Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

[redacted]

Swyddfa'r Prif Weithredwr a'r Cadeirydd

Chair and Chief Executive's Office

[redacted]

8 August 2022

Private & Confidential
Ms C Saunders
Senior Coroner for Gwent
[redacted]

Dear Ms Saunders

Re: Mr Gwynne Samuel

I write in response to the Prevention of Future Deaths Report issued to this Trust on 17 June 2022, following the inquest in relation to Gwynne Samuel.

You asked that the Trust to consider two specific issues:

1) **Confirmation whether the effect of long lies in elderly patients is understood and taken into account during the categorisation process.**

Each ambulance service has a response model that supports the categorisation given to each call (irrespective of which prioritisation system is used). That response model and the decisions made will reflect the demographics of the population and the geography being served by that individual ambulance service. In 2015 the Welsh Ambulance Services NHS Trust introduced its current Clinical Response Model (the Model), which removed timed targets for all but those patients with immediately life-threatening illnesses or injuries. The Model underwent a trial period before being approved by the Welsh Government and fully implemented by the Trust.

The appropriateness of the priority given to each category of call is reviewed and changes are considered by the Trust's Clinical Priority Software Advisory Group (CPAS). In all cases the group will consider the impact any change would have on the volume of each priority of calls received, for example the effect of increasing the number of Red calls would have an impact on

all other codes. The CPAS group also sets an “ideal” response for each type of call, in an attempt to maximise efficient use of resources by avoiding “double dispatch” on calls.

The Medical Prioritisation Dispatch System (MPDS) does not provide a determinant code based on age within Protocol 17 (falls) which would prevent a specific prioritisation change for elderly patients. The principal role of the Clinical Support Desk (CSD) Clinician is to provide additional clinical triage, advice and support to patients to ensure that they can access the most clinically appropriate care for their urgent and emergency healthcare needs, commonly known as Hear and Treat (H&T). In addition to this principal role, the CSD also undertake a range of other clinical functions in pursuance of maximising patient safety for those awaiting an emergency ambulance. This includes reviewing long waiting patients to maintain patient safety. CSD clinicians have the ability to change the responding priority of an incident based on a secondary clinical assessment, this includes increasing the priority where the patient’s clinical acuity indicates this is appropriate. Dispatch guidelines regarding falls and frailty responders are continually reviewed and updated to ensure maximum utilisation of this valuable resource, part of the CSD role is to provide support to falls assistants following an initial assessment to ensure the correct outcome is reached.

The categorisation of elderly patients who suffer falls and are more likely to be affected by the risks associated with lengthy periods of immobility, will be referred to the Trust’s Clinical Priority Software Advisory Group.

Additionally, in 2018, Working in partnership with St John Cymru Wales, the Trust introduced the role of the Falls Assistants (FA). The FA predominately provide a response to patients who have no injuries or where there is a concern for welfare. However, they are able to respond to patients with other medical/frailty presentations, or if this is an injury. This decision will often be supported by a clinical triage and assessment by a clinician, over the phone, prior to allocation. The aim of this new level of response was to ensure those patients often presenting with lower clinical acuity, were provided with a timely response to reduce the risk of further harm.

Within 2021, the Trust successfully awarded a contract to provide a National Falls Assistant Service with at least one Falls Assistant (for 12 hours per day) in each Health Board area, to St John Cymru Wales. A total of eight Falls Assistants operate by day. The Quality Improvement Team are currently working with various stakeholders both internally and externally to further enhance the Falls Assistant provision. This includes the Operations and Clinical/Medical Directorate along with Health Board Partners. We have introduced a further two vehicles by night (funded by WAST) which is currently funded up to and including the 31st March 2023. There are a total of 10 Falls Assistants available per 24 hour period across Wales.

Aneurin Bevan University Health Board and Gwent Regional Partnership Board, continues to fund a Falls Response Service (Paramedic and Therapist) vehicle which operates daily (08.00-20.00hrs). Additionally Betsi Cadwaladr University Health Board and the North Wales Regional Partnership Board, are currently funding two Falls Response Services teams, which operate on weekdays within the East and Central areas. In addition to the specialist falls response, the Trust are working with volunteers (community first responders) and Fire and Rescue Services to provide a designated response to patients who have fallen to ensure periods of immobility are reduced. Enhanced Clinical Desk capacity has been introduced with the Clinical Contact Centre, which ensures patients receive targeted advice when waiting for a response including advice in relation to pressure ulcers and reducing the period of immobility. This is provided as part of the telephone triage and assessment.

