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Ambulance Services in Wales

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Report presented by the Auditor General for Wales to the National Assembly on 4 December 2006

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Foreword by the Auditor General for Wales

The long standing problems of the ambulance service in Wales can be resolved – over time. The draft modernisation plan of the Welsh Ambulance Services Trust Board addresses all the crucial challenges that need to be faced to turn the service round. Successful delivery of that plan in both the short and longer term will be fundamental to establishing an efficient and effective ambulance service for Wales, and will also address those of my recommendations that fall to the Trust for action.

The Trust needs leadership and strategic direction and to address detailed matters of internal efficiency. A particular challenge will be to find ways to improve the match between supply of ambulance services in each area of Wales and the demand for them throughout the day, and to establish what changes to working practices are needed to achieve that.

The ambulance service is not a self contained operation and must be seen as an integral part of the way the NHS delivers clinical services to patients. Effective management of the ambulance service therefore includes effective management of its external relationships. Major external challenges that need to be faced include accommodating changing demand for ambulance services arising from reconfiguration of NHS services, ineffective interfaces with other NHS systems and developing effective partnerships.

There are grounds for optimism about the ability of the ambulance service to meet all these challenges over time because despite the much talked-of problems it has some very important strengths. The current level of funding for day to day operations (as distinct from capital investment) is adequate. Other strengths include the quality of front-line ambulance staff, public goodwill towards the service, the national structure and the emerging modernisation of ambulance and unscheduled care services across the UK.

In addition, things have already started to change within the Trust, with particular progress in respect of internal governance. It is also important to note that the Trust's co-operation with the WAO team during this Inquiry has been exemplary throughout - I am most grateful to all who assisted us – and the fact that the Trust's management has made significant progress in the development of the modernisation plan at the same time as dealing with the impact of this inquiry is to their credit.

This report confirms, however, that the problems of the ambulance service in Wales are long standing and deep seated. Its strengths have been let down by problems of strategy, leadership, governance, process, infrastructure and systems, people and culture.

Severe as the problems are, other ambulance services in Britain have been in a similar position and have been able to turn themselves round given time. For that reason I am able to reach an optimistic conclusion about the ultimate prospects for the success of the ambulance service in meeting the needs of the people it serves.

In accordance with the established convention for my reports I have agreed with the Accounting Officer for the Welsh Assembly Government's Department for Health and Social Services and with the Chief Executive of the Trust, as Accountable Officer for that body, that the facts in the report relating to matters for which they have

responsibility are correct and that the balance of their presentation is fair (although they could not, naturally, be expected to confirm the accuracy of evidence from third parties). All of the judgements made and conclusions drawn are mine alone.

The report records some instances of disagreement between parties as to certain matters. Where such disagreement is not central to the conclusions I draw, I have not necessarily sought to resolve it.

I have undertaken this study of ambulance services in Wales under my normal audit powers. The report is therefore, in that sense, a conventional audit report. The circumstances under which I was invited to conduct the study were not conventional, however, and I have been conscious throughout that it was intended to be a substitute for a public inquiry under the Inquiries Act. For that reason, I took the unprecedented step for an Auditor General's report of holding eight public hearings throughout Wales, and in presenting the results of the study I have deliberately set out the evidence much more fully than is usual in my audit reports.

I also depart from convention in acknowledging here my gratitude to the Wales Audit Office team who carried out the very thorough work this inquiry demanded. Their names are given in Appendix 1. The study has been completed in 148 days at a cost to the Wales Audit Office, at the time of writing, of approximately £170,000 (excluding costs incurred in the translation and publication of the report). It is very unlikely that a public inquiry could have delivered as comprehensive a report so economically or so quickly. For example, the public inquiry into the death of Dr David Kelly reported after 6 months (which is unusually rapid for a public inquiry) but at a cost of £1.7 million.

Summary

1 The Welsh Ambulance Services NHS Trust (the Trust) was set up in 1998 through the merger of five predecessor ambulance services. The Trust's Emergency Medical Service (EMS) handles annually some 317,000 emergency calls, attends 269,000 emergency incidents and transports 63,000 urgent patients. Its Patient Care Service (PCS) provides 1.4 million routine patient journeys a year to hospital for those who would otherwise have difficulty getting to and from hospital appointments. The Trust employs nearly 2,500 staff and had an annual turnover of £115 million in 2005/2006. It works closely with the air ambulance charity, which provides three aircraft. The role of ambulance services is changing to a more clinical focus as a provider of mobile primary healthcare, encapsulated in the Welsh Assembly Government's emerging strategy, *Delivering Emergency Care Services* and the Department of Health report in England, *Taking healthcare to the patient*.

2 There has been growing and widespread public concern about recent events in the Trust, in particular:

- **a** its consistent failure to achieve performance targets, particularly in south-east Wales and some rural areas;
- **b** high profile procurement failures such as the procurement of 46 ambulances that were not fully fit for purpose because the Trust did not provide a coherent specification;
- **c** severe managerial instability arising from the absence of the substantive Chief Executive, Mr Don Page, and the appointment and subsequent resignations of two interim Chief Executives, Mr Roger Thayne OBE and Dr Anton van Dellen. A new substantive Chief Executive, Mr Alan Murray, took up post in August 2006;
- **d** a serious adverse incident in patient care services in which a patient died after being delivered to the wrong address; and
- **e** claims by Mr Thayne that 500 lives were lost avoidably as a result of the way that the service operated.

3 As a result of such concerns, on 11 July 2006, the National Assembly for Wales unanimously voted to invite Jeremy Colman, Auditor General for Wales, to lead an Inquiry into ambulance services in Wales. It proposed that the Inquiry should:

- **a** look at the effectiveness of performance standards, staffing issues, financial and resource pressures, together with any other related matters considered relevant; and
- **b** consider the implications for the future and make recommendations accordingly.

4 To address these points, we therefore sought to confirm the nature and extent of perceived problems with the ambulance service. As well as that diagnosis, we focused strongly on the future and the plans being developed by the new Chief Executive to improve ambulance services in Wales. In the spirit of the NHS Concordat, we worked closely with, and drew upon the emerging findings

of, colleagues from Healthcare Inspectorate Wales, who are undertaking a review of clinical governance, patient care services and specific investigative work to assess the claim that 500 lives were avoidably lost each year because of the way the service operates.

5 We concluded that there are longstanding and severe problems throughout the ambulance service but that they could be resolved over time provided that various internal and external challenges are dealt with. The Board's draft modernisation plan sets out a direction which already addresses the key weaknesses we identified. Our work confirmed that the ambulance service's poor performance was more than a matter of not meeting targets, but also could have compromised patient care. Our diagnosis of the reasons for such performance is that the ambulance service's very considerable strengths – including the quality of front-line staff, public goodwill and the emerging modernisation agenda – have been let down by weaknesses in all the key aspects of good business management.

There are longstanding problems with the ambulance service

6 The speed with which ambulance services respond to emergency patients affects their prospects of survival. Consequently, governments in the United Kingdom have set internationally recognised response time targets based on clinical evidence that responding within eight minutes to an emergency call improves patient care. Although there are some differences in the categorisation of emergency calls, the Welsh Assembly Government's current targets are a lower milestone towards achieving the same target as applies in England, which is to achieve an eight minute response to 75 per cent of Category 'A' calls. In Scotland, the target is to achieve a 75 per cent response rate to Category 'A' calls within eight minutes by 2008, with interim milestone targets.

7 The Trust has generally failed to meet its response time targets and to deliver consistent access to emergency ambulance services across Wales. Although performance has increased in most recent years, the Trust

Current Welsh Assembly Government ambulance response targets

To maintain a monthly all-Wales average performance of ambulance services with at least:

a 60 per cent of first responses to Category A' (immediately life threatening calls) arriving within 8 minutes;

b 70 per cent of first responses to Category 'A' (immediately life threatening) calls arriving within 9 minutes; and

c 75 per cent of first responses to Category 'A' (immediately life threatening) calls arriving within 10 minutes; and

d a fully equipped ambulance will respond to all emergency calls to a level of 95 percent within 14, 18 or 21 minutes in urban, rural or sparsely populated areas respectively.

In all geographical areas that fall below the above targets, targets for improved performance will be agreed with the Welsh Assembly Government. There is a performance standard for GP urgent calls, introduced from April 1999, that in 95 per cent of cases, the ambulance should arrive at hospital no more than 15 minutes later than the time agreed by the GP for urgent patients.

Source: Annual Priorities and Planning guidance for the service and financial framework (SaFF) 2005/2006 and 2006/2007, WHC (2006) 019 Balanced Scorecard for NHS Wales 2006/2007, Welsh Assembly Government, and Health Statistics Wales (2005).

has achieved the 60 per cent average in only two months since March 2004 and performance declined during 2005/2006. The Trust has also failed to achieve:

a the nine and ten minute response time targets for Category 'A' calls;

b response targets for a fully-equipped ambulance to respond to all emergency calls in urban, rural and sparsely populated areas;

c contractual performance levels agreed with HCW for each Local Health Board area; and

d response time targets for GP urgent calls, which have declined significantly since 2000/2001.

In the last three financial years, England has achieved an overall response rate of 75 per cent of Category 'A' calls met within eight minutes, although the Department of Health has raised some concerns about data accuracy in 2005/2006, and there have been some differences in emergency call classification between England and Wales since April 2005. For example, in Wales all children under the age of two have been automatically classified as Category 'A'. In Scotland, the percentage of Category 'A' calls receiving a response within eight minutes is similar to the level in Wales, at 58.5 per cent in 2005/2006.

8 The use of averages skews the performance data because it does not show by how much the Trust missed the eight minute target. A small proportion – half of one per cent – of emergency calls between April 2005 and September 2006 received a response of between one and three hours. The national average also masks consistent regional variations, with performance highest in North Wales and lowest in South-East Wales. There are also some areas with extremely low compliance with response time targets, which include Monmouthshire, Powys, Bridgend and the Vale of Glamorgan. Consequently, while the Trust reaches 60 per cent of Category 'A' calls within eight and a half minutes overall, other patients face long waiting times for a response from the service, especially in some rural areas. This has led to some adverse incidents and could have compromised safe patient care, including patients being transported to hospital by other emergency services.

9 Historically, the Trust has consistently, and to a large extent inappropriately, attributed the failure to achieve targets to increases in demand and insufficient funding to accommodate it. While the volume of emergency incidents has increased by 43 per cent between 2000/2001 and 2005/2006, activity in terms of emergency and urgent patient journeys only increased by 2.8 per cent between 2001/2002 and 2005/2006. The Trust's income increased by 73 per cent between 2000/2001 and 2005/2006, while its staffing has also increased by around 27 per cent since the creation of the Trust in 1998. The number of emergency patient journeys has risen at the same time that the number of GP urgent calls has decreased significantly. The scale of increased demand in Wales was consistent with that experienced by rural services in England. The Trust appears to have been slow to develop alternative responses to demand in the same way as rural services in England. The Trust transports a relatively higher proportion of patients to hospital than rural services in England, which adds to the pressure on Accident and Emergency Departments and the ambulance service, and contributes to long turnaround times for ambulance crews.

10 Of course, the most important element of the ambulance service is the clinical care it provides to patients, and it is essential that this is measured alongside response times to give a

balanced assessment of service performance. However, there are problems with the quality of the Trust's clinical data. Roger Thayne, former interim Chief Executive, claimed that 500 lives were avoidably lost each year as a result of the Trust's relatively low performance in a number of interventions. This claim is still being tested by Healthcare Inspectorate Wales (HIW) who will report separately on their findings in due course. HIW's review has, however, found that the Trust is developing the use of pre-hospital thrombolysis - an important clot-busting drug treatment used for some patients experiencing a heart attack - and that by the end of 2006, all paramedics should have been trained. This should improve the relatively low rates of thrombolysis in Wales compared with the average performance of English ambulance services.

The Trust's key strengths have been let down by a wide range of factors

11 The Trust has some key strengths:

- **a** the strategic framework is favourable and the Welsh Assembly Government's emerging strategy, *Delivering Emergency Care Services*, should open up numerous opportunities for the Trust to play a leading role in the development of unscheduled care services and new models of care;
- **b** there are local examples of good practice and innovation;
- **c** there is significant goodwill towards the ambulance service in Wales;
- **d** there is overall structural stability as a national service that has been through the merger process; strategic national commissioning is an advantage and the proposed merger of the Trust and NHS Direct offers significant potential benefits;
- **e** although many people historically, including the Trust, believed that the Trust is under-resourced, we found little evidence to support this. Our analysis suggests that the Trust has relatively high financial and human resources in comparison with other UK ambulance services. However, there are questions about the efficiency with which resources are used and people deployed. Whilst we found that the Trust had a comparable asset base and received comparable capital funding in recent years, there is also evidence that the Trust requires further capital investment to develop its infrastructure; there is significant scope to deliver improved performance from within existing resources, principally by achieving a better match between rostered hours and predicted demand for services; and
- **f** the Trust's staff are highly regarded by the public, and the majority of staff recognise the need and scope for the Trust to modernise, and have practical ideas about how to change things.

12 However, the Trust has been let down by important failures in all the key areas of business management. Although the Board and new Chief Executive are finalising a modernisation plan, there has been a longstanding absence of strategic direction. Although a five year strategy was produced in 2005, this was not supported by any clear plans for implementation, reflecting wider weaknesses in business planning, and the strategy has been superseded by the draft modernisation plan. In addition, key stakeholders – Trust staff, consultants in Accident and Emergency Departments, other emergency services, the public, Community Health Councils and some acute trusts – do not think that the Trust has a clear vision of the future although this may be changing as the draft modernisation plan develops.

13 The Trust has, to date, consistently achieved its annual financial targets but has not done so in a sustainable way because it has been insufficiently focused on long-term considerations. The Trust was only able to break even in 2005/2006 because of unplanned additional funding and non-recurring gains and is facing a potential deficit of £6.6m in the current financial year, with significant financial pressures in future years. Despite receiving income and capital funding that is comparable overall with other ambulance services, we found that the capital infrastructure was weak. Capital expenditure was often rushed at year end and was not supported by long-term capital planning linked explicitly to a Trust strategy.

14 Internal and external governance has been weak. At Board level, there could have been greater engagement and involvement in the business, exacerbated by the absence of a plan to deliver the strategy, poor management information and an absence of performance management. Despite a clear diagnosis of the problems in the Trust and actions taken individually to tackle the problems, a risk of overlap between the respective performance management responsibility of the Welsh Assembly Government's Department for Health and Social Services Regional Office and principal commissioning role of HCW has made it more difficult to stimulate improvement.

15 There have been significant problems of leadership and managerial capacity. The rapid changes in leadership, and prolonged sickness absences of key executives, have been extremely damaging. Nevertheless, serious problems with managerial capacity existed before the recent turnover: the Trust lacked change management and project management capacity. This is exemplified by the serious deficiencies in procurements, such as the recent ambulance procurement, and weak improvement and performance management arrangements at corporate, executive and individual levels. There has also been a lack of clinical leadership, partly because the Medical Director works part-time for the Trust and has a role as a 'clinical advisor', rather than a clinical lead.

16 Related to management capacity, we identified serious concerns about the culture of the organisation and the way people are managed. Sickness absence levels are high. The numerous secondments – moving staff temporarily to posts other than their substantive post – and lack of performance management mean that roles, responsibilities and accountabilities are not clear and decision-making is slow. This is illustrated by the failure of the Trust to address a number of known problems over several years, such as changing rosters, differential levels of performance and serious problems with the Trust's estate.

17 Staff generally lack performance objectives and appraisal. They also reported a culture of blame and a failure to praise staff or listen to and act on their ideas for improvement. This is reflected in the perception among some staff that the Trust has a culture of bullying and harassment, and the increasing levels of grievances. Communication is inherently difficult in an organisation like the Trust, but it has been poor. This has contributed to the absence of systems to learn from experience and identify and disseminate good practice from within or outside the Trust.

18 Processes have been badly designed and managed. The basic problem is that, although overall resources appear adequate, the supply of ambulance and patient care services does not adequately match peaks of demand, particularly because of inflexible shift patterns and deployment. This can place many individual staff under extreme

pressure, particularly at certain times of day. There is little costing or benchmarking information on which to draw in considering the distribution and use of available resources.

19 There are weaknesses in the management of control centres[1] because of problems with ICT systems and very low job satisfaction. We also identified scope to improve significantly the way calls are classified in control centres and the speed with which they are expedited. PCS systems are not fit for purpose and have resulted in poor service to patients, serious adverse incidents involving patients being delivered to the wrong addresses and an information void. Clinical governance has developed but has not yet become integrated into the management of the Trust and there is scope to broaden the understanding of front-line staff about clinical governance and clinical audit.

20 Systems and infrastructure – estates, fleet and ICT – remain weak and reflect the Trust's poor management of capital. Although there has been piecemeal development of alternative models of service, such as community responders and Rapid Response Vehicles, the Trust's infrastructure represents a significant obstacle to further progress. At focus groups, the main concern of staff was being properly equipped to do the job, with particular problems in the areas of estates, fleet and ICT:

- **a** in estates, the Trust has an outstanding Health and Safety Executive notice relating to 19 sites; there has not been a strategic approach to estates and this is exacerbated by insufficient investment and a lack of estate management capacity;
- **b** in fleet, ambulances are inadequate because of the problems with the recent procurement of 46 ambulances, vehicles are old, have high failure rates and spare fleet capacity has been insufficient. The Welsh Assembly Government has recently announced £16m funding for new ambulances; and
- **c** in ICT systems, the Trust has not invested in key systems such as satellite navigation, which has the potential to deliver improvement in Category 'A' response time performance. There are also problems with the radio network which a major procurement, the ambulance radio re-procurement project (ARRP), is addressing, though it has slipped and is not yet fully funded. And there is no standard system for PCS even though a procurement exercise led to expenditure of around £500,000 on a system that could not be used because it was not fit for purpose.

The problems can be resolved over time provided key challenges are dealt with

21 The scale of the challenges facing the Trust suggests that their resolution will take time. In the past, however, other UK ambulance services have faced similar problems to those in Wales and have been able to turn around the situation. The Trust's Board and Chief Executive have now developed a draft modernisation plan that sets out a direction to address many of the weaknesses we identified. Clear priorities, significantly improved planning and performance management will be needed. The strengths of the Trust and its staff mean that, over

1 The Trust has four control centres that take emergency calls, allocate jobs to crews and manage the deployment of resources.

time, change can be delivered with effective leadership, capital investment in infrastructure and a significant improvement and development of managerial capacity and organisational culture. To deliver such an improvement in line with its emerging modernisation plan, the Trust must address a series of important challenges both external and internal.

22 A number of external challenges face the Trust:

- **a** changes in demand for its services arising from changes in the way hospital services are organised mean the Trust will need to adapt;
- **b** interfaces with other NHS systems need improvement, particularly:
  - **i** lost ambulance hours arising from time lost because of problems handing over patients to accident and emergency departments – so called 'hospital turnaround times'; and
  - **ii** changes in patterns of demand arising from the new GP out-of-hours arrangements.
- **c** PCS contracts are at risk from competition and weaknesses in the Trust's operational processes for PCS;
- **d** managing stakeholder expectations of immediate and fundamental service improvement based on more ambulance stations, more staff and more traditional ambulances, especially in rural areas where new types of service may be more appropriate;
- **e** GP disaffection with the service, manifested by the reduction in GP urgent activity and corresponding increase in emergency calls; and
- **f** the need to develop effective partnerships and develop new service models for unscheduled care, particularly with Local Health Boards.

23 Similarly, the Trust must address a series of internal challenges to deliver improvement:

- **a** the development of sound operational processes in control centres, and improving deployment, efficiency and processes to match resources and demand;
- **b** developing a new culture by improving operational management – effective workforce planning and delivering the benefits of the expensive *Agenda for Change* process which has reduced capacity and increased staff pay, and where the Trust's inclusive meal break policy does not comply with the national agreement; the Trust needs to engage and communicate more effectively with staff, with faster decision making, an increased focus on learning, performance management, change management and robust programme management processes; and it needs to develop a structure that empowers the regions to operate within a corporate framework of accountability and responsibility;
- **c** addressing a challenging financial position – the Trust and HCW are currently negotiating a Service Change and Efficiency Plan, with a projected deficit of £6.6m in the current financial year, but will need to agree a reasonable timescale in which to deliver the efficiency gains that the Trust must achieve from its relatively generous levels of resourcing. In addition, the Trust will need to demonstrate a significant improvement in its capacity to access

and make effective use of the significant capital funding that is available from the Welsh Assembly Government; and

d improving the estate – the Trust has significant problems with its estate and will also need to change its estates model to reflect and support changes in the overall model of service delivery.

Recommendations

Performance

1 The Trust has generally failed to achieve its 60 per cent response time target for Category A calls, which is a significantly lower milestone towards achieving the same target as applies in England, whilst Wales categorises Category 'A' slightly differently than England. **The Trust's detailed business planning should set out how the Trust will deliver and then maintain 75 per cent performance across Wales and how it will achieve a step change in performance in rural areas. At the same time, the Trust should develop a robust, accurate and balanced system of measuring and reporting ambulance service performance that covers key aspects such as:**

a clinical quality;

b measures of progress in transporting fewer patients to hospital;

c patient and stakeholder satisfaction;

d staff morale and cultural change;

e finance and resources; and

f PCS performance.

2 There are significant problems with access to emergency medical services, as shown by performance data and the significant concerns expressed to the team by members of the public. There have been particular problems with response times in some rural areas. **The Trust should conduct a review that leads to the development of regional strategies, consistent with the national plan. These strategies should take account of specific local circumstances, service developments and the need to deliver significant performance improvements and more equitable access. The regional plans should also analyse new models of service that might significantly improve performance in rural areas, as well as the need to maintain cover by double crewed ambulances.**

3 The time ambulances spend at A&E departments handing over patients and then presenting themselves for the next call remains a significant drain on capacity. A monitoring system is in place to measure the length of time ambulances remain at A&E departments. **The Trust should take a much more proactive role in tackling poor turnaround times and monitoring real time delays that occur.**

Strategy

4 The Trust has over-centralised to the extent that the regions have not been empowered to develop appropriate services and to tackle the challenges they face. Headquarters was too operationally focused and consistently failed to deliver strategic change. Internal communication has been a weakness. **The Trust Board and headquarters should focus on longer-term strategic development and the performance management of operations, while the managers in the regions should be empowered to develop and deliver the**

Trust's services to patients. To enable the Board to achieve this necessary level of strategic leadership, it should undergo a programme of Board development. There should be much clearer accountability for results delivered through the performance management system. A communications strategy should support the positive development of the Trust's culture.

5 The public needs to be informed about how a modern ambulance service works and why the changes in the draft modernisation plan are necessary. The public, particularly in rural areas, can help ambulance staff to provide a better service. **In the context of *Delivering Emergency Care Services*, the Welsh Assembly Government should develop a patient information campaign to:**

- **a** explain changes in unscheduled care services, including ambulance services and their changing role; and
- **b** highlight ways in which the public could help the ambulance service deliver a prompt and appropriate response, such as by knowing when and how to call the service, what information they need to provide and how it will be used.

6 The Trust transports a relatively high proportion of people to hospital, despite evidence that a significant proportion of calls could be treated more appropriately without being transported to hospital. This exacerbates pressures on A&E departments, ties up crews unnecessarily and means that patients do not access the most appropriate care. **In implementing its modernisation strategy, the Trust should, with the Welsh Assembly Government where appropriate, develop alternative response interventions including:**

- **a** developing roles, staff and protocols to allow hear and treat and see and treat approaches that avoid transporting patients to hospital unnecessarily;
- **b** expand the number of staff who have had additional education and training to make clinically safe decisions not to convey the patient;
- **c** reintroducing Category 'C' calls and protocols that allow the service to refuse to attend patients where the caller has had a telephone consultation and it is not clinically appropriate to attend;
- **d** monitoring the percentage of patients transported to hospital;
- **e** developing referral protocols with NHS Direct and GP out-of-hours services to ensure that patients access the care most appropriate to their clinical needs;
- **f** expanding successful initiatives such as the field hospitals, set up in Swansea and Cardiff at busy times, that provide appropriate responses to demand for unscheduled care; and
- **g** working with health partners, develop alternative care pathways that provide appropriate routes through the unscheduled care system and increase the clinical role of the ambulance service as a front-line provider of mobile primary and diagnostic healthcare.

7 The ongoing secondary care reviews will lead to a reconfiguration of services that could significantly affect the ambulance service. **The Regional Planning Fora should ensure that the secondary care reviews include a consideration of the impact of any changes on the ambulance service.**

In particular, there is a need to consider the impact of reconfigured services on demand for the air ambulance service.

Governance

8 There have been historical weaknesses in internal governance concerning the Trust Board, some of which have been addressed in recent months. There is a particular need to develop greater clarity of the Board's role, responsibility and decision making. **The Trust should review the roles and responsibilities of Board members to ensure that non-executives are much more actively involved in the Trust, for example through regional non-executive roles. There should also be more robust performance management arrangements for non-executive members of the Board. The Trust Board should also clarify which decisions the Board should take and to communicate more clearly with staff the decisions taken at each Board meeting.**

9 Although national commissioning is a strength, its role in performance managing the contractual delivery of the emergency service has been insufficiently co-ordinated with performance management of the Ambulance Trust as an organisation by the Welsh Assembly Government and there was insufficient input from local health communities. **As the *Delivering Emergency Care Services* strategy evolves, the Welsh Assembly Government should maintain national commissioning but seek to develop regional consortia of Local Health Boards to inform it about the local needs that should inform the commissioning of unscheduled care services, of which ambulance services are a key element. In respect of PCS, the Trust should develop more integrated commissioning of transport services with social services and Mental Health services.**

10 The Trust has experienced a very difficult period, including significant external scrutiny. The Trust has experienced problems in the past implementing strategies. **Now that it has developed a plan to move the service forward, the Welsh Assembly Government should provide the Trust with the space to work towards implementing its plan as quickly as possible with a minimum of distraction, particularly over the next twelve months**.

Leadership

11 Management capacity has been poor at all levels, with confusion about roles and responsibilities, and little management development. **The Trust should assess management capacity urgently and ensure that its leadership has sufficient skills at all levels to manage the organisation effectively. The Trust should develop a leadership and management development programme that is linked to the performance and appraisal system and addresses skills shortages. It should also link the workforce planning processes, which seeks to identify future skill needs, as the organisation moves to more modern working practices. There should be a particular focus on:**

- **a** **change, programme and project management skills;**
- **b** **valuing staff, engaging with them and acting upon their suggestions where considered appropriate;**
- **c** **investigating the potential of team leadership to improve management capacity at local level, particularly through managers having named team members; and**

d **changing the management structure to provide the capacity and skills to deliver change and to manage the organisation effectively on a day-to-day and longer-term strategic basis.**

12 There have been problems with the organisational culture and a lack of clinical leadership, partly because the Trust has not had a full-time clinical director. **The Trust needs to change its culture and become a reflective, learning organisation that learns from adverse incidents and focuses on clinical issues rather than transport. To develop a more clinical focus, it should move towards full-time clinical leadership. It should also take account of the views of its service users and stakeholders in order to improve consistently the quality of care it provides.**

People and culture

13 The Trust has failed to develop robust performance management processes, with key staff lacking objectives and performance appraisals, and significant confusion about roles and responsibilities. **Along with a review of the organisation structure and programme of Board development, the Trust should urgently develop an integrated performance management system that:**

a **incorporate an effective business planning process that translates the Trust's strategy into specific operational business plans, linked to financial planning and service delivery processes;**

b **ensures appropriate and timely monitoring and reporting of performance to enable decisions, action and intervention to take place at the appropriate time and at the appropriate organisational level;**

c **incorporates an effective performance management, and personal development system for all employees where employees have personal targets and objectives that are derived from the strategy and business plan and assessed at least annually through a formal appraisal process;**

d **gives all executives clear and measurable personal objectives which are cascaded from the strategy/business plan;**

e **strengthens accountability and challenge within managerial and Board arrangements to deliver improvement; and**

f **ensures there is timely reporting to the Board of progress against key strategic and operational objectives.**

14 Despite some recent progress, levels of sickness absence remain high and compromise operational efficiency. Following *Agenda for Change*, sickness absence is likely to present even greater direct costs to the Trust. Although basic principles of policy and approach are in place, application has been inconsistent and sickness rates have increased since April 2005. **The Trust should refocus on applying its sickness absence management policies in a robust and consistent fashion, and to speed up benefits realisation in respect of the electronic staff record system, in areas such as manager self-service for sickness reporting and direct access to sickness records.**

15 Developing new service models will require the Trust to develop new capacity and skills. Workforce planning has been an historical weakness. **The Trust should**

produce a detailed workforce plan that includes objectives and timescales, and takes account of enhanced paramedic roles and the modernisation plan, as well as the capabilities of existing staff to move into new roles.

16 In common with many other ambulance services, *Agenda for Change* has been implemented at significant cost to the Trust without yet deriving any modernisation benefits. Meal breaks remain a drain on capacity and the Trust is currently operating an inclusive meal break policy which appears to conflict with the national *Agenda for Change* agreement. **The Trust now needs to work closely with staff and their representatives to deliver rapid benefits from the implementation of *Agenda for Change*. In particular, the Trust should urgently resolve the meal break issue to ensure compliance with the national agreement on *Agenda for Change* and that meal breaks do not compromise capacity through crews driving long distances back to base stations.**

17 There are significant problems with job satisfaction, stress and sickness in control centres, which deliver a vital function within an ambulance service. There are also inconsistencies between the gazetteers in use in the various control rooms, which lead to data quality problems and can lead to problems identifying the source and location of calls. **The Trust should:**

- **a develop a clear strategy to develop the control function, provide appropriate technology and a suitable working environment, listening carefully to the views of staff on improving the control function;**
- **b include in its strategy proposals for linking control and NHS Direct if the proposed merger proceeds, and systems to allow local service provision to be taken into account in telephone assessment and referral where this is the most appropriate pathway; and**
- **c urgently resolve the inconsistencies in gazetteers used in control rooms so that there are compatible gazetteers in all control rooms in Wales.**

18 Staff do not feel valued or listened to by Trust managers, despite the evidence that they are very strongly valued by the public of Wales. **The Trust should communicate more regularly and directly with individual employees, as well as with the Trade Unions. Management development should address the need to recognise and praise staff and to ensure that all employees realise that the Trust recognises their contribution and commitment.**

Process

19 There has been a failure to monitor or manage PCS costs and performance, with five different systems in operation, none of which is fit for purpose. **The Trust should urgently:**

- **a review contracts to establish the service that their PCS clients want and develop common core standards of service;**
- **b develop a standardised PCS management system;**
- **c establish appropriate management arrangements that ensure proper accountability for service management and delivery; and**

d **develop accurate costing information to ensure that the service operates within its income levels and is competitive.**

20 Rosters, both for EMS and PCS, do not take account of demand, which has compromised service quality. The current rosters provide more capacity than is required overall, but not enough capacity at peak times. In some areas, rosters are eight years old and do not reflect recent changes in the demand profile or the context in which the ambulance service provides services. PCS rosters tend to focus on the hours of 8am to 4.30pm and therefore do not support the needs of the NHS or its patients. **The Trust should urgently review its rosters and undertake fundamental changes to ensure that services are arranged around the needs of patients.**

21 Problems in procurement have led to significant wasted money and the acquisition of assets that have compromised the Trust's ability to perform, although there have been some recent improvements in process. **The Trust should designate an executive with responsibility for all procurement. It should also actively liaise with other ambulance services in the UK to learn from their procurement and to avoid duplication. The Trust should also bring in external procurement expertise for the highest-risk procurements to support the restoration of confidence and rigour in its procurement function. Procurement plans should be explicitly linked to national strategy and modernisation plans, and any investment, capital or revenue.**

22 The Trust has experienced significant problems with the buildings that make up its estate. It is subject to an ongoing Health and Safety Executive improvement notice and has not invested sufficiently, either in maintenance or the estates function, to develop a strategic approach to the estate and to meet statutory obligations. **The Trust should benchmark its estate function with a view to providing sufficient capacity to meet the challenging estates agenda. Drawing on previous reviews, the Trust should develop a clear estates strategy that is consistent with the modernisation plan.**

23 Although there have been recent improvements, the Trust has had significant weaknesses in terms of the performance information collected and performance management systems. In particular, the information has been retrospective and does not provide 'real time' management information to enable managers to make decisions at the appropriate time. **The Trust should review its performance information requirements and develop appropriate Management Information Systems that**:

a **provide real-time performance information about the delivery of their modernisation strategy;**

b **capture the right information that the Trust needs to manage its various services (EMS, PCS, HR, Fleet, Estates etc);**

c **are derived from the strategy and business and financial planning processes;**

d **enable the Trust to carry out sophisticated demand modelling, both temporal and geographical;**

e **are consistent across the regions to ensure that the Trust not only has regional management and performance information but also has a corporate overview; and**

f **provide reports at timely intervals for both managers and the Board, and which are part of the performance management regime.**

24 Although there have been a number of adverse incidents in which the other emergency services have transported emergency patients to hospital due to unacceptably long response times, there are no established systems to share learning from these incidents. **Through the Joint Emergency Services Group, the Trust should develop a protocol to learn from serious incidents involving transportation of emergency patients by the police and fire services.**

25 There are concerns about the adequacy of clinical information available to the Trust. **The Trust should identify and implement an audit process for key clinical areas which will produce reliable information about the outcomes of patient care, and should use the adverse incident reporting arrangements already established by the Welsh Assembly Government.**

Capacity, systems and infrastructure

26 The Trust appears to have sufficient overall revenue and staff resources, although there are questions about the efficiency with which resources are used and people deployed. However, there is little costing or benchmarking information to help the Trust assess how capacity might be used more effectively. **The Trust, using its developing information on unit hour utilisation, should carry out more detailed work to cost services. Taking account of its modernisation planning and the development of the Strategic Change and Efficiency Plan (SCEP) for 2007/2008, it should also review the way it uses its capacity to improve efficiency, building in safeguards to avoid any 'levelling down' of performance.**

27 The Trust has consistently met its statutory financial targets over recent years but there is evidence that it has not done so in a sustainable way, including a draft SCEP that predicts a £6.6m deficit for 2006/2007. There is evidence that the service is adequately revenue funded and efficiencies can eventually result from modernisation and matching resources to demand, but that this will require capital investment, particularly to develop a modern and integrated communications infrastructure. **Working with the Welsh Assembly Government and HCW, the Trust should develop robust business cases for all capital investments, including performance gains and revenue savings over a reasonable and achievable timescale. The Welsh Assembly Government and HCW should rigorously assess these business cases using the Gateway Review, or similarly robust process to ensure their fitness for purpose and explicit link to the overall strategy.**

28 Fleet management has been poor with no national fleet manager and evidence that current arrangements are not delivering value for money, particularly the recent ambulance purchase. A new fleet manager has recently been recruited. **The Trust should conduct a fundamental review of its fleet needs and methods of delivery in the context of modernisation plan. The review should produce a clear decision on how best to use the recently-purchased ambulances.**

How to read this report

The conclusions of this report can be read at a glance in the Table of Contents and, in more detail in the Summary. The main body of the report is organised in exactly the same way as the Summary in sections as described below.

