 2004 following the CHI review earlier that year and a PPI Strategy for the period 2005-2009 was updated in January 2006. The Trust has also established a PPI Sub-Committee. Its remit is to review all aspects of the public and patient experience and to ensure opportunities were in place to develop and improve services. We considered the terms of reference of the PPI Sub-Committee to be appropriate. Its reporting route through the Governance Committee of the Board was clear. Further, the Trust's draft Modernisation Plan<sup>2</sup> recognises the importance of working with the public and patients and commits the Trust to partnership in delivering its services.

3.6. At the time of this review the Director of Human Resources was the PPI Lead having taken on the responsibility when the previous post holder left the Trust in August 2006. However some staff were unaware of this change and the record of who was responsible for this brief held by the PPI branch of the Welsh Assembly Government's Department of Health and Social Services was also inaccurate.

3.7. The Trust has appropriate Community Health Council (CHC) representation on its Board, Committees and Sub-Committees. However, relying almost entirely upon those arrangements for formal engagement with the public and patients reduces the Trust's ability to hear directly and act upon the views of patients and the public. While some patient surveys have been undertaken and there had been opportunities for engaging with the wider public, for example through the promotion and development of its 'First Responder' scheme, it would appear that major decisions about the development of the ambulance service in Wales have not benefited from the routine engagement with those for whom the service is designed.

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<sup>2</sup> Paragraph 1.6 of version 8 of 'Time to Make a Difference'

3.8. The Trust has limited capacity to obtain the views of the patients it cares for, and of the community it serves. The Trust has been focussed almost exclusively on time related targets or the volume of non-emergency cases it transports to the exclusion of engaging service users in planning and decision making which may have helped to develop ways of achieving those very targets. We refer elsewhere in this report to the inappropriate use of WAST services by some members of the public. Part of the resolution of that matter may come through finding ways to draw the public itself into engagement and partnership with the Trust.

3.9. The level of support from local communities for their ambulance service is strong, with members of the public willingly donating money for the purchase of equipment for ambulance crews. The use of helicopters in remote rural areas has undoubtedly brought benefit to patients through easier access and a reduction of transport time of the patient to the local receiving hospital. As in England, a significant part of the resources for the helicopter services which support WAST are provided through charitable donation from the Welsh people. Welsh people speak highly of the quality of the face to face service they receive from WAST staff.

3.10. The Trust's PPI Strategy has identified the importance of continuing the development and use of surveys to identify public concerns and priorities. The Trust needs to build further upon that, to find ways of involving the public more formally in development and performance issues and to harness community resources to help identify solutions to some of the challenges it faces.

***Recommendation 1: The Trust's arrangements for PPI should be reinforced through a review of the processes through which the Trust engages with patients and the public to inform its key decision making processes.***

## **Patient Experience**

3.11. Almost without exception patients using WAST were complimentary about the way in which they were treated by front line staff. Patients and carers spoken to during the time of the review praised the hard work and dedication of front line staff of the emergency and patient care services alike. We observed WAST staff performing their duties in a caring and diligent manner. These views were supported by the results of a patient survey undertaken in 2003-04 which highlighted that, of 744 respondents, 97% found the services provided by WAST very satisfactory, satisfactory or fairly satisfactory.

3.12. We observed that many staff went out of their way to ensure that exceptional levels of care were received by patients. There was a good rapport between staff and patients, particularly with PCS staff who often transported the same patients on a regular basis. Where it is possible, the Trust provides the same crew routinely for patients with regular appointments at clinics and this would appear to have some advantages, particularly where more vulnerable patients are concerned.

3.13. However, whatever the effort put in by frontline staff to ensure patients are well cared for, the environment of care often falls short of what might be expected. Reports of the inadequacy of ambulances were underlined by the experience of HIW reviewers. Difficulties in relation to the EMS fleet are fully explored in the Auditor General's Report, and we endorse the findings of that Inquiry. That said, based upon the direct experience of our reviewers in respect of the vehicles they travelled in, facilities for patients transported in emergency service vehicles are generally better than those using PCS.

3.14. Our reviewers travelled in 43 PCS vehicles. Their experiences included:

- inadequacy of some vehicles dispatched to accommodate the types of patients using the service due in part to inadequate information provided to PCS staff;
- discomfort of patients in a number of vehicles; and
- variable quality of cleanliness of vehicles.

3.15. In addition, difficulties with vehicle maintenance were reported.

3.16. While shadowing PCS crews, it became clear that the PCS is particularly affected by ageing vehicles. The environment in which patients are transported is less than desirable. Whilst staff try their best to clean the vehicles, some of them are grubby and in need of repair. Some of the vehicles used have leaking windows and floors and during rainfall these particular vehicles had water running in through the inside of the windows and onto the floor. The heating facilities on board some vehicles have limited variable temperature control and are either very cold or very hot, with little in between. Vehicle suspension was poor in some cases and most of the vehicles that the review team travelled in had basic seats. Some of those seats were loose, and rocked in their mountings. Many of the patients transported are elderly with neck or back complaints; some patients reported the journey itself makes them unwell.

3.17. We note that the Trust's Annual Reports show a decline in the proportion of the PCS fleet under seven years old (93% in 2002-03, 87% in 2003-04 and 81% in 2004-05). During the same period the proportion of the EMS fleet which was less than five years old increased. However, during the course of our review we learned of additional capital funding being made available to the Trust as a result of which 119 new EMS vehicles (43% of the current EMS fleet excluding rapid response vehicles) and 67 new PCS vehicles (28% of the current PCS fleet) had been ordered.

3.18. Some additional failings in the environment of care were observed by our reviewers or were the subject of discussion with front line staff. The lack

of available equipment to replace damaged or soiled kit causes some EMS staff to wash down and reuse the same contaminated equipment or uniform. There are variances in how these washing processes occur. Some kit, usually stretcher straps, or back board straps are washed with disinfectant, and soaked or scrubbed instead of exchanging them.

3.19. The Trust has a contract for the provision of staff uniforms and its policy is that when a uniform becomes contaminated it should be changed as soon as possible and in any event before dealing with the next patient. To facilitate this, each member of staff is issued with six sets of kit. Heavily soiled uniform should be destroyed and the arrangement with the contractor is that replacement will be provided within 48 hours. Protective equipment is also available to staff, for example hand gel, gloves and overalls (although we note that overalls are not available on PCS vehicles). We observed that, in practice, use of these is varied.

3.20. General cleaning of uniforms is undertaken in household washing machines. We were told by some staff that they take their uniforms home to wash and those staff expressed concerns in relation to the possible transmission of infections acquired at work to their family. We are aware that arrangements for the cleaning of uniforms of other health care professionals are similar in other health service bodies and the proper use of protective measures and equipment (as described above) minimises the likelihood of uniforms being a possible source of infection. However, we believe best practice is for the uniforms of health care professionals to be washed at their place of employment or through contracted arrangements. We note that the Scottish Ambulance Service has installed industrial standard washing machines in all its ambulance stations. Clearly making such arrangements carry a cost for ambulance services and the issue itself is one which has wider implications across the health service. We note WAST's intention to introduce new depot arrangements to replace many of its ambulance stations and that would seem to offer an opportunity to ensure that suitable arrangements for the washing of uniforms are put in place.

3.21. Information was frequently not communicated by hospital nursing staff to ambulance crews who were transporting patients with infections. Staff, including those on PCS, receive training on infection and control procedures at induction and through annual refresher training and are issued with handbooks covering that matter. However, some PCS staff felt that the training they had received on the implications of particular types of infection, and how to manage patients accordingly was insufficient.

3.22. As far as EMS is concerned, some issues have been well publicised during the course of the last few months and focus primarily upon response times for emergencies. A number of factors are involved in that issue: availability of vehicles, technology for planning and dispatch, geography and the long distances some ambulances have to travel with patients. The Auditor General's Report shows that the most significant factor is the matching of supply and demand for ambulance services. That Report shows that the Trust is sufficiently resourced but does not utilise its resources optimally to meet demand.

3.23. The situation with regard to PCS is no less problematical. Whilst failures in the PCS systems may not always have the same serious consequences for patients, the level of distress and discomfort caused by PCS system failures affect a far greater number of patients. We observed poor planning practices that gave rise to duplication and over scheduling, resulting in patients not arriving at clinics on time. We were told of times when the unavailability of vehicles meant that staff coming onto a shift could not be utilised in their EMS/PCS role and were either left idle or given tasks such as cleaning ambulance stations.

3.24. We noted instances where incorrect information provided to PCS had led to inappropriate transport being booked for a patient. Patients in these instances had to cancel their appointment altogether and then experience a subsequent delay in getting another appointment. There is a lack of information given to the patient when using PCS. A 'user guide' has been produced by the Trust for hospitals booking discharge or transfer ambulances,

providing guidance on such issues as amount of luggage that can be carried. But there is no written information for the patient to explain the requirements of the patient care service ie what hand luggage could be taken aboard the vehicle, what arrangements there are for wheelchair users, or whom to contact if the transport was no longer required or needed to be cancelled. Invariably journeys are booked via a third party through a hospital ward, outpatient service or GP surgery as well as residential/nursing homes. Patients frequently wish to take items such as 'Zimmer' frames or luggage with them on board a PCS vehicle but there are restrictions on the nature and amount of luggage that can be taken on board. Patients are only informed of restrictions at the time they board the vehicle, occasionally leaving them anxious if an article can not be transported. Staff feel that they are put in a vulnerable position in having either to stand by the formal expectations of the Trust or take on the spot decisions which may not been in line with service policy. Although the route for providing such information to patients may not be straight forward we believe that a leaflet explaining such matters would be helpful and could be distributed through GP surgery's and held on PCS vehicles. Alternatively a poster might be produced which could be displayed in surgeries and clinics. We heard from PCS staff a number of examples of what they believed was inappropriate use of PCS and these included booking of inappropriate transport by GP surgeries, patients using PCS in preference to their own vehicles because of parking charges at hospitals etc. Information made available to patients about the arrangements for PCS could help to mitigate these difficulties.

3.25. Many patients are unable to take their own wheelchair onto WAST transport as the facilities do not exist on the transport vehicles for easy access of passengers and wheelchairs. Space on board vehicles is limited and wheelchair users are encouraged for their own safety to sit in one of the fixed seats unless there are medical reasons preventing that. Many patients are worried that upon arrival at hospital there will be no wheelchair available for them, and this has been the case for some patients. The Trust has recognised this difficulty and when purchasing new PCS vehicles is making provision for space to accommodate wheelchairs.