The Trust continues to work with partners to further expand the model, to ensure patients are able to receive a timely response. In December 2021 the Trust undertook a review of the Medical Priority Dispatch System (MPDS) codes for Falls to determine if there were opportunities to improve the timeliness of response. Following a review, four codes were identified as suitable for Falls Assistants (non-registered, in some areas St John Service) to attend without the need for Clinical Triage, thus reducing the requirement to send an Emergency Ambulance. Furthermore, improvements are actively being considered to improve utilisation of resources and support patients who are waiting for a response. A Quality Improvement Workshop has been prioritised for August 2022, with representatives from across the organisation to identify tests of change and prioritise improvements. This has been delayed due to high levels of escalation within the organisation. However, it will be essential to seek opportunities to increase the levels of utlisation of falls resources, ensuring we are able to maximise response capacity across Wales. The newly formed Older Persons Improvement Group (OPIG), will conduct a review of the guidance provided to patients following a fall, consider the risks associated immobility and will suggest possible improvements, as part of the newly formed group, due to meet in August 2022.

Currently long lie falls calls are reviewed by CSD and upgraded as and when appropriate.

The recent update to ProQA (the system for monitoring data within MPDS) released on 10th May 2022 has split the MPDS code suffix relating to falls on the ground or floor and added time targets as below:

- On the ground floor < less than an hour or unknown
- On the ground/floor 1-2 hours
- On the ground/floor > 2hours

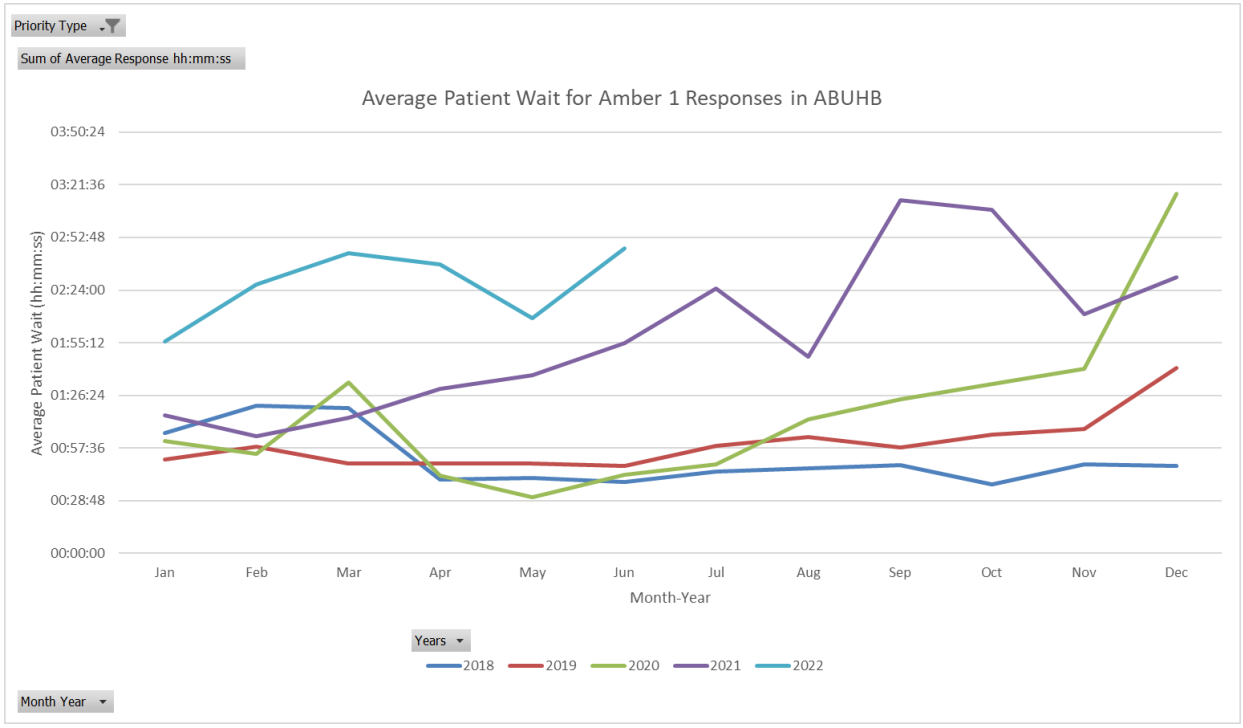
There have been discussions at the National Ambulance Service Medical Executive Directors Group (NASMED) as to whether there should be further MPDS code suffixes for falls longer than two hours. NASMED has also highlighted the issue relating to calls just inside a time target window and calls where there is no further contact as the call does not automatically change if the call falls outside the MPDS code suffix window therefore there will be some patients disadvantaged for not calling back.