1 **Part One: Performance: evidence about the Trust's services**

- i **Emergency ambulance services**
- ii **Patient Care Services**
- iii **Clinical performance**

2 **Part Two: Diagnosis: the reasons for the Trust's performance**

- i **The Trust's strengths**
  Strategic framework
  Examples of innovation and good practice
  Significant goodwill towards the service
  Structural stability as a national service
  Enough resources
  Its staff
- ii **Failures in key areas**
  Lack of strategic direction
  Ineffective governance
  Weak leadership
  Badly designed and managed processes
  Poor systems and infrastructure
  Organisational Culture

3 **Part Three: the prospects for resolving the problems**

- i **Modernisation plan**
- ii **External challenges**
- iii **Internal Challenges**

Part 1: There are longstanding problems with the performance of the ambulance service

1.1 In this Part of the report we examine the evidence about the operational performance of the Trust in recent years. In summary we find that the service provided to patients and users has been generally poor.

1.2 The Trust's two main activities are emergency ambulance services and patient transport services for non-emergency cases, the latter of which is known within the Trust as Patient Care Services (PCS). Both these services need to be performed within an over-arching framework of clinical governance. In this section we show that the Trust's consistent failure to provide responsive emergency ambulance services could have compromised patient care, that the Trust has minimal information about the performance of PCS, despite serious adverse incidents involving patients being taken to the wrong addresses and that, overall, clinical performance needs to improve.

Patient care could have been compromised by the Trust's consistent failure to provide sufficiently responsive emergency ambulance services

1.3 Time is of the essence in emergency ambulance services. In recognition of this Ministers throughout the United Kingdom have set specific performance targets for the time taken by ambulances to reach various categories of patient. Those targets are not arbitrary but reflect evidence as to the clinical outcomes of speed of response. The Trust has consistently failed to achieve important targets overall and there are significant variations between regions in Wales. The Trust's response time performance compares badly with England but appears similar to Scotland. The increase in emergency activity that has occurred in Wales does not account for the failure of the Trust to improve performance. As a consequence of the Trust's poor performance, other emergency services have had to transport patients to hospital, which presents potential risks as the staff of these services may not be adequately equipped or trained to deal with these situations.

The Trust has consistently failed to achieve important performance targets

1.4 The Trust allocates the emergency calls it receives into two main categories:[2]

- Category 'A' – immediately life threatening incidents; and
- Category 'B' – other emergency calls.

1.5 The Trust's Emergency Medical Services also respond to 'urgent' calls which are requests, usually from a GP, to transport a patient within an agreed time limit. The Welsh Assembly Government has set a series of targets to measure how quickly the Trust responds to emergency incidents. These are based on clinical evidence, recognised in the National Service Framework for Coronary Heart Disease, that responding within eight

2 The Trust formerly employed a third Category 'C', neither serious nor life threatening, but ceased using this categorisation during the second quarter of 2006.

minutes to patients suffering heart attacks increases their prospects of survival. Although there are many other important measures of the performance of an ambulance service, particularly clinical outcomes and performance indicators, the speed of response to the most serious incidents is a vital measure.

1.6 Consequently, in 1999, the Welsh Assembly Government set a target that the Trust should respond to 75 per cent of category A calls within eight minutes. This target is consistent with the 75 per cent target that has been measured in England since 2001/2002. However, since April 2003 the Assembly Government has set milestone targets, of 60 and 65 per cent, to support the achievement of the 75 per cent standard. There are also targets to respond to 70 per cent of Category 'A' calls within nine minutes and 75 per cent within ten minutes. There are additional targets for the Trust to provide a fully equipped ambulance to 95 per cent of all emergency calls within 14, 18 and 21 minutes in urban, rural and sparsely populated Local Health Board (LHB) areas respectively. The Trust also has a target to arrive at hospital no more than 15 minutes later than the time agreed by the GP in 95 per cent of instances for urgent cases. Box 1 describes how the clock starts and stops when the ambulance control receives the call and when the response arrives at the scene.

1.7 We did not audit in detail the systems for recording clock start and stop times, but did identify some concerns about the way in which this key performance information is collected, validated and reported:

- reporting the proportion of calls where a response arrives within a set time fails to capture by how much the response exceeds the target time; the Scottish Ambulance Service reports its average response time in minutes and seconds to present what it considers a more balanced view of its response time performance; an alternative approach, which does capture the tail of the response time, is to measure at the 95th percentile; in our sample of Category 'A' emergency incidents where the Trust provided a response (April 2005 – September 2006), the sixtieth percentile was achieved in eight and a half minutes, while the 95th percentile was achieved in twenty two and a half minutes (Appendix 10 provides these figures for each Welsh LHB area);

- the postcode and address databases (gazetteers) used in the Trust's four controls to locate incidents are not standardised, do not recognise all postcodes and do not conform to the British Standards for address databases;

Box 1: Starting and stopping the clock to measure emergency response times

When the ambulance control receives a call, the clock starts when the dispatcher has obtained three key pieces of information from the caller:

- a verified location;
- the caller's telephone number; and
- the primary complaint.

The clock stops when the ambulance arrives at scene and the crew log their arrival with control.

- linked to the problem with the gazetteers, the reliance on post codes and telephone numbers to locate and categorise calls to LHB areas, can lead to anomalies where a location is in one LHB area but has a post code or telephone number for the neighbouring area – this can affect reported performance by LHB area; and

- analysis based on percentages of calls receiving a response within eight minutes by LHB area can be skewed by the very low total volume of emergency calls in some LHB areas.

1.8 East Radnor and the Borders Health Focus Group wrote to us with concerns about actual response times for people in that part of Powys. Because of the weaknesses of measuring performance using averages, we analysed actual response times throughout Wales. Current performance targets for the Trust are based on responding within a certain period to emergency calls but do not set explicit maximum response times. In our sample of 529,000 emergency incidents (both Category 'A' and 'B' calls) across Wales covering the last two years (April 2005 – September 2006), we found that 0.5 per cent (2,541) received a response of one hour or more, of which:

- 2,264 emergency incidents received a first response after between one and two hours; and

- 277 emergency incidents received a first response after between two and three hours.

1.9 There were also 115 incidents recorded as having a first response after more than three hours. We queried these with the Trust and, following further investigations, the Trust claimed that these long response times were attributable to data error. However, this raises questions about the validity of some of the other response times reported.

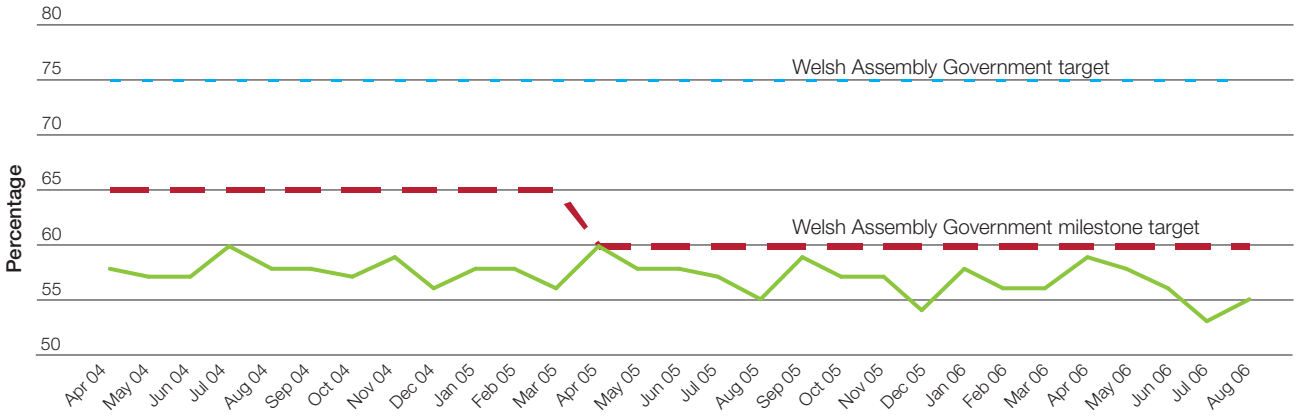
The Trust has not achieved response time targets

1.10 The Trust has increased its performance against the 8 minute Category 'A' response time target, rising from 51.4 per cent in 2001/2002 to 57.7 per cent in 2004/2005, but with a decline in performance to 57 per cent in 2005/2006. Despite this general improvement in performance since 2001/2002, Figure 1 shows that the Trust has achieved 60 per cent performance across Wales in only two individual months since April 2004 (in July 2004 and April 2005).

1.11 Figures 2 and 3 also show that the Trust has not achieved the Welsh Assembly Government's 9 and 10 minute Category 'A' response time targets, since these targets were introduced in April 2005. Monthly performance has ranged from 59 to 66 per cent of Category 'A' calls within 9 minutes, lower than the 70 per cent target, and from 65 to 72 per cent of Category 'A' calls within 10 minutes, below the 75 per cent target.

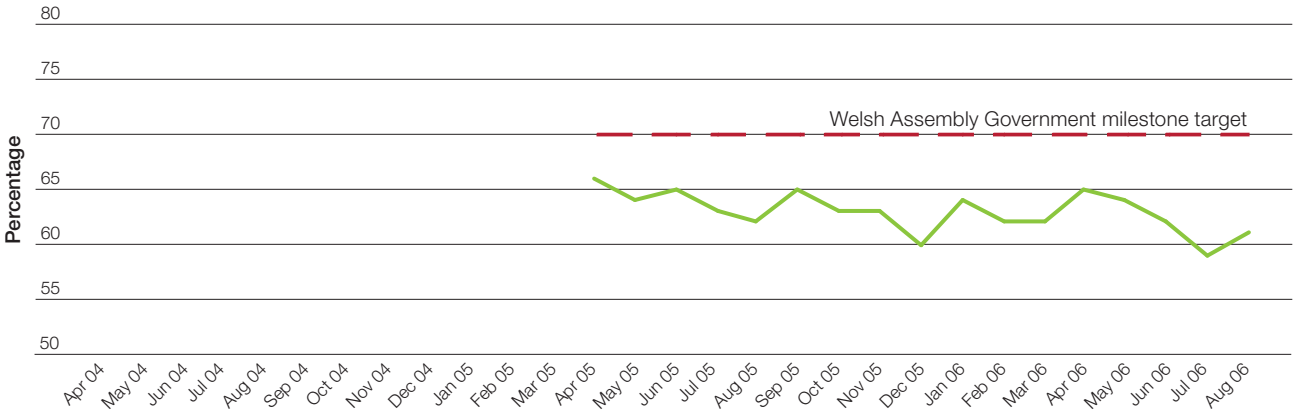
1.12 The Trust is also required to deliver particular response time targets and continuous improvement in each LHB area. In 2005/2006, the Trust delivered contractual performance levels, agreed with Health Commission Wales (HCW), in 9 of the 22 LHB areas. Appendix 3 shows performance trends in each LHB area between April 2001 and June 2006.

Figure 1: The percentage of Category 'A' emergency calls receiving a response within 8 minutes within Wales (shown in green) compared with the Welsh Assembly Government target of 75 per cent (blue) and varying milestone target (red)



Source: Health Commission Wales and Welsh Assembly Government Service and Financial Frameworks 2004/05, 2005/06 and 2006/07

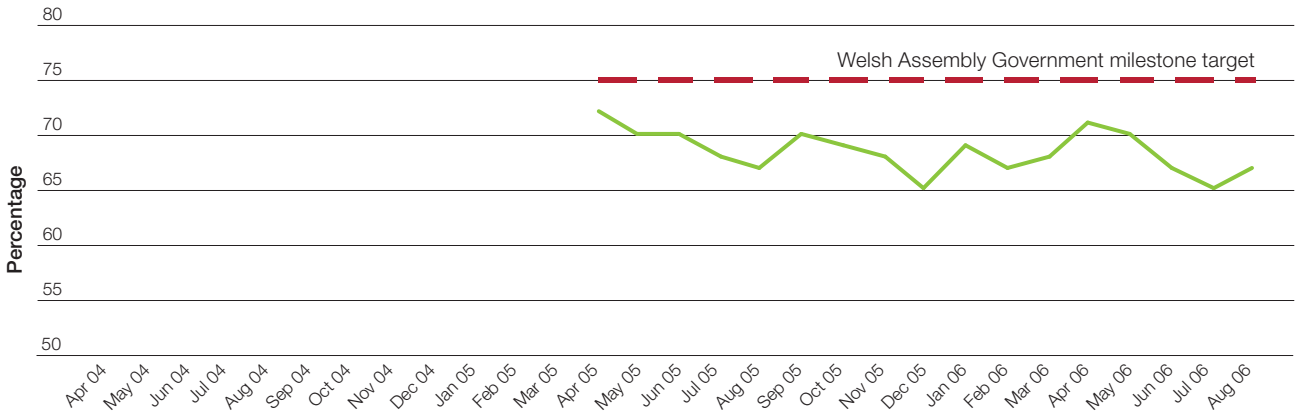
Figure 2. The percentage of Category 'A' emergency calls receiving a response within 9 minutes within Wales (shown in green) compared with the Welsh Assembly Government milestone target of 70 per cent (red)



Note: The Welsh Assembly Government introduced the 9 minute targets in April 2005

Source: Health Commission Wales and Welsh Assembly Government Service and Financial Frameworks 2005/06 and 2006/07

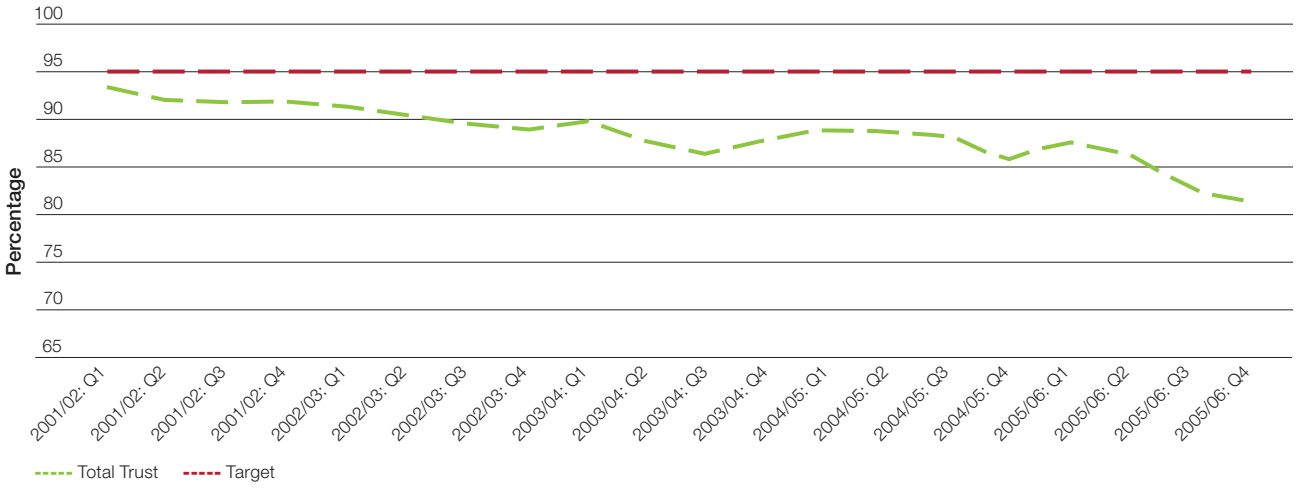
Figure 3: The percentage of Category 'A' emergency calls receiving a response within 10 minutes within Wales (shown in green) compared with the Welsh Assembly Government milestone target of 75 per cent (red)



Note: The Welsh Assembly Government introduced the 10 minute targets in April 2005.

Source: Health Commission Wales and Welsh Assembly Government service and Financial Framework 2005/06 and 2006/07

Figure 4: Declining performance (shown in green) against response time targets to respond to 95 per cent of all emergency calls (Category 'A' and 'B') within 14, 18 and 21 minutes in urban, rural and sparsely populated areas (red)



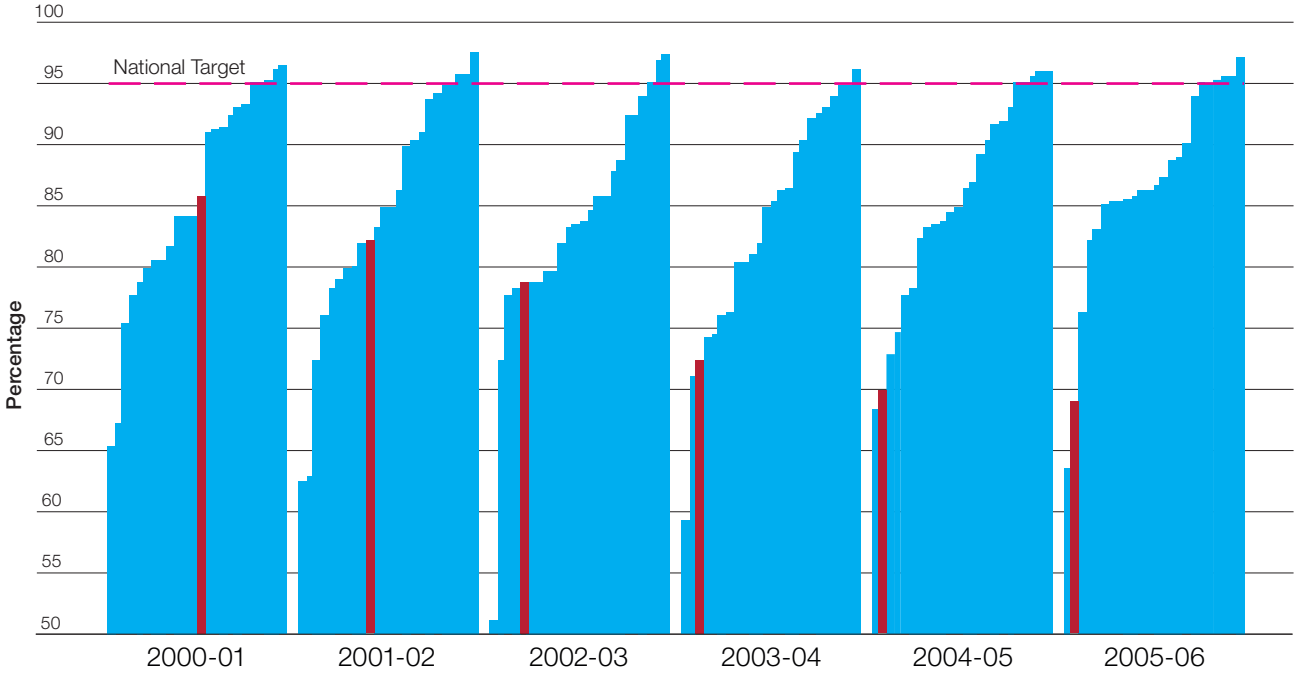
Source: Welsh Assembly Government, Health Statistics and Analysis Unit, KA34

1.13 As well as specific response time targets for Category 'A' calls, the Trust has to meet targets for the time it takes a fully equipped ambulance to attend all emergency calls, reflecting the fact that the initial response may come from a community responder (a lay person trained to provide an initial response to an emergency) or a single-manned rapid response vehicle which may need back-up from a fully equipped double-crewed ambulance in a serious emergency. The DECS project includes a workstream looking at data definitions and targets, which will need to consider the appropriateness of the 'fully equipped ambulance' target for all emergency calls in the light of changing models of service, moves to reduce the percentage of patients transported to hospital where this is clinically appropriate, and the move away from time targets for Category 'B' and 'C' calls in England.

1.14 At the end of 2005/2006, Figure 4 shows that the Trust provided a fully equipped ambulance to all emergency calls within 14, 18 and 21 minutes for urban[3], rural and sparsely populated areas in 85 per cent of cases, against a 95 per cent target. Figure 4 also shows an ongoing deterioration in performance against this target since June 2001.

1.15 Providing a timely service to patients designated as 'urgent' by their GP is extremely important. We heard a number of times that such patients are often sicker than those calling 999 for an ambulance and need a timely response according to their doctor's instructions. However,

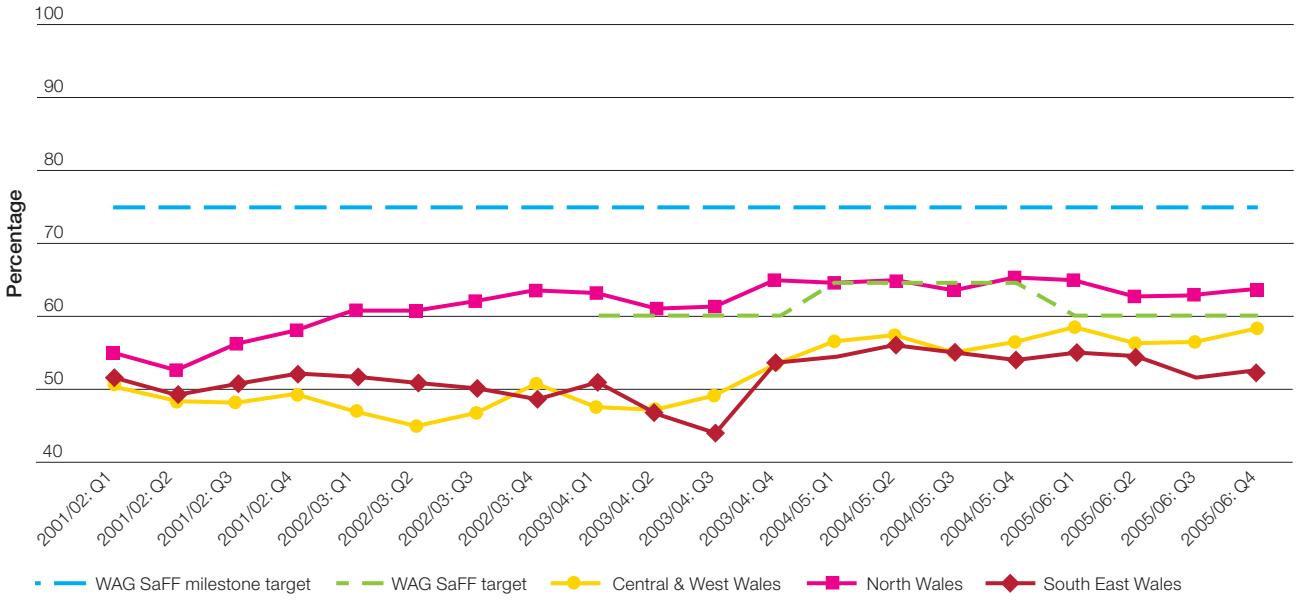
Figure 5: There has been a serious deterioration in performance against the target for 95 per cent of GP urgent calls to arrive at hospital no more than 15 minutes later than the agreed time, which is worse in Wales (red) than in English rural trusts (blue)



Source: Wales Audit Office, based on Department of Health KA34 data and Welsh Assembly Government, Health Statistics and Analysis Unit.

3 For the purposes of this measure, Cardiff is the only unitary authority area in Wales designated 'urban'. The definitions are based on population densities. In England, there are two categorisations – urban and rural, with targets of 14 and 19 minutes in Wales. 12 unitary authority areas are designated 'rural' and 9 'sparsely populated'.

Figure 6: North Wales has consistently performed better than the other two regions against targets to respond to Category 'A' calls within 8 minutes



Source: Welsh Assembly Government, Health Statistics and Analysis Unit, KA34

Case study A: The problems of providing traditional ambulance services in Powys

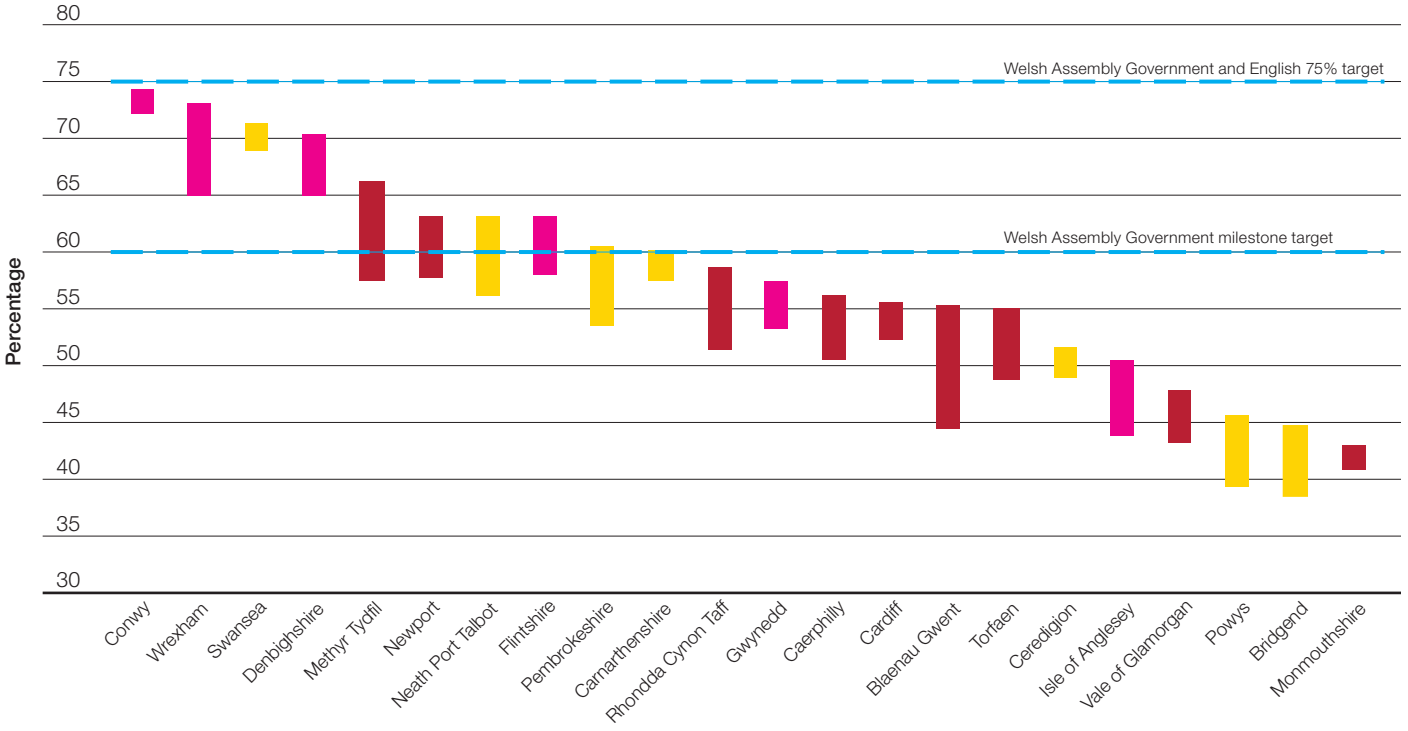
There are very serious and justifiable concerns about the adequacy of ambulance services in Powys. Providing more traditional ambulance services is unlikely to meet the needs of patients in Powys, which is over one hundred miles in length and which does not have a district general hospital within its boundaries. The Trust only responded to 43 per cent of Category 'A' calls in Powys within eight minutes in 2005/2006 . Emergency patients needing support in Accident and Emergency departments are generally transported to district general hospitals in Shrewsbury, Hereford, Abergavenny and Swansea. The long distances involved in reaching incidents, long turnaround times at hospitals, and deployment of crews to respond to incidents they pass on their way back to Powys, means that a single emergency incident can tie up a crew for several hours. Poor deployment planning can mean that this capacity is not replaced because of urgent needs elsewhere, leaving the people of Powys extremely short of cover. Minor injuries units within the county are rarely content to take patients from 999 ambulance calls.

Doing more of the same is unlikely to produce sufficient improvement in service quality for the people of Powys. Although the Trust will need to look carefully at predicted demand for emergency ambulances and shift patterns, new community-based models of service have the potential, backed up by emergency ambulance services and the air ambulance, to improve response times and the quality of service.

Similar challenges exist in other very rural areas, such as Monmouthshire, where response times are very long.

Source: Wales Audit Office

Figure 7: Some unitary authority areas had much higher performance against Category 'A' 8 minute response targets than others in 2005/2006



Regional Key: Central and West Wales (yellow) North Wales (pink) South East Wales (red)

Note: The bars shown for each unitary authority area reflect the range between the highest and lowest quarterly performance

Source: Welsh Assembly Government, Health Statistics and Analysis Unit, KA34

Figure 5 shows that performance against the target to arrive at hospital no more than 15 minutes later than the agreed time for GP urgent calls has declined significantly between March 2000 and March 2006, from 86 per cent to 69 per cent over the six financial years from 2000/2001 to 2005/2006. Interestingly, this period has also seen a 17 per cent decrease in GP urgent activity, at a time when emergency activity rose by around 30 per cent. Figure 5 also shows that, in 2005/2006, the Trust had lower GP urgent performance than all but one of the rural ambulance trusts in England.