3.26. Generally hospitals recognise that patients transported by WAST will arrive within a period of time either side of the specific appointment time they have been given as a result of the contractual arrangements which stipulate that all patients should be brought in at 10.00 am or 2.00 pm. Hospitals have not found it possible to fund transport for patients based on individual appointment times. However, a number of patients arrive well outside of the allotted hospital appointment time due to the 'blanket' transport arrangements which require a large number of patients being collected from various locations and transported to a number of hospital sites. The Trust has recognised the need to redesign the way in which PCS services are delivered, for example through greater use of cars rather than ambulances, and is addressing this matter through its Modernisation Plan.

3.27. Compared to the number of patients transported by the Trust (586,000 between April and August 2006), the number of complaints that are received is relatively small. Interview evidence referred to frequent complaints from patient transport service users about the sporadic and unreliable time keeping of booked PCS transport. The Trust's own formal complaint system records timeliness issues to be the single largest category of complaint received by the Trust both for EMS and PCS. From April to August 2006 there had been 55 complaints relating to PCS of which 30 (54%) concerned timeliness. Some of these complaints were from service users, who, after treatment at hospital felt extremely unwell and were left waiting long periods of time prior to transport home. This was also identified as a problem by some of the hospitals we consulted. The reasons for the delays are numerous. PCS is restricted by staff working rosters and the availability of suitable vehicles at particular times. Further PCS staff are frequently delayed by having to wait for a number of patients to finish their treatment/consultation and board the ambulance before a journey can commence.

3.28. The operating systems of the PCS, together with the demands of hospital systems mean that delivery of patients does not always fit hospital appointment schedules. The co-operation and good will of hospital and PCS

staff helps to alleviate some of the difficulties experienced by patients. All hospitals have, however, agreed to prioritise patients travelling by PCS. Operational PCS staff informally try to prioritise the patients who they know are likely to be unwell after treatment, or are restricted to a specific appointment time at the hospital. Nevertheless the Trust is still subject to the constraints set out above.

3.29. The Auditor General's Report has fully examined matters in relation to EMS response times. His report provides data illustrating the current failure of the Trust in meeting the response targets set down for the Trust. In summary WAST had managed to achieve the 60% target for arrival at patients in Category A<sup>3</sup> in only two months since March 2004. It had also failed to achieve other response time targets.

3.30. Delays in response to EMS calls occur irrespective of the nature of the local geography. Local emergency ambulances based in more sparsely populated areas are sometimes relocated to areas of denser population when the ambulances usually based there are responding to calls. This is a cause of concern to some ambulance staff who told us that in such circumstances, should an emergency arise in the re-located ambulance's local area, the ambulance frequently has to travel long distances back again to reach the patient, resulting in an increased delay. It is clear from discussion with the Trust that this is the result of having no strategic plan for dealing with shifts in demand and matching these to the resources available. This is a matter upon

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<sup>3</sup> Ambulance Trusts use different categorisation systems and, even where they use the same systems, tend to interpret them in different ways. For example, across the UK there are three accepted levels/categories of emergency calls made to ambulance services (A, B and C) which have been rationalised to a two level (combining C with category B calls) system in some Trusts. Indeed, in Wales itself, both three level and two level categorisations have been in place over the last two years. In terms of identifying patient need, there will always be a degree of inaccuracy owing to lack of information from callers, confusion, human error and system constraints and issues relating to the consistency with which a particular presentation by a patient will be identified by different organisations. Category A calls are those identified as immediately life threatening incidents. Category B consists of other emergency calls. Where category C is used it refers to calls which require a response but do not constitute an immediate emergency. In the 2 level system, calls that some Trusts would categorise as C are dealt with as B category calls.

which the Trust is taking action. The Trust's Modernisation Plan has set a number of objectives designed to improve responsiveness to the needs of patients and to ensure access to appropriate urgent clinical care<sup>4</sup>.

Imaginative solutions can be found by WAST to improve response times, for example, through the use of 'first responders' and other alternative pathways for patients, which should enable WAST to meet the target established (in the short term, 60% of category A calls receiving a response within 8 minutes).

The extent to which the target might be increased beyond the 75% proposed for the longer term is a matter of decisions about the overall allocation and use of NHS resources.

3.31. There are frequently delays for patients upon arrival in A&E departments. Hospitals do their best to address the needs of patients and to assess their priority. However, there are at times issues related to these delays. At peak times EMS crews may not be able to hand over a patient to A&E hospital care immediately and due to pressures in A&E, patients may have to wait in a public corridor or within an ambulance in a car park in full view to the public and often in pain, albeit whilst still under the care of EMS staff. Whilst not the fault of the Trust, there is no dignity here and the situation is degrading for patient and carers alike. WAST will need to continue to work with its partner Trusts to encourage expedient handover of patients on arrival at A&E.

3.32. With regard to other factors affecting the patient's experience, the Trust has both an 'Equality and Diversity Policy and Guidance' and a 'Race Equality Scheme'. These documents address matters relating to recruitment, the equality impact of policies, monitoring to ensure compliance with legislation, training to equip staff for their responsibilities, and the appropriate use of 'positive action' to redress inequalities experienced by black and minority ethnic staff.

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<sup>4</sup> Paragraph 2.2.1 of version 8 of 'Time to Make a Difference'

3.33. The Trust has produced a 'Safeguard and Welfare of Children Policy' in line with Welsh Assembly guidance and the recommendations found in the 'All Wales Child Protection Procedures'. The policy is supported by the work of a Child Protection Working Group which is a Sub-Group of the Trust's Clinical Governance Sub-Committee. In respect of vulnerable adults the Trust has a policy in place which sets out procedures to be followed in relation to alleged or suspected abuse of a vulnerable adult.

3.34. In relation to language issues, the Trust has implemented a multi-lingual phrase book which is used by ambulance crews when dealing with patients for whom English is not their first language. This booklet covers 31 languages and also features a deaf/blind alphabet. The Trust also uses the 'Language Line'; a service that enables any person who rings the emergency control room to speak to the control staff in their language of choice.

3.35. The Trust has a Welsh Language Scheme. The scheme aims to ensure that staff are encouraged to develop their roles through the medium of Welsh and the Trust's services are planned and organised taking into account the needs of Welsh speakers. The Trust believes that the linguistic profile of its staff reflects the profile of the parts of Wales to which they provide a service, staff having been recruited locally. The Trust's Welsh Language Implementation Group received a report in February 2005 identifying the number of Welsh speakers within localities. That showed that there were 366 (14.4%) fluent Welsh speakers among the 2,535 staff then employed by the Trust. Fluent speakers were predominantly located in the north and central and west regions of the service. In addition to those fluent in Welsh the Trust employs a number of staff who have some Welsh language skills. The Trust aims to ensure that each member of staff is aware of the procedures to follow when dealing with telephone calls from Welsh speakers and a database of people who are available to deal with calls through the medium of Welsh is to be established. Informally, the Trust tries to ensure that there is at least one Welsh speaker on every shift in the North Wales control centre.

3.36. The Trust's Welsh Language Implementation Committee monitors the Welsh Language Scheme. The committee reports through the Human Resources Committee to the Trust Board.

3.37. The Trust's current arrangements for managing complaints are good. The Trust received between 250 and 300 formal complaints a year and in the first two quarters of 2006-07, 52% of complaints related to EMS and 48% to PCS. Regular reports are provided concerning the progress of a complaint, guidance has been issued for staff responsible for local investigation and central administrative processes are sound. WAST staff agreed with views expressed by some patients that in the past WAST had not been an organisation which handled complaints positively and it had been reluctant to acknowledge its own failures. We were told that that position had changed when the first Interim Chief Executive was appointed. Complaints management staff saw that appointment as marking an important change introducing a more patient oriented approach and willingness to make apologies where appropriate, although some frontline staff continue to feel that there is room for further improvement.

***Recommendation 2: The Trust should review its arrangements for the planning and control of PCS and in the light of that introduce fleet management and staffing schedules to adapt its resources to meet peak demand. In consultation with its commissioners and patients it should ensure that its arrangements include sufficient flexibility to meet their needs.***

***Recommendation 3: The Trust should review the standard of its fleet and implement a programme of maintenance and renewal which, over the next three years, will produce improved standards of reliability and comfort for patients.***

***Recommendation 4: The Trust should work with the CHCs, hospitals, primary care providers and the public to ensure that patients have the information they need about WAST services and to encourage members of the public to use its services effectively.***

***Recommendation 5: The Trust should put monitoring mechanisms in place to ensure that uniform is issued in sufficient quantity and is replaced quickly. While proper use of protective clothing and equipment make cross infection a minimal risk, ideally, staff should not take uniform home. The Trust should work with the Welsh Assembly***

***Government's Department of Health and Social Services and its commissioners to determine and implement the most appropriate arrangements for uniform cleaning.***

***Recommendation 6: The Trust should ensure that its Infection Control Policy is being properly implemented throughout the Trust and seek appropriate further advice where necessary.***

## **Use of Information**

3.38. The Trust's Three Year Rolling Clinical Governance Development Plan, last reviewed in March 2006, identified the key actions required of the Trust following the 2004 CHI Review. Among those actions are a number associated with the use of information by the Trust. Since the CHI Review the Trust has developed an Information and Communication Technology (ICT) Strategy, although that has not been disseminated across the Trust. During the time of this review the Trust appointed a Director of ICT. Similarly, other matters requiring attention were found to have reached preparation or development stage, but were not yet fully implemented. Another CHI recommendation, which remains in the category of no significant progress having been made, concerns the implementation of a process to define how improvements in the quality of patient care might be achieved through the use of information.

3.39. Overall, we found the Trust's information systems, its understanding of the importance of information and the resources deployed to generate meaningful and accurate information to be inadequate. This was true for many areas of information used by the Trust, for example:

- ***Information for command and control of EMS vehicles*** WAST has no all-Wales system for pinpointing the location of its vehicles and its radio system is subject to failure in some parts of the country. Command and control management varies from region to region, although EMS control systems for managing availability and deployment of EMS units are more consistent than for PCS since they are supported by a single electronic

planning system. However errors do occur in the inputting of data for both EMS and PCS. Some of these minor lapses or limitations in information passed to crews have had potentially serious consequences. The incorrect data may relate to the wrong town, the wrong house name or number or the wrong hospital department. The Trust uses an Advanced Medical Priority Dispatch System (AMPDS) which is a protocol driven system providing a robust risk management system of questioning callers and then automatically prioritising their calls. The Trust is implementing an ambulance radio replacement scheme which should help crews when accessing and checking information from control centres.