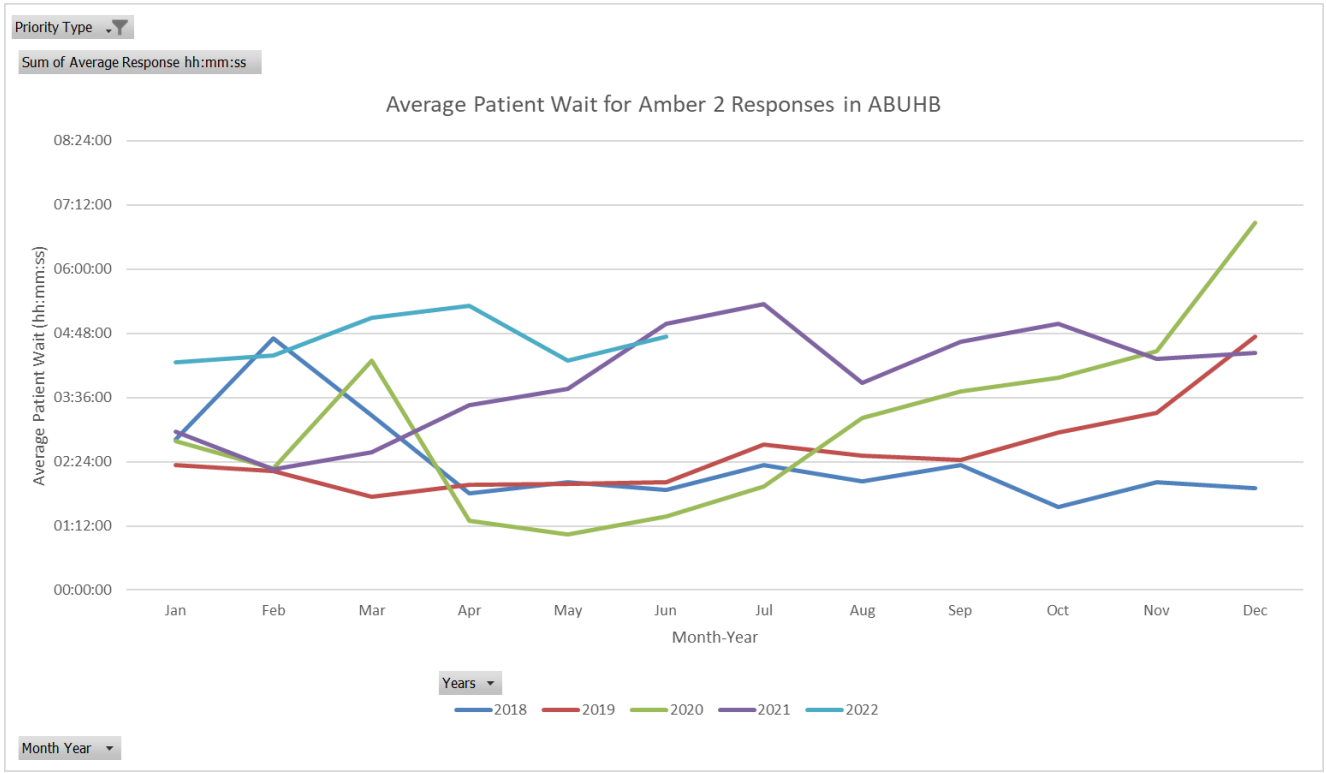
For this reason, the Trusts CPAS has agreed to prioritise the three variations the same initially as the original categorisation of the code – on the ground or floor and monitor data and further updates from NASMED. The rational for this decision is that due to current demand pressures it is unlikely the Trust will be in a position to send a response or do something differently in the time targets allocated to the each MPDS code suffix. This decision is subject to review and change based on further updates from NASMED. The Older Persons Improvement Group, will review data from the new MPDS code and suffix to consider recommendations to CPAS in relation to whether there would be a benefit to different priorities being assigned to codes, due to less than 1 hour, 1-2 hours or over 2 hours. This will need to be balanced and proportionate in respect to other clinical presentations.

To provide you with absolute assurance, the Trust is aware of the risks and the impact that delays in care and treatment can have on patient outcomes. This is not the level of service that we want to provide for the people in Wales. I hope that this response as provided you with a level of assurance that we as an organisation are doing everything in our control to reduce the level of risk, harm and the impact that the system pressures is having on patients in our communities.

2) Confirmation of the current waiting times for Amber 1 and Amber 2 responses and any plans in place to improve responsiveness.

The average response times to Amber 1 calls in the Aneurin Bevin University Health Board area is currently 2 hours, 29 minutes and 15 seconds. With response time to Amber 2 calls in the same area being 4 hours, 36 minutes and 9 seconds.
Below are graphs which illustrate the response times to Amber 1 and Amber 2 calls in the Health Board area over the past 54 full years, along with this year to date.





The Trust is the national all Wales provider of 999 and Emergency Medical Services (EMS); 111 urgent remote clinical advice and Non-Emergency Patient Transport Services (NEPTS) with a workforce of over 4000 and operating a fleet of over 700 vehicles from more than 100 premises nationwide. The Trust annual revenue turnover is more than £260m. During the pandemic the Trust has also nationally operated mobile COVID testing units.