There are consistent regional variations in response time performance

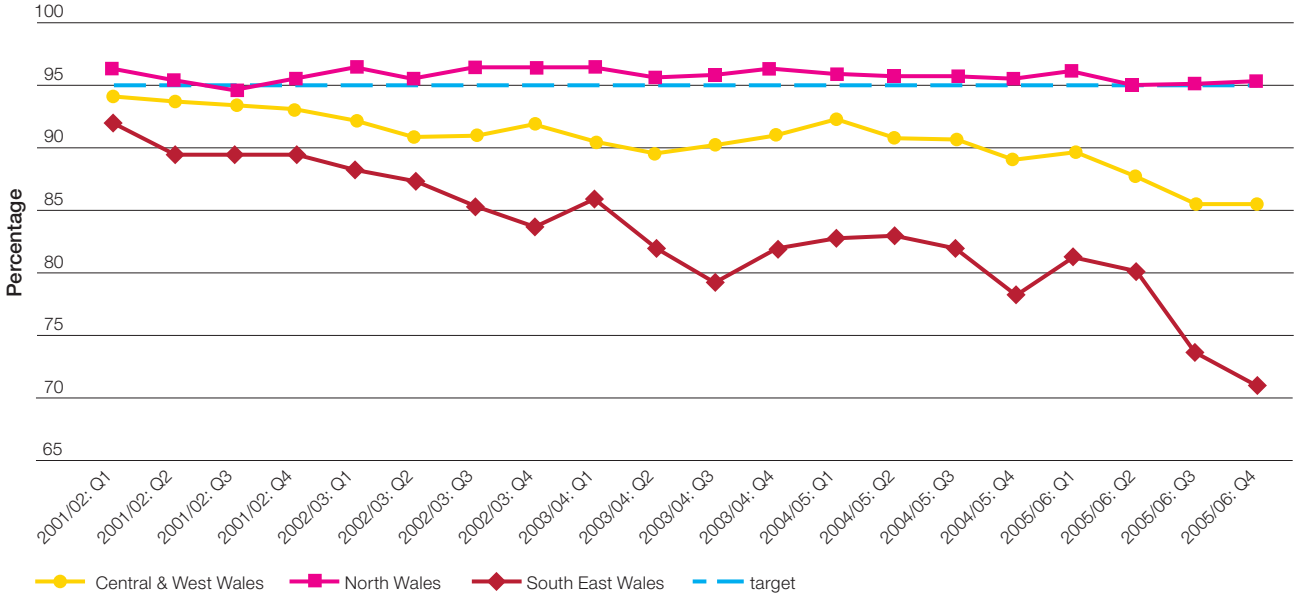
1.16 Despite the overall and consistent failure of the Trust to achieve important performance targets across Wales, some parts of Wales have services that respond more quickly than others. The Trust is split into three operational regions. Figure 6 shows that the Category 'A' responses times within 8 minutes has varied between regions. The North Wales region has responded to at least 60 per cent of Category 'A' calls within 8 minutes in 16 of the 20 quarters between 2001/2002 and 2005/2006. Neither the Central and West nor South East regions has ever achieved a quarterly performance of 60 per cent on this measure over the same period.

1.17 Figure 7 illustrates the range of quarterly performance in responding to Category 'A' incidents in each unitary authority area during 2005/2006. Figure 7 shows that some unitary authority areas have high levels of performance. For example, in Conwy 72 to 74 per cent of Category 'A' calls received a response within 8 minutes; in Swansea, 69 to 72 per cent of calls received a response within 8 minutes; and in Denbighshire and Wrexham, the equivalent figures were 65 to 70 per cent and 65 to 73 per cent respectively.

1.18 Conversely, Figure 7 shows extremely poor response times in some unitary authorities. In Bridgend, Monmouthshire, the Vale of Glamorgan and Powys no more than 50 per cent of Category 'A' calls received a response within eight minutes in any one quarter of 2005/2006. We received evidence from residents of these areas, and their representatives, about their concerns in respect of response times. Such response times have eroded public confidence in the ambulance service in these areas. It is inevitable that geographical factors and low population density should present difficulties but we found little evidence that the Trust has sought to mitigate these problems through seeking to develop new models of service delivery. Case Study A shows how rurality and geography have affected response times in Powys. However, the very poor performance in Bridgend shows that rurality is not the only cause.

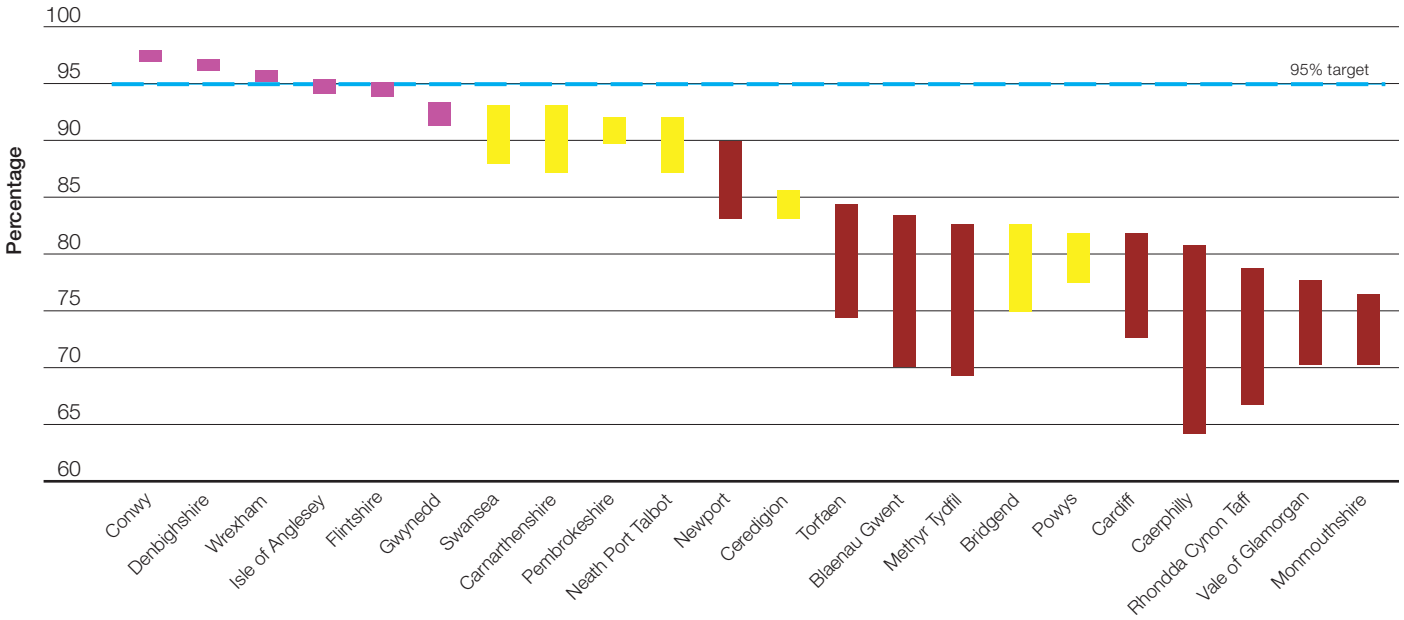
1.19 There has also been consistently better performance against the overall response time target for all emergency calls (both Category 'A' and Category 'B' calls) in North Wales than the other two regions. The all-Wales trend has been in a gradual decline (Figure 4), but Figure 8 shows that performance in North Wales has been in line with the Welsh Assembly Government target, while there has been a marked decline in South East Wales and, to a lesser extent, Central and West Wales.

Figure 8: Performance against response time targets to respond to all emergency calls (Category 'A' and 'B') within 14, 18 and 21 minutes in urban, rural and sparsely populated areas has been consistently better in North Wales than the other two regions



Source: Welsh Assembly Government, Health Statistics and Analysis Unit, KA34

Figure 9: Percentage range of quarterly performance in 2005/2006 responding to Category 'A' and 'B' emergency calls within 14, 18 or 21 minutes according to service classification in each unitary authority area of Wales



Regional Key: Central and West Wales (yellow) North Wales (pink) South East Wales (red)

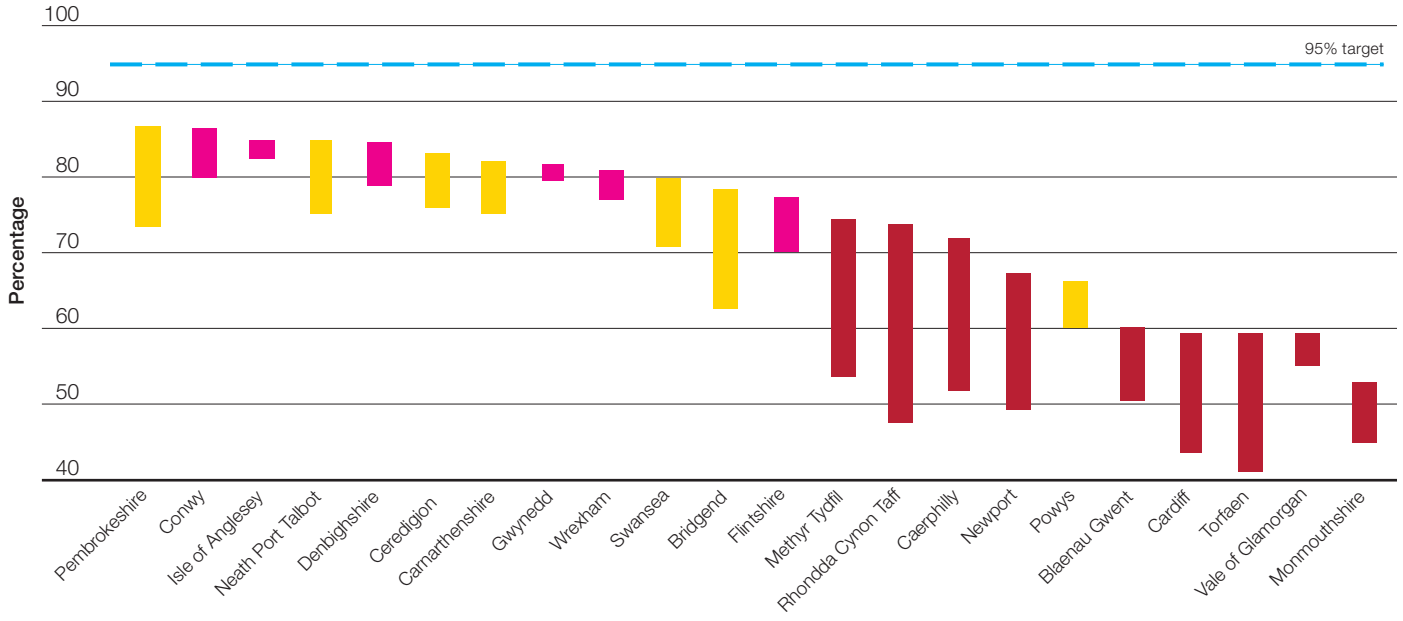
Note: The bars shown for each unitary authority area reflect the range between the highest and lowest quarterly performance

Source: Welsh Assembly Government, Health Statistics and Analysis Unit, KA34

1.20 The response rates for all Category 'A' and 'B' emergency calls vary considerably, both in standard of performance and consistency, between unitary authority areas. Figure 9 illustrates the range of quarterly response time performance in 2005/2006 for the Trust responding to Category 'A' and 'B' emergency calls within 14,18 or 21 minutes according to service classification in each unitary authority area of Wales. At the extremes, incidents in Conwy consistently received a response between 97 to 98 per cent within the time target set by the Welsh Assembly Government, whereas Category 'A' or 'B' emergency calls in the Caerphilly unitary authority area received a response between 64 and 81 per cent within the target time set by the Welsh Assembly Government.

1.21 There is also regional variation in performance against the target to arrive at hospital no more than 15 minutes later than the agreed time for GP urgent patients – 57 per cent arriving within 15 minutes of the agreed time in the south east region, compared with central and west, 75 per cent, and North Wales, 81 per cent. Figure 10 shows the range in quarterly performance by unitary authority area, with the Trust arriving within 15 minutes of the agreed time in between 45 and 53 per cent of cases in Monmouthshire, 44 and 60 per cent of cases in Blaenau Gwent, and 41 and 60 per cent of cases in Torfaen.

Figure 10: Quarterly performance range for GP urgent calls arriving no more than 15 minutes later than the agreed time in 2005/2006



Regional Key: Central and West Wales (yellow) North Wales (pink) South East Wales (red)

Note: The bars shown for each unitary authority area reflect the range between the highest and lowest quarterly performance

Source: Welsh Assembly Government, Health Statistics and Analysis Unit, KA34

Emergency response time performance compares badly with English services but appears similar to Scotland

1.22 As Wales is predominantly rural, we compared its performance with the former rural ambulance services in England.[4] Wales has used a call prioritisation since September 2003 and there have been differences in emergency call classification between England and Wales since April 2005, for example in Wales all children under the age of two have been automatically classified as Category 'A'. Overall, 80 per cent of call classification categories result in identical call prioritisation in England and Wales. The Trust estimates that Wales classifies an additional 6 per cent of calls as Category 'A' than it would if it applied the English definition relating to children under the age of two. Our analysis of a sample of 471,000 emergency calls during the period April 2005 to September 2006 shows that, overall, there would have been only 0.6 per cent more Category 'A' calls in Wales had it applied the same call categorisations as England (Figure 11). On this basis, we do not think that the differences in call categorisation between England and Wales invalidate comparisons of response time performance.

1.23 Figure 12 shows that the 23 rural services in England responded to between 69 and 88 per cent of Category 'A' calls within 8 minutes in 2005/2006 compared with the figure of 57 per cent in Wales, although a recent review found some incorrect reporting, related to clock start and stop times, in six English services of which

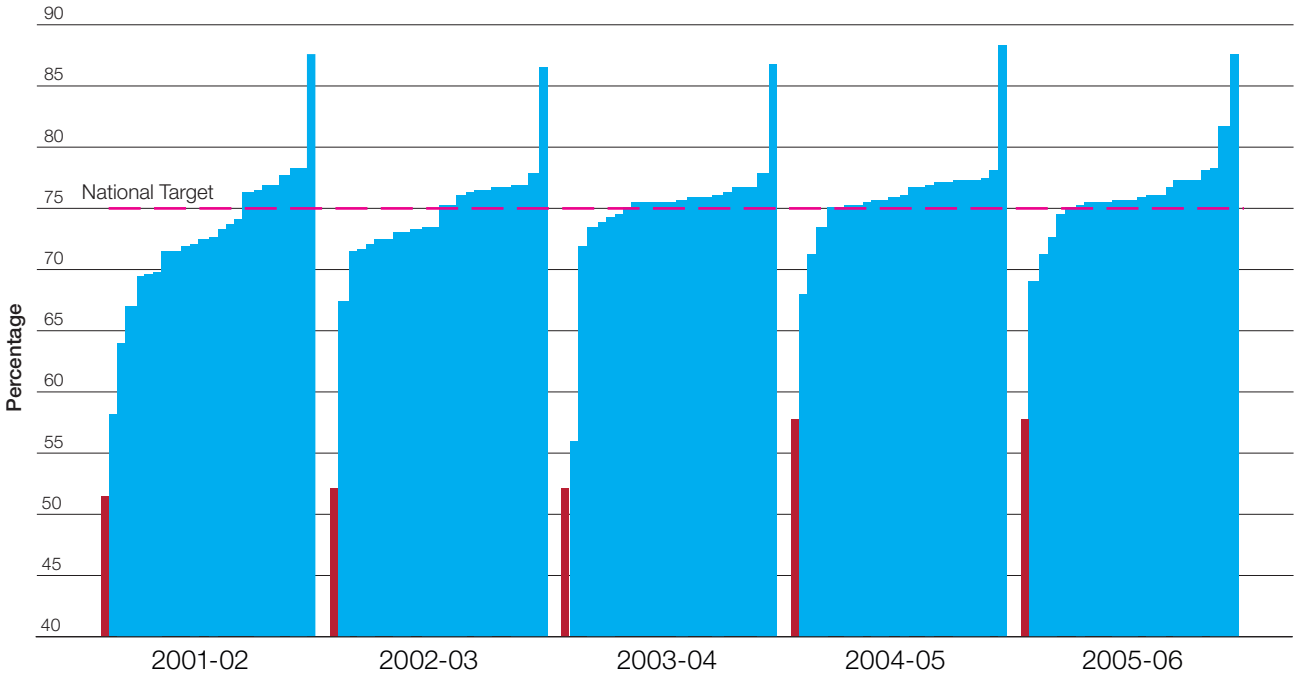
4 In response to the recommendations of the Department of Health report, *Taking healthcare to the patient*, Ambulance Trusts in England have recently undergone a series of mergers and have reduced from 31 to 12 services, with Staffordshire working towards merger with West Midlands.

Figure 11: Difference between English and Welsh categorisations of emergency calls, applied to a sample of Welsh emergency calls between April 2005 and September 2006

	Welsh categorisation of emergency calls	Welsh calls using English categorisation of emergency calls	Difference
Category 'A' (Red)	180,363	181,482	+1,119
Category 'B' (Amber)	216,280	219,184	+2,904
Category 'C' (Green)	74,641	70,618	-4,023

Source: Welsh Ambulances Services NHS Trust

Figure 12: Category 'A' emergency incidents: percentage of responses within 8 minutes in Wales (red) and English rural Ambulance Trusts (blue)



Source: data supplied by WAG Health Statistics, KA34; and English rural Ambulance Trusts: Department of Health, KA34

three were rural services. This poor performance compared with English rural services[5] dates has been a consistent trend since 2001/2002. Analysis carried out by the Trust shows that Welsh performance looks little better relative to English rural services using performance for the twelve rural unitary authority areas in Wales.

1.24 It is difficult to benchmark overall emergency response performance including Category 'B' calls because slightly different response time standards apply for Category 'B' calls in England and Wales, with an 18 minute standard in Welsh rural areas and 19 minutes in English rural areas. However, we were able to compare Welsh performance for GP urgent

5 Department of Health, *Ambulance Services, England: 2005-2006*

Figure 13: Wales has the lowest response time performance for Category 'A' calls compared with England and Scotland

Year	2003/2004	2004/2005	2005/2006
	Responses to Category 'A' calls within 8 minutes (per cent)	Responses to Category 'A' calls within 8 minutes (per cent)	Responses to Category 'A' calls within 8 minutes (per cent)
Wales	52	57.7	57
Scotland[1]	56.5	57	58.5
England	75.7	76.2	74[2]

1 Scottish performance data is for the mainland only and excludes the islands.
2 This figure has been adjusted to reflect concerns about data recording in six English Trusts.

Source: Wales Audit Office

calls with English rural services, and found that Wales compared badly with England. Figure 5 shows that while GP urgent performance declined in Wales between 2000/2001 and 2005/2006, it improved overall in England during the same period, and all but one English rural service performed better than Wales.

1.25 Although Category 'A' performance has been higher in England at national level, Figure 13 shows that performance in Scotland has been similar to that in Wales in recent years. Figure 12 also shows that English rural trusts have achieved higher response time performance than Wales. The Scottish Ambulance Service has also measured average response times for Category 'A' calls, which fell from 8.6 to 8.4 minutes between 2004/2005 and 2005/2006.

Poor response times have led to other emergency services transporting patients to hospital

1.26 During the course of the inquiry, we received evidence that one of the negative consequences of long emergency response times is that other emergency services have been forced to transport emergency patients to hospital because of the failure of ambulances to attend, or have faced harrowing waits for paramedics to arrive at the scene of serious incidents (Case Study B). We received detailed submissions outlining the extent to which the emergency services had transported emergency patients to hospital in 2006. This showed that the Welsh police forces, fire and rescue services transported a minimum of 90 patients to hospital between January and August 2006. These incidents took place predominantly in South East Wales and were reported by the Gwent and South Wales Police and the South Wales Fire and Rescue Service, with particular problems in Bridgend, Cardiff, Rhondda Cynon Taff and Newport. Generally, officers involved in these incidents reported that they had waited for between twenty and thirty minutes before taking the personal decision to transport the patient to hospital. When speaking to Trust control rooms to find out the estimated time of arrival for the ambulance, the Trust provided other emergency services with the following responses:

- no ambulances available;
- we are stacking calls;
- your call is eighth in the queue (incident involved a female who had been stabbed); and
- an ambulance will be sent when one is available – and then the police controller was cut off (incident involved a man collapsed in a roadway).

1.27 The statistics do not do justice to the seriousness of such incidents which should be avoided at all costs because they cause the following serious problems:

- carrying emergency patients to hospital in a police or fire vehicle carries clinical risks as vehicles are not suitably equipped, and fire and police officers have first aid training not paramedic training;
- it distracts the other emergency services from fulfilling their core responsibilities; and
- if the patient dies while technically in police custody in the vehicle, this automatically triggers an investigation by the Independent Police Complaints Commission, and a death at the hospital after transport by the police could be deemed a 'death after police contact'; deaths in police custody are a performance indicator for each force which are reported annually, and which may affect forces' reputations.

1.28 We found no formal systems of communication between the other emergency services and the ambulance service to learn from such incidents and jointly to take steps to minimise their occurrence or to identify ways to handle them more effectively in future.

There has been an increase in emergency activity in the Trust which is consistent with rural trusts in England but which does not fully explain the failure to improve performance

1.29 The Trust has consistently cited unfunded increased demand as a root cause of its consistent failure to achieve performance targets. Demand for emergency ambulance services can be measured in a number of ways:

- the number of emergency calls received;
- the number of responses; and
- the number of patients treated and transported.

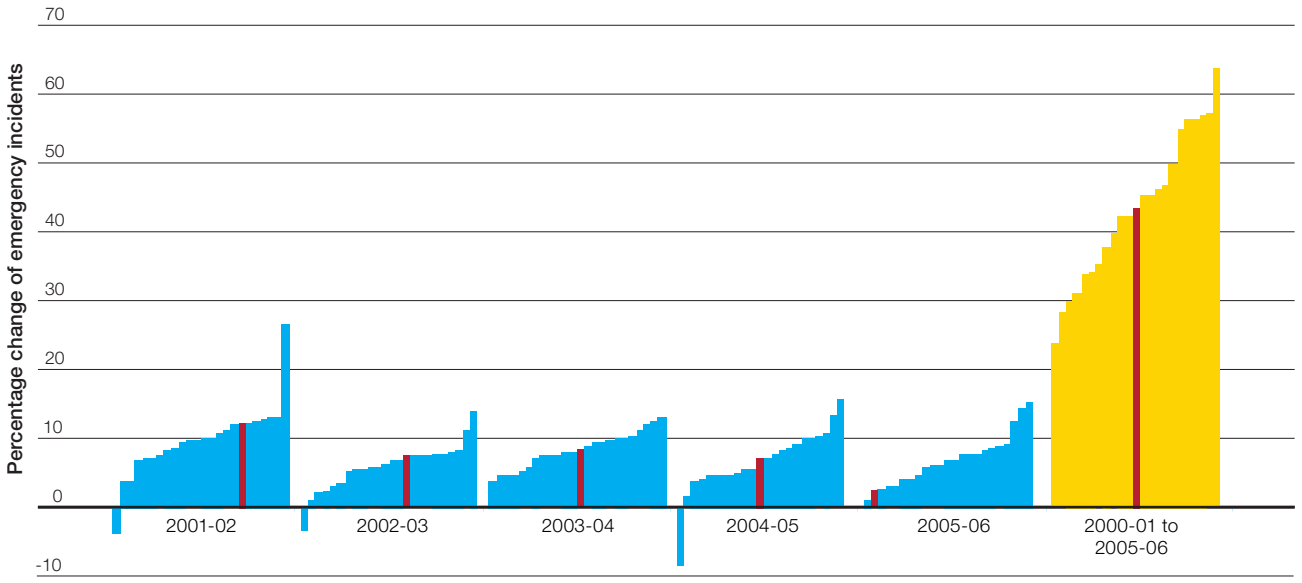
Case Study B: Examples of incidents where police services have transported patients to hospital or faced long waits for an ambulance to arrive

1 Following a serious assault on a female in Bridgend, resulting in lacerations to the head, the ambulance service stated that the nearest available ambulance was in Rhondda, and that the estimated time of arrival "could take some time". After 45 minutes, the police officers conveyed the injured woman to hospital.

2 The ambulance service asked for police assistance in Newport after a man had taken an overdose of painkillers, and had drunk half a bottle of whisky. It was reported that he was likely to be violent and police officers were redeployed from another incident. He was not violent but clearly needed emergency medical treatment and an ambulance was called. The ambulance arrived 38 minutes later, by which point the man was lapsing in and out of consciousness in the care of police officers.

Source: Submission to the Auditor General from the Joint Emergency Services Group

Figure 14: Between 2000/2001 and 2005/2006, the percentage increase in emergency incidents for the Trust (red) was in the middle of the range when compared with English rural ambulance services (blue and yellow)



Note: Figures for individual years represent the percentage change in the number of incidents compared with the previous year.

Source: Welsh Ambulance Services NHS Trust: National Assembly for Wales, SDR 102-2006; English rural Ambulance Trusts: Department of Health, KA34

1.30 The number of calls the Trust receives has increased significantly, but is not necessarily the most appropriate measure of demand for emergency ambulance services because of:

- duplicate calls to report the same incident;
- calls asking for an updated estimated time of arrival; and
- the fact that not every call results in the activation of an emergency response.

1.31 The number of emergency incidents requiring a response is a good measure of demand for emergency medical despatch services. The numbers of emergency incidents (calls resulting in response arriving at the scene of the incident) have risen by 43.3 per cent in Wales between 2000/2001 and 2005/2006. Figure 14 shows that the increase in emergency incidents in Wales has been in the middle of the range when compared with rural ambulance services in England. Whilst 43.3 per cent is a significant increase in demand, Figure 10 clearly shows that greater increases have been experienced in some of the English rural counterparts, supporting the conclusion that increasing emergency activity does not fully explain the Trust's failure to meet its performance targets.

1.32 Figure 15 shows that a 19 per cent increase in emergency patient journeys has been accompanied by a 30 per cent decrease in the urgent workload. Overall between 2001/2002 and 2005/2006, there has been a 2.8 per cent increase in the total number of emergency and urgent patient journeys. This analysis suggests that, while there has been a change

Figure 15: Changes in the number of emergency and urgent patient journeys

Financial Year	Emergency	Urgent	Total
2001/2002	178,000	90,000	268,000
2002/2003	195,000	80,000	276,000
2003/2004	203,000	74,000	277,000
2004/2005	208,000	66,000	275,000
2005/2006	212,000	63,000	275,000
Movement 2001/2002 – 2005/2006	**19%**	**-30%**	**2.8%**

Note: Numbers of journeys have been rounded to the nearest thousand

Source: Welsh Ambulance Services NHS Trust

in the profile of demand which will have placed new pressures on the Trust, this is not as significant as suggested by the Trust in some statements from the Board and correspondence with HCW, its main commissioner. The change in patterns of demand may reflect GP dissatisfaction with the deteriorating speed of response to urgent calls (Figure 5), and a consequent trend to encourage patients, who would previously have been GP urgents, to call 999 themselves to secure a response.

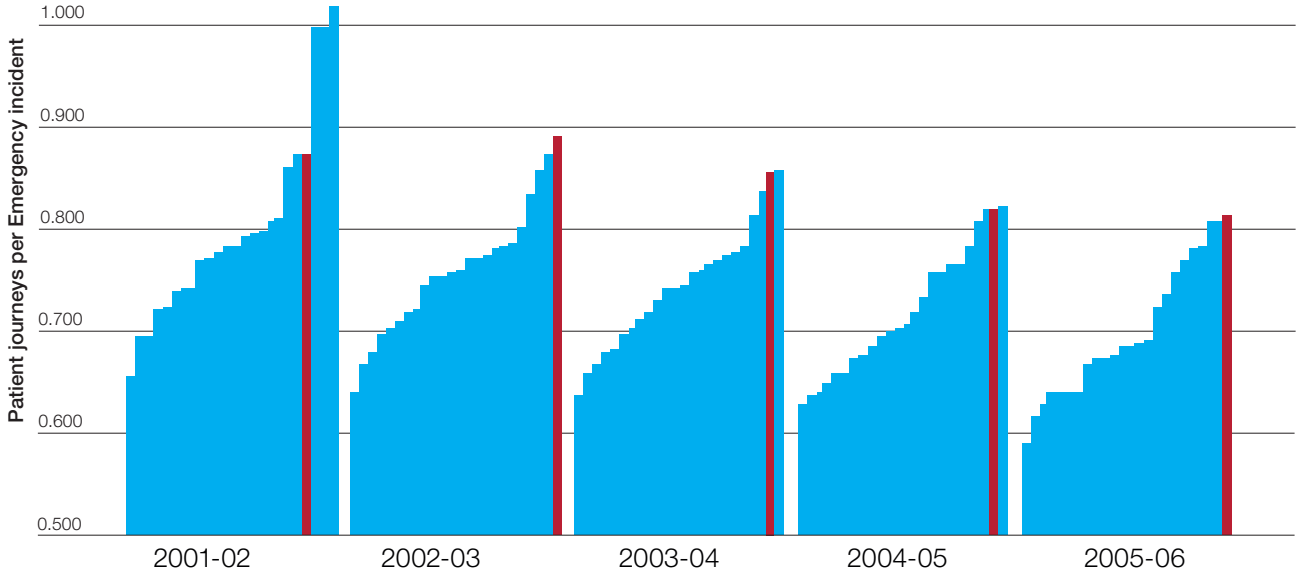
1.33 Our analysis of performance data for other Trusts suggests that Wales has been less successful than English trusts in accommodating increased demand by changing the way it responds to incidents. Transporting patients to hospital takes a significant amount of time, particularly in the rural areas of Wales. The Department of Health report, *Taking Healthcare to the Patient* (Box 4) identified that only ten per cent of emergency calls are truly life threatening, and that potentially at least one third of patients in England should be able to benefit from treatment at or closer to their home or the scene, rather than being unnecessarily transported to hospital.

1.34 Some English trusts have found new ways to respond to demand for unscheduled care, particularly in minimising the number of attendances at scene that lead to the patient being taken to hospital when that is not clinically necessary. Not only does this make the best use of ambulance capacity, but it also reduces the significant pressures on accident and emergency services in acute trusts, and minimises the impact of long handover times tying up ambulance crews because of pressures on accident and emergency departments. We found that rural English ambulance services have reduced the proportion of patients transferred for each emergency incident that required a response. Figure 16 illustrates this declining trend and also highlights that the overall numbers of patient journeys per emergency incident remains high relative to English rural Ambulance Services.

There is little information about Patient Care Services performance and there have been serious adverse incidents

1.35 The Trust has not maintained a sharp focus on its Patient Care Services, despite the fact that it provides some 1.41 million journeys each year and has individual contracts with

Figure 16: Emergency patient journeys (headcount) as a proportion of total emergency incidents



Source: Wales Audit Office, based on Department of Health KA34 and Welsh Ambulance Services NHS Trust data

the 13 acute trusts in Wales, 6 English Trusts and Powys LHB. The Trust still operates five different regional systems to run PCS, based on its five legacy organisations, which are not compatible with each other and, in one case, is still not computerised. Consequently, there is no useful management information on this important service and how it performs, such as:

- the number of patients on a PCS vehicle;
- the cost of taxis and escalating voluntary car service bills;
- crucially, given that the acute trusts could seek patient transport services from the open market, the Trust does not know what it actually costs to provide the service nor does it know what it should cost;
- the number of patients who do not attend; and
- a robust analysis of demand for PCS and whether the current shift pattern of working between 08:30 and 16:30, Monday to Friday, is the best model to meet the needs of patients and the acute trusts that commission PCS.

1.36 This total absence of performance management for patient care services is of particular concern in the light of serious adverse incidents involving Patient Care Services, one of which involved a patient dying after being delivered to the wrong address.

Figure 17: Reported thrombolysis rates in Wales in 2005/2006 were below those of England

	Percentage of patients having thrombolytic treatment within 60 minutess of calling for help (ambulance services or acute trusts)	Percentage of eligible patients that received pre-hospital thrombolysis (ambulance service)
Wales target	60%	–
Wales	31%	10%
England target	68%	–
England (average)	58%	18%

Source: How the NHS manages heart attacks, fifth report of the Myocardial Infarction Project (MINAP), June 2006

Clinical performance needs to improve further

Rates of pre-hospital thrombolysis are rising but can increase further

1.37 Although they are linked, it is essential to measure and focus on both clinical performance and response times. The Trust is currently training its paramedics in thrombolysis, a clot-busting technique which is a clinical response when patients have a heart attack, administered either pre-hospital by ambulance paramedics or upon arrival at hospital. By the end of the 2006 calendar year, all paramedics in the Trust will have received training in this important technique.

1.38 Among other measures of the treatment of heart attacks, the MINAP (Myocardial Infarction National Audit Project) project measures progress in thrombolysing patients. The latest, and fifth, public report shows that, on two separate measures, there is scope to increase rates of thrombolysis in Wales (Figure 17). The percentage of patients having thrombolytic treatment within 60 minutes of calling for help is delivered jointly by the ambulance service and other acute trusts, whereas the pre-hospital thrombolysis is delivered by the Trust alone.