- **Information for planning improvements to clinical services** The Trust relies heavily upon the data available from the Patient Clinical Record (PCR) it generates in respect of every EMS patient. However, the system for capturing and transferring this data is not robust (see Chapter 4). In addition, while the Trust appears to have a small group of people with good analysis skills and an able National Clinical Audit Manager, the resources allocated to the task are small and only sufficient to enable part of the required information analysis to be taken forward. There is also concern that the data captured and used in systematic analytical processes is frequently flawed and there are few data sampling audits to test the accuracy of stored data. Staff reported that compliance checks conducted on PCRs did not reflect the effectiveness of patient care given at 'the scene' and only provided feedback on how well each of the pro forma PCR boxes had been filled in. There are no spaces on the PCR forms for EMS staff to record accurately the treatment regimes administered when they are out of line with usual protocols and not in accordance with the PCR form.
- **Performance data** The Trust has tended to focus almost entirely on short term targets in its strategic planning process. By concentrating on these the Trust had lost sight of the needs of the service viewed from a wider strategic perspective. Greater analysis of performance data would have

allowed the organisation to achieve measurable staged improvements over the longer term.

- **Incident Reporting** The Trust uses a standard incident form, the Adverse Incident Report (AIR) to report actual or near miss incidents. There is evidence from front line staff that there is some under recording of potentially harmful incidents for a variety of reasons. Some staff reported being overwhelmed with paperwork following a patient care incident, or being excessively tired due to overtime or call volume affecting the completeness of incident reporting. We were told by some staff that data feedback from the AIR forms is not widely published and disseminated at all levels within the service.
- **Patient Care Services** The Trust holds no useful information about PCS. There are a number of different planning systems in use across Wales, no performance data other than the volume of patients transported is collected and there is no systematic view about what data is important to collect and analyse. Our finding in relation to this is similar to that of the Auditor General. We note that over the last eight months the Board has been addressing the matter of PCS data and a proposal for rectifying the situation was considered in November 2006.

3.40. In each of the above areas failures have been identified. Some of these have been strategic, in terms of agreement at Board level about what information is needed and how it will be used to determine and drive the direction of the Trust. The Board has been taking steps to deal with this. Some failures are operational, relating to staff training and ensuring a good understanding among all staff about the importance and value of information to all staff of the Trust. There are implications in terms of resources both of staff (the requirement for data capture and entry onto electronic systems and analysis) and technology (the procurement of robust electronic systems to resolve some data capture issues and provide consistent, Wales wide,

analytical tools) to address these failures. The Trust's Modernisation Plan contains a number of objectives to improve the usefulness of information<sup>5</sup>.

3.41. However, it is nevertheless acknowledged that there are pockets of good practice or initiatives within the Trust, including:

- A Trust wide initiative to collate data for nationally driven cardiac audits related to thrombolysis in patients suffering Myocardial Infarction (MI). Trust thrombolysis officers keep records of staff qualified to administer thrombolytic drugs and monitor data from patient outcomes.
- Information being shared with partner organisations. For example, at one hospital (Morrison hospital in Swansea), staff assess the clinical outcomes of trauma patients treated by the hospital and for some cases invite ambulance crews who attended the particular incident to attend a multi-disciplinary audit meeting where the individual case is assessed. The aim is to identify good practice.

***Recommendation 7: The Trust should determine at Board and senior management level the information it requires to manage strategically and operationally and identify the services with which it will benchmark its own performance.***

***Recommendation 8: The Trust should review the resources required to deliver its information needs.***

## **Processes for Quality Improvement**

### ***Risk Management***

3.42. Since the CHI Review the Trust has introduced a comprehensive risk register and developed an improved adverse incident reporting policy and procedure, but limited progress was found to have been made in providing training for staff in relation to risk management.

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<sup>5</sup> Paragraph 2.6.1 of version 8 of 'Time to Make a Difference'

3.43. A number of CHI recommendations were found not to be fully addressed and some of those identified as being completed in the March 2006 review of the Trust's Three Year Rolling Clinical Development Plan were found to be incomplete. For example, the Trust reported that effective systems were in place to prevent the risk of cross infection. However, we noted inconsistent application of hygiene precautions in relation to the vehicle environment which compounded the difficulties staff experienced in keeping PCS vehicles clean. Earlier in this report we have set out concerns in relation to infection control.

3.44. Much of the risk related to PCS is managed as a result of the familiarity of PCS crews with regular routes and regular patients. The likelihood of risks to vulnerable patients rises when staff are required to work in unfamiliar areas, are under time pressures, are tired and stressed and asked to make additional journeys prior to finishing a shift. The control systems introduced to minimise risk for patients using PCS vehicles are still not uniformly implemented and consistently in use across the Trust (see Chapter 5).

3.45. From our observations, there was limited evidence to demonstrate that, at the operational level, information about potential risks, incidents and complaints are acted upon appropriately, communicated and ultimately enforced. There is widespread variation in practice from that set out in Trust policies and procedures.

### ***Clinical Supervision and Risk Reduction***

3.46. There was little evidence to demonstrate that PCS staff received supportive operational supervision. However, some EMS staff praised the clinical supervision they received, reporting that their work was regularly assessed by operational assessors. Refresher training was reported to be timely and appropriate and most EMS crews we asked reported that they were confident in accessing clinical guidance in the event of query or uncertainty whilst 'out in the field'.

3.47. There were worrying limitations in procedures for checking the qualifications and suitability of all working staff. For example, there are variations in the procedures for checking staff driving licences. At some stations this check happens annually and the documents are physically examined whilst at others the checks do not occur, or are cursory, sometimes with copies being accepted. It was reported that eyesight checks are not conducted within the Trust, other than those that may occur as part of an initial joining medical. Details of paramedic registration are held on a database within the training department. Every month Locality Ambulance Officers (LAOs) check the registration status for all their paramedic staff against the Health Professions Council (HPC) website and submit a monthly report to the training department. If the training department does not receive a report it then follows up this matter. All paramedics have been informed that they will not be allowed to practice if there is any doubt about their registration. During our observation visits it appeared that there were some paramedics who were still unclear about these.

3.48. Some staff reported that they were unclear about the role of the Occupational Health Unit (OHU). Staff are vaccinated against Hepatitis B either in mid service or upon first joining. Occupational Health write to staff at the five year point to remind them that they have to come in for a status check and in the north and central and west regions, Occupational Health follow up non responders. The Trust is less certain that non responders are followed up in the south region, which may account for some staff telling our reviewers that responsibility for ensuring follow up status checks occur were left with each individual.

3.49. There were, however, examples of safe systems of work in practice.

- The control and audit of generic drugs. In the south east region and Powys a system of sealed drugs boxes, which are individually numbered is in use. Each box contains a set number of inventory required drugs ready to go on the road. The relevant expiry date was on the outside of the box and it

was sealed with an evident tamper proof seal. The boxes were exchanged at the end of every shift unless the seal was intact. Boxes are logged out and logged in with records kept of any drug usage. Old used boxes are restocked by station staff or individuals on light duties. A decision has been made to roll out this system throughout the Trust.

- Appropriate arrangements for the issue of controlled drugs.
- Coloured mops with individually marked buckets to clean allocated areas eg toilets, insides of vehicles, sluice areas etc.

### ***Clinical Audit***

3.50. Since the CHI Review, the Trust has produced a Clinical Audit and Effectiveness Strategy and a structure for its delivery had been set in place. A Clinical Audit and Effectiveness Working Group was established under the chairmanship of the Trust's Medical Director which reported to the Clinical Governance Sub-Committee. Part of the Strategy was to provide training for staff in clinical audit and some training has been provided for a small group of staff. The Strategy also identified the importance of information gathering and the quality of data available for audit purposes. An annual audit plan was also developed. WAST's modernisation plan contains a number of objectives aimed to achieve improvements in clinical audit and effectiveness.

3.51. The Strategy relies upon a small dedicated team, as a central resource, and the capacity of the Trust to engage the enthusiasm of all staff who, following some training, should play their part in ensuring clinical effectiveness throughout the Trust. That is a praiseworthy goal; however, there was little evidence that the Trust was close to achieving that outcome and it may be that the resources to achieve it have been underestimated. Notwithstanding this, it is clear that the leadership and management capacity of the Trust has not so far been adequate to take forward the Strategy.

3.52. The Trust has appointed one of its Regional Ambulance Officers to act as Clinical Governance lead on a 'seconded' basis. It had been suggested that this was appropriate since the lead role needs to be a full time one and there are advantages to the lead being an 'ambulance person'. In addition, a National Audit Manager reports to the Clinical Governance Lead and has made good efforts to increase the Trust's capacity to manage its data and to provide helpful analysis of that data. Audits have been taken forward: the three we saw demonstrated good attention to the examination of matters of clinical interest to the Trust. The National Audit Manager's ability to take clinical audit forward is, however, limited by the lack of resources available in regions and localities. Resources for audit have not followed the production of the Trust's Strategy and only limited work has been possible using thrombolysis officers as champions of audit. Clinical audit training has also been provided for clinical operations managers, which has been productive with some useful outcomes arising. However, that training did not have the anticipated longer term impact in terms of clinical operations officers being able to commit themselves to audit work.

3.53. It is clear therefore that the Trust's Strategy for clinical audit and effectiveness is impacted upon by lack of resource and this has particular repercussions for the wider clinical governance agenda. The Trust needs to re-examine the resources it commits both in terms of leadership and management and in terms of 'front line' information and audit staff. It is our view that a service the size of WAST, with the complexities it faces in delivering modern clinical services, requires a full time Clinical Director post driving forward clinical excellence. Duties of this post would include:

- time to be directed at ensuring the Board and managers receive clear professional guidance about clinical priorities, best clinical practice and a wide range of training matters relating to staff;
- giving proper support for those in regional lead roles; and

- ensuring that frontline staff have the opportunity to engage with WAST's medical expert to exchange information and in order to deliver service improvements.

3.54. While the role of National Clinical Audit Manager is working effectively, it is also clear to us that the Trust needs to provide leadership for clinical audit and effectiveness at a regional and local level. While it is a matter for the Trust to determine how that might best be provided, as an example, at regional level provision may not need to be full time. At a local level, the attempt to engage clinical operations managers with clinical audit might prove a way forward, if it were possible to formalise that arrangement and provide protected time for the audit responsibilities. The way in which these posts would link to the national role would need to be clear.

3.55. The Trust's use of people in seconded roles is considered elsewhere in this report and is referred to in the Auditor General's Report as being a symptom of roles, responsibilities and accountabilities not being clear within the Trust.