The Trust welcomes the opportunity to provide this response, which outlines the circumstances and nature of the Service's current operating context, the factors which have contributed to current pressures and the efforts the Service is making to alleviate those pressures.

The issues outlined in this document are evidenced in the supporting data/information pack (Appendix 1).

In providing this response the Trust Board acknowledges that H.M Coroners across Wales have, over several years, recorded Prevention of Future Deaths reports and other recommendations in respect of health services in Wales, including the Welsh Ambulance Service (the Trust).

Such recommendations are taken extremely seriously by the Board. In spite of the efforts made, there is an acknowledgement that progress in stabilising and improving ambulance service response times across has not been as rapid, or as effective, as would have been wished.

This response sets out several key issues which have served to adversely affect the Trust's performance in recent years, including during the Covid-19 pandemic, and particularly in the first half of the 2022 calendar year.

It also sets out the steps taken to improve matters so far and the likely position moving forward.

Background

The Trust is commissioned by the seven local health boards (LHBs) in Wales via the Emergency Ambulance Services Committee (EASC).

The Committee is formed by the Chief Executives of the seven LHBs and presided over by an independent Chairperson appointed by the Health Minister. EASC has appointed a Chief Ambulance Services Commissioner (CASC) to undertake a lead role in supporting the local health boards in commissioning emergency ambulance services from the Trust within the context of the wider unscheduled care system (and, from 2016, Non-Emergency Patient Transport Services in Wales).

The arrangements effectively create a commissioner/provider relationship in which the seven LHBs are collectively responsible for securing the provision of an effective emergency ambulance service for Wales. The Trust, therefore, is responsible for supplying the urgent and emergency medical services that the LHBs require, based on a commissioning framework.

Commissioners set commissioning intentions on an annual basis reflecting the service standards and operational performance developments they expect to see.

The Trust finances flow largely via EASC, with further monies coming either directly from Welsh Government or individual health boards, where they choose to commission additionality for their populations.

Since October 2015, the Trust's clinical response model has been predicated on clinical outcome rather than target response time, save for its one formal target of responding in eight minutes to

65% (nationally) of calls which fall into the RED category, namely those which are categorised as immediately life threatening.

Prior to the Covid-19 pandemic, national performance had generally been at or above target since 2015, although decaying performance had started to become apparent more latterly and there were geographic variances in performance that had not been entirely eradicated.

Right-sizing the Organisation

Against that backdrop of a gradual erosion of performance, in 2019 a national *Demand and Capacity Review* was commissioned.

The review, which was led by world leaders in ambulance forecasting and modelling, Operational Research in Health (ORH), and was undertaken collaboratively on behalf of the Emergency Ambulance Services Committee (EASC), was itself an output of the Welsh Government's *Amber Review* published in 2018.

The Demand and Capacity Review was carried out through 2019 and its outcome was formally reported to EASC in January 2020 where all of the recommendations from the review were endorsed.

One of the main findings of the Amber Review, was that many patients in the amber category of serious but not immediately life-threatening calls were waiting too long because of challenges relating to ambulance availability.

The Review identified that the Trust had a gap between the number of full time equivalent (FTE) staff funded to fill its response rosters and the number of FTEs required to fill those rosters. This is referred to as the "relief gap".

The ORH concluded that bridging the gap would require an investment of 263 staff on a full time equivalent (FTE) basis across Wales. The Emergency Ambulance Services Committee (EASC) agreed to invest in the Trust, over a two year period – 2020/21 and 2021/22, and close the "relief gap", while it was agreed re-rostering would help improve the alignment and mix of resources allied to patient demand.

Throughout the pandemic, work has continued to recruit the additional staff and progress with the roster review, as key planks in the Trust's response to the need to stabilise and improve performance long term. The Trust delivered an uplift in staff numbers in 2020/21 of 136 FTEs and 127 FTEs in 2021/22 with the final groups of staff concluding their training and becoming operational in Q1 22/23.

In the same time period, the Trust agreed to take steps to reduce abstractions due to sickness absence, to increase 'hear and treat' rates (where patients are triaged and given advice rather than deploying an ambulance) to 10.2% and to implement new rosters across Wales.

The ORH modelled that, with this additional resource in place, the Trust efficiencies delivered and a reduction in hospital handover delays to December 2018 levels, a national red response rate of 67.3% within 8 minutes and an amber 1 mean response time of 34 minutes would be achieved at the end of 21/22.

Performance Pressures
There are several factors in combination which have led to the significant performance pressure under which the Trust now finds itself.