The Trust has explained that English ambulance services commenced their implementation plans and paramedic training at an earlier stage and that, when compared against the performance of English services at a similar stage of implementation, the Trust is performing well in terms of pre-hospital thrombolysis and is increasing rates. The Trust has also raised concerns about the accuracy of the figures on pre-hospital thrombolysis, which it relies on other NHS trusts to record. The Trust is working collaboratively with its partners to resolve these problems and improve the quality and completeness of the MINAP data.

We are not able to report at this stage on the extent to which improved performance might save additional lives

1.39 In May 2006, public statements by the then Interim Chief Executive, Mr Thayne, included reference to an estimate of 500 lives which might be saved by the Trust as a result of improved performance. As part of its review of the Trust, Healthare Inspectorate Wales (HIW) has been reviewing that suggestion. We had hoped to be able to include a summary of their findings in this report but HIW has not yet concluded this element of its investigations and will report separately in due course.

Part 2: The Trust's strengths have been let down by a wide range of factors

2.1 In this Part we present a diagnosis of the Trust's performance, namely the reasons underlying the disappointing performance described in Part 1. We conclude that the Trust has a number of important strengths both absolutely and relative to other ambulance trusts in the United Kingdom. We find, however, that in the past these strengths have been let down by important failures in all key aspects of business management.

The Trust has a number of key strengths

2.2 Despite its present problems, the Trust has strengths in the following areas:

- a strategic framework that presents opportunities for development;
- examples of innovation and good practice;
- significant goodwill towards the ambulance service in Wales;

Box 2: Delivering Emergency Care Services

The Welsh Assembly Government's vision is to *'provide a service that ensures patients – no matter how or when they contact any of the emergency or unscheduled care services – are assessed and then seen by the most appropriate health care professional at the most appropriate time'.* DECS covers all unscheduled care services, emergency medical and surgical assessment,NHS Direct, all primary care services, including GP out-of-hours services, social services, mental health services, the ambulance service and A&E departments. It seeks to improve the planning of emergency and unscheduled care services, and take an integrated approach to all levels of emergency and unscheduled care as part of a single system.

The key aims for the future ambulance service in Wales are to:

1 be the first point of contact for unscheduled care, with greater flexibility in the type of response provided;

2 increase joint working with others involved in call handling and triage to allow a more structured and flexible response;

3 develop new service models to see and treat, or treat by telephone (hear and treat) those who do not have a genuinely life-threatening emergency;

4 deploy ambulance staff in other settings, for example by developing paramedics' roles so that they often work for other unscheduled care providers to support alternative care pathways;

5 improve dramatically response times by providing alternatives for those who do not require an emergency response; and

6 locating ambulance services in the context of a regional unscheduled care plan with appropriate changes to commissioning.

Source: Delivering Emergency Care – An integrated approach to unscheduled care in Wales, Welsh Assembly Government consultation document, July 2006.

- structural stability as a national service with national commissioning;
- enough human and financial resources to deliver performance in line with expectations elsewhere in the United Kingdom; and
- its staff.

The strategic framework will provide significant opportunities

2.3 The Welsh policy framework for unscheduled care – all unplanned clinical events – is changing. The Welsh Assembly Government is currently consulting on *Delivering Emergency Care Services* (DECS), which is described in Box 2. Estimates suggest that only 10 per cent of 999 calls are genuinely life-threatening, which means that ambulance services should develop alternative models of care, other than double-crewed ambulances, to enable them to provide a more appropriate response to meet patients' needs.

2.4 The principles of DECS are consistent with those of the Department of Health's document on the future of ambulance services, Taking healthcare to the patient (the so-called 'Bradley report'). This document, which focuses only on ambulance services, rather than the whole of the unscheduled care system like DECS, advocates the further development of ambulance services, so that they become clinically-driven mobile providers of healthcare services, rather than a patient transport or emergency service. Such service developments can help to provide more appropriate responses to people who call 999 but do not need a double-crewed ambulance, and which can significantly compromise emergency medical service capacity. Concerns about the inappropriate use of the service were the third most significant concern of staff participating in our focus groups (Appendix 4). Box 3 provides examples of inappropriate use of ambulances, from a diary sent to the inquiry team by a serving paramedic employed by the Trust. These reflect

Box 3: Reported examples of the inappropriate use of 999 ambulances

- A patient with abdominal pain for 36 hours, who had decided that she had suffered enough. She did not attempt to contact a GP service or A&E or NHS Direct, she just thought to dial 999.
- A call to a male who had been assaulted three days ago and was complaining of rib pain.
- A crew travelling 12 miles to a person who was cold. Let me make this clear, we are not talking about hypothermia, we are talking, 'I am cold, could you put the fire on'.
- A 999 call to a woman who had suffered with a headache for two weeks.
- The patient was due for surgery in England and despite knowing about the operation arranged urgent transport through the GP out of hours service in the early hours of the day he was to go to hospital. I can only assume that this service did not know the patient, but they took on board this task and arranged transport for that day – with the surgery being scheduled for the next day. The patient failed to follow the hospital's procedure to contact them before travelling and, on arrival, we were told that the operation had been cancelled. They kept him there on the unlikely chance that the operation going ahead on the next day may be brought forward and as such he stayed. This case took an emergency crew out of Wales for three hours, obviously removing a valuable resource from the system.

Source: Diary supplied anonymously by a serving paramedic with the Trust

problems with the overall unscheduled care system and ambulance control, as well as the way the public uses the ambulance service.

2.5 A Department of Health report champions the significant expansion of the roles and training of paramedics (see Box 4 below).

2.6 These examples provide opportunities for the Trust, its employees, those who use its services and other providers of unscheduled healthcare. The very serious problems providing adequate services in many rural areas reflect the scope to support ambulance capacity with community-based paramedics who could provide emergency services and whose advanced skills can enable them to see and treat the patient without them needing to be transported to hospital. CPOs can also work in primary care and minor injuries units. In areas like Powys, where transporting patients to hospitals outside the county leads to a significant drain on capacity to deal with genuine emergencies, the development of such roles provides opportunities to improve the quality of services and response times.

2.7 Although the Trust has developed some new models of response (paramedic practitioners, alternative care pathways, rapid response vehicles and community responders), it has done so in a piecemeal way and is still a service that operates in a largely traditional manner. The broader development of new roles and more modern approaches to meeting changing demand for services is not well developed in Wales, which the data on the percentage of patients transported suggests. Case Study C shows how East Anglia developed new roles and service models that reduced the percentage of patients transported to hospital.

2.8 In addition, the DECS strategy provides a significant opportunity for the Trust to provide a wider range of unscheduled care services, using its existing capacity (see Box 2). For example, the Trust could consider:

- bidding for GP out-of-hours services, perhaps provided from A&E departments;
- providing paramedic services to support the management of long-term conditions in the community;
- working with partners to develop new care pathways for patients accessing the unscheduled care system;

Box 4: Taking healthcare to the patient: extending the role of paramedics in England

The vision espoused by the report includes ambulance services providing a wider range of services, such as diagnostics, primary care and chronic disease management in the community. To support such developments, new roles will be developed for paramedics and nurses, such as:

Emergency Care Practitioner – an advanced practitioner capable of assessing, treating and discharging or referring patients at the scene. Specific higher training (and qualifications) are required for this role, which can take some time.

Community Paramedic Officer – an advanced practitioner based in local communities, often in primary care, who provides emergency responses but also primary care services. CPOs are often used in rural communities, such as East Anglia Ambulance Service (Case Study C).

Source: Taking Healthcare to the Patient, Department of Health (June 2005)

Case Study C: Community Paramedics in East Anglia Ambulance Service have reduced the proportion of Category 'B' patients transported

After the publication of a public inquiry into the Trust, a series of changes led to improve performance and services, particularly in rural areas with poor road infrastructure. The Trust had provided a very traditional ambulance based around double-crewed ambulances and few single responders.

The Trust expanded community responder schemes in rural areas. Also, in 2001, the Trust established the Community Paramedic Officer (CPO) role, based in GP surgeries but employed by the East Anglia Ambulance Trust. They respond to 999 calls and provide a range of community services, such as:

- taking blood in people's homes;
- carrying out electrocardiograms (ECGs);
- minor injuries work;
- supporting specialist clinics, such as asthma and diabetes; and
- conducting acute visits on behalf of the GP to carry out an initial assessment and recommend a course of action.

CPOs were targeted at areas with poor response times, and tended to go into the market towns to provide a visible presence for the service. There have been a number of beneficial results, including improvements in Category 'A' and GP urgent performance, as well as dramatically reducing the proportion of Category 'B' calls that lead to the patient being transported to hospital, although the Trust had a relatively high proportion of Category 'A' calls transported to hospital.

There are some risks in the CPO approach that the Trust has had to manage:

- management accountability when the CPO is based in the GP surgery and may 'go native';
- initial resistance from paramedics who may regard working on an ambulance as being the highest value work;
- skills decay because the CPOs deal with fewer life-threatening incidents – rotation with ambulance crews can help offset this risk;
- relief, as it is difficult to provide cover when CPOs are on leave; and
- the impact of Agenda for Change anti-social hours payments which have tended to lead to CPOs being paid less than traditional paramedics, although East Anglia Ambulance Service has sought to provide out-of-hours work to CPOs to offset this risk.

Source: Wales Audit Office and benchmarking report conducted by ORH

- providing mobile diagnostic services in the community, particularly using telemedicine to send the results to the secondary care provider; or
- developing a new high-dependency service to meet the needs of those with urgent but not emergency needs.

There are examples of innovation and good practice within the Trust

2.9 There are some examples of innovation and good practice that have been developed on a piecemeal basis across Wales. Although these are not universal, they have the potential

to support the development of new service models to better meet patients' needs, improve clinical care and drive down response times.

2.10 One particularly successful innovation has been the development of partnerships to deliver medical treatment centres in Cardiff and Swansea city centres at peak times. Although some of the demand for these mobile services has been new demand, which probably would not have led to an ambulance being deployed, there is strong evidence, both quantitative and qualitative, that these innovations have reduced the number of patients needing to be transported to hospital and improved the quality of care (Case Study D).

2.11 The Trust has also developed two Emergency Care Practitioners who have received in-depth training and have been deployed in south east Wales. In addition, advanced paramedic practitioners have been developed and deployed in some parts of south Wales. Case Study E shows the impact of these advanced paramedic practitioners in reducing the number of patients transported to hospital.

2.12 The Trust has also developed community responders, lay people trained in life saving skills, who can respond from within the community to complement the fully-equipped ambulance. The Welsh Assembly Government has also purchased community defibrillators. Community responders are especially valuable in providing

Case Study D: Cardiff Medical Treatment Centre

This scheme is a partnership between the Trust, Cardiff Council, Cardiff and Vale NHS Trust, St John Cymru Wales, South Wales Constabulary and the Welsh Rugby Union. It involves providing night time medical care in Cardiff city centre at peak times, such as Christmas and New Year, and following major sporting events, using a Mobile Medical Response Unit (MMRU) and a medical treatment centre based at the Millennium Stadium. The MMRU is made up of a Trust triage vehicle, staffed by a driver and a paramedic, supported by transport vehicles provided by St John Cymru Wales and the Trust. Patients are either treated in the triage vehicle, taken to the treatment centre at the Millennium Stadium, or transported to hospital.

Although this scheme will have met latent demand from patients who probably would not have ended up on an ambulance, an evaluation of the scheme found that 67 per cent of patients who required treatment from the MMRU were able to be treated without a hospital visit. A further 19 per cent went to hospital following treatment at the medical centre, taking with them their paperwork and x-ray requests, helping speed up treatment at the A&E department. The evaluation found that only 7 per cent of patients who needed treatment required an EMS ambulance to transport them to hospital. As a consequence, EMS vehicles were largely freed of city centre calls. The police also commented that the scheme helped free up their time because they did not have to wait with patients until an ambulance arrived.

Source: An independent evaluation of the Mobile Medical Response Unit and Cardiff Medical Treatment Centre arrangements in Cardiff City Centre, Tim John, July 2006

Case Study E: Advanced paramedic practitioners

In November 2005, the Trust introduced advanced paramedic practitioners into the Vale of Glamorgan, Swansea and Bridgend. These paramedics have received additional training and are able to provide an alternative range of treatments to those provided by existing paramedics. In November and December 2005, the three paramedic practitioners attended 246 patients, treating 68 per cent at home, referring 8 per cent to another source of healthcare without emergency ambulance transport, and transporting only 24 per cent to an A&E department by ambulance.

Source: Report by the Acting Director of Operations to the Trust Board, January 2006

rapid treatment for people having heart attacks (paragraphs 2.169-2.171). In addition, the Trust has participated in the development of some alternative care pathways for unscheduled care services. These have included alternative care pathways to allow patients to access the most appropriate source of care without automatically being transported in an ambulance (see Box 5).

There is significant goodwill towards the ambulance service in Wales

2.13 Our public hearings and submissions from members of the public and service users showed that, despite widespread concerns about response time performance and service cover in particular areas, there is clear evidence of the widespread public support and goodwill towards the ambulance service in Wales. This is a major strength for the Trust as it seeks to modernise and improve.

2.14 Another indicator of public goodwill is Wales' air ambulance service. In 2005/2006, the £1.6m cost of leasing and running the two permanent helicopters was met mainly through public fundraising by the Air Ambulance Charity, with a £229,000 contribution from the Trust (a third helicopter was introduced temporarily to cover Powys in the summer months of 2006 and will cease to operate at the end of November). Paramedic salaries for the service are funded centrally via HCW, in line with similar services in England.

2.15 The two permanent air ambulance helicopters are based at Caernarfon and Swansea and attended over 1,300 incidents and carried over 548 patients in 2005/2006. The air ambulance is able to take off within two and a half minutes of receiving a call and has an average flying time of 14.5 minutes. Aircraft are available on line for ten hours a day, seven days a week, which improves patient outcomes, mitigates difficulties in rural areas and frees other vehicles to respond to emergency incidents. The Trust's annual report for 2005/2006 states that the cost of running the air ambulance is likely to rise significantly – it says that new generation aircraft must be in place by 2009 but need to be ordered 18 months in advance.

2.16 At our public hearings, many people expressed the opinion that the air ambulance should be fully publicly funded and a more formal part of the ambulance service in Wales. This is a matter of policy for the Welsh Assembly Government but Wales is no different to England in this regard. In Scotland, however, the air ambulance is an absolute necessity to reach the islands and areas of extreme rurality, and receives £9m annual funding from the Scottish Executive.

Box 5: Assess and Refer pilot scheme

The Trust set up an Assess and Refer pilot scheme in Flintshire, adapted from the Kent model. The Trust provided a five day training course. The scheme considers 6 presenting conditions for which there is an algorithm, clinical notes, and guidance. There are currently 3 alternative pathways of care. Between April and September 2005, the Assess & Refer scheme has saved a median of 17:32 minutes per job cycle compared with the standard operational job cycle, which is typically between 60 and 70 minutes.

Source: Wales Audit Office, based on Trust report on Phase 1 of the Welsh Emergency Care Access Collaborative sustainability project, September 2005.

The Trust has structural stability as a national service, with national commissioning and scope for further national developments

2.17 The Bradley report in England, (Box 4) led to a programme of mergers to create twelve large ambulance services from the previous 31 services from 1 July 2006. The Trust benefits from having been through such a merger and from being a single national service covering the whole of Wales.

2.18 Nevertheless, many people who provided evidence to the inquiry team expressed the view that the creation of a single Trust had produced an organisation that could not provide appropriate services across an area the size of Wales. Although we believe that there should be greater operational autonomy for, and managerial capacity within, the Trust's regions to develop local unscheduled care services to meet patients' needs, we disagree that the single Trust should be split up because:

- **a** the lack of management capacity we found in the single Trust is unlikely to improve by creating more trusts;
- **b** a demerger would cause huge disruption after an extremely turbulent period for the Trust;
- **c** having a national Trust should not prevent the development of innovative local schemes if the management structure is appropriate; and
- **d** creating a number of new ambulance trusts in Wales would result in a significant increase in administrative costs.

2.19 Having a single Trust in Wales provides a number of advantages that represent a genuine strength in delivering the principles of DECS. Subject to improvements in management, it can provide economies of scale, improved career opportunities for staff and greater capacity to learn and do things differently.

2.20 The fact that emergency medical services are commissioned by a single national commissioner, HCW, is a strength because this increases the simplicity and speed of the commissioning structure. Although there are practical difficulties in liaising with 22 Local Health Boards, there is a need to improve the liaison between LHBs and HCW to ensure that its national commissioning takes account of local needs; the development of regional unscheduled care plans under DECS represents a further opportunity to link national and local commissioning to improve ambulance services.

2.21 As part of its consultation on DECS, the Welsh Assembly Government included proposals to bring NHS Direct Wales into the Trust from 1 April 2007. There are clear synergies at a national level between the telephone advice already provided by NHS Direct and the development of a broader range of ambulance services and roles. The opportunities of this merger include the scope to develop:

- **a** more hear and treat services;
- **b** alternative care pathways to respond more appropriately to the very many patients who do not require a fully-equipped ambulance response;
- **c** new and enhanced roles for paramedics and nurses;
- **d** an increased range of primary care services;
- **e** improved clinical triage and call categorisation; and
- **f** increased managerial and clinical capacity.

The Trust has enough human and financial resources

2.22 In common with many parts of the NHS, the Trust could doubtless find ways to spend any additional funding it received on further improvements to services. The service performance demanded, and the funding to support it, is ultimately a matter for the Welsh Assembly Government. In saying, as we do, that the Trust has "enough" human and financial resources we mean that the resources with which it has been provided should have been sufficient, if appropriately applied, to provide a level of service that would have been comparable with ambulance trusts elsewhere in the United Kingdom.

2.23 In that sense, the Trust has:

- enough staff;
- enough revenue;
- but needs further capital investment, partly as a result of poor management of capital.

Indicators suggest that the Trust has enough staff to meet demand

2.24 Many people have expressed the view that the Trust has insufficient staff to meet the demands placed on it effectively, and that this perceived shortage of staff is a contributory factor in the Trust's poor performance. Consequently, we examined whether the Trust has sufficient staff and whether it uses them as effectively as possible to meet demand.

2.25 Although workforce information and planning was poor (paragraphs 2.120-2.121), staff numbers (headcount) increased by 27 per cent between the creation of the Trust in 1998 and the 2005/2006 financial year. Sixty-five per cent of EMS staff are paramedics and 35 per cent are technicians, a relatively highly trained workforce.

2.26 We compared the number of staff in Wales with the number of people employed in English services. We found that the Trust has a high staffing proportion with one employee for every 1,184 residents: only two of the 31 English ambulance services had higher staffing than the Trust.

2.27 There are other indications that the total number of staff employed by the Trust may not be a constraint. Mr Thayne, while still Chief Executive of Staffordshire, carried out a benchmarking report that compared the Trust with Staffordshire. His report suggested that the EMS establishment in Staffordshire was one quarter of that in Wales but that its EMS workload was 44 per cent of that in Wales. The new Chief Executive has stopped an exercise to recruit 102 technicians, initiated with a view to addressing the impact on capacity of *Agenda for Change*, on the basis that they are not required. This mirrors comments made to us by regional operational managers that they did not need the additional staff. The paramedic capacity already available within the Trust represents a significant opportunity to address poor performance by changing working practices, developing new roles and providing additional unscheduled care services.

2.28 We also considered whether existing staff were effectively utilised. While there is no doubt that many staff within the Trust have extremely busy, hectic and stressful jobs, the overall way in which they are organised does not match the supply of people to demand for services as well as it should. We found that many trained paramedics are filling managerial roles and represent an effective loss of capacity and skills for the service. We also heard concerns about relief – being on call to cover unexpected

shortfalls – which, though an important element of providing an effective service, has been badly organised and disruptive.

2.29 We drew on an analysis of demand and the rostered hours of cover in each region, carried out by the new Chief Executive, Mr Murray. Mr Murray's analysis suggested, as the Thayne benchmarking report had previously, that the Trust has not organised its staff in such a way to meet peaks of demand effectively. The demand analysis does not account for hours lost due to sickness, vehicle failure, meetings or secondments, which means that it is based on planned hours rather than those actually delivered. The analysis suggested that the Trust's rosters were planning to provide over 50 per cent more hours of cover than it needed to meet demand, but that it was providing too many hours of cover when they were not needed and too few at times of peak demand, (Figure 29). Accounting for 'lost hours'[6] which are estimated to be around 20 per cent in the south-east but very much lower in the other two regions, this means around a 30 per cent surplus of hours, which suggests that the Trust has enough staff overall, but that the way it organises their time is inadequate to meet demand.

The Trust appears to have enough revenue but needs further capital investment, partly as a result of poor management of capital

The Trust has been adequately revenue resourced

2.30 Emergency services (EMS) in Wales are commissioned by a single national strategic commissioner – Health Commission Wales (HCW), which is an executive arm of the Welsh Assembly Government. Patient Care Services (PCS) are commissioned under contract by other NHS Trusts. The Trust also receives income directly from the National Assembly for Wales and other sources. In 2005/2006, the Trust received £115m total income: £81m from HCW, £16m from other NHS Trusts and £9m from the Welsh Assembly Government. Figure 18 shows that the Trust's income has risen by 73 per cent over the six year period between 2000 and 2006.

2.31 Our review identified that, compared with other rural ambulance services, Wales has received a higher income per head of population. Figure 19, shows that, the Trust has received the highest total income per head of population, relative to a sample of other UK rural ambulance services which includes Scotland and Northern Ireland.[7]

2.32 We also examined funding per square mile covered to assess whether this affected our conclusions about the relative resources provided to the Welsh Ambulance Service. Figure 20 shows that funding per square mile in Wales has, in 2004/2005 and 2005/2006, been lower than in the North East and East Anglia ambulance services, but that it has been significantly greater than in Scotland and Northern Ireland.

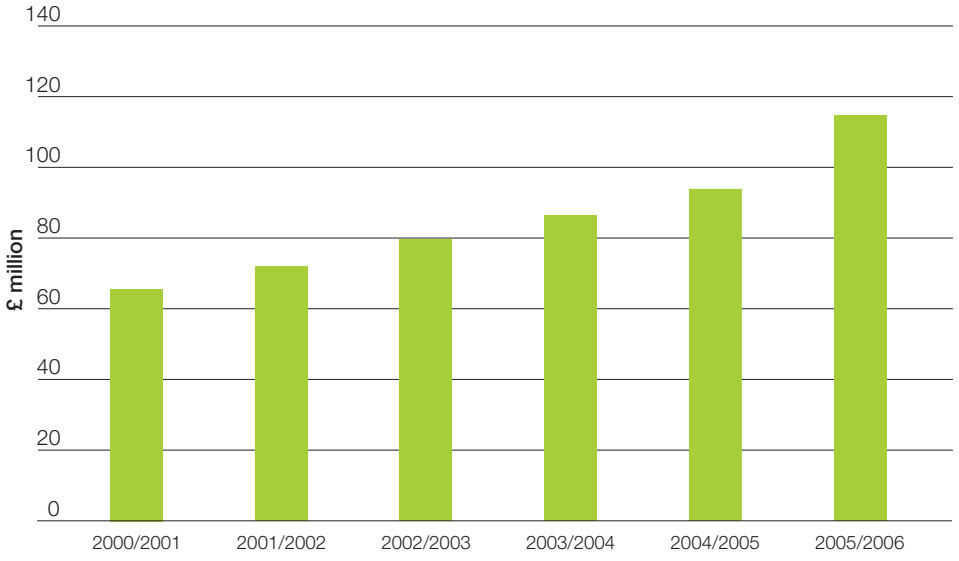
The relationship between regional funding and performance needs further exploration

2.33 A District Audit report in 2001, *Commissioning Emergency Ambulance Services*, identified substantial differences in the amount of funding and resources available regionally for the Trust's Emergency Medical Service in 2000/2001, when the service was commissioned by the five former health authorities in Wales (Appendix 5). The North Wales region received the highest funding per head of population, rota hour and journey and achieved the highest standards of

6 Lost hours are those planned but not produced, for example because of sickness, leave, unfilled secondments, meetings, vehicle failures and inefficient working practices.

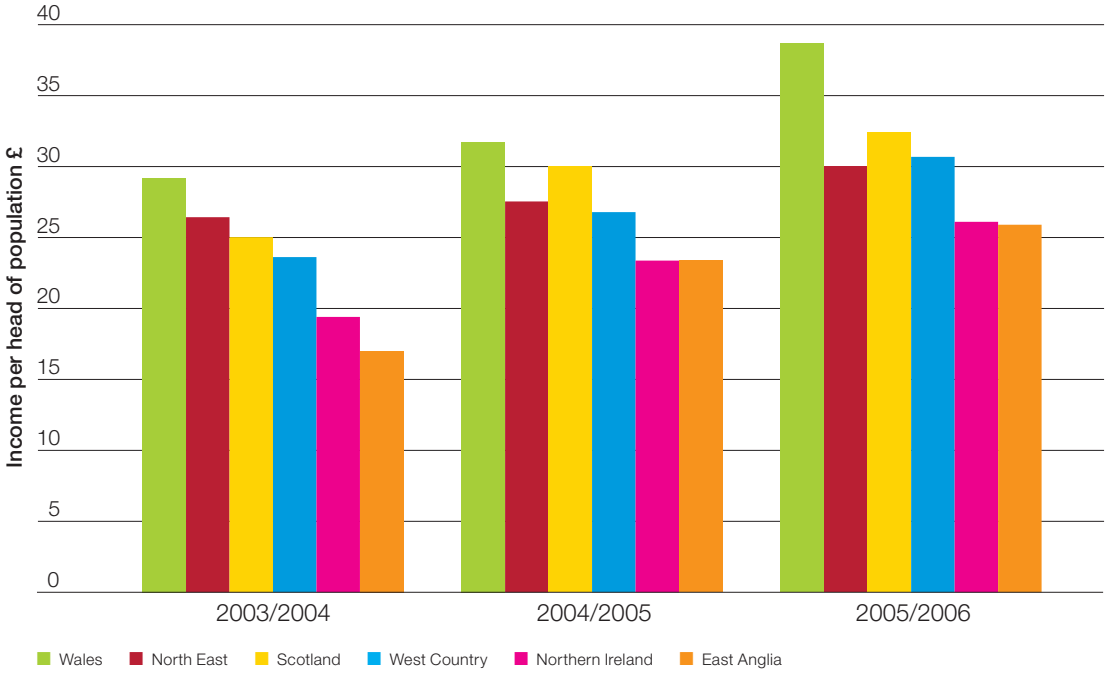
7 We have compared audited financial information with a selected sample of comparable English ambulance trusts and with the Scottish and Northern Ireland ambulance services. We have not compared financial information for the same data set as the performance analysis due to the lack of complete and robust financial information readily available from a single source.

Figure 18: The Trust's income has risen in recent years



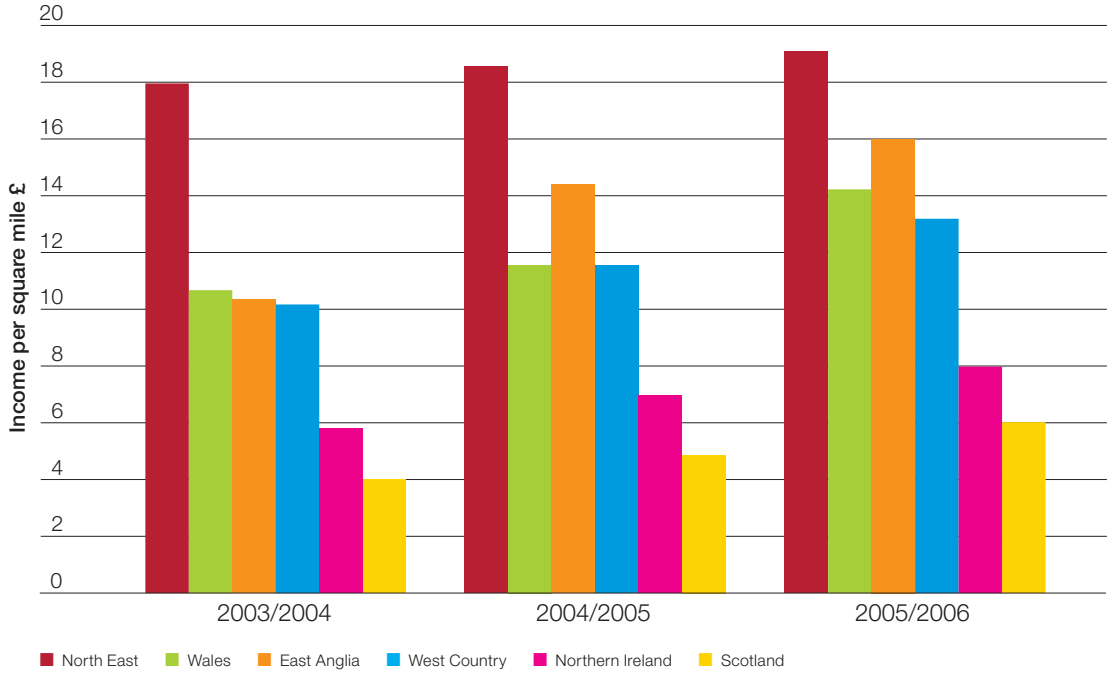
Source: Wales Audit Office, based on audited financial statements.

Figure 19: The Trust has received relatively more income per head of population compared to other benchmark rural ambulance services



Source: Wales Audit Office, based on Audited Financial Statements

Figure 20: There are some substantial differences in funding per square mile between Wales and other benchmark rural ambulance services



Source: Wales Audit Office, based on Audited Financial Statements

performance as regards responses to Category 'A' or 'B' calls. However, the report noted that, whilst differing standards of performance were evident, it was less clear whether this was due to the adequacy of funding or to the effective use of resources made available to the Trust.

2.34 The information currently available from the Trust suggests that, on two measures, such differential funding levels between the three regions of Wales persist today (Figure 21), as do differences in performance as illustrated previously in Part 1. However, the costs presented in Figure 21 exclude fleet and estate related costs which, in 2005/2006, were met from a central budget and are not able to be separated on a regional basis. Costs per emergency incident, scene attended and EMS journey are not consistent across the regions, which may reflect rurality, the road network and the number of receiving hospitals as well as the additional cost of providing cover across Wales. North Wales has median costs but achieves the highest response time performance for Category 'A' calls, while the South East costs the least but produces the lowest response time performance. Rural areas (with low population densities) tend to have lower response rates and longer round-trips to hospital, all of which tends to increase the cost per response, which means that these results need further detailed analysis to identify the scope for improved efficiency.[8]

There are indicators that the Trust has not used its resources efficiently

8 Audit Commission, Technical Note, Statistical Comparison of Unit Costs and Response Times between Emergency Ambulance Services, 1998.

Figure 21: Comparison of regional EMS costs and performance in 2005/2006

	Region		
	North Wales	Central and West	South East
Cost per EMS incident	£162	£177	£127
Cost per EMS journey	£218	£219	£161
Percentage of Category 'A' incidents attended within 8 minutes	64%	58%	53%

Source: Wales Audit Office

2.35 In 2005/2006 the Trust spent £115m, of which £85m related to staff costs, £14m to transport, £3m to premises, £4m to depreciation of their asset base, and £9m on other costs.

2.36 Expenditure is incurred maintaining the Trust's existing infrastructure and historical working practices but these are not based on a current review of demand and options for the most efficient means of service delivery. Historically, the Trust has not analysed the full costs of PCS and EMS as separate services. Consequently there is insufficient information to conclude whether the services are independently efficient. Trust officers have told us that there is cross subsidisation between the services. In the absence of costing information for each part of the service, our review considered total revenue expenditure and found that, compared with a sample of five other UK rural ambulance services (including Scotland and Northern Ireland), the Trust had the highest total expenditure per head of population over the last three financial years.

2.37 Our analysis found that in 2005/2006 the Trust's staff and transport costs (excluding lease costs) were the highest type of cost per head of population when compared with our sample of five benchmark UK rural ambulance trusts.

2.38 Three external reviews have also found that the Trust is relatively expensive and/or that there is scope for efficiencies to be made.