3.56. We met a number of people in the Trust who were enthusiastic about the possibilities afforded by clinical audit to support a learning culture within the Trust. However, that enthusiasm did not yet appear to be wide spread throughout the Trust. Paramedics demonstrated commitment to increasing their skills and other staff expressed their desire to extend their knowledge and experience. Overall there appeared to be good indications that a learning culture could be developed within WAST.

***Recommendation 9: The Trust should review the role of Clinical Director and put in place a full job description for the post. It should also ensure that clinical leadership at Trust, regional and local level is in place to support the major improvements required in relation to clinical governance.***

***Recommendation 10: The Trust should ensure that appropriate resources are available to the National Clinical Audit Manager to take forward its Clinical Audit and Effectiveness Strategy.***

## **Staff Focus**

### ***Equality and Diversity***

3.57. The Trust has an Equality and Diversity Policy which addresses such matters as recruitment of staff. It is supported by a Recruitment and Selection Policy and other HR policies and procedures. Equality and Diversity training is one element in the induction programme for new staff and the Trust also provides refresher courses.

3.58. Diversity and equality were found not to have been systematically embedded within the Trust's practices. Some staff said that while they would like to think that they have a fair and supported opportunity to progress their careers within the service, in the past that had not always been the case for some individuals. They told reviewers that:

- different questions had been asked of candidates for the same post; and
- simpler non-clinical questions had been asked of external candidates.

Staff would benefit from having clearly stated routes for PCS staff to develop within WAST, and the Trust needs to ensure that its selection processes provide a level playing field for both internal and external candidates for EMS posts.

### ***Education and Training***

The Trust has an Education and Training Strategy appropriately referencing work on the Agenda for Change and the Knowledge and Skills Framework. It is a high level document supported by an implementation plan which the Trust Board is responsible for monitoring.

3.61. Education and training is encouraged by the Trust as a means of ensuring continuing development of its staff. However, it requires that staff undertake some development opportunities in their own time. Whilst that may be appropriate where staff are trying to improve their opportunities for the future, we do not believe it is appropriate where development relates to improving performance of staff in their current role. For many it can be impracticable for them to use personal time for development purposes, for example, because of family commitments, presenting a bar to their development. Also staff shortages are such that time off is often difficult to arrange.

3.62. Among the opportunities that staff can access are the Ambulance Care Award, (a three year Degree course leading to a qualification as a Paramedic Practitioner) and the European Computer Driving Licence.

3.63. Mandatory training for Paramedics and EMS staff is monitored by LAOs and the Trust's training department. Most Paramedic and EMS staff reported regular attendance at refresher training, together with attendance at mandatory re-qualifying sessions.

3.64. PCS staff frequently reported feeling undervalued by the organisation. Apart from initial training, most staff stated that they have received little if any refresher training. One of their biggest issues is that because they wear the ambulance service green uniform they are expected to have a good working knowledge of basic life support and cannot readily be distinguished from emergency care staff. Frequently, PCS staff have received no first aid training for many years. The Trust has acknowledged this and has recently included two days clinical training within its foundation course and was considering proposals for catch up training as part of post proficiency courses. Staff expressed dismay that whilst first responders carry oxygen and an automatic defibrillator, they have little if any equipment or training to cope with emergency incidents and we were told of frequent examples of PCS staff being approached by members of the public to report emergency incidents.

With the drive to reduce death rates from coronary events it would be beneficial to have PCS staff well trained and able to resuscitate patients in a timely manner whilst awaiting the arrival of an emergency care team.

3.65. The Trust has been making efforts to introduce a routine appraisal system for staff. However, the majority of staff we spoke to had not had any form of Continuing Professional Development Review (CPDR) or staff appraisal for a number of years. Many confirmed that they would want a review if only to air concerns and issues over local practices. A number of managerial staff reported having received no training for their current post and no training in staff review and appraisal processes. This was also reflected among some of the more senior managers who told us that they had had no CPDR for some time. Since regular CPDRs are a fundamental building block within effective organisations, this is of considerable concern.

### ***Working Environment***

3.66. The environment within which staff work suffers from a number of difficulties. This report has already outlined those relating to the condition of vehicles. The quality of the ambulance stations and station facilities varied tremendously across the Trust. While we saw some excellent modern, well cared for buildings, there was a proportion of the Trust's buildings that were less than satisfactory. In the past, the inability of the Trust to direct funding towards its estate has affected the environmental conditions for many staff at stations.

3.67. Some station infrastructure is old, dirty and in obvious state of disrepair. In addition, an Improvement Notice was served upon the Trust in respect of a number of its sites by the Health and Safety Executive (HSE) in 2003. This is also referred to in the Auditor General's Report. The initial notice was in respect of 40 properties and at the time of our review 19 properties were still the subject of this notice. The Trust has committed £1.4 million to resolve these issues in the 2006-07 financial year.

3.68. The physical cleaning arrangements of ambulance stations varied across the Trust. At some stations EMS and PCS staff were required to clean all areas within the station in addition to their normal duties, while at others a cleaner was employed. This practice could affect control of infection requirements.

### ***Communication***

3.69. The Trust has a communications group chaired by the Director of Human Resources. At the time of our review that group was conducting a review of communication within the Trust and designing a new communications strategy. While the Trust does publish two bulletins 'SIREN' and 'INSIGHT' it still has a number of internal communication issues. There were comments from operational staff that a large amount of information concerning proposed changes within the Trust are gained from the media rather than from information provided by the Trust, despite the Trust making efforts to share press releases with staff prior to publication. The internal communication chain within the Trust does not appear robust. Clinical directives or changes in practices are generally announced by typed memo which are pinned to notice boards. The Trust also placed notification on its website. While the Trust issued notices together with explanations for any changes to be made, there is no consistent method in force across the Trust to ensure that all such directives have been read and understood by the relevant staff. Only a few stations provided acknowledgement slips with the directive requiring staff to sign to show that they had read the directive.

3.70. Although the views of staff have been sought as part of consultation exercises, some staff felt that their views have then been ignored. Many staff are represented by Trade Unions and Unions recognised by WAST contribute to the Trust's consultations about the development of the Service and hold formal membership of relevant groups within the Trust.

## **Staff Welfare**

3.71. Staff welfare is a cause for concern for many staff. An informal counselling support network using colleagues as a “listening ear” was introduced several years ago. Volunteering staff had their telephone numbers made accessible so that any member of staff could speak to them in the event of welfare issues arising. There is also an independent counselling service available to staff. The Trust contract with the provider of this service sets out an expectation that calls to the counselling service will receive a response within one working day, however we were told by some staff that it sometimes takes up to three days to establish contact. Most paramedics cite the need for time during shifts to discuss emotionally traumatic experiences. There are facilities for staff to have up to a fortnight’s recovery time to get over a particularly traumatic event and there is no stigma attached to this.

3.72. A number of staff reported that understaffing at some localities gives rise to the need to work long hours on a regular basis and sometimes having to be redeployed to other stations often some distance away. The effect of this is to cause some staff to report feeling excessively tired, which in turn could have a detrimental effect on patient safety and care. Where possible the Trust should consider how these issues might be mitigated, in particular through re-examination of shifts/rota. We have noted that the Trust’s Modernisation Plan<sup>6</sup> addresses this matter through a number of objectives.

***Recommendation 11: The Trust should ensure that within its developing culture diversity issues are addressed, including those relating to gender, race and disability.***

***Recommendation 12: The Trust should review its training and education programme with particular emphasis upon the training and development which should be provided for PCS staff. Development plans need to be based upon regular CPDR and the Trust needs to ensure that such reviews are being delivered regularly.***

***Recommendation 13: The Trust should identify and plan for improvements in its estate and facilities to ensure that staff work in a safe environment through which their work is properly supported.***

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<sup>6</sup> Paragraph 2.1.4 of version 8 of ‘Time to Make a Difference’.

***Recommendation 14: The Trust should establish systems to ensure effective communication with staff across the whole of the Trust.***

***Recommendation 15: The Trust should ensure there are sufficient staff rostered to enable staff to take timely statutory rest breaks during their work and consider how, in the longer term, adjustments of shift/rota arrangements could minimise additional pressures on staff.***

## **Leadership, Strategy and Planning**

3.73. The professional leadership at senior levels of WAST has been in a state of some disarray for a considerable period of time. There has been a significant period of instability of leadership, which has undoubtedly affected morale within the service. Although problems appear to have dated back much further, the recent history serves to illustrate the difficulties through which the Service has struggled to deliver good frontline services. The details of the changes at the top of the organisation have been clearly set out in the Auditor General's Report. These changes saw four people (the substantive Chief Executive, an acting Chief Executive and two interim Chief Executives) each carrying out the Chief Executive's role over a period of nine months. Vacancies in key roles such as Director of Operations and sickness among other key post holders has meant that the day to day work of the Trust has appeared to some frontline staff as having been carried out in spite of, rather than with, the assistance and involvement of senior management. The few senior managers who have remained throughout this difficult period have been over stretched in their work.

3.74. Various concerns were expressed during this review about the past management style within the Trust. Staff commented on the 'remoteness' of senior management in the past and their lack of presence at operational level; they had not had confidence in the Trust's senior management to make effective decisions regarding service provision; they were rarely consulted and when consultation did occur, their comments and observations appeared to have been ignored; and there had been an impersonal style to implementing important service changes.

3.75. The Trust's capacity for leadership and management at all levels of the organisation has also been a key factor in preventing the progress which might have been expected to have been delivered since the CHI Review.

3.76. However, during the course of this review the Trust has appointed a highly experienced ambulance service manager as its new Chief Executive and we were pleased to note the enthusiasm with which all levels of the Trust have greeted his appointment. During his short time in post he has been seen to try to engage the operational staff by writing personal individual letters of encouragement to each of them and visiting staff at stations and encouraging debate. He has acknowledged the difficulties that the service currently faces and carries the hopes of many ordinary operational ambulance staff. The Chief Executive has produced a comprehensive modernisation plan for the Trust that, although still subject to consultation, has received a positive response from staff. The plan itself is set for a decade, although much of the progress that should issue from its implementation will be marked in the first few years. The Board has responded by establishing a Modernisation Committee, the non-executive chair of which is clear about the extent to which his Committee and the Board can help to drive forward the Plan, as well as ensure that it remains on course and is properly monitored.

3.77. In addition to the new Chief Executive, the Board has moved to fill the vacant Director of Operations post. Further posts where there are vacancies or where new roles will be created as part of the modernisation plan should, when filled, further consolidate the improved capacity for leadership at the most senior levels.