In broad terms, these pressures can be defined as:
a) Increased demand (particularly from the second wave of the pandemic in 2020 onwards)
b) Higher acuity of patient – in part potentially a consequence of delayed presentation because of pandemic
c) Growing levels of workforce absence, both because of the Covid pandemic and more particularly the Omicron/BA2 strains, and, increasingly, because of environmental issues triggered by excessive delays at hospitals – the concept of "moral injury"
d) Excessive delays in the handing over of patients at hospital, a function both of increased demand across the system and of the paucity of social care provision (the reasons for which are many and various), resulting in, at the time of writing, some 1,200 patients remaining in hospital beds across Wales when they are medically fit for discharge. This has led to chronic congestion within the hospital system and very poor patient flow resulting in delayed handover of care to Emergency Department staff upon arrival of an ambulance and thus delays in response in the community.

Nationally in Wales, 999 call volumes have been increasing, and volumes weekly since October 2021 have generally exceeded the levels of demand compared to the previous three years (please see graphs in supporting data pack).

Our forecast is currently one where volume continues to exceed previous levels of 999 demand. Within this demand are repeat callers who use 999 multiple times because of excessive waiting times in the community. We should note that this type of repeat call, often referred to as an Estimated Time of Arrival (ETA) call, is different to those that could be said to be vexatious.

Since 2019, changes have been noted in demand patterns. There has been a notable increase in red demand, which shifts the overall acuity of the calls we receive and puts different pressures on resources. Importantly and generally, more resources per red incident are clinically required compared to other category of calls.

As a result, further collaborative modelling has been undertaken by ORH which has confirmed that this change requires additional response capacity, specifically in terms of single responder / car capacity. No additional funding has been announced at the time of writing for 2022/23 for any further growth in front line response.

In addition, the COVID-19 pandemic has also had a significant impact, changing patterns of demand as the waves have progressed, and changing operational processes (for example the donning and doffing of personal protective equipment) which have impacted on response times and flow.

As a service, it is acknowledged that absence rates are unsustainably high though patterns of increase do have strong correlation to the waves of the pandemic. The pre-existing Managing Attendance Policy for NHS Wales was appropriately adjusted to exclude Covid related absences from management action and at the time of writing these arrangements are expected to conclude on 30 June 2022. Further, and perhaps as a reaction to the unprecedented delays which staff are encountering at hospitals, rates of attendance are improving more slowly than we would ideally like.

Significant investment has been made over recent years in the Trust's health and well-being offer for staff, which is now regarded as sector leading.

This notwithstanding, absence rates remain stubbornly high although these are not out of kilter with other ambulance services across the United Kingdom. As a result, an extensive attendance management improvement plan has been developed with a range of measures aimed at improving attendance and supporting our people back to work.
However, the "moral injury" reported by staff remains equally high, as the environmental stress of working under sustained and relentless pressure takes its toll.

Much of that "moral injury" is derived from the excessive handover delays at hospitals being experienced over very extended periods.

With the entire health and care system under pressure and chronic congestion in hospitals, April saw some 30% of the national emergency ambulance capacity (Emergency Ambulance and Urgent Care Ambulance able to transport a patient) rostered to work lost and unable to respond to emergency calls as a result of delayed handover of care at hospitals.

This results in several things: extremely poor patient and staff experience; extended waits in the community which result, regrettably, in some patients coming to harm; staff frustration leading to increased absence from work and diminished public and stakeholder confidence in the service.

It is also recognised that there may be opportunities within some of the legacy operating practices for efficiency such as time lost by the Trust's own crews (post-production lost hours), for example when they return to base for meal-breaks. However, it should be noted that on average this takes 18.5 minutes on each occasion a crew returns to station for a rest break which given our extended geography doesn't present as unreasonable.

The Trust has been working closely with its trade unions on this, and all of the issues outlined in this response, to ensure solutions are identified and delivered in partnership.

Data specific to the Aneurin Bevan University (ABU) Health Board area are included in the data pack, but generally the data for ABU is consistent with the all-Wales picture in respect of growing demand, excessive handover delay, acuity, and absence.

Patient Safety
It is a sad fact that the cumulative effect of the performance pressures outlined above has a detrimental impact on patient safety.

There is recognition across the United Kingdom that hospital handover delays cause direct and indirect patient harm and a poor-quality service. A recent structured clinical review of handover delays England wide was commissioned by the Association of Ambulance Chief Executives and published in November 2021. This review highlighted that 8 out of 10 patients waiting over one hour were assessed as experiencing some level of harm, with just less than 1 out of 10 patients classified as experiencing severe harm. Welsh Ambulance Service NHS Trust –AACE report on hospital handover delays: Statement from the Chief Executive (wales.nhs.uk)

The Trust has an incident reporting and investigation process in place, aligned to the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. A multidisciplinary panel meets at least weekly to review all patient safety incidents assessed as potentially causing serious or catastrophic harm. Internal investigations are undertaken to

identify learning opportunities and improvement actions are subsequently developed and implemented.