- Operational Research in Health (ORH) identified in 2001 that at least a 5 percentage point improvement in performance against the Category 'A' eight minute target could be achieved through efficiency measures (Box 7);
- Prior to becoming the Trust's Interim Chief Executive in March 2006, Mr Thayne's benchmarking report of 2005 identified significant potential improvements in efficiency through service modernisation; and
- In 2006, external consultants identified that the cost of the Welsh EMS was higher per head of population, incident attended and call received than many other UK ambulance services (Appendix 6).

2.39 The Trust has not routinely benchmarked its costs internally or with other ambulance services, beyond Mr Thayne's benchmarking report and a benchmarking exercise for control centres in 2005. Consequently the Trust has not assured itself of the efficiency of its own activities or services or learnt from best practice. Trust staff told us that they can see ways that the service can operate more efficiently

Figure 22: The Trust's asset base and capital expenditure is comparable to other rural services

Ambulance Service	2005/2006 Asset base per head of population £	2005/2006 Asset base per square mile £	Average annual capital spend (2003-2006) per head of population £	Average annual capital spend (2003-2006) per square mile £
Wales	12.70	4.68	1.69	0.62
East Anglia	4.41	2.73	0.60	0.37
North East	12.62	8.53	1.81	1.22
Scotland	15.26	2.51	2.55	0.42
Northern Ireland	10.49	3.18	1.83	0.55
West Country	10.34	4.49	1.19	0.52
Average	11.42	3.39	1.71	0.51

Source: Wales Audit Office, based on audited financial statements

without reducing the service to the public (paragraphs 2.49-2.53). This was reaffirmed by interviews with financial and management staff who stated that the Trust could operate more efficiently within their current levels of resources. A costing and benchmarking exercise is needed to inform modernisation planning.

2.40 The review by external consultants ORH identified the significant additional funding required to meet the targets set by the Welsh Assembly Government. The Assembly Government introduced additional recurrent funding of £1m in 2002/2003 and a further £2.5m in 2003/2004 to improve response times. While the initial funding in the last quarter of 2003/2004 corresponded to the achievement of 60 per cent of Category 'A' responses taking place within 8 minutes, this was not sustained in 2004/2005 or 2005/2006.

Despite receiving comparable capital to other rural services, the Trust remains in need of further capital investment

2.41 Figure 22 shows that in recent years the Trust has had an asset base and capital expenditure comparable to other rural ambulance services in the UK. Trust officers have told us that they expect the impending valuation by the District Valuer to significantly reduce the value of its land and buildings, because of the lack of investment in estates since the last valuation in November 2002. The asset base of English Trusts was revalued in April 2005.

2.42 Despite the comparable asset base and capital expenditure in recent years, our review identified that the capital infrastructure at the Trust was weak, particularly in respect of estates, fleet, ICT and communication systems (paragraphs 2.175-2.194). The current Chief Executive has proposed a ten-year capital investment plan of £132m as part of his modernisation review

Box 6: There is strong public support for front-line ambulance staff

'They are overworked people and they really do an excellent job.'

'I think the people, the operational staff of the ambulance service, need to be far more valued than they are at the present moment.'

'I could not fault the treatment and attention I was given. I give my wholehearted support to the paramedics for the treatment I received.'

'They worked on my father trying to 'bring him back' for a long while – it seemed until we as a family were ready and able to accept his death. They were very professional and compassionate and made a horrific time a little bit easier to bear.'

'She is an 85 year old lady who has suffered two heart attacks and, on both occasions, the paramedics were with her within minutes and she feels their attention was superb – she couldn't praise them highly enough.'

'The ambulance crew finally arrived at 7.50 p.m. They apologised profusely for the delay which they said was due to the changeover of shifts. They were really wonderful in dealing with my husband and the dreadful condition he and the bathroom were in. They were marvellous in reassuring us, cleaned him up a bit, carried out all sorts of emergency tests and transferred to him to the University Hospital of Wales where all the tests proved inconclusive. But if it had been a heart attack he would surely have died while waiting for help.'

Source: Written submissions to the Auditor General

(paragraphs 3.94 and Figure 44). Currently, these plans are necessarily indicative, including broad estimates built on themes in the modernisation plan, rather than derived from operational plans based on a comprehensive analysis of demand and options for a more effective and efficient service delivery. The plans have not yet been submitted to the Welsh Assembly Government.

The Trust's staff are a key strength

2.43 The Trust is in a service business. Its staff are therefore a crucial resource. We consider that they are a key strength too, because:

- the public recognises the skill and commitment of front-line staff;
- A&E consultants also view the staff positively;
- management relations with the trade unions are positive; and
- staff generally recognise the need to modernise.

The public have commended front-line staff

2.44 A key theme which emerged from our inquiry was the strong public support for and appreciation of the front-line ambulance staff. Although the public raised many concerns about the way the ambulance service was run, they consistently praised front-line staff for their professionalism and commitment (Box 6). The Board of CHCs in Wales told us that, generally speaking, the anecdotal evidence that they receive makes it clear that people are satisfied with and grateful for the efforts of the field staff; and that the only problem is whether they respond within the desired timescale. Finally, Dr van Dellen emphasised in a report to the Welsh Assembly Government upon his departure, that the Trust's front-line staff should be viewed as a key asset of the service, with a

high percentage of paramedics among the front-line staff and a number of degree paramedics. Mr Thayne told us that front-line crews in Wales were as good as those elsewhere.

A&E consultants have positive views of ambulance staff

2.45 We conducted a survey of consultants in A&E departments. We asked consultants to tell us about the comments patients make about crews from the Trust – they said that patients provide positive feedback and we received no examples of negative feedback. In addition, A&E consultants had generally positive views about the clinical care provided by front-line paramedics and technicians. Most consultants responding to our survey believed that ambulance staff make appropriate clinical decisions about the appropriate use of pain relief agents, cannulation, using aspirin in chest pain and the management of asthma and diabetes.

Positive relations with the Trade Unions are a strength but will need to be effectively managed to deliver necessary change

2.46 There has been considerable discussion about the role of the Trade Unions within the Trust and whether their influence is too strong. We met the principal trade union representatives on a number of occasions and reviewed relevant documentation. We were struck by the fact that the Trust enjoys a generally positive relationship with the staff side. Board members highlighted their view to us that the involvement of three staff side representatives at Board meetings was valuable. The Trust has a range of partnership structures and mechanisms for joint consultation that have the potential to support accelerated decision-making and finding solutions to the Trust's problems outlined in this report.

2.47 However, others view the staff side as a potential barrier to progress, particularly in regard to key modernisation issues, such as meal breaks and roster reviews. The Trade Unions appear to be extremely well organised, communicate effectively with their members and have talented people working for them. Several people expressed the view that the unions have effectively filled part of the void created by the Trust's lack of managerial capacity.

2.48 Rather than a threat, we regard the good relations with the unions as a potential strength for the future. However, more effective management and communication, directly with staff as well as through the unions, will be essential to delivering necessary change on key issues, such as meal breaks and roster reviews. An important element of that change will be to work closely with the unions: it is encouraging that the unions will sit on the Modernisation Committee of the Board that the new Chair has established. We were also encouraged by the stated commitment of the union representatives we met to modernisation and change. They appeared to recognise the value to their members of developing new roles, training, career paths and new service models to better meet the needs of patients.

Most staff recognise the need to modernise

2.49 A key strength of the Trust in moving forward is the fact that the majority of staff appear to recognise the need to modernise. Figure 23 shows that around 8 out of 10 staff responding to our survey both believed that most staff are prepared to work in different ways to improve services, and that they can see ways in which the Trust can operate more efficiently without reducing the quality of service to the public. These findings were consistent across the three regions and between different groups of staff.

Figure 23: Most staff recognise the need to operate more efficiently and believe that most staff are prepared to work differently

Source: Wales Audit Office survey of the Trust employees, analysed and reported by Beaufort Research Ltd

2.50 Staff stressed the need to modernise at the focus groups we held, raising the importance of developing local flexibilities and care pathways, and recognising that the Trust needs to be able to deliver a response that is more appropriate to the needs of the patient (Appendix 4). Staff also highlighted the importance of making better use of the Trust's resources, to get more from them and to stop doing what is not needed. Most staff we interviewed understood the importance of changing the way the Trust operated and the opportunities this presented for them and service users. Staff provided us with a wide range of good ideas about improving the Trust which we have shared with the new Chief Executive who has used this information to inform his own ongoing meetings with staff about their ideas for improvement.

2.51 Front-line staff are generally well-trained. In our survey, 68 per cent of respondents said that they had been adequately trained to do their job, with 16 per cent disagreeing. The level of agreement was highest for front-line operational staff and lowest in the control room and non-operational management. The Trust has, in the past, focused on clinical training and has successfully increased the clinical nature of the training provided; staff have learned new techniques such as thrombolysis, the use of resuscitating devices, and all paramedics should have received thrombolysis training by the end of the 2006 financial year.

2.52 The modernisation agenda will expand the training needs of staff, particularly to support paramedics in new ways of delivering care, for example by becoming ECPs and CPOs (see Box 4). One of the many potentially positive benefits of delivering the emerging DECS strategy should be a broadening of the range of training the Trust provides for its staff, to facilitate more appropriate responses to the majority of calls that are not genuinely life-threatening. Taking healthcare to the patient (Box 4) estimates that up to 90 per cent of patients calling 999 do not need advanced life-saving skills, although they do need urgent primary care. Consequently, high quality training to enable staff to see and treat, or assess and refer, patients in the community,

without transporting them to hospital, has the potential to deliver significant benefits across the whole unscheduled care system.

2.53 The Trust accepts that it has management capacity issues that need to be addressed. Training and development should encompass not only clinical staff, but also managerial and support staff, to ensure that they have the skills to fulfil their roles as effectively as possible. The Trust recognises that training and development for middle managers has been a weakness but this should be addressed through the knowledge and skills framework within *Agenda for Change,* and implementation of the draft modernisation plan. The Trust will also need to ensure adequate specialist training for those working in functions such as fleet, estates, ICT, HR and finance.

The Trust has been let down by failures in a number of key areas

2.54 Having seen clear evidence of considerable strengths in the Trust, we examined why its performance has nevertheless been disappointing for many years. We found failures in all the key areas of business management, namely:

- an absence of strategic direction;
- a short-term approach to financial management;
- ineffective governance;
- weak leadership;
- poorly designed and managed processes;
- poor systems and infrastructure; and
- serious concerns about organisational culture.

There has been no effective strategic direction for the Trust

There has been an absence of a clear vision for the future of the organisation and strategy to deliver it

2.55 Ambulance services generally face a number of clear opportunities and threats, as demand for services changes, new models of service delivery emerge and the configuration of health services changes. This provides opportunities to develop new ways of working, provide new services, and take a leading role in the provision of mobile primary healthcare across the whole system of health and social care. Consequently, the development of a clear strategic vision for the Trust, and of plans to deliver the vision, has been an essential requirement for it to operate effectively.

2.56 The Trust's new Chief Executive is currently developing and consulting on a detailed modernisation plan, *Time to make a difference*, which will form the Trust's strategy for the future. The Trust has developed previous strategies which the new modernisation plan will supersede. The rapid changes in strategy are perhaps not surprising, given the changes in leadership since November 2005, but the absence of a clear, agreed vision and strategy, supported by sound business planning processes, has been a major barrier to change and improvement.

2.57 The Trust has produced various strategy documents:

- a strategy 2005-2009;
- a strategic action plan, agreed in January 2006;
- a business plan 2006/2007, developed by Dr van Dellen; and

- *Time to make a difference: transforming ambulance services in Wales*, which is currently subject to consultation.

2.58 The strategy 2005-2009 was developed after the Trust came under pressure to develop a modernisation vision and strategy from the Welsh Assembly Government Department for Health and Social Services North Wales Regional Office, central Welsh Assembly Government divisions and HCW, in the middle of 2004. These organisations met in July 2004, and all parties expressed concern about the performance and strategic direction of the Trust and its ability to modernise and change. This meeting took place shortly after the then Commission for Health Improvement (CHI) published in February 2004 a clinical governance review that criticised the strategic management of clinical governance in the Trust.

2.59 It is unusual for external pressure to be necessary to encourage an organisation to produce a strategy: effective organisations scan their environment continuously, have strategic planning processes that are embedded within their day-to-day operations and strive continually to improve services through robust corporate planning processes. Nevertheless, it was external pressure in 2004 that impelled the Trust to produce the strategy 2005-2009 and the strategic action plan, as well as to accept external advice from Roger Thayne. However, the Trust failed to support these high-level documents with any clear business or action plan that set out how the strategic objectives would be delivered. Senior managers in the Trust told us that they lacked the leadership and capacity to translate the strategic documents into clear, deliverable action plans. The lack of costed plans, clear priorities and individual responsibilities raises significant doubts about whether the Trust knew how it would deliver modernisation. In its 2005/2006 annual report, the Welsh Assembly Government Department for Health and Social Services North Wales Regional Office identified the ongoing need for the Trust to develop and communicate a clear vision and modernisation plan for the next five years.

2.60 The Trust's strategic planning has also been compromised by a 'one size fits all' approach. We found that, although there are many common factors, there are also differences in the main strategic challenges and opportunities that face the different regions of the Trust, and particular challenges in some localities, such as Powys which covers a very large geographical area in which there is no district general hospital. Consequently, there needs to be more effective strategic planning at a regional and local level, within the framework of the corporate strategy, to ensure the development and delivery of appropriate changes that can meet specific local requirements.

2.61 The significant weaknesses in the Trust's strategic direction are reflected by the consistent confusion of stakeholders about the strategic direction of the Trust:

a only 12 per cent of staff agreed that the Trust kept them well-informed of its future strategic direction;

b the Joint Emergency Services Group expressed the view that the 'strategic direction of the Welsh Ambulance Service has been and remains unclear', although it recognised that the modernisation plan should provide this clarity of remit;

c only one of the 13 A&E consultants who responded to our survey agreed that the Trust had a clear plan for improvement that is well understood within the A&E department – six were neutral, four disagreed on the whole and two disagreed

strongly. Eight out of 13 disagreed – two strongly – that the Trust had consulted the A&E department about its plan; and

d one Trust Chief Executive wrote to us to highlight the importance of the Trust developing a clear sense of strategic direction which aligns with the Department of Health report, *Taking Healthcare to the Patient.* Another highlighted the need to develop new roles and to integrate the ambulance service much more closely with the whole unscheduled care system, to develop a single integrated unscheduled care team that meets local patients' needs.

Financial targets have been achieved but not in a sustainable way because the Trust has not been sufficiently focused on long-term financial considerations

2.62 One of the achievements of the Trust has been its achievement of statutory financial targets to break even and meet the external financing limits. In 1999/2000, the Trust predicted a £3m funding deficit to meet the costs of its reconfiguration as a national Trust. The Welsh Assembly Government provided additional funds and agreed a financial recovery plan with the Trust. The Trust repaid the funds and achieved financial balance by 2004/2005 in line with its agreement with the Welsh Assembly Government. The Trust has, however, predicted a significant revenue deficit in the current and future financial years and is negotiating a Strategic Change and Efficiency Plan (SCEP) with the Welsh Assembly Government to manage its financial recovery, and enable it to meet the statutory financial target to break even.

2.63 Our examination of the Trust's underlying financial position and of its current financial difficulties indicates that it has been too focused on the achievement of the annual financial target to break even, rather than sustaining the long-term financial position. In particular:

- revenue budgets have not been derived from any long-term financial strategy but have been merely a roll over of the previous year's out-turn;
- financial balance has been achieved through essentially short-term measures; and
- capital funding has been only weakly managed.

2.64 Revenue budgets have not been explicitly aligned to a long-term organisational strategy or medium-term business plans to improve services, identify efficiencies and manage financial pressures. Revenue budgets are essentially a rollover of the previous year's outturn, with adjustments for non-recurring items and an inflationary uplift. Budgets therefore reflect the Trust's existing infrastructure and working practices, rather than key strategic priorities and an analysis of demand and review of options to improve the efficiency and effectiveness of services.

2.65 The Trust does not systematically produce, monitor or benchmark adequate costing information to identify inefficiencies and to learn from best practice. The Trust does not monitor, analyse or compare the full cost of its core EMS and PCS activity. Nor does it adequately collect or compare the costs of other services, such as fleet and estates.

2.66 Since 2001/2002 the Trust has carried an income and expenditure reserve deficit due to an increase in long-term provisions not being funded by the Welsh Assembly Government. The reserve deficit began as £2.2m 2001/2002 and by 2005/2006 had

reduced to £1.4m. Trust officers told us that the Welsh Assembly Government agreed that the deficit could be left to erode over time.

2.67 Despite receiving adequate revenue funding (paragraphs 2.30-2.32), the Trust is facing significant financial pressures. In 2005/2006 the Trust broke even as a result of £7.4m additional funding and unplanned non-recurring gains, composed of the following:

- £2.2m additional funding to meet *Agenda for Change* costs;
- £3.2m transfer of capital resources to revenue on special dispensation from the Welsh Assembly Government;
- £1.9m release of provisions; and
- £0.1m interest gained on the investment of *Agenda for Change* funding.

2.68 Capital management has also been weak. Despite a comparable asset base and capital expenditure in recent years (paragraphs 2.41-2.42), we found evidence that the Trust's capital infrastructure was in need of significant investment, particularly in respect of estates, fleet, ICT and communications equipment.

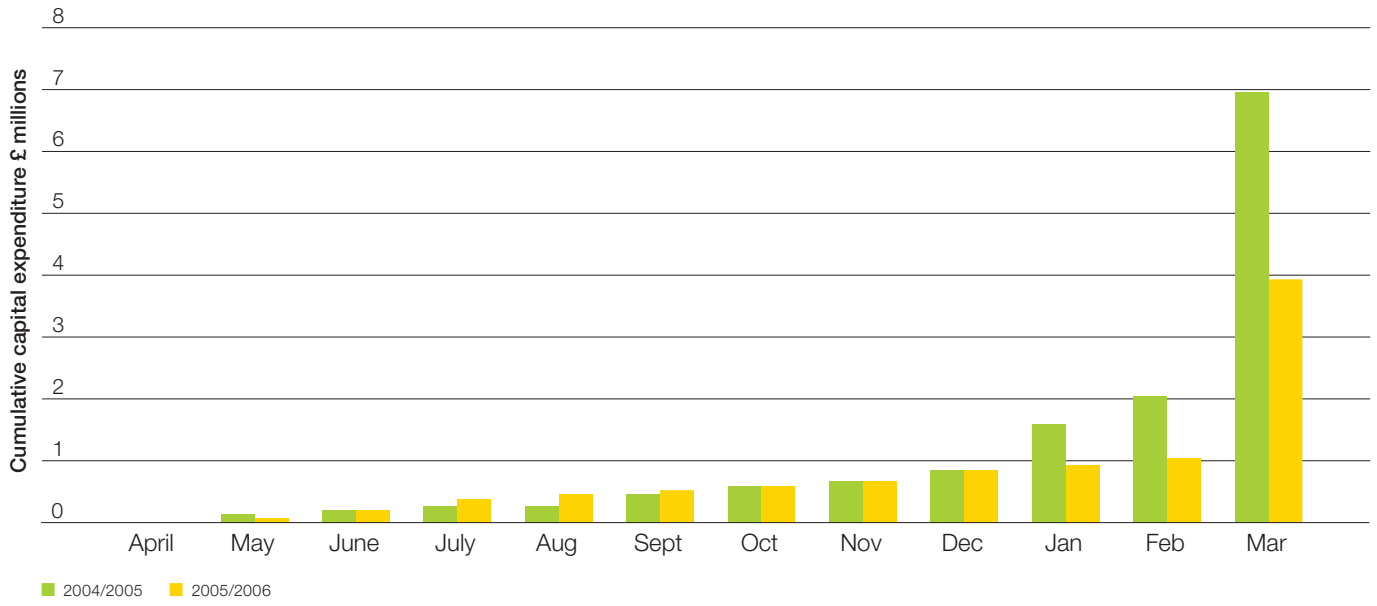
2.69 Long-term capital planning has not been explicitly linked to a Trust strategy or quantifiable future revenue savings. There have been serious deficiencies in capital procurement processes which have led to capital being wasted, (paragraphs 2.195-2.207).

2.70 Each year the Trust has transferred a significant amount of its discretionary capital funding to revenue to meet vehicle leasing costs. In 2005/2006, £3.2m of the Trust's £3.9m recurring discretionary capital funds were transferred to revenue. The Trust was then reliant on additional and unplanned capital funding (£1.5m) that became available from the Welsh Assembly Government at the end of the financial year to fund their capital expenditure needs.

2.71 Trust officials told us that capital decisions were rushed at the year end when there was greater confidence about the availability of resources for capital expenditure, but this made it very difficult to plan more than a few months in advance and may have contributed to capital not being used in the most effective way. The Trust was insufficiently proactive in developing business cases in preparation for the later availability of capital or with a view to securing additional capital from the Assembly Government. This was a factor in the procurement of the chest compression devices (Case Study K). Our analysis of cumulative capital expenditure shows how the majority of capital expenditure was incurred in the final months of the financial year (Figure 24).

2.72 Mrs Lloyd, the Head of Health and Social Services in the Welsh Assembly Government, told us that capital funding had been, and continued to be, available but that the Trust had not until recently submitted timely and robust business cases to access capital. The Trust's Director of Finance disputed this claim. However, Mrs Lloyd told us that the Assembly Government was prepared to consider supporting a capital scheme to purchase rather than lease vehicles as long as the business case could demonstrate value for money in the long-term. The Assembly Government had only recently received a business case to purchase additional vehicles, which it had approved.

Figure 24: Capital expenditure is considerably higher at the end of the financial year



Source: Wales Audit Office, based on Welsh Ambulance Services NHS Trust Monitoring Returns to the Welsh Assembly Government

Governance has not been effective in securing improvement

Internal governance has been weak

2.73 The Trust Board has a key role to play in setting the direction for the organisation, overseeing progress towards strategic goals and monitoring operational performance. There are a number of other committees that support the Board:

- HR Committee;
- Audit Committee;
- Governance Committee;
- Remuneration Committee; and
- a new Modernisation Committee.

2.74 We found evidence that, historically, the Board did not adequately set and monitor a strategic direction for the executives and organisation. In this regard, the Board has been hampered by the poor quality of information it received. Non-executives explained that the poor quality and availability of information from successive Chief Executives had hampered scrutiny. Performance monitoring reports were around two hundred pages long and did not provide meaningful analysis of such a large quantity of data. Similarly, the Board has not received accurate costing information, linking financial and performance information. Some Board members told us that when they asked executives for more information to aid their understanding, they believed the executives' response was to swamp them with a large amount of data rather than meaningful management information.

2.75 There has been no benchmarking of the Trust against other ambulance services, which has compromised the Board's understanding of the business. Some non-executives told us that they had asked the executives to produce benchmarking information but that this was not

forthcoming, partly because the executives, wrongly, stated that Scotland was the only appropriate comparator. The impact of Mr Thayne's benchmarking report reflects the significance of this omission – benchmarking should be a routine part of running an effective organisation. Even where organisations differ in important ways – as Staffordshire and Wales do – the results of benchmarking exercises raise important questions that can act as a driver of improvement.

2.76 It is essential for executive and non-executive members of the Board to have a good understanding of the business. Although our interviews suggested that the current non-executives now understand the key issues facing the Trust, historically there may not have been the depth of understanding of the business required to move it forward, partly because of the frequency of Board meetings and the fact that non-executives did not all feel that the previous Chair had fully involved them in decision-making. The following issues suggest this:

a there has been a strong focus on perceived increases in demand, and the level of funding for the organisation, despite the fact that other similar services have experienced similar or greater increases in demand (paragraph 1.29-1.34) and the Trust has received additional funding as a result of the ORH report (see Box 7);

b before the Thayne benchmarking report of April 2005, the Board appears to have been unaware that the Trust was relatively generously funded or of the extent of the problems with the way it was operating;

c both Mr Thayne and Dr van Dellen highlighted concerns about the Board's understanding of the Trust's position. Mr Thayne produced a report, which the Board discussed in closed session in May 2006, and Dr van Dellen produced a report for Mrs Lloyd of the Assembly Government upon his departure. Both raised their concerns about the lack of Board's understanding of the seriousness of the problems in the Trust, particularly in regarding the service as 'average'. They repeated these concerns in interviews with the Wales Audit Office. Board members felt that they had not had sufficient opportunity to discuss and challenge these claims;

d regarding improving performance against targets, the Trust consistently focused on the additional funding requirements it felt it needed to achieve certain response times but did not pursue the 5-6 per cent efficiency gains the ORH report said the Trust should be able to deliver by improving its processes, or the fact that the Welsh Assembly Government had provided one third of the identified funding but the Trust had not delivered sustainable improvement in performance once it had achieved 60 per cent in March 2004; and

e there are significant problems with Patient Care Services, yet this has not been a priority because of the Board's focus on EMS response time performance and the financial position.

2.77 There is also historical evidence that the Board was not effective in scrutinising performance. One obvious weakness is that the Board met only quarterly, plus an Annual General Meeting, under the previous Chair, Mr Norris. The new Chair, Mr Fletcher, who took up office on 1 April 2006, has instituted monthly meetings. The previous Chair told us that the use of the Trust's other committees and 'awaydays' was a more appropriate way to do business, and expressed the view that monthly meetings

Box 7: Operational Research in Health Limited (ORH) Study

In early January 2001, the National Assembly commissioned Operational Research in Health Limited (ORH) to undertake a study of emergency ambulance cover in Wales.

ORH reviewed emergency ambulance and 'responder' cover across Wales to identify optimum resource deployments to allow targets to be met efficiently.

The study concluded that, based on a 3 per cent annual increase in demand, the Trust could improve the service-wide Category 'A' performance against the 8 minute standard by 5 percentage points based on existing resources with some modernisation in how the service was delivered. They also provided a series of different options of investment to hit minimum targets at a Unitary Authority level (see table below).

Options set out in the ORH report

Target at Unitary Authority Level			Additional Annual Cost
Category 'A' 8 minute	All emergency calls within 14, 18, 21 minutes	GP urgent calls – arrival within 15 minutes of the agreed time	£ million
60%	95%	95%	4.7
75%	95%	95%	6.7
85%	95%	95%	8.9

As a result of the ORH study, in 2002/2003 the Welsh Assembly Government provided £1m additional funding and in 2003/2004 HCW provided the Trust with an additional £2.5m recurrent funding to start to improve performance. While performance improved in the last quarter of 2003/2004, this was not sustained in 2004/2005 and 2005/2006.

Source: Wales Audit Office, adapted from ORH study.

'gave an air of crisis'. However, other Board members indicated that the regular 'awaydays' generated good discussion and ideas, but that very little happened as a result. They also told us that the 'awaydays' did not happen as regularly as had originally been planned.

2.78 Given the poor performance of the Trust, and the significant problems with service provision, leadership, management capacity and the overall health of the organisation, quarterly meetings were insufficient. Given the often poor quality of information presented by executives, quarterly meetings seem to be a factor in the inability of the Trust to develop and maintain momentum in developing and then implementing a clear strategic vision. Nevertheless, Mr Norris told us that one of the reasons for moving to quarterly meetings was to help executives provide the Board with more strategic papers of a higher quality.

2.79 The Board has also lacked a forward programme, both for the main Board and its other committees, to guide its work and to make the best use of the limited time and expertise of non-executives. There has been no regional responsibility of non-executives which could contribute to non-executives' understanding of the business on an all-Wales basis and help to support managers in resolving some of the regional variations in performance.

2.80 The absence of a clear vision and strategy for the organisation has compromised the effectiveness of the Board. Weaknesses in performance management have exacerbated this. As well as weaknesses and gaps in the information provided to non-executives, the previous Chair failed to agree written performance objectives with the then Chief Executive, Mr Page, although some discussions about his performance took place sporadically. In turn, individual objectives were not regularly agreed and documented between Mr Page and members of his executive team. As a consequence, the Board was slow to identify and act upon weaknesses in management capacity.

2.81 The circumstances surrounding Mr Page departing the Trust are an example of a failure to involve non-executives appropriately and to manage the performance of the organisation and its leaders (Case Study F). Mr Page had been successful in bringing together the predecessor

Case study F: Mr Page's departure reflects weaknesses in internal governance

In July 2004, the various external governance organisations met to discuss serious concerns about the Trust. Subsequently, during 2005 the previous Chairman agreed that Mr Page's voluntary premature retirement would be 'in the interests of the efficiency' of the service.

The former Chairman wrote to Mrs Lloyd explaining that "Mr Page has recently realised that he would wish to pass the challenging leadership mantle to a new Chief Executive who would have the renewed vision, enthusiasm, skills and leadership style to take this organisation to a different level of development."

Both the former Chair and former Chief Executive believed that Mr Page had reached an agreement with the Welsh Assembly Government on this, which would take effect from the end of November 2005.

This case reveals serious governance issues:

- the Chair sought to initiate a meeting of the Remuneration Committee to discuss significant issues about the terms of Mr Page's proposed departure via e-mail, rather than a meeting, in late November; some of the non-executives expressed the view that there had been little or no prior consultation from the Chair or time to consider this decision and a decision was not made until March 2006;
- the former Chief Executive's performance does not appear to have been managed effectively, and there is no record of any performance management on the former Chief Executive's file; Mr Norris had written to Mrs Lloyd in April 2004 indicating that Mr Page had met all of his objectives, yet by the following year had entered into discussions with Mr Page about his future; Mr Page told us that Mr Norris had not provided him with written performance objectives although they discussed priorities more generally;
- the concerns about the Trust appear to have emerged very rapidly, possibly as a result of external pressures; non-executives told us that they had raised concerns individually with the Chair about Trust leadership, but that they had not been aware that others had done the same; the Board should have discussed and addressed these issues earlier in the interests of the organisation and the individuals concerned; and
- the issues of the terms of Mr Page's departure should have been discussed earlier by the Board rather than the previous Chair seeking to rush the decision through in November after discussions with Assembly Government officials, which placed non-executives in an invidious position.

Source: Wales Audit Office

trusts to form a single Trust for Wales after a long career in the ambulance service. The case study relates to the adequacy of governance rather than Mr Page's performance.

2.82 The weaknesses in strategy, performance management and governance have led to an overall lack of accountability for the performance of the organisation and of the senior executives responsible. There have been a series of very damaging mistakes in procurement, yet we found no evidence of this being picked up in the appraisals of senior executives.

2.83 A series of known problems has not been addressed effectively:

- **a** differential performance levels and processes have not been addressed, and good practice has not been disseminated effectively within the Trust or from services outside Wales;
- **b** in 2001, the ORH report (Box 7) highlighted the fact that the Trust could better match supply and demand through improved dynamic cover practices and roster changes, yet rosters still remain to be reviewed and changed;
- **c.** there have been very serious problems with the Trust's estate over a number of years, with an ongoing Health and Safety Executive notice, but there has been no clear decision about future estates strategy despite a number of external reviews;
- **d** audit reports have highlighted weaknesses in performance management arrangements, particularly in supporting the Board to oversee strategic priorities, yet there has been little progress in improving the performance management framework in line with the auditors' recommendations of October 2004;
- **e** annual performance reports from the Welsh Assembly Government Department for Health and Social Services North Wales Regional Office have raised similar issues;
- **f** the issue of transferring capital to revenue to cover car leasing costs has been a known problem for some years but the Trust did not until recently submit a business case on which it and the Welsh Assembly Government might find a sustainable solution. This has significantly reduced the level of planned discretionary capital available to the Trust; and
- **g** executives did not bring the new system purchased for PCS to the Audit Committee to identify what had caused the problems and to learn lessons for future procurements.

2.84 Despite these weaknesses, there is some recent evidence of progress in strengthening the Board and management structures and improving internal governance:

- **a** since April 2006, the Board has moved to monthly meetings;
- **b** a governance development programme is ongoing with support from the Trust's internal auditors;
- **c** all non-executives told us that they are much more closely involved in decision-making under the new Chair than they were under the previous Chair;
- **d** the new Chief Executive, Alan Murray, has agreed, documented personal objectives which have been shared with all Board members;
- **e** a new company secretary has recently been appointed;

f the events of the last 18 months appear to have served to inform non-executives of the scale of the problems facing the Trust; and

g the Chair has established a Modernisation Committee, which will oversee the delivery of the Trust's modernisation plan and the Service Change and Efficiency Plan (SCEP).