3.78. At Board level, much has been done to overcome the weaknesses identified at the time of the CHI Review. The Board has redesigned its committee structure, particularly in relation to governance and, since his appointment in April 2006, the new chair has introduced monthly Board meetings to replace the four formal meetings a year through which the Board had, hitherto, attempted to discharge its responsibilities. Non-Executive

Directors now have clearly identified responsibilities and active roles in respect of the Board's sub-committee structure. The new chairman has introduced performance appraisal and objective setting for Non-Executive Directors and agrees the Chief Executive's plans with him. Together these arrangements mark important progress in the extent to which the Board is now in a position to take responsibility for the strategic direction, performance and activities of WAST.

3.79. The further work that remains to be done concerns the renewing of management at middle, first line and supervisory levels. The difficulties the Trust has experienced in the past with regard to leadership and management have been present at all levels of the organisation. At regional and local level the difficulties have been characterised by management vacancies, over use of secondments (only partially resolving one problem by creating another one and often drawing paramedic trained staff from important front line roles), no or inadequate management training for first time managers and little follow up training for more experienced managers, lack of clarity about management roles and no clearly designated line or team management. The process of renewal will need to address each of those issues. An important early task will be to provide clarity about what is expected of managers and the training necessary to ensure that they are equipped to deliver the necessary personal and organisational change.

3.80. More work also needs to be done to engender a single, modern and forward looking culture across the entirety of the Trust's operations and regions. The review identified remnants of an old style culture still in existence that looked back to predecessor ambulance services in Wales, that did not equally value the various services provided by the Trust, such as EMS and PCS, did not understand the need to engage patients and the public sensitively and effectively, and did not accommodate or show behaviours relevant to the gender balance amongst the workforce. The Trust will need to take positive steps to tackle these as part of creating a modern and unified culture.

***Recommendation 16: The Trust should complete its appointments to vacant management posts and having identified those posts which need to change or to be created under its Modernisation Plan should fill those posts without delay.***

***Recommendation 17: The Trust should ensure that its induction and continuing professional development for leadership and management roles addresses the need to create and sustain managers who have the required knowledge and skills to perform their roles effectively.***

***Recommendation 18: The Trust should take further action to create a culture within WAST to ensure its ability to deliver a common strategy, support regional operational management and to improve staff morale.***

***Recommendation 19: The Trust should take forward the full review, initiated by its modernisation plan, of the contribution of PCS within WAST, identifying the common values and synergies with other parts of the service, including the anticipated integration with NHS Direct Wales. The future leadership and management of PCS, together with the relationship between PCS and EMS functions, staff and roles should then be formally determined by the Board.***

## **The CHI Review and HIW's Findings**

3.81. CHI published its report of its review in February 2004, some two and a half years prior to the commencement of the formal interviews and observation work for this Special Assurance Review.

3.82. While the two exercises are not strictly comparable they do examine the same areas of clinical governance and this review was also designed to consider the progress the Trust had made in relation to its CHI action plan.

3.83. CHI assessed seven areas of clinical governance and based upon its assessment in relation to each of those areas, identified where it felt the organisation to be in terms of development and performance against a 4 point scale. Table 1 below shows the assessment made by CHI in 2004.

| <b>Table 1: CHI's Assessment*</b>       |                             |
|---|-----------------------------|
| <b>CHI's Clinical Governance Review</b> | <b>CHI Report WAST 2004</b> |
| 1. Patient involvement                  | I                           |
| 2. Risk management                      | ii (a)                      |
| 3. Clinical audit                       | I                           |
| 4. Staffing and staff management        | ii (c)                      |
| 5. Education and training               | ii (c)                      |
| 6. Clinical effectiveness               | ii (a)                      |
| 7. Use of information                   | I                           |

\* An explanation of CHI's assessment scale is provided at Annex A

3.84. On the basis of the evidence gathered it is clear that the CHI Review did have some impact upon the Trust. An action plan to address the particular matters identified by CHI was produced by the Trust and this has been subject to regular review by the Trust to determine the progress made. The CHI recommendations have been subsumed into the Trust's Three Year Clinical Plan, progress against which is reviewed on a quarterly basis by the Board's governance committee.

3.85. Progress has been made in relation to the development of policy documents for areas where they had not previously existed. A good example is the production of the Trust's Clinical Audit and Effectiveness Strategy. The Trust has also taken some steps to action the strategies it has put in place. However, much remains to be done to embed clinical audit into the Trust. In particular there are resourcing, technology and integration issues which need to be addressed. Based upon our assessment, it is likely that were the CHI methodology applied and the same form of assessment made as that used by CHI, the Trust would show some improvement in its position compared with that in February 2004, albeit our assessment is that the Trust has not progressed to level iii for any of the areas of clinical governance assessed. Patient involvement and the use of information were found to be particularly weak areas.

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3.86. In summary, we found WAST to have moved forward since the CHI review in relation to the production of documents setting out policy and procedures. However, there has been less success in achieving real change across the whole of the organisation. Some elements of central policy have been implemented in some parts of the organisation, but we found considerable lack of consistency in practice and failure of some developments within the Trust to have impact across the whole of WAST. As stated in other parts of this report we believe that the Trust now needs to give attention to the following:

- improving the capacity and quality of its leadership and management at all levels;
- developing a single culture in WAST;
- increasing the capacity of the Trust to understand what it is doing (ie getting data capture and analysis right); and
- improving the capital resources of the Service – estate, vehicles and technology.

3.87. We have made recommendations elsewhere in this report to assist the Trust in taking these matters forward.

## **Chapter 4: Assessment of the capacity of WAST to improve patient outcomes**

4.1. It is clear that the number of patients cared for by WAST who might survive severe health crises could be improved through consistent application of the best modern responses to such incidents as heart attacks.

4.2. However, the extent of the improvement that might be achieved is more difficult to assess and obtain agreement upon. One assessment estimated that 500 additional lives might be saved per annum. This was based on the projected numbers of lives saved achievable by WAST if it performed at the same level as the most highly performing services in the world (such as Reno, Nevada). Achieving such an improvement is predicated upon WAST increasing the use of thrombolysis, improving its resuscitation of patients and better trauma care.

4.3. Published data collected from Wales and the English Ambulance Services<sup>7</sup> in relation to thrombolysis show that in 2005-2006 WAST provided pre-hospital thrombolysis for 10% of eligible cases against an England average of 18%. WAST began to use thrombolysis rather later than the majority of English Ambulance Services and its performance at the two year stage was a little below the average for other UK trusts when they had been at a similar point of introduction. Should WAST performance reach the levels now achieved elsewhere in the UK, there would be a consequent increase in the number of patients who might survive a heart attack. Since the original calculations were made, clinical practice in WAST has developed. In particular, the proportion of paramedics able to perform thrombolysis has increased and it is anticipated that all paramedics will have been trained to thrombolysate patients by the end of 2006.

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<sup>7</sup> Myocardial Infarction National Audit Project (MINAP), fifth public report June 2006 'How the NHS Manages Heart Attacks' Royal College of Physicians

4.4. In 2006, WAST examined improvements achievable in overall survival rates that would arise following the successful resuscitation of patients. That analysis suggested that between 9 and 77 additional lives might be saved if WAST raised its performance to the level of that achieved in Scotland<sup>8</sup>.

4.5. Examination of the data produced from these different sources leads to different estimates of the potential for increasing survival rates of patients. There are a number of factors giving rise to these differences. Those identified by HIW are:

- the quality of the data recorded by WAST;
- the use of different comparators;
- using data from different time periods;
- a statistical error, which did not take into consideration the difference between absolute and relative risk;
- differences in bystander cardiopulmonary resuscitation (CPR) rates between Wales and high performing English Services.

4.6. These matters are explored further below.

### ***Data Quality***

4.7. The quality of data held by WAST is variable. In addition, some data used to assess the quality of performance in terms of outcomes for patients has to be obtained from hospital databases. The prime source of data is the PCR which is completed by ambulance crews. Data quality may be compromised in a number of ways:

- the initial completion of this form has some variability relying on individuals to complete the form in what are often stressful circumstances (first risk to data quality);

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<sup>8</sup> One study in Scotland has shown a rate of survival to the point of hospital discharge of 6.7% whereas WAST analysis suggested a rate of 3.1%. Two studies in different parts of England have shown rates of 2.2% and 4.6%.

- subsequently the hand-completed record is transferred to a central data inputting centre in Swansea, introducing the risk of the record being lost in transfer (second risk to data quality); and
- at the data-inputting centre, the patient record card is electronically scanned into the Trust's database. There are understood to be errors which arise at the scanning stage (third risk to data quality).

4.8. As a result, there are doubts about the completeness of data captured and entered into the Trust's systems. The analysis that resulted in the estimate that 500 additional lives might be saved each year recognised these difficulties: in particular, in relation to what is believed to be under reporting of myocardial infarction (MI) in Wales. It therefore included a calculation of the expected rate of MI for the population of Wales based on the figures for Staffordshire.

### ***Comparators***

4.9. There has been no agreement as to what the most appropriate performance comparisons are. For example the analysis from which the estimate of 500 derived compares the performance of WAST in respect of the return of spontaneous circulation (ROSC) to patients at the point of hospital admission with the success achieved in Reno, Nevada, USA. This analysis indicated that the percentage of patients who had achieved ROSC from those where resuscitation was attempted was 30% for Reno and 25% for Staffordshire. The figure for Wales was 11% and the average for England was also 11%. On the other hand, the Trust's own analysis compares performance to that of the Scottish Ambulance Service or the average performance for all UK Trusts.

### ***Statistical Error***

4.10. The issues relating to the effect of treatments and the comparison of actions taken by health service employees are complex. Estimates of the effect of changes in performance can be subject to miscalculation as a result of statistical errors. One such error appears to affect the analysis leading to the estimated 500 potential lives that might be saved. In relation to one element of that calculation a figure referring to relative risk seems to have been applied to the data as if it was a figure of absolute risk<sup>9</sup>. The effect of that error was an over estimate of the order of 130 against the figure of 500.

### ***Bystander Cardio Pulmonary Resuscitation***

4.11. An additional factor that may influence the difference in ROSC rates between WAST and Staffordshire is the very low rate of bystander resuscitation (prior to ambulance arrival) in Wales. Staffordshire quote a rate of 17% compared with 3% (WAST audit conducted in 1996) that has been documented for Wales. Bystander CPR has been shown to increase survival rates by as much as three fold. The difference in bystander CPR rates between the two areas may also to some extent contribute to the differences in ROSC rates between Staffordshire and Wales.