The Trust is recognised by Health Inspectorate Wales as having a strong culture of reporting harm, with serious adverse incidents (SAIs) being reviewed both via the Trust's Serious Case Incident Forum (SCIF) and being reported nationally to Welsh Government.
A significant proportion of SAIs are also shared by the Trust with health boards for joint investigation, particularly where handover delays/long community waits are deemed to be a pertinent factor in the outcome for the patient and/or their poor experience. Where an emergency department handover delay is considered a primary causation of a SAI/National Reportable Incidents (NRI), the details of the incidents are provided to the Health Board using an agreed transfer process known as 'Appendix B'.

During 2021 the NHS Wales Delivery Unit undertook an analysis of 'Appendix B' reports, submitted by the Trust to the Health Boards. The analysis focused on identifying any trends or themes of potential patient harm caused by the Trust's inability to respond to calls due to NHS Wales system pressures. Finding from the analysis included:

a) 'The most common contributory factor detailed in the Appendix B is handover delays, where WAST resources are delayed in handing over patients upon at hospital sites in keeping with nationally agreed handover timescales'.
b) 'Given that in 71 (84%) of cases the outcome has been death, with the vast majority of these deaths occurring prior to WAST, the data indicates that the window of opportunity to provide medical assistance to seriously unwell patients in the community, classed as Amber 1 calls, is being routinely missed, and likely on the balance of probability to be a causative factor in the timing of patients death, given they were alive at the initial call but deceased upon arrival 6.5 hours later (on average)'.

Similarly, all Health Boards receive quarterly reports on quality and safety incidents as they relate to their areas and populations, for whom they have population health responsibility.

At the time of writing, the issue of patient safety is very high on the Board's agenda, with its committees considering in May 2022 a number of papers evidencing harm and expressing their concern about the safety of patients in the current operating climate.

It is the risk to patient safety which is the Trust's key driver in redoubling its efforts with Welsh Government, commissioners and other stakeholders to drive real improvements at pace.

Healthcare Inspectorate Wales (HIW) undertook an inspection of the Trust and published their report 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' which covered 1 April 2020 and 31 March 2021. The inspection covered all Emergency Departments (ED) across Wales. Recommendations from the report include:

a) Health Boards and Welsh Government should consider what further actions are required to make improvements regarding the patient flow issues impacting on delayed patient handover. This may include consideration of whether a different approach is required by the Trust, Health Boards, and social care services within Wales, to that taken to date in tackling this system-wide problem.
b) Health Boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process the handover of patients from ambulances.

c) Health Boards must ensure that appropriate representation is present at the Trust's Serious Clinical Incident Forum meetings, to aid with the timely management of concerns and service improvement.

Following publication of the Report the Emergency Ambulance Services Committee (EASC) recently set up a task and finish group chaired by the Deputy Chief Ambulance Services Commissioner to respond to the recommendations. The membership of the group is determined locally but should as a minimum consist of clinical and operational representatives from each of the 7 Health Boards. Membership also includes representatives from the Trust and Welsh Government.

Addressing the Issues

It is fully acknowledged that the issues confronting the health and care system are not easily resolved.

That said, the safety of patients is, at differing points, compromised because of system pressures and the Board of the Welsh Ambulance Service recognises that this is unacceptable.

As a result, a number of actions have been put into place to try and mitigate risks to patients, with variable levels of success, while wider system and governmental conversations are now in an acute phase at the time of writing following escalation by me and other senior officers at the Trust.

Detailed below is a brief overview of the actions which have been taken, or proposed to commissioners, by the Trust, in a bid to alleviate the current pressures.

Resource Escalation Action Plan (REAP)

The aim of this plan is to describe the arrangements in place to be considered by the Trust in response to a strategic or dynamic assessment of pressures affecting or likely to affect service delivery. The plan sets out a set of triggers based on various metrics that will identify pressure on service delivery and act as a guide to support decision-making. It outlines a categorisation of pressure on a scale of 1 to 4 with associated actions for consideration. This categorisation is considered and set weekly by a group of senior operations managers. Given many of the actions that can be taken within REAP take some days to take effect this plan is designed to be a proactive forward looking tool to be used for short periods of additional pressure regardless of cause. It is not designed for sustained long term or permanent use at high levels of escalation. A copy of the plan appears as Appendix 2 to this statement.

Clinical Safety Plan

The Clinical Safety Plan (CSP) provides a framework for the Trust to respond to situations where the demand for services is greater than the available resources. It recognises that causes can be multifaceted impacting either demand for services, the capacity to respond to demand, or both.

The CSP provides a set of tactical options that are flexible and immediate so that the Trust can dynamically react to situations to ensure those patients with the most serious conditions or in greatest need according to their presentation remain prioritised to receive services.

At its core, it achieves this by introducing a principle of ‘can’t send’ so that available capacity when it is constrained can be targeted at those who need it the most, which results in some callers being advised that an ambulance is not available to respond.