External governance has not been sufficiently co-ordinated

2.85 HCW has commissioned ambulance services in Wales since 1 April 2003. The 13 acute trusts in Wales, 6 trusts in England and Powys LHB commission patient care services. The Welsh Assembly Government Department for Health and Social Services North Wales Regional Office has been responsible for the performance management of the Trust since April 2003, with input from the Welsh Assembly Government Department for Health and Social Services Directorate of Performance and Operations on policy, and quality directorate on clinical matters.

2.86 The external governance organisations correctly diagnosed many of the issues facing the Trust and have sought to take various actions to address them. There was a meeting on 16 June 2004 between HCW, CHI reviewers and the Welsh Assembly Government Director of Performance and Operations. There was a further meeting on 7 July 2004 between HCW, the Welsh Assembly Government Department for Health and Social Services Regional Office and the Welsh Assembly Government policy and operations and quality directorates to discuss concerns about the organisation. These concerns reflected many of the issues highlighted in our report, and led to the decision to seek external assistance for the Trust, which eventually resulted in Mr Thayne producing his original benchmarking report in April 2005. In particular, both HCW and the Welsh Assembly Government Department for Health and Social Services North Wales Regional Office clearly sought to push the Trust to improve its performance against Ministerial targets and to encourage the organisation to develop a clear modernisation strategy. In addition, Ann Lloyd, Head of the Department for Health and Social Services, and Derek Griffin, North Wales Regional Director, of the Welsh Assembly Government, met the Chair and Chief Executive on a number of occasions and met some of the non-executives in February 2006 and April 2006, to raise their concerns about the organisation and how to address the lack of management capacity within the Trust. Both the regional office and HCW individually visited Staffordshire Ambulance Service in January and April 2005 respectively.

2.87 Nevertheless, we also found evidence of difficulties between the parties involved in external governance:

a there were problems agreeing the minutes of the meeting between the external governance bodies of July 2004 (and following action); consequently, the agreed minutes state that since the meeting it has become clear that there is 'no overall agreement as to the way forward'; Mrs Lloyd told us that she over-ruled this and ensured agreement about how the decision to engage external support should be taken forward; and

b when the Trust argued vigorously against HCW's attempts to introduce rewards and penalties into the 2004/2005 Heads of Agreement for achieving 60 per cent performance, the regional office expressed concerns about the impact and potential for the Trust's performance to fall as a consequence of the method proposed – as a result, HCW agreed to drop its plans to introduce rewards and penalties.

2.88 We also found that there was some wider risk of overlap about the external governance arrangements and the respective roles of the various organisations. Both HCW and the regional office have a role in performance management. HCW is responsible for ensuring the achievement of the service specification it commissions, which covers quality, targets, funding and activity. The regional office is responsible for ensuring that the Ministerial targets are achieved and monitors the organisation against a balanced scorecard that measures four perspectives of performance (stakeholders, resource utilisation, management process and innovation and learning). However, HCW's role focuses on one part of the Trust's business, whereas the Welsh Assembly Government Department for Health and Social Services Regional Office has a focus on the whole organisation.

2.89 In addition, some interventions by the bodies responsible for external governance have not been sufficiently co-ordinated. There were particular problems around the original benchmarking report produced by Mr Thayne. The Welsh Assembly Government Department for Health and Social Services Regional Office told us that it had discussed the need for assistance with the Chief Executive and Chair of the Trust, who then invited Mr Thayne to carry out the benchmarking report. HCW officials told us that they had not been involved in establishing the terms of reference of the benchmarking review. In addition, HCW officials experienced difficulties obtaining a copy of Mr Thayne's original benchmarking report from the Trust and that the Trust did not provide HCW with a copy of the report, produced in April 2005, until the December of the same year.

2.90 Recognising the risk of overlap between performance management and commissioning for this unique organisation within NHS Wales, Mrs Lloyd has asked the Director of Performance and Operations to draft a memorandum on roles and responsibilities , which she will issue in March 2007, after the Trust has given its views on these proposals.

2.91 There have been consistent problems between the Trust and HCW in agreeing Heads of Agreement to support the delivery of SaFF targets, both under Mr Page and Mr Thayne. The Welsh Assembly Government Department for Health and Social Services Regional Office's annual report in 2004/2005 referred to relationship issues between the Trust and HCW, while documents from HCW claim that the Trust adopted a confrontational approach to their EMS commissioner, with disagreements appearing to centre on the financial resources necessary to achieve targets. Historically, the Trust argued that increased demand necessitated additional resources. Problems agreeing the 2004/2005 Heads of Agreement led to an unacceptably late arbitration meeting, facilitated by the Welsh Assembly Government's Regional Office, in January 2005, less than three months before the end of the financial year in question. Subsequently, in 2006, Mr Thayne argued against the imposition of an improvement plan and SCEP, which would show over time how the Trust would return to balance, at a time when he believed investment was necessary to deliver changes in service models. There are ongoing discussions about the SCEP for the current financial year, which covers the whole organisation and not just the elements of it commissioned by HCW.

2.92 Further indicators of the problems with external governance are manifested in a number of other ways:

a commissioning has not yet, in common with most services in England, sufficiently focused on clinical outcomes and a broader range of indicators of performance. Expert commissioning is important for ambulance services so that the commissioner understands the specific issues involved in providing ambulance services. Case Study G demonstrates two different commissioning systems, used in Scotland and East Anglia, both of which benefit from expert commissioning;

b the strength of focus on delivering a 60 per cent response rate for Category 'A' calls has tackled the symptoms rather than the causes of poor performance, and may have constrained the delivery of broader improvements in services and the way the organisation operates;

c In a report to the Board, one of the reasons cited by Mr Thayne for his resignation as interim Chief Executive was that 'the seriousness of the Trust problems and the need for action were not fully understood by the Trust Board, the North Wales Region or the Welsh Assembly Government'; both Board members and the Welsh Assembly Government dispute this assertion. Mrs Lloyd has also told us that Mr Thayne gave her different reasons for his resignation; and

d additional resources have been provided but have not delivered sustainable improvements; in response to the ORH report, the Welsh Assembly Government introduced additional recurrent funding of £3.5m in two tranches in 2002/2003 and 2003/2004; this led to the delivery of 60 per cent performance in March 2004,

Case Study G: Commissioning emergency ambulance services in Scotland and East Anglia

The Scottish Ambulance Service (SAS) aims to balance the local focus of a national service through a 'commissioner and provider' relationship between the Board and its divisions. The Board and the executive team align themselves with the Scottish Executive and consider themselves responsible for setting and maintaining the strategic direction of the service by 'commissioning' ambulance services from the six 'providing' regional teams. Regional managers align themselves with local NHS Boards and Regional Health Boards to maintain a local focus for the services they provide. There are central support services for the regions but the centre aims to empower regional teams by ensuring they are responsible and accountable to the centre for their own performance (it has to be noted that the accountability between the Welsh Assembly Government and the NHS in Wales is different to the accountability between the Scottish Executive and the NHS in Scotland).

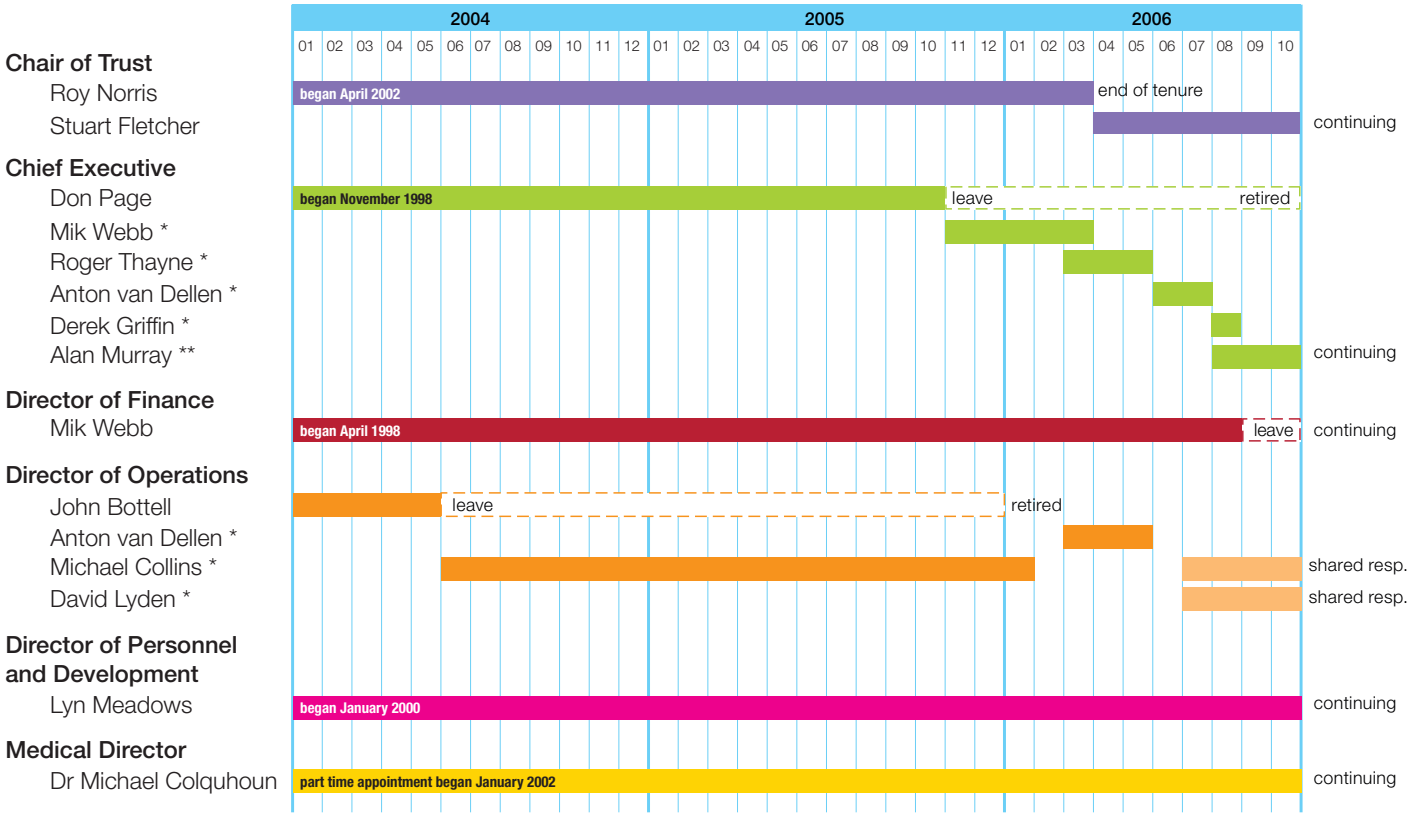
SAS holds local and national Annual General Meetings to affirm regional autonomy.

SAS is funded centrally from the Scottish Executive. They believe that local commissioning by each health board would be inefficient and would potentially produce a divergent service with different local levels of care dependent on the financial health of local health boards. As a national service they can control resources and funding efficiently, which fits well with the service's perception of the executive being a 'commissioner' of local service delivery.

In the former East Anglia Ambulance Trust, a consortium, with representation from all of its constituent Primary Care Trusts (PCTs), commissioned emergency ambulance services. The consortium employed a lead commissioner who liaised between the ambulance service and PCTs. Clear and agreed 'rules of engagement' for decision-making were central to the effective operation of this system, for example to ensure that all members of the consortium contributed to investments if a majority vote carried the decision. There were occasional tensions when the financial position was difficult, but the Trust told us that the system worked well and contributed to service development in East Anglia.

Source: Wales Audit Office and interviews with the Scottish Ambulance Service and East of England Ambulance Trust

Figure 25: In the last 18 months, there has been considerable instability at the top of the Welsh Ambulance Services NHS Trust



Notations: * Acting or Interim; ** Chief Executive Designate until 1 October 2006

Source: Wales Audit Office.

in line with the SaFF target to achieve 60 per cent by the end of the financial year; subsequently, the Trust has not been able to maintain this performance, achieving 60 per cent in only two months since April 2004, (paragraph 1.10). The decision to frame the 2003/2004 response time target as a target to be achieved by the end of the financial year, rather than across the whole of the year, was intended to encourage the Trust to deliver the target in a sustainable way, but the Trust appears to have focused on the single month of March 2004, as its subsequent failure to maintain 60 per cent performance suggests. The Welsh Assembly Government intended for the Trust then to maintain and improve on that target but the Trust did not make the fundamental changes necessary to deliver sustainable change, and performance fell after March 2004.

There has been weak leadership in the Trust

2.93 There are many dimensions to leadership. In our view the Trust's leadership has been weak in a number of respects:

- rapid changes of leadership during the last year have been damaging;
- clinical leadership has not been well resourced; and
- there has been a lack of management capacity.

Rapid changes in leadership have been extremely damaging and reflect the wider problems in the Trust

2.94 In the last 18 months, the Trust has undergone a period of intense instability in the leadership of the organisation. Figure 25 shows the changes of people in key positions over that period, which followed a seven year period of relative stability in which there was a single Chief Executive, Mr Page, and two chairs, Eifion Pritchard (1998-2001) and Roy Norris (2002-2006). Nevertheless, the Trust has not had a substantive director of operations in post since June 2004, when the previous director began a period of long-term absence, and his departure from the Trust in January 2006.

2.95 Mr Page became absent from work in November 2005. His contract subsequently ended on 30 September 2006. Between November 2005 and the appointment of Alan Murray as Chief Executive designate in August 2006, four people were either acting Chief Executive or interim Chief Executive. During this period, a new Chair, Stuart Fletcher, was appointed from 1 April 2006, at the end of Roy Norris's term of office.

2.96 The overall period of instability in leadership over the past 18 months has, inevitably, caused problems within the ambulance service. Mr Thayne became interim Chief Executive in March 2006, initially on a part-time secondment and subsequently on a full-time basis after his resignation from Staffordshire. The opportunity to appoint Mr Thayne as interim Chief Executive appeared advantageous to the Board given the knowledge of Wales he obtained by producing the benchmarking report; his record of achievement in Staffordshire; and the fact that he was immediately available as a result of his resignation from Staffordshire. He had brought with him from Staffordshire, Dr van Dellen as interim director of operations. The North Wales regional director informed us that their brief was to stabilise the organisation and to improve performance wherever they could, while the Board advertised for a substantive Chief Executive. Board members and Welsh Assembly Government officials told us that they believed Mr Thayne had given an undertaking to stay at the Trust until a substantive Chief Executive had been appointed. However, Mr Thayne told us that he gave no such undertaking. He resigned in May 2006 after two months in post. Essentially, the reasons for Mr Thayne's resignation appear to have centred on his belief that there was insufficient understanding of the scale of the problems facing the Trust and support for the required solutions. Dr van Dellen then took over as interim Chief Executive. He resigned in July 2006: he stated publicly that his resignation was because he could not commit long-term to working in Wales, and cited similar issues about the Trust on his departure that Mr Thayne had raised. These issues were set out by Dr van Dellen in a private report to Mrs Lloyd, Head of the Department for Health and Social Services in the Welsh Assembly Government:

- the lack of Board-level understanding of the seriousness of the problem;
- lack of support within the Trust for the changes he wished to introduce; and
- problems he perceived working with the Trade Unions and in bringing in people whom he believed could turn the organisation around.

2.97 We found that Mr Thayne and Dr van Dellen strove to modernise the organisation very rapidly because of their serious concerns about the way the organisation operated and its poor performance. Many staff, including senior executives, informed us that there were differing views of Mr Thayne's strong management style: some said that the rapid decision-making was welcome while others felt intimidated. There were also confrontations with HCW and the Welsh Assembly Government Government Department for Health and Social Services North Wales Regional Office, and evidence that Mr Thayne threatened to resign on a number of occasions before his eventual resignation. Many people we spoke to, within the Trust or outside, supported Mr Thayne's vision of the organisation and its modernisation, but questioned his method of introducing change. It appears that Mr Thayne and Dr van Dellen attempted, because of a genuine desire to improve the service, to move an organisation previously in a 'steady state' forward too quickly towards a vision which few if any people disputed, with resulting disruption and distress for many staff. There had been a long period of stability and a somewhat insular culture prior to this.

2.98 Despite some of the negative consequences of this turbulent period, we found that there were some clear benefits that represent opportunities for the organisation to build upon:

- this period significantly raised awareness of the need for the Trust to modernise and an improved understanding of the direction in which the Trust needed to travel;
- there was a stronger focus on improving performance to save patients' lives;
- there was a strong focus on developing performance information, key performance indicators and on using information to improve performance, in stark contrast to the previous use of performance information; and
- a heightened awareness of the scope to improve efficiency and that available resources needed to be matched more closely with demand for services.

2.99 There is evidence that historically the Trust lacked strong leadership at Board level. We heard evidence that the previous Chair, Mr Norris and former Chief Executive, Mr Page, had a poor relationship and that this relationship deteriorated over time, compromising the effective working of the Board. Mr Page did not engage as fully with the Board as its members would have wished. The previous Chair, Roy Norris, became less involved once it became clear that he did not intend to reapply for the position of Chair towards the end of 2005. Non-executives told us that they were much more involved in decision-making under the new Chair, with the issues surrounding the departure of Mr Page a good example of non-executives being insufficiently involved in decision-making, (paragraphs 2.81 and Case Study F).

Clinical leadership has not been well resourced

2.100 Clinical leadership has been provided by a part-time medical director, Dr Colquhoun, who spends half of his week working for Cardiff University. He told HIW reviewers that his role was one of a clinical advisor, rather than a conventional medical director. He has produced documentation on clinical governance, but HIW informed us that the clinical governance framework would have been enhanced if it had been personally led by a clinical director employed full-time within the Trust. There is little clinical support in the regions, and HIW told us that they believed there was a need to bolster regional clinical leadership. Full details on clinical leadership will be available in HIW's forthcoming clinical governance review of the Trust.

There has been a lack of management capacity

2.101 We have found a number of important areas in which there appears to have been a lack of management capacity in the Trust. These were:

- project management, especially in relation to some major procurements;
- performance management, both corporate and of individuals;
- poor change management; and
- many aspects of people management.

There has been a shortage of project management capacity

2.102 There have been examples of the Trust lacking project management capacity. In particular, the project management arrangements for a number of failed procurements – particularly the recent ambulance procurement and North Gate PCS computer system – fell down largely as a result of failures of project management, (paragraphs 2.195-2.197). In addition, executives did not have the capacity to translate the strategic plans they had developed into operational action plans.

Performance management has been under-developed

2.103 The Trust has suffered from significant weaknesses in performance management, both corporately and at the level of individuals. There has been no established or robust performance management framework for individual staff, from Board level (paragraph 2.80) downwards. This relates to the lack of strategy and overall direction. Responding to our survey, only 30 per cent of staff agreed that they were given clear personal performance objectives, while 10 per cent agreed that they received regular feedback on their performance. Only 6 per cent of those responding to our survey who provide patient care said that they received regular feedback on their performance. Our interviews and focus groups with Trust staff supported these findings – 12 out of 15 locality ambulance officers, key operational managers, indicated that they had not had a performance appraisal this year. The introduction of the knowledge and skills framework under *Agenda for Change* will introduce performance appraisal and personal development planning for staff.

2.104 Within the Trust there has also been little effective performance management at corporate or regional level. Very long performance reports have been provided to non-executives, but there had been little effort to pull together key performance indicators until Mr Thayne and Dr van Dellen produced the 2006/2007 business plan. The Trust did complete its Balanced Scorecard reports for the Welsh Assembly Government Department for Health and Social Services Regional Office, but this tool was not used internally to drive the service forward. The development of a small but balanced set of key performance measures, which identify the extent to which an organisation is delivering its strategic objectives, cascaded to regional and individual level, is a fundamental pillar of sound management.

2.105 The Trust's performance management appears to have been fixated on the target for Category 'A' response times, and on achieving financial balance. There has been very little focus on measuring important components of delivering these and other important targets for an ambulance service, such as indicators of clinical performance, measures of the efficiency with which the Trust produced, distributed and utilised ambulance unit hours the percentage of patients transported to hospital, and measures of PCS performance.

2.106 Performance information has also been weak, largely because there was not a strong culture of performance management or prioritisation of performance management information,

Case Study H: Performance management systems in other ambulance services

Staffordshire Ambulance Service has developed a real-time performance management system that enables its management to track its resources in real time and to measure efficiency very tightly. The service bases its overall budget on the efficiency with which it plans, distributes and utilises its ambulance unit hours. Sophisticated analysis of demand allows the service to predict where ambulances need to be deployed and stationed and to be able respond to small changes in external circumstances, for example roadworks.

Source: Wales Audit Office

(paragraphs 2.74-2.75). A recent consultant's report, commissioned by the Trust, found that 'management have little visibility of the performance of the service in a way that will enable the outcomes of patient care events to be improved'. Operational managers have had inconsistent access to performance information and have had variable levels of understanding. Performance information has been historical, often produced at the end of the month and has not been in real time to enable managers to manage resources proactively according to the prevailing circumstances of any particular day.

2.107 Some ambulance services have developed more sophisticated performance management systems that enable close and proactive management of resources (Case Study H). Consequently, the historical absence of robust demand analysis, costing information and benchmarking data has compromised the ability of the Board to make the best use of the resources available to it and to develop a culture of accountability for performance and improvement.

There has been poor change management

2.108 The Trust has lacked change management skills. Before Mr Thayne's arrival, change management was too slow and lacked direction. While Mr Thayne and Dr van Dellen were at the Trust, they tried to move the organisation forward more quickly than was possible with the available management capacity. This is reflected by the views of staff – only 13 per cent of staff responding to our survey had confidence in the ability of managers to lead change successfully. Several staff observed that there needed to be much better communication and information about changes that were happening.

2.109 Change management capacity has been a concern of several other stakeholders and led Mr Thayne to bring in outside consultants to work in the Trust. Because of his concerns about the willingness and ability of many senior and middle managers to lead and deliver change, Dr van Dellen believed that he needed over a dozen 'change agents' to join him to deliver the extent of change required. Trust staff who submitted evidence to the inquiry team, through interviews, public hearings, surveys, focus groups and the Internet, often told us about a perceived unwillingness of managers and some staff to change, listen and learn.

There are problems with people management

2.110 Effective management of people is fundamental to the delivery of an effective service business. We found problems with a number of aspects of people management in the Trust, as follows:

- managers generally had not been adequately trained to do their job;
- unclear roles and responsibilities;
- a high and increasing incidence of disciplinary cases, grievances and suspensions;

- weak workforce planning; and
- high rates of staff sickness absence.

General management has been poor

2.111 We found little evidence that local managers had been adequately developed to undertake their roles. The structure of the service does not identify teams of staff with clear lines of accountability, and there are various titles in use which serve to confuse even some long standing staff about who does what in the management line. Staff development is patchy and for many non existent; there has been no personal development system and managers have not had personal objectives set for them, let alone staff more widely.

2.112 Staff we spoke to, or who participated in our focus groups, cited a culture in which they are rarely praised and often blamed, with a management style where managers do not often seem to listen. Staff told us that there were no forums where they could discuss problems and share good practice. Some staff expressed the view that if you raised issues with managers nothing ever got resolved, so they had stopped raising issues. Among staff participating in our focus groups, 'managing people and the organisation' was the second highest of their ten priorities for improvement (Appendix 4). In particular, they cited the need to improve management capacity and capability at all levels.

2.113 To address management capacity issues, the Trust established a management development programme two and half years ago called *'Leadership begins with me'*. The first cohort of 16 managers have access to the Public Service Management Wales (PSMW) People Exchange Programme, and a second programme has commenced with 17 managers. Access to the programme is by competitive application but there is not yet a process in place to identify individuals who would most benefit from this type of programme.

Roles, responsibilities and accountabilities are not clear

2.114 We found evidence of confused roles, responsibilities and accountabilities. Although secondments are a legitimate tool, we found evidence of their widespread use, with unfilled substantive posts common. Secondments often reduce the capacity of the organisation to provide front-line services.

2.115 In addition, there are confused accountabilities. Managerial and financial responsibilities are often different. For example, PCS staff are managed by Locality Ambulance Officers, but financial responsibility for PCS services rests with the national and regional PCS managers. Control staff are managed by the national and regional control managers, but Locality Ambulance Officers are accountable for response time performance, which is heavily influenced by the Trust's four control centres.

2.116 At very senior levels, we were told that key staff had not agreed clear direction or measurable objectives for their roles, or been told to whom they were accountable. We also heard from a number of staff that the lack of clear roles, responsibilities and accountabilities and reporting lines meant that they often reported to more than one person.

There has been an overall increase in disciplinaries, grievances and suspensions over the past six years, although the Trust is unable to fully quantify them over time

2.117 Many of the staff that we spoke to expressed concerns about the apparently high levels of grievances, disciplinaries and suspensions across the Trust. These issues are clearly related, as a grievance case could subsequently result in a member of staff being disciplined and then suspended.

2.118 The Trust has been unable to provide comprehensive data on the numbers of grievances, disciplinaries and suspensions over time and we found evidence of regional differences in the monitoring and recording of these cases. The figures available show a reduction in the number of suspensions to just three in 2005/2006. The Director of Personnel explained that this was because she now approved all suspensions herself. However, there has been a significant increase in the number of grievances, from seven in 2001/2002 to 35 in 2005/2006. The Director of Personnel told us that this illustrates a positive culture of staff feeling able to raise issues. While this may be true, it has also been suggested to us that the high levels of grievances reflect a lack of confidence in management. This could lead to staff taking formal action under grievance and dignity at work policies to try to resolve situations and 'get their voice heard'. Use of the formal procedures in this way has a significant resource impact, in terms of the time taken to investigate and resolve issues that could have been dealt with through a more appropriate and less resource intensive mechanism.

2.119 Information on suspensions, disciplinaries and grievances has not historically been reported to the Trust Board. However, figures for disciplinaries and grievances now form part of the Trust's key performance indicators for 2006/2007, and there is some evidence that the Trust is now tackling this issue, as the Board's Modernisation Plan has an objective to reduce by 25 per cent the number of formal grievances lodged.

Workforce planning has been weak

2.120 The primary purpose of the workforce plans that the Trust submit annually to the Welsh Assembly Government is to identify and seek funding for the Trust's education and training needs for EMS, PCS and control staff. We found little evidence of effective and comprehensive workforce planning to identify current and future staffing levels and skills needed to deliver the Trust's strategic direction/plan. Workforce planning tends to take place at a corporate level, based on historical patterns and has not been based around creating new roles and anticipated future staffing levels and skill mix requirements. The current workforce plan (2005/2006 – 2009/2010) does not include an assessment of the effects of modernisation, and has not yet been accepted by the Welsh Assembly Government.

2.121 *Agenda for Change* (paragraphs 3.56-3.66), has only been incorporated within the workforce plan in relation to the impact of the reduced working week and increased annual leave. For example, recruitment of 102 technicians was underway to meet the capacity gap likely to be caused by the reduction in the working week under *Agenda for Change.* We found no clear evidence to support the decision to recruit 102 technicians, and Alan Murray has suspended the recruitment since taking up post, although 40 technicians had already been recruited. Some managers in the regions expressed their belief that they had enough staff in their region without the additional technician recruitment.

Despite some recent progress, staff sickness absence is continuing to have a significant financial impact

Levels of staff sickness absence increased sharply in 2005/2006

2.122 In *The Management of Sickness Absence by NHS Trusts in* Wales (January 2004), the previous Auditor General reported that the Trust lost 6.8 per cent of contracted hours to sickness absence in 2002/2003. The Welsh Assembly Government Department for Health and Social Services has since set a Service and Financial Framework (SaFF) target for all NHS trusts in Wales to reduce sickness

absence to 4.2 per cent of contracted hours (matching the target set by the Department of Health for the NHS in England).

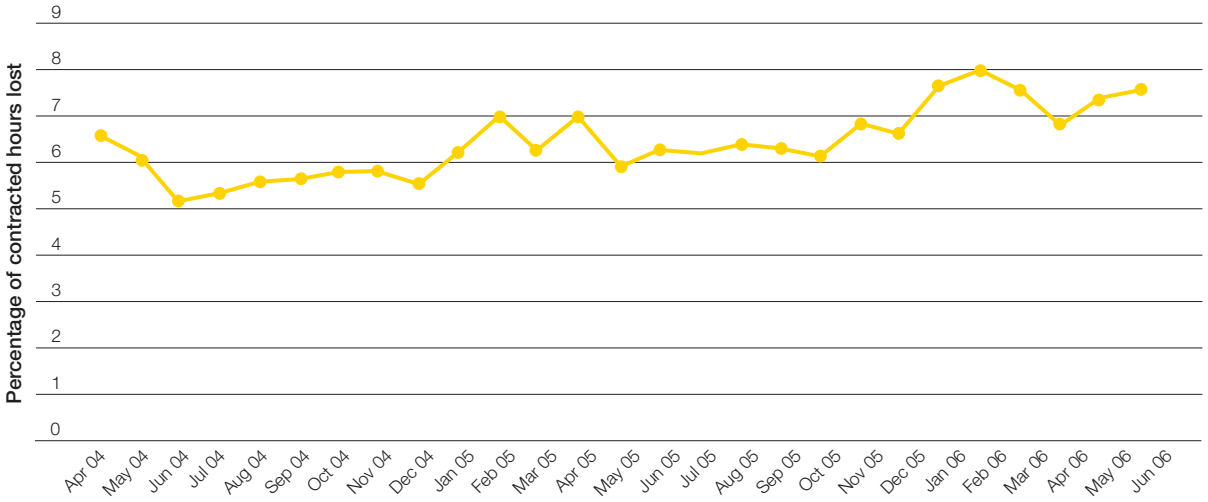
2.123 By the end of 2004/2005, the Trust had succeeded in reducing its reported sickness absence to 5.45 per cent of contracted hours, but the Trust reported a sharp increase, to 6.32 per cent of contracted hours, in 2005/2006, with a particular peak in absence between January and March 2006 (Figure 26).

2.124 However, sickness absence is by no means a problem unique to the ambulance service in Wales, and although English ambulance trusts reported an average sickness absence rate of 6.0 per cent in 2005, almost half of these trusts reported rates higher than in Wales (Figure 27). Higher levels of sickness absence are sometimes associated with occupations that expose employees to known health risks including manual handling, violence and aggression, and shift-working. These issues are particularly relevant to front-line ambulance personnel, although the Trust has invested heavily in manual handling and conflict awareness training in an attempt to mitigate these risks. The Trust has also contracted with an independent counselling service which, during 2005/2006 provided direct support to 124 members of staff, delivered training to Trust staff on bereavement and breaking bad news, and undertook a well being survey in the North Wales region.

2.125 There are, however, substantial differences in the rates of sickness absence reported across the three regions of the Trust, as well as between different groups of staff and localities (Appendix 7). For the two groups of staff with the highest levels of sickness absence – control room staff (8.72 per cent) and those working in the Monmouthshire locality (11.05 per cent) – sickness absence is clearly contributing to problems with operational performance, although it may also be symptomatic of the pressures on staff in these areas.

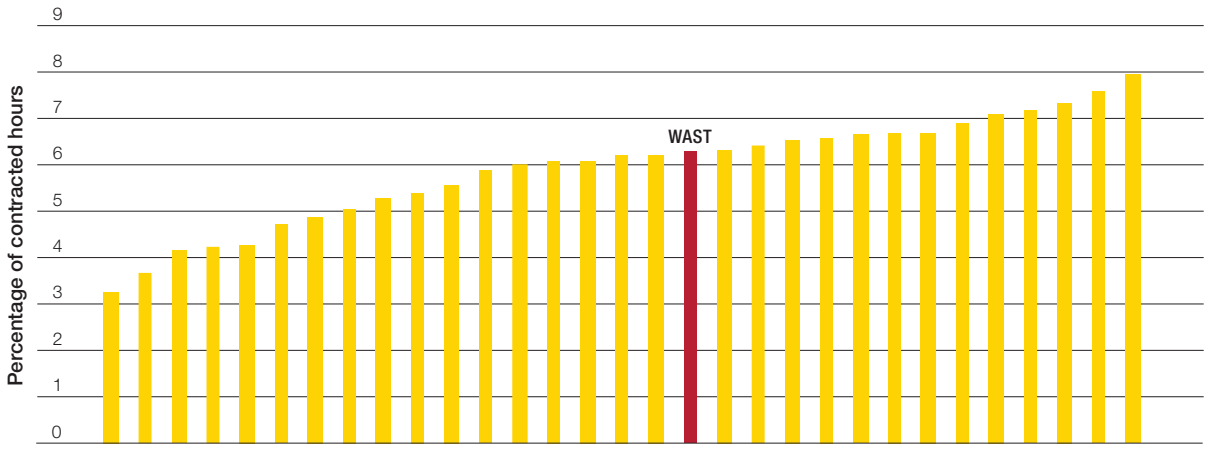
The Trust's annual figures for 2005/2006 understate the true extent of sickness absence, while the suggestion that sickness absence rates have halved since 1999 is misinformed

Figure 26: Sickness absence trend by month (any period between April 2004 and June 2006)



Source: Wales Audit Office

Figure 27: Sickness total for 2005/2006 compared with other English ambulance trusts



Note: The English figures relate to the 2005 calendar year, while the the Trust figures relate to the 2005/2006 financial year.