4.12. In summary, while it is clear that more lives could be saved as a result of developments and improvements in WAST's services any calculation of the precise number is likely to be imprecise and inconclusive for the reasons set out above. Any attempt to produce further estimates at this stage would also be subject to some of the difficulties set out above but it is clear that accurate and reliable information on this matter is required for the future, not least to assist WAST managers in planning service and performance improvements but also for the Trust to be able to reliably chart improvements in survival rates against the performance of other ambulance services. The

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<sup>9</sup> Annex B provides further explanation of absolute and relative risk.

implementation of the following recommendations will assist the Trust in achieving this goal.

***Recommendation 20: WAST should take action to ensure that data in respect of clinical performance is of sufficient quality to enable useful analysis to improve the performance of the Trust.***

***Recommendation 21: WAST should identify and implement an audit process for key clinical areas which will produce reliable information about the outcomes of patient care.***

***Recommendation 22: The WAST Board should agree appropriate benchmarks for comparison of WAST performance to highlight areas for further improvement of performance.***

***Recommendation 23: The WAST Board should ensure resources are in place to increase the contributions of WAST to survival of patients suffering health crises, such as an increased capacity for thrombolysis.***



## **Chapter 5: 2003 Incident and Effectiveness of Trust Incident Reporting Systems**

5.1. The incident which prompted this enquiry is summarised in the Background chapter of this report. Subsequently there has been at least one further incident of a patient being delivered to an incorrect home address. In addition, we are aware of one incident in which a patient was left on board a parked PCS vehicle at an ambulance station at the end of a shift. Her presence aboard the vehicle was only discovered by accident.

5.2. Following the incident in 2003, WAST conducted an investigation which produced a formal report of its findings and set out a number of recommendations. These were:

- dedicated crews who know patients, or at least one crew member who is familiar with the patients to be used for routine PCS operations whenever possible;
- a formal system for booking patients in and out of day hospitals that is standard across Wales;
- patients being treated in Elderly Mentally Ill (EMI) centres being handed over to a competent carer when returned home; and
- the use of identifying wristbands for patients.

### **The Independent Review of the Incident**

5.3. An independent Review established by the South East Wales Regional Office of the Welsh Assembly Government's Department of Health and Social Services concluded that:

- (i) *'The action already planned by both Cardiff and Vale and the Welsh Ambulance Services NHS Trusts be supported, namely:*

- i.i That dedicated staff are identified to book patients in and out of Day Hospital settings.*
  - i.ii That ambulance crews are advised of their responsibilities to ensure that patients are clearly identified to them by Day Hospital staff.*
  - i.iii That EMI/Day Hospital patients are not left unaccompanied by ambulance crews unless there are specific instructions to do so.*
- (ii) There is a need to review patient identification methods within Day Hospital settings. Consideration of ethical issues for EMI patients is crucial, however it is suggested that models used elsewhere across Wales and the UK are reviewed to assess how clear identification methods can be adopted whilst maintaining patient dignity (Cardiff and Vale NHS Trust has indicated that a review of patient identification methods has commenced).*
- (iii) That the Ambulance Control list provided to ambulance crew members setting out the names and addresses of patients for transportation also indicates whether a carer can be expected when the patient is returned home.*
- (iv) That the process for development of the patient list by Ambulance Control in conjunction with the Day Hospital Unit is reviewed and that any changes to the list are confirmed by the Ambulance Control back to the Day Hospital Unit.*
- (v) That the Welsh Ambulance Services NHS Trust should assess how its staff interpret the meaning of 'a place of safety', and clearly establish whether an ambulance might be considered to be a place of safety should there be a reoccurrence of such an event in the future.*
- (vi) That the interim guidance on the reporting of serious incidents is reassessed to ensure that proper escalation procedures can be*

*introduced to avoid any ambiguity of whether incidents should be reported via this system.*

- (vii) The Welsh Ambulance Services NHS Trust undertakes an audit of patients incorrectly dropped off at the wrong address and takes any appropriate action required as a consequence of the audit.*
  
- (viii) It is not apparent from the Review completed to date whether the circumstances surrounding the incident of 20 August 2003 at Morfa Day Hospital are restricted to Cardiff and Vale NHS Trust and its relationship with the Welsh Ambulance Services NHS Trust. In order to minimise the risk of reoccurrence of such events across Wales, it is suggested that consideration is given to a similar review of systems and procedures across Trusts in the remainder of Wales to ensure that the risk of future such incidents are minimised.*
  
- (ix) It is also suggested that further work is undertaken to assess how PCS services might be more closely integrated with Day Hospital services, such that crew members became full members of the patient care team.'*

## **WAST Response to the Independent Review**

5.4. HIW has reviewed the report of WAST's investigation and the Independent Review. These successfully identified the key issues which needed to be addressed to avoid further incidents similar to that subject to review. In the light of that, WAST produced a Patient Handover Policy and Procedure for Day and EMI Units which stated that:

- (i) 'When a primary carer is expected to accept a patient upon their return and is unavailable and a secondary carer is also unavailable, the carer/s should be contacted if their details are known so that a return time can be established. A decision can then be made to either wait for the carer, return at a later time or take the patient back to the unit if it is*

*still staffed or to the nearest A&E department (should the patient have an identification tag ie a wristband then this must be left in situ).*

*Patients should not be left in an unaccompanied environment unless there are specific instructions to do so. Contact should be attempted with the EMI/Day units where hospital staff may have additional information and may be able to offer advice.*

- (ii) It will be the responsibility of ambulance control to seek authorisation from the discharging unit (should the discharging unit be closed then procedures outlined in (i) will apply) when considering leaving a patient in an unaccompanied environment. This must be recorded in the control log identifying the date, time, name and grade of staff and any other general notes.*
- (iii) For those patients deemed to be vulnerable, in agreement with hospital Trusts, the patients must be identified on arrival at the unit with an agreed method of identification to remove any doubt as to the patient's name, address and carer details. The correct identification of the patient remains the responsibility of the appropriate EMI/Day units.*
- (iv) When patients are being returned from the EMI/Day units, each patient will be individually identified to ambulance staff by staff at the units during the handover in order to confirm the patient's identity and destination. Appropriate documentation to record this process will be agreed with individual units.*
- (v) When a new member/s or transferred member of staff of the ambulance service convey patients to a EMI/Day unit or when a new patient is added to the list, then appropriate induction regarding the units' procedures and the patient's needs must be undertaken and recorded by the WAST. The Locality Ambulance Officer will be responsible for ensuring induction training and appropriate documentation has been completed.*

- (vi) *To avoid ambiguities that occur when each Trust has differing patient lists the following procedures will be adhered:*
- i.i Upon arrival at the EMI/Day units the ambulance service list of attendances will be the master sheet that the unit uses to document the details of the patients that have been conveyed to them.*
  - i.ii For the return journey, the EMI/Day units list will be the master sheet that the ambulance service uses to document the details of the patients that are to be returned home.*
  - i.iii Where patients have wristbands attached it will be the responsibility of the WAST staff to remove this once confirmed that the patient is at the correct address and/or has been left in the care of the nominated carer. Wristbands will be kept on station for a period of two weeks and will be stored in the Patient Clinical Records cabinets by the Locality Ambulance Officer once reconciled against appropriate journey sheets.*
- (vii) *The EMI/Day units will endeavour to allocate dedicated staff as a point of contact for the confirmation of patients' details. It is of paramount importance that the ambulance service has no doubts as to the address that each patient is being returned to and the details of a carer/s if one or more are to be expected at the home on the patients return.*
- (viii) *Periodic risk assessments regarding the robustness of the system will be undertaken in conjunction with appropriate NHS Trust to ensure systems remain viable and safe.*
- (ix) *Periodic audits will be undertaken in partnership with NHS Trusts to ensure compliance with local procedures.'*

5.5. These procedures introduced between WAST and Cardiff and Vale NHS Trust following the specific incident in 2003, were discussed and agreed

with all Welsh NHS Trusts and introduced across Wales. That action was consolidated by a Welsh Health Circular (WHC[2005]0113) which required NHS Trusts to ensure that the agreed procedures were adopted in all EMI units and regularly reviewed to ensure compliance.

## **HIW's Findings and Recommendations**

5.6. In the course of our observation work reviewers took particular note of procedures used for the management of vulnerable patients and we concluded that the policy and procedure outlined above has not been adopted consistently across WAST.

5.7. Vulnerable patients use PCS to attend a wide variety of clinics, not just EMI Day Units. Journey lists for PCS crews examined as part of this review did not appear to identify vulnerable patients and did not include details of carers or other specific material to assist the crew to ensure incidents did not occur. Formal handover of patients was not consistently undertaken by all crews and hospital staff. Wristband identification was not systematically in use. In relation to the latter, we found some crews who used this form of identifying patients routinely and systematically, other crews who were more selective in using the wrist bands and others who did not use them at all. Arguments for not using them focused on concern for the dignity of the patient and concerns that applying wristbands without consent might amount to assault.

5.8. We identified inconsistencies in the use of the journey lists by ambulance crews. As a minimum, we expected to see these sheets used to record the times patients were picked up from home, times of arrival at hospital, time picked up from hospital and time delivered back home with a check to show that the patient had been returned to the care of the appropriate person. We did not find journey lists being used consistently in that way. In other words we could not identify that WAST was establishing audit trails for its PCS work.

5.9. In the light of our review it is clear that further work needs to be done both to devise more thorough and, if possible, 'fail safe' systems for the management of vulnerable patients by PCS staff and to ensure that systems which are put in place are implemented and applied consistently across the whole of WAST.

5.10. In conclusion, while the Trust has revised and implemented new policies for PCS following the incident in 2003, these are not yet sufficiently robust and are not being implemented consistently. As a consequence there is a continuing risk that similar incidents could occur in the future. The Trust therefore needs to re-review these policies, strengthen the monitoring of their implementation and extend them to all groups of patients in order to manage this risk more effectively.

5.11. In respect of the Trust's Incident Reporting System the arrangements for incident reporting are appropriate. It is clear that incidents are reported and we noted good examples of staff 'self reporting' incidents. However, some staff did state that the pressures of the working day did not always make this easy. It was clear that a 'no blame' culture which encourages staff to report mistakes is growing.

5.12. Overall, we believe that the Trust has made progress in the matter of incident reporting, but that there is still some work to be done to ensure that staff prioritise completion of AIR forms and are persuaded of the value of doing so both for the Trust and for themselves.