The level of CSP is constantly monitored, and decisions to escalate to higher levels are made by the Strategic Commander and depending on the level are supported through clinical and executive consultation. A copy of the plan appears as Appendix 3 to this statement.

Seasonal planning including forecasting
As well as utilising the services of ORH in longer term demand and capacity modelling, the Trust also commissions services from Optima who use simulation models which can predict output performance based on a range of input assumptions.

Through the pandemic period, the Trust has worked hard to improve its shorter term forecasting, and has produced quarterly reports which set out what performance is likely to be, given a series of assumptions around demand and available capacity. The accuracy of these reports has been good, and they have been used within the Trust and in discussions with commissioners, to develop mitigating action plans where performance is forecast to be below that required.

Additional Capacity

Throughout the period of the pandemic, additional Urgent Care Service capacity has been provided through an agreement with St John Ambulance Cymru. This has been financially supported by our commissioners wherever possible and concluded at the end of March 2022 without ongoing financial support.

To further mitigate the risk significant hospital delays are causing the service, cohorting crews provided by a private provider are being used to care for patients delayed outside Morriston and the Grange Hospitals while specific funding remains available.

During the periods of extended hospital handover delay that the Trust is experiencing, this initiative enables frontline crews to offload patients to appropriate clinicians in order for vehicles to be available and respond to waiting calls in the community, and ensuring that patients receive a more timely response which results in reduced patient safety incidents and improved patient experience.

The initiative has positive impacts on staff morale, reducing the amount of hours that crews queue outside hospitals and the subsequent well-being concerns that this entails. We have not, however, been in a position to deploy such an approach in North Wales, as a result of lack of suitable accommodation and financial availability.

Voluntary overtime remains available for all operational/clinical staff across the Trust without financial restriction and whilst uptake has reduced in recent months, largely as a result of the current workplace experience, we continue to see in excess of 5,000 hours per week being worked. Controls to restrict the overall spend on overtime may need to be introduced as the year proceeds should the financial position require it.

Roster review

The roster review, as agreed as part of the Demand and Capacity Review, has been progressing well. The review is being supported by an external company, Working Time Solutions (WTS), who are experienced in these reviews across other ambulance services, other public sectors

and industry. The work has progressed through a series of four working parties in each local area, attended by front line staff, managers, resource team and trade union partners.

The four working parties have now concluded, and it is anticipated that the new rosters will be implemented between September and November 2022. As outlined above, by aligning rosters more closely with demand patterns, this will have the equivalent impact of an increase of 72 WTE.

The roster review process was paused in 2021/22 whilst additional modelling was undertaken to understand the impact of the increases in red demand and a further decay in emergency department handover lost hours. The outcome of that modelling was that further single staffed car capacity was required, totalling 90 WTE additional staff, and this has now been built into the new rosters. Commissioners have agreed that the modelling is correct, but no additional resources have so far been made available for 2022/23, which means that the new rosters will initially operate with an inbuilt relief gap.

Roster Review Project – ABUHB

Funded FTE Increase (closing the relief gap)	53.58
Unfunded FTR Increase (CHARU)	30.84
Gross % Increase in Front Line Establishment (funded and unfunded)	27%
Net % Increase in Front Line Establishment (funded)	20%

Escalation

WAST Operational Delivery Unit

The Operational Delivery Unit (ODU) acts as a central hub providing coordination for the Welsh Unscheduled Care System with a link between the Trust, Welsh Government, and all the Health Boards through a system-wide view.

The purpose of the ODU is to keep the unscheduled care system in Wales flowing by supporting existing internal and external operational management arrangements. It provides a management overview of the Trust and broader unscheduled care system delivery by monitoring and reacting to real time performance inhibitors that challenge timely and effective patient care.

The ODU currently has four main areas of focus to achieve this purpose; to maintain pan-Wales situational awareness, to consider performance, limit post-production lost hours and plan for the upcoming 24 hours.

Alongside the four areas of focus, the ODU has three main objectives to ensure system wide performance.

a) *Pre-empt:* Identify and analyse potential risks and issues over the next 24hours and current trends

b) *Mitigate:* With the aid of local teams, develop actions to mitigate or negate any identified risks/issues

c) *React:* Dynamically react to situations as they unfold and take decisions on whether to react

System and Peer Groups

The leadership team of the Trust has taken every opportunity to escalate concerns across the system over a period of months
.
Professional leads, peer groups, and government have been apprised of the risks, harms and challenges in various forums in addition to formal reports and correspondence, while commissioners have been presented with the same and a currently unsupported Transition Plan (see below) to try and ameliorate the worst of the performance issues and attendant harms.
The Trust also uses regular media and stakeholder briefings to explain the issues, both to encourage appropriate use of urgent and emergency healthcare by patients while ensuring stakeholders are sighted on the issues and what is being done to mitigate harms and improve performance.