Source: Wales Audit Office

2.126 As in many organisations, managers and HR staff acknowledged that there was likely to be some under-recording of sickness absence, despite efforts to consolidate common reporting systems across the three regions of the Trust. In time, the new NHS Electronic Staff Record should eliminate the current reliance on a paper based reporting system which, given the geographical spread of staff, is likely to contribute to recording errors.

2.127 We did not examine the accuracy of individuals' sickness absence records but we did identify an anomaly in the way in which the Trust's annual sickness absence rate for 2005/2006 was calculated, which excluded staff who had left the Trust's payroll during the period. This included several staff who had been on long-term sickness absence for much of the year. Taking those cases into account and, based on the average sickness absence rate reported for each month in 2005/2006, it is likely that the Trust's overall sickness absence rate was nearer to 6.7 per cent of contracted hours.

2.128 Trust-wide trends in sickness absence were presented in a report to the Trust's HR Committee in May 2006. Despite the increase in sickness absence during 2005/2006, this report stated that sickness levels had halved since 1999/2000. We found no evidence to support this claim which was based on a comparison with the rate of 13.2 days per person identified in a District Audit report from October 2001. This figure is not comparable with the percentage of contracted hours lost definition which is now used by the ambulance service, in common with the other NHS trusts in Wales to measure sickness absence rates.

The costs of staff sickness absence are likely to increase as a result of Agenda for Change

2.129 The Trust has valued the direct cost of salaries paid to staff while off sick as £3.9m in 2005/2006. However, the true cost to the Trust is much greater because of the need to replace staff to provide adequate levels of cover, particularly in front-line services, as well as the

management and administrative time required to deal with sickness absence and manage its impact. These replacement staff costs are likely to increase as a result of *Agenda for Change,* with the Trust now required to pay overtime at a rate of time and a half, rather than at the normal daily rate. And change can be stressful for some staff, and may increase the risk of sickness absence.

There is a particular problem with long-term sickness absence

2.130 In the sickness absence figures presented to the HR Committee in May 2006, the Trust reported that 11 per cent of sickness absence cases were attributed to long term absence in 2005/2006 (defined as absences of 28 calendar days or more). However, this statistic does not reflect the true impact of long term sickness absence, which accounted for 39,520 (68 per cent) of the 57,810 calendar days lost to sickness absence over the same period. Overall, 451 staff reported at least one period of long term sickness absence in 2005/2006 which, even accounting for staff turnover, equates to around one in six staff. Some long term sickness absence is, of course, inevitable. For example, 12 per cent of the long term sickness absence reported in 2005/2006 was attributed to post operation recovery.

Core policies and procedures for managing sickness absence are broadly in line with good practice, but there are problems with implementation

2.131 The Trust has, over the past three years, reviewed its sickness absence policies and procedures and these contain many of the basic features of good practice. This includes a requirement for return to work interviews after all periods of absence, and trigger points for management intervention in response to frequent short-term absence. These trigger points are intended to pick up on staff who report three or more separate absences, or 12 working days of absence in any 12-month period. In respect of the first of these two triggers, this applied to a total of 653 staff in the 12-month period from 1 April 2005 to 31 March 2006, although an almost equal number of staff (658) reported no sickness absence.

2.132 However, the sickness absence report presented to the HR Committee in May 2006 acknowledged that there were ongoing problems with the application of these procedures, with managers concerned about the apparent complexity of the policy, while a report to the Trust Board in January 2006 reported that managers were finding it difficult to make the time to carry out these procedures. In addition, some of the HR managers that we spoke to recognised that the HR team had perhaps lost some of its own focus on this issue because of other competing pressures on their time, notably the delivery of *Agenda for Change* and the NHS Electronic Staff Record System.

2.133 There are also ongoing problems in obtaining appointments for occupational health referrals, which are contracted out to other NHS trust providers across Wales. These problems with occupational health provision are, again, not necessarily unique to the Trust and may reflect the problems reported by the previous Auditor General in 2004 in relation to all NHS Trusts in Wales. We also received correspondence from the Welsh branch of the Association of NHS Occupational Physicians (ANHOPS), which includes representatives from eight of the Welsh NHS trusts that provide occupational health services to the Trust. This correspondence raised concerns from the perspective of the service providers about: the apparent lack of up to date and consistent service level agreements between the Trust and the other NHS Trust providers; variations in the financial arrangements for providing these services; inconsistencies in pre-employment screening,

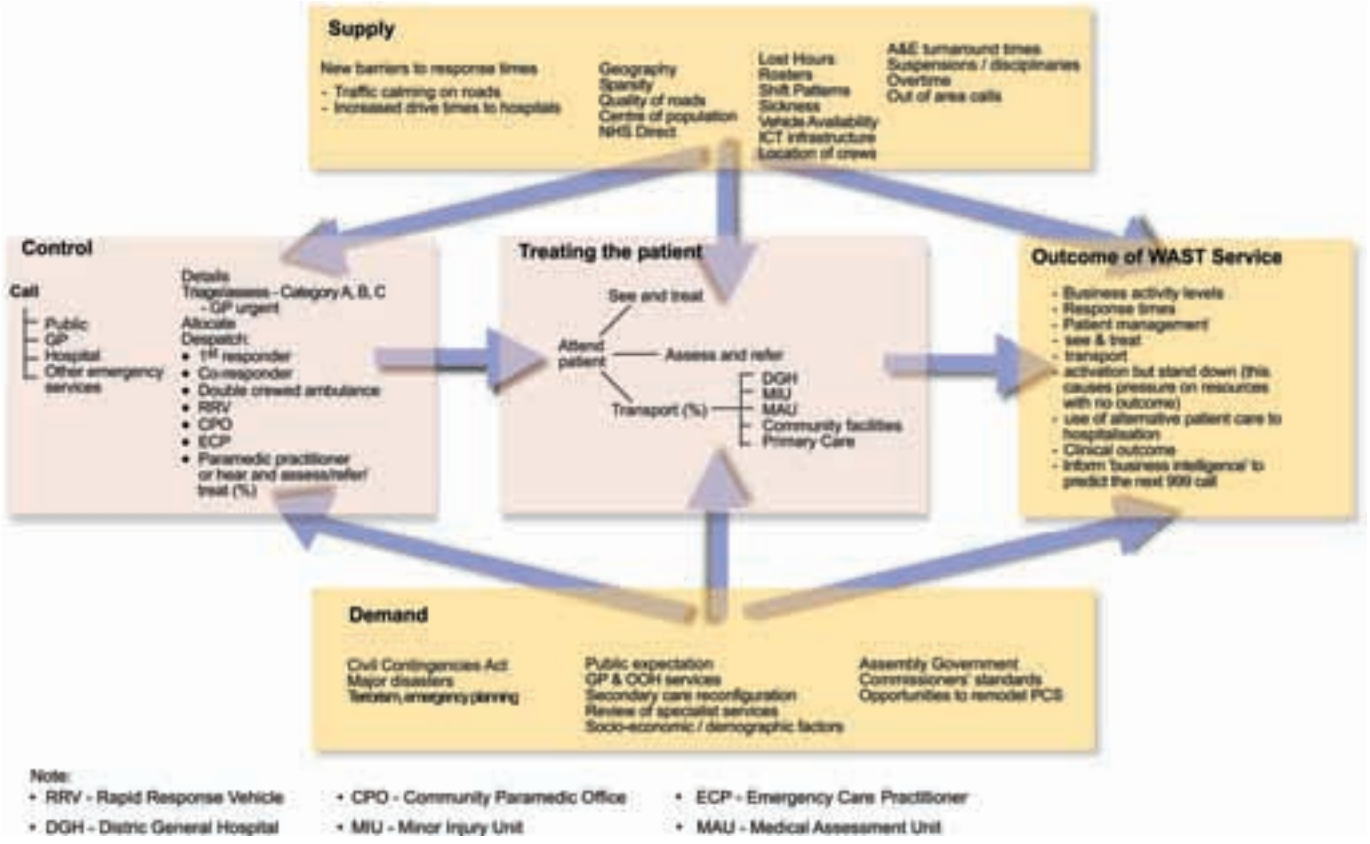
particularly for existing staff who change roles; and problems in communication between ANHOPS members and Trust managers. There is also anecdotal evidence to suggest that return to work recommendations made by occupational health providers were not always followed. The Welsh Assembly Government will shortly be issuing updated advice on health clearance for NHS staff, as well as new standards for occupational health provision. These developments provide an opportunity for the Trust to revisit the way in which occupational health services are provided.

Processes are badly designed and managed

2.134 We have examined the Trust's operational processes and have found evidence of bad design and management in each of the four key areas, namely:

- emergency services – services are not systematically matched to demand;
- control rooms – inconsistent processes leading to poor performance;
- Patient Care Service – weak or non-existent processes; and

Figure 28: Supply and demand influences the provision of ambulance services



Source: Wales Audit Office

- clinical governance – not integrated into managerial processes.

Ambulance services are regularly supplied at times and in places where they are not needed and regularly not supplied when and where they are

The deployment of available resources does not optimally match demand

2.135 There is significant public concern about whether there are sufficient ambulances – vehicles and crews – to meet demand, both across Wales and in particular localities. Long response times for emergency calls compound such concerns. Figure 28 explains the factors that influence demand for ambulance services and their supply.

2.136 The efficient use of ambulance resources requires sophisticated analysis of demand, temporally and geographically, to enable services to predict how many ambulances and other forms of response they need at different times of the day and in different places. Historically, the Trust has not conducted such analysis. Mr Thayne's original benchmarking report first raised awareness of some of the techniques that could be used to examine demand and supply of ambulance services to optimise their use to improve services. His initial benchmarking report suggested inefficiency in the way the Trust deployed and used its ambulances in comparison with Staffordshire.

2.137 We examined a demand analysis conducted by Alan Murray since his arrival in Wales. Although the Trust is unable to count by hour of the week the number of 'lost hours' through meetings, sickness, vehicle failures and other reasons, the analysis compared the number of rostered hours (planned hours rather than the number of hours actually delivered) with peaks of average demand for ambulances every hour of the week, based on an analysis of historical patterns of demand. Figure 29 shows that Mr Murray's analysis suggests that Wales has a much higher weekly supply of rostered hours than it needs to meet average peaks of demand.

2.138 The position shown in Figure 29 is complicated by the inability of the Trust to measure accurately the planned hours that it 'loses'. Alan Murray has done some initial work which has led to an estimate that the Trust produces around 80 per cent of its planned hours. Removing 20 per cent of the rostered hours from the figures shown in Figure 29 still leaves a healthy surplus of hours supplied. The Trust's inability to meet response time targets suggests that the available hours are not distributed to the right places, scheduled at times of peak demand or that hours are lost at peak times. The Trust also loses time due to long turnaround times at hospitals, (paragraphs 3.15-3.20).

Figure 29: Weekly rostered hours are significantly higher than predicted demand

	South-east	Central and west	North	TOTAL
Rostered hours	9,647	5,054	5,354	20,055
Required hours	4,261	2,474	2,321	9,056
Difference	5,386	2,580	3,033	10,999
Percentage of rostered hours required	56%	51%	57%	55%

Source: Wales Audit Office, based on the Trust's demand analysis

2.139 Mr Murray's recent analysis suggests that the configuration of shift patterns does not optimise the supply of resources at times of peak average demand. Although there are enough hours of supply in total, these are not configured to meet peaks of demand. At times of low demand, there tends to be too much supply, and at times of peak demand, there is often insufficient supply, which leads to chronic pressure on crews and control rooms, as well as other emergency services, (paragraphs 1.26-1.28), and unacceptably long response times. The Trust generally operates traditional 12 hour shifts which, under the 37.5 hour working week under *Agenda for Change*, can mean that staff work only three shifts each week. If shifts generally start at similar times, the Trust can over-resource the quieter times of the day (usually the early morning) before the peak demand kicks in (usually during the afternoon and early evening, rising again towards midnight.

2.140 Other factors also compromise the supply of ambulances at key times:

a crews are responsible for checking their vehicles at the start of a shift; this can often take forty minutes or more; other Trusts operate '*Make Ready*' systems where vehicles are fully prepared by specialist teams, with associated infection control benefits, so that crews are available from the start of their shifts;

b meal breaks can reduce cover – crews receive an undisturbed meal break after six hours of a shift; in some areas of Wales, controls do not disturb crews during meal breaks, even if there is a 999 call; we heard that some crews return to their base station for the meal break, often involving a long drive, on the basis that they cannot carry food on the ambulance, have no money on them while on duty, or have special dietary needs that require them to return to base; the Trust is currently negotiating the status of meal breaks within the *Agenda for Change* agreement, as the current policy of including meal breaks within the 37.5 hour working week is non-compliant with the national agreement (paragraph 3.66); and

c long travelling times at the end of shifts, especially in rural areas or where crews have been significantly displaced from their base, can lead to it being impractical to deploy certain crews very late in their shifts.

2.141 There are also problems matching supply and demand in PCS, although the extremely poor management information makes it difficult to quantify. In most parts of Wales, PCS operates generally between the hours of 8:30 and 16:30 on weekdays, whereas hospitals are providing services at a wider range of times, particularly as day surgery becomes increasingly prevalent. Consequently, patient transport services may not optimally meet the needs of patients and their hospitals, and could lead to other Trusts incurring unnecessary expenditure on taxis, or the Trust providing an expensive emergency vehicle, during the hours when PCS services are not available. In North Wales, PCS staff work until midnight in Wrexham, with the longer hours of service helping to accelerate discharge, save bed costs and providing much cheaper routine transport than EMS.

The significant use of overtime suggests that the Trust has not matched supply and demand

2.142 Overtime is an important part of providing adequate cover but is also an indicator of whether the Trust has adequately matched supply and demand. We analysed the use of overtime and its management at the Trust during the 2005/2006 and found that overtime at the Trust is significant. In 2005/2006 Trust staff worked 384,300 hours

overtime. This is equivalent to 3 hours a week for every member of staff. However, 25 per cent of Trust staff received no overtime payment during 2005/2006.

2.143 A small number of staff worked very significant amounts of overtime. Fourteen members of staff worked over 1,000 hours overtime in 2005/2006. After annual leave, this is equivalent to these staff working, on average, more than 21 hours' overtime each week. One member of staff worked almost 1,400 hours' overtime, an average of almost 30 hours per week. Such levels of overtime raise significant health and safety issues as well as issues of compliance with the European Working Time Directive. It also supports the anecdotal evidence that processes for allocating available overtime have been poorly managed.

2.144 There are also geographical differentials in the distribution of overtime. Many of the highest overtime earners are clustered in South East Wales, particularly the Gwent area. This is an area of high demand and problems meeting performance standards. There are smaller clusters around other geographical locations, such as Carmarthenshire. There is an inconsistent spread of overtime between geographical areas.

2.145 We were told in interviews that overtime working is the key driver of travel expenses but this was not supported by the evidence. Of the top 20 expense claimants, 10 worked no overtime.

2.146 Further, our analysis does not support the theory that overtime was used at the year-end to improve performance against targets in 2005/2006. The March overtime payments were less than one twelfth of that for the annual total overtime.

There are weaknesses in the management of control

The controls do not operate consistent processes

2.147 Ambulance controls play a pivotal role in the effective deployment of ambulances and ensuring appropriate responses to calls. They also deal with people in the stressful position of making a 999 call. Their main functions are to:

- **a** take details of the caller's name, the location and the nature of the problem;
- **b** decide on the category of call;
- **c** despatch the most appropriate vehicle or person to send to respond to the incident; and
- **d** monitor progress in responding to the call.

2.148 Since 1998, the Trust has reduced the number of controls from nine to four, with the fourth – Church Village – scheduled to close but without a firm date. We found that there were inconsistent processes between the four controls. There are also complications when crews and vehicles move between the boundaries of areas covered by the various controls.

2.149 We found no evidence of regular contact between the controls to share ideas and good practice, which is compounded by a lack of performance information about call cycles and the time taken to answer the call once the telephone rang.

2.150 We also found that the use of standby and preferred response points (locating vehicles where demand is most likely to occur) was not in consistent use. Revised deployment plans based around locating vehicles at locations that maximise the prospects of meeting predicted demand, rather than in ambulance stations,

were introduced by Dr van Dellen but do not appear to have been implemented consistently, particularly in the South-East region where the plan was amended because of concerns about its effectiveness and some resistance to change.

The performance of controls is hampered by the lack of ICT

2.151 The performance of controls is hampered by the lack of modern information and communications technology. The following weaknesses are particularly significant:

a Automatic Vehicle Locating systems (AVLS) are not available in all parts of Wales, which means that control staff, who are often responsible for 20 or more vehicles, do not have visual confirmation of the exact location of vehicles, (paragraph 2.194), and are unable to locate Rapid Response Vehicles on the same screen as ambulances; Case Study I shows the problems that the lack of AVLS can cause;

b radio communication with ambulances is of variable quality with some staff using their own personal mobile telephones as a means of communication with control;

c data systems to send details of calls directly to ambulance vehicles are not consistently available, which means that details have to be passed via speech radio or personal mobile phones; once the details have been communicated, the lack of satellite navigation on vehicles can compromise the efficiency of control because staff sometimes have to assist crews to locate the incident; and

d four gazetteers are in use to identify locations; the fact that there are four different gazetteers causes problems with the data in control because hospitals have different names on the various gazetteers and do not recognise all postcodes, which requires retrospective sanitisation of data to ensure that calls are allocated to the correct hospital and LHB area; the systems in use are inconsistent, incompatible with each other and together do not comply with the British Standard BS7666 that specifies a standard format for holding details on every property and street.

Case study I: Problems caused by poor technology in controls

During a visit to a Welsh control room, we observed an incident where an ambulance crew appeared to have been dealing with an emergency call for an unusually long time. Following further enquiries, we found that the crew was clear at the A&E department and, without reference to the control room, had returned to their base station with a journey time of between 20 and 30 minutes, instead of notifying control that they were clear. Radio cover is poor in this area – where crews cannot contact control by radio, the procedure is to call from a telephone in A&E.

During the hour or so that had passed since the crew left the hospital without the control's permission, control had difficulty in sending resources to a serious road traffic accident on the M4, as well as two further 999 calls. Staff in the various controls told us that some crews "regularly" return to base stations without permission, which causes significant problems. On returning to stations crews who are due a meal break should start that break after 15 minutes. In this case the crew did not do so, which further compromised capacity as a result of poor information systems to locate and track resources.

Source: Wales Audit Office

There is poor morale and management in controls

2.152 Sickness levels in control are high, and staff have expressed concern about stress arising from shortages of operational and control room resources, and a perception of bullying. In the case of the control rooms, these staff accounted for 22 per cent of all stress/psychological related absence reported across the Trust during 2005/2006, and yet they account for less than 10 per cent of the total Trust workforce. We heard concerns about morale from staff working both on EMS and PCS control.

2.153 In our survey, job satisfaction was lowest among control room staff, where dissatisfaction with their job ran at 44 per cent. We also found that only 31 per cent of control room staff responding to our survey felt that they would be supported by their manager if they had a problem.

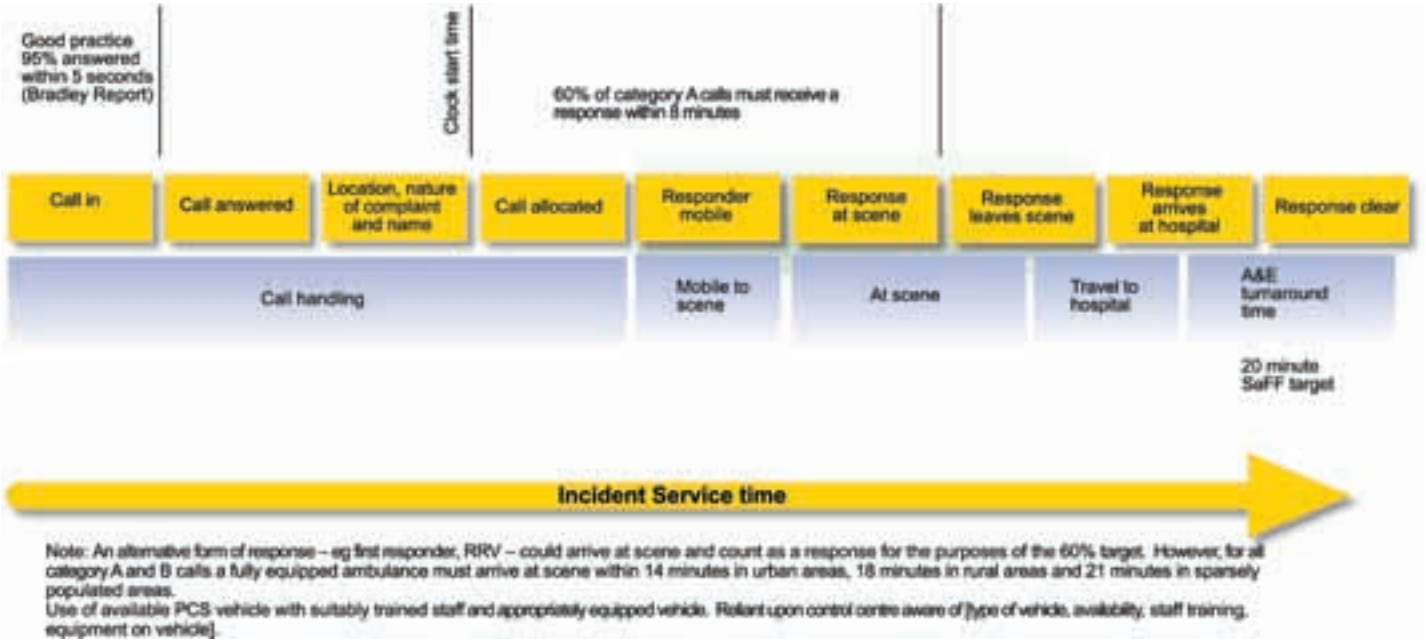
2.154 The physical environment in control rooms is very poor. This is especially the case in Mamhilad where working conditions are dark, cluttered and dirty.

2.155 Control room staff have also expressed concerns about the adequacy of their training. The highest proportion of any group responding to our survey – 31 per cent – disagreed that they had been adequately trained to do their job. All EMS call takers are accredited emergency call takers using the Trust's Advanced Medical Priority Dispatch System (AMPDS) but we found examples of accreditation having lapsed because of disciplinary incidents and a lapsed qualification requiring reaccreditation.

There are indicators that control could operate more effectively

2.156 We found that the components of the call cycle indicators (Figure 30) do not comply with known best practice of completing

Figure 30: Components of ambulance incident service times



Source: Wales Audit Office

the call cycle within 30 seconds in 95 per cent of cases. The call cycle times in Welsh controls are significantly lower at the 95th percentile than benchmark figures.

There is a lack of clarity about the future of sharing joint controls with other emergency services

2.157 One Trust control is co-located with the police and fire control in Carmarthen. Although located on the same site, it is not a genuinely shared control operating joint systems with co-located control staff because the three services operate separate controls on the same site. There was a proposal to co-locate controls in North Wales but this proposal did not proceed because the Trust Board was not convinced of the benefits of the initiative and its fit with DECS.

2.158 The new Chief Executive has stated publicly his agreement with the concept of shared controls. The Joint Emergency Services Group's submission to the Auditor General also strongly advocates the development of genuinely shared controls. They see significant economies of scale and spreading of good practice in the spirit of *Making the Connections*. They also see opportunities to build on existing close and productive working relationships between the ambulance service and other emergency services, and the scope to improve significantly responses to major incidents. Joint control rooms are the norm in the USA, but the Welsh Assembly Government, which is currently evaluating the scope for shared controls, and ambulance service may wish to pursue a different policy direction by aligning the ambulance service more closely with other clinical, rather than emergency, services, particularly through the proposed merger with NHS Direct and closer working with GP out-of-hours services.

PCS processes are weak and inconsistent

2.159 There are weaknesses in PCS services across Wales, that stem largely from weak and inconsistent systems. Five different systems exist in the predecessor ambulance trust areas, none of which is fit for purpose. This is exacerbated by the lack of a control system, which compromises planning, the efficient use of resources and ultimately performance monitoring and service development. There is no costing information about the individual contracts let with the 13 acute trusts and Powys LHB. This means that the Trust does not know which contracts are profitable and which make a loss, individually or collectively, and there are currently no common standards or contracts.

2.160 HIW reviewers informed us that PCS service quality is extremely variable across Wales. This results from poor planning, vehicles and staff availability. HIW told us that PCS vehicles were old and uncomfortable. Crews receive lists of patients at the start of the day but there is significant duplication, for example different crews being sent to the same street or engaging in 'double runs'. HIW told us that the service runs well in the morning but plans fall into abeyance after midday because of the unpredictability of outpatient clinics. This may not be uncommon among ambulance services, but the poor planning means that there is little scope to adapt to inherent uncertainties, and crews can end up thinly stretched and struggling to get a lunch break.

2.161 There is little evidence that the Trust has prioritised PCS because of its focus on EMS performance targets. General management capacity problems within the Trust have exacerbated this lack of focus and PCS is seen very much as the 'Cinderella' service. Usually managed by EMS staff, PCS staff feel very much the poor relation and many believe that

there is no longer a route from PCS to EMS. This has resulted in a poor service, with eligibility criteria inconsistently applied and acute Trusts telling us about patients often arriving late for appointments or the failure of PCS ambulances to arrive delaying patients' discharge.

2.162 There have also been a small number of adverse incidents involving patients being transported to the wrong address and, in one tragic case, a patient dying after being left at the wrong address. The Trust was fined £20,000 in respect of that incident. The Trust has introduced new procedures but HIW have told us that they are unable to give an unqualified assurance that such an incident could not happen again. This is because their reviewers did not find a common understanding of the new procedures, and had differing willingness to use the tags now introduced to track individual patients. There is also inconsistency in how crews record their day which means that there are weaknesses in the audit trail, which could affect the Trust's ability to avoid a further adverse incident.

2.163 In addition to services provided by Trust employees, PCS also provides services through some 350 volunteer drivers and taxi firms. They are generally paid at a rate of 34p per mile (although there remain some local variances). Total expenditure on PCS in 2005/2006 was £4.2m. The Trust has very little management and costing information on the service. For example, no information is available on whether the costs of service level agreements with specific trusts are being recovered from the respective contracts. However, a specification is currently being compiled for a computerised scheduling system, which will also provide effective management and costing information.

2.164 It is particularly important to have robust controls of expenditure on the voluntary car service and taxi suppliers of PCS services. The Trust checks only 6 per cent of invoices from volunteers and taxis before payment despite past audit evidence of abuse of the system. The new scheduling system will make payments to taxis and volunteers on the basis of bookings and standard mileages, thereby providing a much more robust check on payments after the system is introduced in April 2007. Black cabs are used exclusively in the Cardiff area. Two companies provide these services. Unlike taxis used in other parts of Wales, they are paid at their normal hire rates. The two companies used were selected some years ago on the basis of being able to cope with the anticipated volume of work and no competitive tenders were invited. The use of black cabs is reducing, and it is intended to replace them largely with in-house provision. However, if their use remains significant, competitive tenders should be obtained for the service.

Clinical governance has developed but is not an integral part of managerial processes

2.165 Full details on clinical governance will be available in HIW's forthcoming clinical governance review of the Trust.

2.166 The Commission for Health Improvement (CHI) published a report in 2003 that criticised clinical governance in the Trust. In responding to that report, the Trust developed clinical governance systems and structures, but HIW reviewers told us that these had been suspended during Mr Thayne's period as interim Chief Executive. Mr Thayne informed us that he had sought to refocus clinical governance on collecting better clinical data. Recent changes have seen non-executives join the Clinical Governance and Risk committees. Following the CHI review, clinical operations managers were established in each of the three regions to champion clinical audit and Public Patient Involvement. However, the HIW review found evidence that:

- clinical governance structures were not integral aspects of management processes, partly because staff lacked training and awareness in clinical governance and line managers did not take responsibility for clinical governance matters; and

- patient and public involvement is not well-developed although there are CHC representatives on the Trust Board, and on the Patient and Public Involvement and Clinical Governance Committees.

2.167 Clinical audit has developed because of the efforts of the clinical audit manager and individual enthusiasts but there are few supporting structures. Data is input manually, with insufficient resource and several different systems. HIW told us that the overall culture of the Trust is not conducive to clinical audit but there is some good practice on which the Trust can build further progress as follows:

- the Trust carried out an audit in Cardiff and Vale NHS Trust to examine the consequences of changes in women's services; and

- the clinical audit department provided a training course for clinical operations managers which involved them carrying out a practical clinical audit.

The Trust has poor systems and infrastructure

2.168 The Trust delivers its services by managing staff who work within a context of systems and infrastructure. In addition to the weaknesses described above in strategic direction and operational management, we found that the systems and infrastructure themselves present problems, as follows:

- the Trust has generally operated a single model of service when there is evidence that alternative models bring advantages in some of the situations the Trust faces. It has developed some alternative models of service but on a small scale so far;

- the Trust's physical and ICT infrastructure is a constraint on its ability to deliver an acceptable standard of service; and

- procurement of new systems and infrastructure has been beset by problems.

There has been some development of alternative models of service

Community responders have been developed but could be utilised more effectively with greater clarity of roles and responsibilities

2.169 The use of community responders to provide an initial response to emergency incidents has delivered a number of benefits to patients. Where there is appropriate training, supervision and clinical governance, there can be particular benefits in rural areas, where community responders can often reach those in their communities much more quickly than an ambulance to administer defibrillators or other lifesaving techniques. Community responders are people, based in local communities, who have been trained in basic lifesaving techniques who can provide an initial response to an incident while awaiting a fully equipped ambulance. First responders are often employees of other emergency and public services, others with clinical training or members of the public.

2.170 Figure 31 shows the number of community responder schemes, trained community responders and the number of incidents they attended in 2005/2006 and the percentage of the total emergencies that these represented.

2.171 While some members of the public attending our hearings expressed concern about the use of community responders, community responders are recognised as a valuable source of lifesaving

Figure 31: The Trust has developed community first responder schemes

Region	Number of schemes	Number of responders	Number of incidents attended in 2005/2006	Percentage of all emergency calls
South east	51	558	543	0.21%
Central and west	38	769	1,897	0.55%
North	17	187	348	0.22%
WALES	106	1,514	2,788	0.37%

Source: Wales Audit Office

capacity working in tandem with fully crewed ambulances. We also heard concerns from trained community responders that their capacity had not been utilised as effectively as they could have been by the ambulance service in Wales. In particular, they believed that there was scope to improve advanced training and understanding of community responder schemes within ambulance controls, by improving significantly the clarity about the roles and responsibilities of community responders within the overall clinical service provided to patients. One clear challenge with the community responder scheme is to ensure robust clinical governance, ongoing training and supervision. The draft modernisation plan includes an objective to develop a strategic approach to the development and deployment of community responders, supported by a series of targets for community responders in respect of Category 'A' responses within 8 minutes. This reflects the importance of the targeted use of community responders in East Anglia (see Case Study C).

St John Cymru Wales volunteers contribute to capacity

2.172 Volunteers from St John Cymru Wales provide support for the Trust at very busy times of the year or at times of peak demand. They act as first responders providing defibrillation to those suffering heart attacks and provide cover from volunteers at major events. St John Cymru Wales volunteers have also provided occasional ambulance cover at times of significant pressure in parts of Wales.