***Recommendation 24: The Trust should revise its procedures in respect of vulnerable patients to include all such patients, recognising that they will be accessing the full range of NHS and social provision.***

***Recommendation 25: The Trust should ensure that arrangements for identification and transfer of vulnerable patients between itself and carers or other parts of the NHS are formalised and operated consistently across Wales.***

***Recommendation 26: The Trust must ensure consistent reporting of untoward incidents and the ability of WAST to learn from them. Personal feedback to staff is one of the key ways of ensuring that under reporting is reduced.***

## Chapter 6: Summary of Recommendations Showing Relationship to CHI Review of February 2004 and the Recommendations of The Auditor General's Report December 2006

| HIW's recommendations  | Auditor General's recommendations                    | WAST Modernisation Plan goals |
|--|--|-------------------------------|
| 1. The Trust's arrangements for PPI should be reinforced through a review of the processes through which the Trust engages with patients and the public to inform its key decision making processes.   | 12, 19(a)  | 3.2                           |
| 2. The Trust should review its arrangements for the planning and control of PCS and in the light of that introduce fleet management and staffing schedules to adapt its resources to meet peak demand. In consultation with its commissioners and patients it should ensure that its arrangements include sufficient flexibility to meet their needs.  | 15, 17(a), 17(c), 19(a), 19(b), 19(c), 19(d), 20, 26 | 2.1.4; 2.6.4; 2.3.1           |
| 3. The Trust should review the standard of its fleet and implement a programme of maintenance and renewal which, over the next three years, will produce improved standards of reliability and comfort for patients.   | 21(a), 28  | 2.6.4; 2.6.5                  |
| 4. The Trust should work with the CHCs, hospitals, primary care providers and the public to ensure that patients have the information they need about WAST services and to encourage members of the public to use its services effectively.  | 5(b)   | 3.3.4; 3.2                    |
| 5. The Trust should put monitoring mechanisms in place to ensure that uniform is issued in sufficient quantity and is replaced quickly. While proper use of protective clothing and equipment make cross infection a minimal risk, ideally, staff should not take uniform home. The Trust should work with the Welsh Assembly Government's Department of Health and Social Services and its commissioners to determine and implement the most appropriate arrangements for uniform cleaning. | No reference   | No reference                  |

| <b>HIW's recommendations</b>  | <b>Auditor General's recommendations</b> | <b>WAST Modernisation Plan goals</b> |
|---|--|--------------------------------------|
| 6. The Trust should ensure that its Infection Control Policy is being properly implemented throughout the Trust and seek appropriate further advice where necessary.  | No reference                             | No reference                         |
| 7. The Trust should determine at Board and senior management level the information it requires to manage strategically and operationally and identify the services with which it will benchmark its own performance.  | 1, 1(a)-(f); 23(a)-(f)                   | 2.1.2; 3.1; 1.3; 2.5.1               |
| 8. The Trust should review the resources required to deliver its information needs.   | 1, 13(b), 23                             | 2.1.2; 3.1                           |
| 9. The Trust should review the role of Clinical Director and put in place a full job description for the post. It should also ensure that clinical leadership at Trust, regional and local level is in place to support the major improvements required in relation to clinical governance.             | 12                                       | 2.1.1                                |
| 10. The Trust should ensure that appropriate resources are available to the National Clinical Audit Manager to take forward its Clinical Audit and Effectiveness Strategy.  | 1, 12, 13(b), 23, 25                     | 2.1.2                                |
| 11. The Trust should ensure that within its developing culture diversity issues are addressed, including those relating to gender, race and disability.   | 11(b)                                    | 2.5.6                                |
| 12. The Trust should review its training and education programme with particular emphasis upon the training and development which should be provided for PCS staff. Development plans need to be based upon regular CPDR and the Trust needs to ensure that such reviews are being delivered regularly. | 11(a)-(b); 13(a)-(f), 18                 | 2.1.3; 2.1.2.6                       |
| 13. The Trust should identify and plan for improvements in its estate and facilities to ensure that staff work in a safe environment through which their work is properly supported.  | 22                                       | 2.6.2                                |
| 14. The Trust should establish systems to ensure effective communication with staff across the whole of the Trust.  | 8, 11(b), 16, 18                         | 3.3                                  |

| <b>HIW's recommendations</b>  | <b>Auditor General's recommendations</b> | <b>WAST Modernisation Plan goals</b>                  |
|---|--|---|
| 15. The Trust should ensure there are sufficient staff rostered to enable staff to take timely statutory rest breaks during their work and consider how, in the longer term, adjustments of shift/rota arrangements could minimise additional pressures on staff.   | 20                                       | 2.1.4   |
| 16. The Trust should complete its appointments to vacant management posts and having identified those posts which need to change or to be created under its Modernisation Plan should fill those posts without delay.   | 12                                       | 2.4.3; 2.5.3; 2.5.4                                   |
| 17. The Trust should ensure that its induction and continuing professional development for leadership and management roles addresses the need to create and sustain managers who have the required knowledge and skills to perform their roles effectively.   | 4, 6(a), 6(b), 11, 13(d), 13(e)          | 2.5.3; 2.5.4; 2.1.3.6; 2.1.5.4; 2.1.6.1; 2.4; 2.5.4.7 |
| 18. The Trust should take further action to create a culture within WAST to ensure its ability to deliver a common strategy, support regional operational management and to improve staff morale.   | 12                                       | 2.5.5; 2.5.6; 2.5.2                                   |
| 19. The Trust should take forward the full review, initiated by its modernisation plan, of the contribution of PCS within WAST, identifying the common values and synergies with other parts of the service, including the anticipated integration with NHS Direct Wales. The future leadership and management of PCS, together with the relationship between PCS and EMS functions, staff and roles should then be formally determined by the Board. | 9, 17(b); 19                             | 2.3.1   |
| 20. WAST should take action to ensure that data in respect of clinical performance is of sufficient quality to enable useful analysis to improve the performance of the Trust.  | 23, 25                                   | 2.1.1; 2.1.2; 2.6.1 2.5.5; 2.3.1.6                    |
| 21. WAST should identify and implement an audit process for key clinical areas which will produce reliable information about the outcomes of patient care.  | 23, 25                                   | 2.1.2; 2.1.2; 2.6.1; 2.2.2.2.                         |
| 22. The WAST Board should agree appropriate benchmarks for comparison of WAST performance to highlight areas for further improvement of performance.  | 23                                       | 2.6.1   |

| HIW's recommendations   | Auditor General's recommendations | WAST Modernisation Plan goals |
|---|-----------------------------------|-------------------------------|
| 23. The WAST Board should ensure resources are in place to increase the contributions of WAST to survival of patients suffering health crises, such as an increased capacity for thrombolysis.                  | 1(a), 12, 24                      | 2.5.1; 1.3                    |
| 24. The Trust should revise its procedures in respect of vulnerable patients to include all such patients, recognising that they will be accessing the full range of NHS and social provision.                  | No reference                      | 2.3.1.10                      |
| 25. The Trust should ensure that arrangements for identification and transfer of vulnerable patients between itself and carers or other parts of the NHS are formalised and operated consistently across Wales. | No reference                      | 2.3.1.10                      |
| 26. The Trust must ensure consistent reporting of untoward incidents and the ability of WAST to learn from them. Personal feedback to staff is one of the key ways of ensuring that under reporting is reduced. | 25                                | 2.5.1.6; 2.5.3.3              |

### An Explanation of CHI's Assessments

On the basis of the evidence collected, CHI's reviewers assess each component of clinical governance against a four point scale:

- I Little or no progress at strategic and planning levels or at operational level.
  
- li (a) Worthwhile progress and development at strategic and planning level but not at operational level, OR  
  
(b) Worthwhile progress and development at operational level but not at strategic and planning level, OR  
  
(c) Worthwhile progress and development at strategic and planning and at operational level, but not across the whole organisation.
  
- lii Good strategic grasp and substantial implementation. Alignment of activity and development across the strategic and planning levels and operational level of the trust.
  
- lv Excellence – coordinated activity and development across the organisation and with partner organisations in the local health economy that is demonstrably leading to improvement. Clarity about the next stage of clinical governance development.

### Explanation of Absolute and Relative Risk

By risk we mean likelihood of an event. For example the risk of a horse winning a race may be 5%, or the risk of a man getting cancer if he is a life time smoker may be 16%. These are called absolute risks. When applied medically they generally refer to the likelihood of something happening following a treatment or following exposure to something detrimental to health. In other words what is the likelihood of somebody getting better if they take a given medicine.

To take a very simple hypothetical example to illustrate the difference between absolute and relative risk we might look at hiccups. Research could have shown that the chances of hiccups stopping after a shock were 4%. Other research may have shown that there is a 6% chance of hiccups stopping if you take a spoonful of vinegar. These are both absolute “risks”. They mean that if 100 people had hiccups and were given a shock you would expect 4 of them to get better. The vinegar remedy would be expected to cure 6 people.

Relative risk is when we compare the two treatments. As vinegar would be expected to cure 2 more people - that is 50% more than the shock - the relative risk is 50%. That is compared to what the shock would deliver, the vinegar would deliver 50% more.

In terms of ambulance use of thrombolysis we are comparing how much more chance a patient has of surviving if thrombolysis is administered compared to if it is not.

Research has suggested that the chance of dying if thrombolysis was given in a hospital was 9.48% and that the chance of dying if thrombolysis was administered before reaching hospital were 7.86%. These are absolute rates, but the 7.86% is 17% lower than 9.48%, so the pre hospital chance is about 17% better than if patients wait to be thrombolysed at hospital. This does not mean that 17% more patients survive if thrombolysis is given earlier, it is merely a way of quantifying the comparative benefits or risks of two treatments. The use of the 17% relative risk as a figure for absolute risk will result in an over estimate of the effect of thrombolysis.

An easier way to think of this is to go back to the hiccup example. Vinegar may be 50% better in terms of relative risk than the shock treatment, but this doesn't mean that 50 out of 100 people are likely to be cured by it. There are still likely to be just 2 more people cured.