Similarly, partnership groups, including Regional Partnership Boards where the Trust is a member, have been apprised of the issues and early conversations with local authorities in particular are progressing (subject to capacity constraints on both sides) to identify collaborative opportunities to reduce conveyance and improve the experience of patients.

Transition Plan

The Trust is committed to doing all that it can to reduce clinical risk, improve patient care and outcomes, ensuring that patients get the right service, in the right place, every time. The data in support of this statement shows that there is much more to do, with some actions within the Trust's control, and many which are outside of its control.

As a result of concerns about clinical risk and patients coming to harm, the Trust developed a Transition Plan, which was submitted to commissioners in December 2021. In essence, this plan was a bid for investment, as well as setting out the actions to be taken within the Trust to continue to improve efficiency and to transform its delivery model.

The case proposed additional investment to increase front line capacity by around 300 FTE across the Emergency Medical Service (EMS), including advanced practice paramedics (APPs). The proposed investment, building on previous investment, together with the delivery of a series of changes and efficiency improvements commenced over the last two years, would provide a range of significant benefits:

a) an increased capacity and resilience in our core service to meet the needs of the population of Wales in a safe and timely way, improving outcomes for patients and reducing clinical risk and harm;
b) an improvement in the working lives of our frontline staff, alleviating the causes of stress and sickness and further improving our ability to provide the required capacity;
c) a transition away from the traditional model of ambulance services, towards a transformed state in which patients are increasingly treated at or near home, avoiding unnecessary conveyance to an Emergency Department (ED), improving patient outcomes, and relieving pressure within the urgent and emergency care system;
d) a realignment of resources, ensuring that their value is maximised in the most effective and efficient way to meet patient needs.

Significant pressures within the 999 service in the last 12 months have led to very poor patient experience and outcomes, with response times lengthening for all categories of patients, and too many patients coming to serious harm as a result.

The Trust has also had to deploy its Clinical Safety Plan more often than it would want, and at times, has been unable to send any ambulance response to patients in lower acuity categories, adding risk to patients and to other parts of the urgent and emergency care system.

Despite the proposals being put forward by the Trust, to-date the Transition Plan remains unfunded although, at the time of writing, discussions continue with commissioners and government.

Closing Observations

The pressure facing the Welsh Ambulance Service and the wider health and care system are sustained, extreme, and not new. They are issues which have been evident for far too many years.

The recent pandemic and its impact has thrown into sharp relief the fragility of that system and, with competing priorities around urgent, unscheduled and planned care, health boards and government are having to manage multiple issues at a time when there is limited capacity, energy and resources to drive forward solutions in the quantum required to make a sufficiently significant impact.

All partners, whether in health or social care, recognise that something needs to be done differently, and all acknowledge that patients/clients are the net losers in the currently overheated system.

As an ambulance service, we recognise that there are issues within our gift to resolve (e.g. attendance, post production lost hours) and there are tangible plans in place to address these.

All these actions, the quantum of which remain insufficient to offset system wide inefficiencies, at best demonstrate that the Trust has considered every possible way in which we can react to and mitigate the impact of these pressures, which are fundamentally outside of our control.

Taken together, the Trust Board believes the organisation has taken all possible steps to manage and mitigate the impact of acute system pressures, including those which are beyond our control but impact on our ability to respond in a timely way or provide patients with the experience they have a right to expect.

However, there are no easy answers. The key issue will be the pace and urgency with which the system can respond to the matters at hand, recognising that, following repeated WAST escalation, this is now starting to gain traction.

While significant collaborative work continues to be undertaken on these issues, there is little that the ambulance service can fundamentally do to insist on discrete actions, beyond lobbying and highlighting the very significant patient safety concerns which arise, particularly from extended waits outside hospitals, which inevitably also result in excessive waits for those patients awaiting help in the community.

Similarly, the role of Welsh Government will be considerable both in terms of resourcing and policy direction if we are to see the real and tangible shifts away from a hospital and conveyance

model of care, to one which really focuses on upstream and community-based models of integrated care.

The Trust will continue to press for real systemic change at every opportunity and continues to do its very best to deliver a consistent service at a time of significant societal difficulty.

To conclude, our response to Mr Samuel was not the level of service that we want to provide for the people in Wales. I hope that this response has provided you with a level of assurance that we, as an organisation, are doing everything in our control to reduce the level of risk, harm and the impact that the system pressures are having on patients in our communities.

Whilst writing I would like to extend my sincere condolences to Mr Samuel's family on their sad loss. I would also like to extend the offer to meet with you to discuss our response in more detail and provide you with any further assurance you may require regarding our commitment to continual improvement to support the prevention of future deaths.

Yours sincerely

Chief Executive

Encl: Action Plan
Appendix 1 – 3