Rapid response vehicles have been developed in some areas

2.173 The Trust has developed new models of service, including rapid response vehicles. There are now 1,280 hours each week of cover from rapid response or other intermediate tier vehicles in Wales, provided by 39 rapid response vehicles. Rapid response vehicles represent 11 per cent of the Trust's fleet, but their effectiveness is compromised by the fact that controls cannot locate them in the same way as they can traditional double-crewed ambulances.

Infrastructure and equipment are a major constraint

Stakeholders believed that poor infrastructure and equipment were a significant problem

2.174 Our analysis of the results of staff focus groups showed that their main priority for improvement was 'being properly equipped to do the job' (Appendix 4). This included having sufficient vehicles that are fit for purpose, equipment and the effective management of assets

to get the most out of what is available. It also includes issues around ICT. The quality of infrastructure and equipment was also a consistent theme at our public hearings and in the written submissions we received. There was real concern about vehicles that were not fit for purpose, the condition of the Trust's estate and ICT facilities. Such concerns about infrastructure and equipment clearly affect the confidence of staff and the public in the ambulance service in Wales.

The Trust is trying to address its longstanding problem with estates

Problems caused by the age and condition of the estate have not been fully resolved, resulting in action by the Health and Safety Executive

2.175 As at September 2006, the Trust occupied 99 buildings, 64 owned and 35 leased across Wales. This overall number of properties is largely unchanged since the creation of the Trust in 1998, although there has been a reduction in the number of control centre locations, from nine to four, investment in a new National Training College for Wales and provision of a number of new or significantly refurbished ambulance stations, such as those at Barmouth, Chepstow and Milford Haven. In addition, the Trust has occupation or use of 77 radio mast sites, both leased and owned.

2.176 In 2004, the Trust commissioned an estates condition survey which indicated that over one third of the estate was in a sub-standard physical condition – status C and D (Figure 32). This is not a new problem – in 2001, the Trust's original estates strategy noted that a substantial proportion of the estate inherited upon creation of the Trust was of poor quality. To a large extent, the condition of the estate reflects the age of buildings and, at the end of 2004/2005, information supplied by the Trust to Welsh Health Estates showed that 50 per cent of the estate dated from before 1965, with 14 per cent dating from before 1948. The one-off cost of bringing the estate up to an acceptable standard, i.e. condition A or B, was estimated by the Trust to be almost £1.9 m, although estates staff have suggested that this may not fully reflect the true cost to deliver the required improvement in the estate, which they estimate will be as much as, if not more than, the cost of backlog maintenance.

2.177 The sub-standard condition of the estate resulted in the Health and Safety Executive (HSE) issuing an Improvement Notice on the Trust's estate, in 2003. Although some progress has been made to address the initial concerns raised by the HSE in respect of 40 properties, there are still 19 properties that are the subject of this notice and the Trust has until March 2007 to address

Figure 32: Condition of the Trust estate

Category	Description	Percentage of estate
Condition A	The asset is as new and can be expected to perform adequately to its full normal life	42 per cent
Condition B	The asset is sound, operationally safe and exhibits only minor deterioration	23 per cent
Condition C	The asset is operational but major repair or replacement is currently needed to bring up to condition B	7 per cent
Condition D	The asset is operationally unsound and in imminent danger of breakdown.	28 per cent

Source: Tribal Secta, Review of the Welsh Ambulance Services Trust Operational Estate, Interim Report, March 2006

these issues. After this time it is likely that the HSE will take further action, having already extended the Improvement Notice on three occasions. This action could include the serving of prohibition notices, prosecution or fines.

The Trust has secured £1 million external funding to address major risks in its property portfolio, although there is the possibility that some of this money will be spent at sites that do not have a long-term future

2.178 In December 2005, Welsh Health Estates confirmed that the Trust had been successful in three bids submitted under the terms of the Welsh Assembly Government Department for Health and Social Services Major Risk Framework. These bids represented a total funding package of £977,077 and provide for improvements at 14 ambulance station sites relating to the physical condition of the buildings, engineering services (such as electrical and mechanical installations) and improvements to accommodation to comply with statutory legislation (such as the lack of inclusive facilities for female and male staff and provision of adequate infection control). The Trust is contributing a further £51,424 to the project. The Trust has also committed an additional £300,000 from its own discretionary capital to carry out peripheral works at these and a further five properties which are the subject of the HSE's Improvement Notice. In addition to the works planned for these 19 properties, the Trust is putting in place alternative operational arrangements through collaborative working with other emergency service providers which will enable nine obsolete (in terms of age and fitness for purpose, and being beyond economic repair) ambulance station buildings to be closed.

2.179 The Trust's estates manager explained to us that his current priority is to ensure that these works are undertaken as swiftly as possible, and at least before March 2007, to address the timetable required by the HSE's Improvement Notice. Tenders for the works to be carried out using the Major Risk Framework funding were issued in early October 2006. Although the Trust has a clear responsibility to address the issues raised by the HSE, it is possible that some of this money will be spent improving properties that are subsequently deemed surplus to the Trust's requirements, as it finalises the details of its modernisation plan and new estates strategy.

The Trust has lacked capacity in its estates management function

2.180 Historically, the Trust's estates department has consisted of an estates manager and assistant estates manager, reporting to the then Director of Operations. Both the estates manager and his assistant left the Trust in 2005/2006, to be replaced by a new estates manager and a member of staff who is supporting him on a temporary basis. The Trust does not directly employ any maintenance staff, with these services provided by external contractors, including other NHS trusts, although the new estates manager told us that this presented logistical problems in arranging for any works to be undertaken.

2.181 As part of the fieldwork for our examination of *NHS Energy Management in Wales* (published December 2005), the previous estates staff raised concerns about their ability to provide sufficient coverage of estates issues across the whole of the estate, complicated by the sheer numbers of buildings and their spread across Wales. This lack of capacity meant that broader aspects of estates management, such as the monitoring and management of energy consumption (the Trust spent approximately £450,000 on energy for its buildings in 2005/2006) and the development and implementation of an environmental management system in line with the requirement of Welsh Health Circular (2002) 116, had not been addressed in any meaningful way.

2.182 The new Head of Estates recognised these pressures and, in the case of energy management, was confident that he could deliver significant savings in expenditure if he had the time to commit to this issue, but that the immediate priority was the development of the future estates strategy and addressing the HSE Improvement Notice. Nevertheless, the Carbon Trust is in the process of undertaking energy surveys at a number of Trust sites with a view to bidding for resources from the £3.5 m energy efficiency fund established by the Welsh Assembly Government Department for Health and Social Services. However, decisions on the viability of any significant energy saving measures will have to take account of the development of the new estates strategy, and the extent to which any measures will provide significant benefits within the useful life of the buildings concerned.

The make-up of the Trust's estate has not been driven by business need

2.183 It is difficult to compare the Trust's estates revenue and capital costs with those of other ambulance trusts on a reliable basis. However, based on the current condition of many of the Trust's properties, and the very existence of the HSE notice, it is clear that there has been insufficient expenditure to bring buildings up to the required standard.

2.184 More importantly, there has been insufficient 'strategic' investment in the estate, aligned to wider modernisation of the service. In March 2006, the Trust received an interim report from external consultants (Tribal Secta) following their review of the Trust's operational estate. The rationale for this review was described as being based on the need to:

- deliver service modernisation in a manner that ensures sustainable improvement in the delivery of operational performance targets;
- improve the overall condition of the estate by addressing the current facility constraints and provide a working environment for staff that is fit for purpose; and
- improve the cost effectiveness of the estate allowing revenue to be released.

2.185 This work, originally commissioned in 2005 concluded that, *"there is little doubt that a programme of estate rationalisation is required to support the delivery of a modern fit for purpose service"*. However, this message is not particularly new, as in April 2001 the ORH report identified 90 optimum locations from which to improve response times, of which only 12 coincided with existing ambulance station sites. Although the Trust's original estates strategy in 2001 put forward 28 stations for relocation, drawing on the recommendations of the ORH report, it is clear that limited progress was subsequently made to convert these proposals into firm action. For example, the ambulance station and workshops in Dolgellau were recognised in 2001 to be in dire need of replacement for reasons of building conditions and health and safety. Yet it has since taken some five years for the future of this station to be resolved (the station being closed with staff moving to share facilities locally with the fire service).

There are serious fleet problems

2.186 The Trust's fleet is composed of 656 vehicles, including 231 emergency ambulances, 42 rapid response vehicles, 239 PCS ambulances, 64 non ambulance transport service vehicles and 80 other vehicles. The Trust owns 289, 44 per cent, of its vehicles, and leases the other 56 per cent. The Trust spent £6.5m on fleet services in 2005/2006. It operates four in-house workshops, two in North Wales and

Figure 33: Critical vehicle failure rate, April 2006

	South East Wales	Central and West Wales	North Wales	Total
EMS	8%	8%	7%	8%
PCS	6%	12%	7%	8%
Total	7%	10%	7%	8%

Source: Welsh Ambulance Services NHS Trust data

two in the South East. Vehicle maintenance in the central and west region takes place through a number of third party workshops.

2.187 The average age of the fleet is 7 years, but the condition of vehicles remains a concern. Figure 33 shows that in April 2006 the Trust lost around 8 per cent of available fleet hours through critical vehicle failures.

2.188 One of the key issues with the Trust's fleet is that the recent procurement of 46 ambulances that were not fully fit for purpose and the JAKAB procurement which also failed to deliver fully useable ambulances, (Case Study J). The Trust is operating a seven year depreciation cycle, yet 43 per cent of its EMS ambulances are older than their replacement age of five years. In total, 30 per cent of the entire fleet is older than its replacement age (Figure 34). This is compounded by the procurement failures around the fleet, and short-term maintenance – in the course of our fieldwork we observed the use of 'gaffer tape' to make temporary repairs to enable vehicles to stay on the road. HIW reviewers also identified problems with the PCS fleet, which they told us was old and uncomfortable. In October 2006, the Welsh Assembly Government announced funding of £16m to purchase an additional 119 emergency ambulances and 67 PCS vehicles.

2.189 There has been a problem with management capacity for fleet due to the long-term absence of the fleet manager. Temporary support from Mersey Regional Ambulance Service helped to fill this gap but the Trust appointed a full-time fleet manager in September 2006, who will develop a fleet strategy to support the overall modernisation plan for the Trust. A key issue will be to provide sufficient fleet cover to enable vehicles, services and cover to be properly maintained.

2.190 The Trust has a computerised fleet management system with the capability to provide a control system for vehicle workshops. Although there are plans to upgrade the system and roll out its usage across the Trust, currently the system only works in one of the North Wales workshops due to networking and training limitations. Without access to the system and trained users, compounded by the long-term absence of the fleet manager, the Trust has been unable to produce useful fleet information to benchmark costs internally and externally to ensure that the current arrangements are delivering value for money.

2.191 There are a number of different arrangements in place for maintenance. Owned and leased vehicles are maintained in house or by third party garages, some costs are met by the Trust and some are the responsibility of the

Figure 34: Summary of fleet age

Vehicle Type	Total vehicles currently in use	Number of vehicles older than replacement life	% of vehicles in use older than replacement life
EMS	231	100	43
PCS	239	39	16
Specialist	55	18	33
Non-ambulance transport services and Health Courier Services	64	14	22
Rapid Response Vehicles	42	8	19
Paediatric	1	0	0
Grade 3 intermediate tier	24	19	79
Total	656	198	30

Source: Wales Audit Office

lease company. Trust officers stated that there was significant scope for a review of the value for money achieved by the range of arrangements in place. Front-line crews provided anecdotal evidence of significant lost time driving to workshops or waiting for travelling mechanics to repair or service vehicles, contributing to the loss of planned unit hours.

2.192 Management control of maintenance work undertaken in third party workshops has been poor. As an example, records to confirm that vehicle maintenance has been undertaken have not been provided or monitored by the Fleet office. The annual cost of this work is approximately £0.2m.

2.193 The Trust does not operate a '*Make Ready*' (paragraph 2.140) system whereby a specialist team prepares vehicles before shifts to maximise their cleanliness and ensure the availability of paramedics to attend incidents during their shifts, rather than them spending time preparing vehicles. This system, which is already in use in some other ambulance services, merits consideration by the Trust within the context of its new fleet and estates strategy, and the wider modernisation plan. There are also other developments elsewhere which the Trust should consider – the Scottish Ambulance Service is developing proposals to operate joint fleet services with other public services, particularly by rationalising transport arrangements with local authorities.

The Trust needs to make better use of ICT

2.194 The Trust suffers from the paucity of ICT systems available to it. There is a lack of satellite navigation in ambulances and mobile data terminals, which the Chief Executive of the London Ambulance Service told us has the potential to improve significantly response time performance. Some staff confirmed to us as had been reported in the press that they have

provided their own satellite navigation systems to help them reach incidents and to reduce stress at work. Control rooms sometimes lack AVLS and GPS systems (paragraph 2.151), and there is a major ongoing £54m procurement to provide a new radio network as key wavelengths are being withdrawn. In addition, clinical information is collected on paper, and there are risks of losing important clinical data or information about adverse incidents. The Trust has not yet started to use telemetry to improve clinical services by providing information in advance to A&E departments or to reduce the need to transport patients to hospital.

There have been serious deficiencies in capital procurement processes which have led to significant wasted money and opportunities, although systems have now been developed

There have been procurement weaknesses for some time

2.195 The efficiency and effectiveness of the ambulance service is dependent to a large degree on having the right equipment and technology in place. With only limited capital resources available it is critical that the Trust invests wisely, prioritises effectively and procures the assets it needs to deliver its business objectives. The Trust's record in this area has been very poor.

2.196 The Trust has not had a coherent capital strategy in place (paragraphs 2.68-2.71). As a result there has been a tendency for procurements to be ad hoc, driven more by the desire to spend available monies by the financial year-end than to meet demonstrable business needs.

Case Study J: Poor procurement has led to significant failed procurements

PCS scheduling system

A new IT based scheduling system for the Patient Care Service had, by March 2006, cost the Trust £0.44m in capital and a further £0.4m in revenue. After testing and piloting, the system has not been rolled out across the whole Trust because of concerns about its fitness for purpose which have led to the Audit Committee commissioning a review. There is a risk that the costs incurred will have to be written off.

Ambulance procurements

In 2002, the Trust entered into an agreement with a company to purchase, and have fitted out, 30 emergency ambulances. The company was declared insolvent prior to fitting out three of these vehicles. These three vehicles have never been used and are still in storage; they cost £83,000. Following an engineer's report it was found that the remaining vehicles did not meet safety standards as emergency vehicles and therefore have had to be deployed within the Patient Care Service.

In 2005, the Trust arranged to purchase and convert into emergency ambulances 46 Renault Master Vans at a cost of £2.4m. After these vehicles had been converted it was found that the new ambulances had a weight overload on their front axles, which rendered the vehicles potentially unsafe. As a result the Trust has had to spend £120,000 to make the vehicles operational and to extend existing leases while modifications were made. The Trust is able to use the vehicles but in a restricted way, for example being unable to carry relatives with the patients. Full details of the Renault procurement can be found in the auditor's report on the procurement, which we have published on the Wales Audit Office website, www.wao.gov.uk.

Source: Wales Audit Office

2.197 Significant procurements have been progressed in isolation by individual parts of the Trust without the input of professional procurement advice and expertise. As a result there have been several examples of poor and potentially unlawful procurements (Case Study J) which have compromised value for the money. Each of these procurements was characterised by the following factors:

- poor or no project management;
- limited professional procurement input;
- poorly designed specifications;
- an inadequate audit trail of procurement documentation;
- a lack of internal co-ordination;
- failure to manage relationships with suppliers effectively; and
- in the case of both ambulance procurements, the Trust also failed to adequately test the market, failed to procure ambulances that were fully fit for purpose and, in so doing, failed to demonstrate adequately that it had achieved value for money.

The Trust sought to develop new systems for procurement in the light of these cases

2.198 Following these high profile failures, in 2005, the Trust appointed a new procurement manager to bring professional discipline to future procurement exercises through a more consistent and corporate approach to procurement. There is some evidence that these systems had begun to address the weaknesses in procurement processes.

However, there were further procurement weaknesses during 2006

2.199 In April 2006, soon after his appointment, Mr Thayne wrote a memorandum to the Trust Board seeking approval to appoint a firm of consultants to "*establish as quickly as possible the current status of the Trust and to be able to inform the action plan to develop the organisation into a high performance ambulance service*". Mr Thayne also believed that time was of the essence because Mrs Lloyd, Head of the Assembly Government's Department for Health and Social Services, had asked for an initial report on the Trust by mid May 2006. Mrs Lloyd told us that she would not endorse any action that might breach Standing Financial Instructions or Standing Orders. The proposal was to focus particularly on fleet, estates and ICT infrastructure. The value of the contract was £58,700, although this was not paid for some time because of concerns that the original brief had not been fully delivered. We understand that a settlement has now been agreed between the Trust and the firm of consultants. In proposing the firm of consultants to undertake this work, Mr Thayne stated that "*other consultancies would not fully comprehend the management processes required and culture needed to develop System Status Management (SSM)*". On the basis of the Chief Executive's recommendation that a decision needed to be taken urgently to expedite the work because, as he asserted, '*failure to take notice of the situation as reported could lead to the continued loss of life and risk of a total collapse of the Service*', the consultants were forthwith appointed. We have found no evidence that the Chief Executive's memorandum was considered formally by the Board prior to the appointment of the consultants and no formal waiver of Standing Financial Instructions appears to have been actioned. We saw no evidence that this company was the only company capable of delivering this exercise and believe it likely that there would have been significant competition for a contract

of this nature. Indeed the company appointed was newly formed and therefore without a track record of its own. The Trust exposed itself to significant risk, is unable to demonstrate it has obtained value for money and has opened itself to allegation of unethical practices. Even if this company was the only one capable of delivering this assignment, we also found that:

- no purchase order was raised and no other quotes were obtained or market testing undertaken to check value for money;
- no financial checks of the company were undertaken;
- no contract was drawn up; and
- there was no specification agreed by the Trust.

2.200 Mr Thayne has told us that details of the consultancy proposals were circulated to members of the executive team prior to the appointment and that senior officers could have raised any concerns they had. We accept this was the case. However, an informal mechanism such as this is no substitute for following the formal procurement and approval processes set out in the Trust's Standing Financial Instructions.

2.201 On 16 May 2006 Mr Thayne submitted a further memorandum to the Board asking that it *"formally approves the appointment of the management consultants".* However by this time the consultants had already been appointed and had commenced work. The memorandum records that, at the request of the Chair, *"in order to safeguard the position of both individuals and the Board discussions* [had taken place] *with the Trust auditors to ensure that the proposals conformed to Trust Standing Financial Instructions".*

2.202 We have discussed this matter with the Trust's auditors. They have confirmed that they were approached by the Director of Finance but they did not provide any assurances that the proposed contract award was in accordance with Standing Financial Instructions. Rather, they stressed the importance of the Trust taking action to ensure that the arrangements complied with Standing Financial Instructions, and wrote to the Director of Finance in response to Mr Thayne's memorandum of April 2006 setting out a number of key issues which they believed the Trust should address before appointing the consultants. The Director of Finance forwarded these e-mails to Mr Thayne, which raised the following issues:

- Have [the Trust] separately been able to justify that this work needs to be undertaken in the first place?
- Mention is made of the various work undertaken by [the consultants] in England and Scotland but has anyone approached these trusts for a reference, even an informal one?
- It seems that other consultancies are discarded a bit too easily… other firms may be interested
- [The price per day] seems reasonable but [the Chief Executive refers] to it being the lowest level for consultancy – have [the Trust] actually checked this. What about travel expenses – depending on where [the consultants] are based this could add significantly to the bill.
- Is [the number of days] too much or too little? Seems a lot of days for a consultancy project (particularly if there is an expectation of substantial Trust resource being required as well). You could argue that it might be

better to pay £1,000 a day for 50 days and get real specialist input, rather than pay a lower rate for a longer term. Quality is the issue!

2.203 We are unclear what action, if any was taken to address the concerns raised by the auditors. It is evident however that the assurances provided by Mr Thayne at the Trust Board of 16 May 2006 that the auditors had confirmed that the proposal complied with Standing Financial Instructions was not accurate.

2.204 In our view the Board was placed in an invidious position, being asked to approve the award of a contract which had already been awarded without competition and in contravention of the Trust's Standing Financial Instructions. Members of the Board have told us that they were uneasy about approving the contract award but took assurance from Mr Thayne's report that he had confirmed with the Trust's auditors that the arrangements complied with the Trust's Standing Financial Instructions.

2.205 Mr Thayne also initiated a series of procurement processes for IT systems and clinical equipment after his arrival in March 2006. These procurements appear to have been progressed without the direct involvement or professional input of the procurement department, although we have been told that they were discussed, at least in summary detail, by the Trust's executive management team.

2.206 Within weeks of Mr Thayne's appointment as interim Chief Executive, the Trust spent £0.76m on purchasing 155 automatic chest compression devices. Mr Thayne has described the urgency which existed to spend this money by the end

Case Study K: Procurement of chest compression devices

The interim Chief Executive Mr Thayne recommended the purchase of 155 automatic chest compression devices at a cost of £0.76m.

The Trust completed the purchase of these devices from a single supplier without competition and complying with the legal requirements to advertise in OJEU and for the successful supplier to complete a pre-purchase questionnaire.

The Chief Executive completed a standard form requesting that the Board waive its Standing Financial Instructions for the purchase of equipment with a value of £0.764m despite the waiver form stating that the Standing Financial Instructions may only be waived for purchases of between £15,000 and £99,695 and that *"Above £93,738 EU Regulations apply and cannot be waived by the Trust".* The form states that the reason for the request to waive Standing Financial Instructions was because only one supplier had a product able to meet guidelines set out by the UK Resuscitation Committee. The waiver form was dated 24 March 2006 and an e-mail was sent to the company on the same date ordering the equipment, albeit the e-mail does state that the purchase was *"subject to Trust Board approval on 28 March 2006'.* An official order was raised on 27 March 2006 and the equipment was delivered to the Trust in two batches on 30 and 31 March 2006. The request to waive the Standing Financial Instructions was not formally presented to Members until July 2006, by which time Mr Thayne had left the Trust and the equipment was already in use.

The Interim Chief Executive did report the proposed purchase to a closed meeting of the Board on 28 March 2006. The Board was told in this meeting that the device was the *"only automated device suitable for use by the ambulance service and a monopoly supplier for an automated CPR device".* We have found no evidence to support this claim and indeed the interim Chief Executive acknowledged in his report to the Board that there was a *"potential alternative supplier"* but that this supplier *'would not contest the decision'.*

continued...

The Interim Chief Executive advised the Board that the purchase would be subject to the waiver of Standing Financial Instructions and that there was no need to advertise the contract in the Official Journal of the European Union as the supplier was a monopoly supplier. Board minutes do not record that there was any discussion of the legality of the proposed procurement arrangements; of the need to demonstrate value for money; or indeed that the equipment had already been ordered. The minutes record that an e-mail from the Trust's Medical Director was shared with the Board, which highlighted research questioning whether these devices improve clinical outcomes. However, the Interim Chief Executive told the Board that the *"Director of NHS Wales (Mrs Lloyd), and Health Commission Wales (HCW) were 'generally supportive of the intention to purchase this equipment, subject to Board approval"*, (although this is disputed by Mrs Lloyd). On this basis the Board approved the purchase.

It is a matter of serious concern that such a significant purchase was undertaken without any proper business case, option appraisal or procurement specification, particularly given the strongly divergent views about the clinical effectiveness of these devices.

Moreover, the Trust had a duty under European law to test the market to see whether other suitable products and suppliers existed and to provide potential suppliers to modify existing products to comply with a required specification. We have found no evidence to suggest that waiving the SFIs was justifiable.

Mr Thayne has told us that he believes the action taken to procure these devices was appropriate and justifiable on the basis that it would save more patients' lives. He does not accept that a competitive process was necessary as he spoke directly with an alternative supplier and this supplier was unable to match the price of the supplier he selected. We do not accept this argument. The fact remains that the Trust had a duty to comply with European law and Standing Financial Instructions. Furthermore, in conducting informal discussions with potential suppliers in respect of such a major contract, the Trust has been laid open to allegations of impropriety, particularly as the alternative supplier was subsequently selected without competition as the preferred supplier for another major contract, the purchase of defibrillators (Case Study L).

Following the purchase of the equipment, the Trust took steps to legitimise retrospectively the procurement. The supplier was asked to complete a pre-purchase questionnaire and the Trust placed an award notice in the Official Journal of the European Union. This notice justified the decision not to seek competition on the grounds of "extreme urgency brought about by events unforeseeable by the contracting authority and in accordance with the strict conditions stated in the Directive". There is no evidence that any such urgency existed, other than a desire on the part of the Trust and the interim Chief Executive to spend its available budget by the financial year-end. This is not an appropriate consideration in deciding whether to seek competition.

Source: Wales Audit Office

of the financial year. He told us that his first priority would have been to purchase satellite navigation devices but that this would not have been possible in the time available before the end of March. However, at the time of Mr Thayne's appointment, the Trust had already developed other plans to spend the money on buying out existing vehicle leases, although there are questions about the basis of this proposal. Case Study K describes the deficiencies in the procurement of 155 chest compression devices.

2.207 There were also weaknesses in a number of other procurements for which business cases were in development (Case Study L), which sought to address weaknesses in the Trust's infrastructure. These procurements were due to go before the Board for approval but this did

Case Study L: Weaknesses in procurement processes that are now being reviewed

Proposed purchase of 103 defibrillators at a cost of £1.8m

In April to July 2006 a procurement process was progressed to replace 103 defibrillators.

The business case is deficient in all material respects. Specifically it fails to:

- identify a business need;
- specify the Trust's requirement; and
- identify procurement options.

Moreover, the business case recommends the purchase of the equipment from a single supplier. Mr Thayne told us that he approached this company and obtained quotations from it as it was an existing supplier of the Trust. It appears that there was no intention to use the existing All Wales framework agreement for the purchase of the equipment. Failure to use this framework or to seek competition through advertisement in the Official Journal of the European Union was anti-competitive and if a contract had been let would have been unlawful. Furthermore, Mr Thayne's approach to a single possible supplier without the involvement of the Trust's procurement department was in our view very unwise and has laid the Trust open to allegations of impropriety. Whilst the procurement process was being progressed, a member of staff who had been appointed by Mr Thayne on a temporary contract and was involved in the procurement process was offered, and accepted, a job with the proposed supplier. The Trust continued to use him in a limited capacity in the procurement process, prior to his leaving its employment, although the member of staff concerned has stressed that his continued involvement was with the full knowledge of the Trust's executive management team.

In July 2006, the Procurement Department carried out a review of the business case for the procurement and expressed grave concerns regarding the integrity of the procurement process. The procurement proposal has been withdrawn.

Computer Aided Dispatch (CAD) System

Between March and June 2006, the Trust's IT Manager was tasked with reviewing options for a new Computer Aided Dispatch (CAD) system to track and plan vehicle movement, prior to a procurement process commencing. The estimated cost of this procurement is in excess of £1m.

Subsequently, a temporary project manager was appointed to the Trust to progress both this and two other procurement processes: Emergency Call Location System (EMCLP), and Automatic Vehicle Location Navigation and Mobile Data System (AVLS).

In June 2006, the project manager invited a firm of consultants to present to the Trust on CAD Systems and to provide indicative prices. During this presentation the consultants identified a specific product as a solution to the Trust's needs and also identified specific EMCLP and AVLS systems this product could interface with. The consultants are the UK distributors of the product identified. This activity was likely to have given the supplier a commercial advantage and was therefore anti-competitive.

In July 2006, the Procurement Department carried out a review of the business case and expressed grave concerns regarding the procurement process. On 27 July 2006 the contract was advertised in the Official Journal of the European Union and the Trust has received 14 expressions of interest. This procurement process is ongoing.

continued...

Emergency Call Location Package (EMCLP)

The Trust also commenced a process to procure an Emergency Call Location system. Such a product would enable the ambulance service to pinpoint the precise location of emergency calls. The procurement process was not pursued via the Procurement Department. A business case for this procurement was produced but is deficient in a number of key respects:

- it referred throughout to one product;
- it concluded that only one supplier can provide the necessary technology; and
- it recommended the purchase of a product without a call to competition.

After an internal review of the procurement process, the Trust has now advertised the contract in the Official Journal of the European Union and has received 11 expressions of interest, indicating that there are other suppliers capable of meeting the Trust's requirement.

Automatic Vehicle Location Navigation and Mobile Data (AVLS)

The Trust also sought to procure an AVLS. This equipment would enable the Trust to identify the precise location of every ambulance. This procurement is likely to have a value of several million pounds.

In March 2006, the proposed procurement was advertised in the Official Journal of the European Union and 54 expressions of interest were received from prospective suppliers.

Following this exercise, a Trust official visited the premises of one potential supplier in order to draw up a specification for the procurement. This provided a commercial advantage to this supplier.

A business case was produced but was deficient. The business case stated that 'preferred supplier stage has been reached'. This was before any tenders were received or evaluated. The actions of the Trust have been anti-competitive and have compromised the integrity of the procurement process. This procurement is ongoing.

Source: Wales Audit Office

not happen as the procurement department decided, appropriately, to suspend them after the resignation of Dr van Dellen, because of concerns about the basis of the business cases:

- 103 defibrillators;
- computer-aided despatch system;
- emergency call location package; and
- automatic vehicle location navigation and mobile data (AVLS).

There are serious concerns about the organisational culture

2.208 A number of current and former employees of the Trust told us that they perceived a culture of bullying and harassment within the organisation. Inevitably, there is a fine line between robust management and a perception of bullying. Nevertheless, despite the Trust's dignity at work policy and policies to tackle bullying and harassment, the perception of bullying is an important issue for the Trust to address.

2.209 Linked to this, we found that there was a culture in which suspensions and grievances appear to be common (paragraphs 2.117-2.119). There appears to be a lack of confidence in management, which leads to staff taking formal action under grievance and dignity at work policies to try to resolve situations, rather than trying to work with managers to improve their situation.

2.210 We also found that job satisfaction is low among some of the Trust's employees and is a crucial issue for the Trust to address. Of those responding to our survey, 47 per cent were satisfied with their job, but 34 per cent were dissatisfied. Job satisfaction was lowest in control rooms, where 44 per cent of staff expressed dissatisfaction.

The Trust has not fully developed a clear corporate identity

2.211 One of the major achievements of the early years of the Trust is that the previous services have been merged, and the existence of a single national service is a strength rather than a weakness for the future of the Trust. Nevertheless, staff still believe that the Trust lacks a strong corporate identity. Seventy per cent of staff responding to our survey do not believe that the Trust headquarters and its three regions operate on a consistent basis. During our fieldwork in the three regions, we also found evidence of regional variations in terms and conditions and operating processes, such as controls, meal breaks and shift patterns.

Communication has been weak

2.212 Trust staff consistently expressed concerns about communication. Communication is inherently difficult in an organisation in which staff are spread across over 100 sites and in which most do not have ready access to a computer and the Trust Intranet. Staff have many ideas about improving the Trust yet even at relatively senior levels they told us that they have not been listened to or encouraged to provide ideas for improvement.

2.213 Another consistent theme was the need to provide information to staff, particularly at a time of rapid change. Only one in every ten people responding to our staff survey agreed that the Trust kept them informed of its future strategic direction. This reflects potential weaknesses in communicating with external stakeholders about the future strategic direction of the Trust (paragraph 2.61).

There has not been a culture of learning

2.214 We found little evidence that the Trust has established effective systems to encourage the identification and dissemination of good practice. There appears to be little communication between regions on how they are tackling common problems and how some areas – for example Conwy and Denbighshire – have achieved high levels of performance yet others have not. There appears to be a piecemeal approach to spreading good practice and, in some quarters, a reluctance to adopt good practice if the idea was not generated in a particular locality.

2.215 The widespread perception of a blame culture in the Trust militates against developing a culture of learning and sharing. Learning from adverse incidents and complaints is especially important as the service develops an increasingly clinical focus. Yet, we found that the Trust's approach to dealing with complaints was somewhat defensive. However in its discussion with complaints staff at the Trust HIW noted that there had been a change in approach commencing when Mr Thayne had become Interim Chief Executive. This marked a greater determination to learn from complaints and to be prepared to make appropriate apologies when they were justified.