## Annex C

### List of WAST Ambulance Stations visited during the course of the review

|            |               |
|------------|---------------|
| Amlwch     | Lampeter      |
| Bargoed    | Llandough     |
| Barry      | Llanidloes    |
| Blackweir  | Merthyr       |
| Blackwood  | Mold          |
| Brecon     | Neath         |
| Bridgend   | Pontypool     |
| Caernafon  | Porthmadog    |
| Chepstow   | Pwllheli      |
| Colwyn Bay | Rhyl          |
| Cwmbran    | Swansea       |
| Denbigh    | Tenby         |
| Dolgellau  | Tumble        |
| Ferndale   | Wrexham       |
| Flint      | Ystradgynlais |
| Gelli      |               |
| Hawthorn   |               |
| Heath      |               |
| Holywell   |               |
| Holyhead   |               |

### Healthcare Inspectorate Wales

Healthcare Inspectorate Wales (HIW) was established on 1 April 2004 by the National Assembly for Wales to discharge the responsibilities specified for the Assembly in the Health and Social Care (Community Health and Standards) Act 2003. HIW has been established as a Unit within the Assembly with a formal independence provided through delegations made under the 2003 Act to the Chief Executive of HIW.

HIW's core responsibility is to undertake reviews and investigations into the provision of NHS funded care either by or for Welsh NHS organisations in order to provide independent assurance about and to support the continuous improvement in the quality and safety of Welsh NHS funded care. In doing so, HIW must play particular regard to:

- the availability of and access to healthcare;
- the quality and effectiveness of healthcare;
- the management of healthcare and the economy and efficiency of its provision;
- the information provided to the public and patients about healthcare and;
- the rights and welfare of children.

The frameworks of Clinical Governance and Healthcare Standards set by the Welsh Assembly Government are central to the way in which HIW assesses Welsh NHS organisations and Welsh NHS funded care.

In this respect, HIW is committed to:

- strengthening the voice of patients and the public in the way health services are reviewed;
- working with others to improve services across sectors and agencies;
- working with other regulators/inspectionates to ensure that the public, NHS organisations and the Assembly receive useful, accessible and relevant information about the quality and safety of Welsh NHS funded care and;
- developing more effective and co-ordinated approaches to the review and regulation of the NHS in Wales.

On 1 April 2006, the responsibility for the regulation of independent healthcare transferred to HIW from the Care Standards Inspectorate for Wales under the remit of the Care Standards Act 2000. Independent healthcare settings include acute hospitals, mental health establishments, dental anaesthesia settings, hospices, private medical practices, and clinics where prescribed techniques include class 3b and 4 lasers.

In addition on 1 April 2006, following the abolition of Health Professions Wales, HIW assumed responsibility for the statutory supervision of midwives and also entered an agreement with the Nursing and Midwifery Council (NMC) to conduct annual monitoring of higher education institutions in Wales which offers approved NMC programmes.

### GLOSSARY

#### Glossary of Terms

**accountability** – liability to answer for conduct/performance.

**action plan** - a timetable of agreed tasks designed to address a specific set of problems; in the context of an inspection, designed to respond to its recommendations.

**acute** (of an illness) - short term, coming sharply to a crisis.

**Agenda for Change** - a new pay system for NHS staff introduced in December 2004. Under Agenda for Change basic pay is determined by using a new NHS job evaluation scheme which is designed to ensure equal pay for work of equal value.

**appraisal** (of staff) – an assessment of the extent to which a persons performance meets the standards or objectives required of her/his post.

**audit** - originally applied to assessment of the accuracy and probity of financial accounting; now extended to cover any assessment activity which sets out to assess the extent to which a product/outcome matches the criteria set.

**benchmarking** - comparison of practice or performance with that of others, with the purpose of identifying and emulating best practice.

**cardiac, cardiology** - to do with the heart, the branch of medicine concerned with the heart and it's diseases.

**care pathway** - a defined set of treatment and care steps designed to meet the particular need of each patient.

**carers** - people who look after their relatives and friends for no pay, often in place of a nurse.

**clinical audit** - evaluation and measurement by health professionals of how far they are meeting standards that have been set for their service. Standards may be set by health professional's themselves or others.

**clinical director** - the clinician who is accountable for clinical and sometimes management elements of service delivery.

**clinical effectiveness** - the degree to which a treatment achieves the health improvement for a patient that it is designed to achieve.

**clinical governance** - a “framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish” (Welsh Office: ‘Quality Care and Clinical excellence’).

**clinical incident** - an event which occurs in a hospital or in community health services from which actual or potential harm may have been experienced by patients or the public.

**clinical information** – (1) information about treatments given to a patient by a health professional (2) information about clinical practice collected by an organisation for management purposes.

**clinical outcome** - the impact effect of a treatment on the health or well being of an individual.

**clinical risk** - risks associated with various health care treatments.

**clinical risk management** – the systematic assessment and subsequent protective actions undertaken to understand the various levels of risk attached to each form of treatment and ensure that those risks are minimised.

**clinician/clinical staff** - a fully trained health professional – doctor, nurse, therapist, technician etc.

**clinical supervision** - a formal process of professional support and learning which enables individual practitioners to develop practice and enhance patient protection and safety of care in complex clinical situations.

**commissioning** - the process of identifying local health needs, drawing up plans with strategic partners to meet those needs, identifying appropriate health services and making agreements with health service providers to ensure that services are delivered.

**Commission for Health Improvement (CHI)** – a predecessor public body for the Healthcare Commission. Until 2005 it was responsible for inspection of health service bodies in England and Wales.

**Community Health Council (CHC)** - not-for-profit, community-based health promotion, advocacy and policy organisations. CHCs were established in 1992. They were set up to strengthen community participation in defining state and local policy that impacts healthcare access and quality. CHCs represent the public interest in the NHS and have a statutory right to be consulted on health service changes in their area.

**consent** - permission, granted by a patient (or, in the case of minors, a parent or guardian) to allow a health treatment, examination or investigation to be undertaken.

**Continuing Professional Development (CPD)** - a continuing learning process that complements formal undergraduate and postgraduate education and training.

**dialysis** – is an artificial process in which waste products and unwanted waters are removed from the blood.

**Emergency Medical Services (EMS)** – the branch of an ambulance service responding to emergency calls from the public and urgent GP requests.

**expert patients** - people living with a long-term health condition, who are able to take more control over their health by understanding and managing their conditions, leading to an improved quality of life.

**freedom of information** – the right of individuals to access information held by public bodies, subject to some exceptions. The rights are set out in the Freedom of Information Act 2000.

**Health Commission Wales (HCW)** – an executive agency of the Welsh Assembly, responsible for commissioning specialist health services for the people of Wales.

**Information Management and Technology (IM&T)** - the structures and systems through which an organisation manages data, information and knowledge to address the challenges it faces in providing services and ensure high quality outcomes.

**incident reporting system** - arrangements through which critical incidents are recorded and brought to the attention of managers responsible for their elimination or reduction.

**infection control** - a set of procedures to prevent the spread of infection, which will include, for example, washing of hands, use of sterile equipment etc.

**Knowledge and Skills Framework (KSF)** - a directory of knowledge and skills required by posts in the NHS. The KSF is a valuable tool which helps identify the need for training and development to ensure an individual is fully developed in their post. It also helps individuals map how they might progress in their career.

**Locality Ambulance Officer (LAO)** – local manager responsible for delivery of WAST services.

**Local Health Boards (LHB)** - statutory bodies responsible for implementing strategies to improve the health of the local population, securing and providing primary & community health care services and securing secondary care services.

**medical director** - the term usually used for a doctor at trust board level responsible for all issues relating to doctors and concerning medical and surgical issues within the trust.

**myocardial infarction (MI)** – a blood clot is formed in the arteries, which restrict the oxygen to pass through the heart, and eventually causes a heart attack.

**National Health Service (NHS) Trusts** - a self-governing body within the NHS, which provides health care services. Trusts employ a full range of health care professionals including doctors, nurses, dieticians, physiotherapists etc. Acute trusts provide medical and surgical services usually in hospital(s). Community trusts provide local health services, usually in the community, e.g. district nurses, chiropodists etc. Combined trusts provide both community and acute trust services under one management.

**national indicators** - statistics recorded by the Department of Health / Welsh Assembly Government on a range of specific treatments to allow comparison and measurement of NHS organisations.

**National Institute for Health and Clinical Excellence (NICE)** - a special health authority producing guidance for the NHS and patients on medicines, medical equipment and clinical procedures.

**National Service Framework (NSF)** - guidelines for the health service on how to manage and treat specific types of disease and illness.

**no blame culture** – a culture promoted within an organisation to create a learning environment in which staff feel comfortable about saying when things have gone wrong because they know they will not be blamed for their error, but instead will be encouraged to learn and prevent a recurrence.

**outcome** - the result of a treatment, service or prevention programme.

**patient involvement** - the amount of participation that a patient can have in her/his care or treatment. It is often used to describe how patients can change, or have a say in the way that a service is provided or planned.

**Patient Clinical Record (PCR)** – the record completed by ambulance crews setting the condition of the patient and treatment provided. In other UK ambulance Trusts, this is more usually referred to as the Patient Record Form (PRF).

**Patient Care Services (PCS)** – this term is used by WAST for services which elsewhere in the UK are known as patient transport services. This is the branch of an ambulance service which provides transport to outpatient clinics, day treatment centres etc.

**performance management** - the use of a review process, focusing on standards and objectives, to assess how well a person, team or service is working.

**performance monitoring** – a system which routinely collects and analyses how well a particular service or procedure meets targets or standards.

**primary care** - family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

**resuscitation** - a range of procedures used when someone has suddenly become seriously ill in a way that threatens their life.

**risk assessment** - an examination of the risks associated with a particular service or procedure.

**return of spontaneous circulation (ROSC)** – a term used to denote the regaining of heart function following an intervention with a patient who has suffered cardiac arrest.

**secondary care** - specialist health care, usually provided in hospital, after a referral from a GP or health professional.

**Service and Financial Framework (SaFF)** - the agreements between the Welsh Assembly Government and NHS organisations that form part of the performance management arrangements between these bodies.

**stakeholders** - a range of people and organisations that are affected by, or have an interest in, the services offered by an organisation, In relation to health services includes, for example: patients, carers, staff, unions, voluntary organisations, Community Health Councils, social services.

**tertiary care** - services provided by specialised hospitals or departments that are often linked to medical schools or teaching hospitals. They treat patients with complex conditions who have usually been referred by other hospitals or specialist doctors

**thrombolysis** – is the breakdown of a blood clot within an artery or a vein through medical treatment.

**Trust board** - a group of people who are by statute responsible for major strategy and policy decisions in each NHS trust. Typically comprises a lay chairman, five lay members, the trust chief executive and executive directors.

**Welsh Ambulance Services NHS Trust (WAST)** – The Trust responsible for the provision of the whole range of ambulance services for Wales.

**Wales Audit Office (WAO)** – The office of the Auditor General for Wales responsible for a wide range of financial audit, value for money and other reviews in respect for all public services in Wales.

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