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Clinical governance review

Welsh Ambulance Services NHS Trust

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Introduction

The Welsh Ambulance Services NHS Trust (the trust) was established on 1 April 1998 following a merger of four ambulance trusts in Wales, together with the ambulance services previously provided by Pembrokeshire and Derwen NHS Trust.

The trust covers an area of 8,000 square miles and serves an indigenous population of 2.9 million people in diverse communities ranging from large urban areas such as Cardiff and Swansea to small isolated communities in areas like Powys and Snowdonia. The picturesque nature of much of the area and popular coastline attract large numbers of seasonal visitors.

The trust employs approximately 2,300 staff and provides: pre hospital emergency treatment and care; urgent patient admissions and inter hospital transfers; patient care services; non ambulance transportation; and call handling for some GPs. The trust operates from a large number of owned and leased premises across Wales. These include more than 90 ambulance stations, four control centres, a national ambulance training college and associated regional training centres, a trust headquarters with three regional offices and five vehicle maintenance workshops.

It divides its day to day operations into three geographical regions, the north, central and west, and the south east using approximately 223 emergency vehicles, 254 patient care service vehicles and 109 other specialist vehicles including helicopters, fast response and control vehicles.

On a daily basis the trust manages the delivery of pre hospital care within a framework made complex by its size, the diverse landscape, an inconvenient road and rail network, a highly dispersed population and long journeys to some hospitals.

The trust has had to work hard to introduce an all Wales ambulance service culture. It has had to deal with some barriers to change, including staff perceptions, previous managerial structures, differing staff working arrangements and some local opposition to rationalisation, which has made it difficult to achieve economies of scale.

The trust has had to cope with the complexities of the merger and the real difficulties encountered by inheriting a financial debt, poor estate, vehicles and equipment, an ageing radio communication infrastructure and inadequate information technology.

In the early days of the trust, decisions were taken to prioritise vehicle replacements and equipment over new information technology. These decisions were made with patients and staff in mind. However, the trust now finds itself in need of good quality information to move clinical governance forward but without the full information technology infrastructure to support this.

The funding arrangments under the old health authority structure created an uneven distribution of resources which has made it difficult for the trust to deliver an equitable service. The formation of Health Commission Wales should help overcome this problem, by redistributing resources equitably across rural and urban communities.

The trust feels that its financial constraints hinder its ability to fully implement a development programme to achieve a clinically focused service.

The trust has had to deal with the uncertainties of restructuring and new relationships brought about by the formation of the National Assembly for Wales, and the reshaping of the NHS in Wales with the

Introduction *continued*

introduction of local health boards and, most recently, the trust's new accident and emergency commissioning arrangements being dealt with by Health Commission Wales.

This report by the Commission for Health Improvement (CHI) gives an independent assessment of how well the trust ensures high standards of care and what it is doing to continuously improve the quality of services.

For this report, CHI looked at clinical governance in the emergency, urgent and patient care services across the trust. Letters and comments were received from over 180 statutory stakeholder, community and voluntary organisations, staff, patients and carers. Interviews were conducted with 175 staff and 30 sets of observations were made at different sites across the trust. The review is part of a rolling programme of reviews of clinical governance in NHS organisations in England and Wales.

Clinical governance is the system of steps and procedures adopted by the NHS to ensure that patients receive the highest possible quality of care, ensuring high standards, safety and improvement in patient services.

What is the purpose of the review?
CHI's clinical governance reviews set out to answer three questions:

1 What is it like to be a patient here?

2 How good are the trust's systems for safeguarding and improving the quality of care?

3 What is the capacity in the organisation for improving the patient's experience?

What is covered by a CHI review?
CHI's review assesses seven areas of clinical governance. The areas are:

1 patient involvement

2 risk management

3 clinical audit

4 staffing and staff management

5 education and training

6 clinical effectiveness

7 use of information

CHI's review also describes two further areas:

1 the patient experience

2 the trust's strategic capacity for developing and implementing clinical governance

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

i Little or no progress at strategic and planning levels or at operational level.

ii a) Worthwhile progress and development at strategic and planning level but not at operational level, OR

b) Worthwhile progress and development at operational level but not at strategic and planning level, OR

c) Worthwhile progress and development at strategic and planning and at operational level, but not across the whole organisation.

iii Good strategic grasp and substantial implementation. Alignment of activity and development across the strategic and planning levels and operational level of the trust.

iv Excellence – coordinated activity and development across the organisation and with partner organisations in the local health economy that is demonstrably leading to improvement. Clarity about the next stage of clinical governance development.

What are CHI's conclusions about Welsh Ambulance Services NHS Trust?

What was the overall impression of the trust?
In view of the exceptional range and complexity of the issues that the trust has had to address since its inception in 1998, it is a credit to the trust that it has begun to develop the clinical governance agenda over the last 28 months. However many areas of clinical governance are still underdeveloped and not integrated within the mainstream activities of the trust.

In its early years the trust focused significant attention on ensuring the success of the merger. The trust is now at the stage of its evolution where it must invest further effort in developing the clinical quality agenda.

There are some impressive pockets of high quality work being undertaken to support the development of clinical governance, which has involved many individuals throughout the trust. The work of the cohort of individuals in the clinical operations structure has been significant in this. These initiatives need to be integrated and spread much more widely across the organisation. The trust has many skilled and enthusiastic staff who, if further empowered, could effect further cultural shifts and make significant improvements in the delivery of high quality clinical services to those served by the trust.

What are CHI's conclusions based on its review of the trust?
The barriers to full integration of clinical governance need to be removed for the trust to progress further.

Some aspects of the management structures need to be reviewed for clinical governance to progress. The development over recent years of a parallel set of structures for clinical governance should be reconfigured so that clinical governance is fully integrated with the trust's mainstream activities.

Despite the trust outlining responsibilities for individuals and committees in key trust documents, staff report these to be unclear and CHI's evidence shows that they are not understood. This leads to uncertainty and inconsistency in decision making.

The lack of an embedded strategic approach to clinical governance, coupled with poor quality information and poor monitoring of progress, hinders effective planning and leaves the trust vulnerable to substantial risk and the potential for poor quality patient care. The trust informed CHI that it is in the process of reviewing its strategic plan.

A major challenge for the trust board is to continue to move towards an open, just and fair culture.

What areas of notable practice were identified?
The trust has worked well within the new NHS Wales structure to ensure that partner organisations are involved in its clinical governance conferences.

The trust has developed undergraduate and postgraduate degree courses in pre hospital care and paramedic practitioners.

The systematic approach to pilot schemes, adopted by the trust to evaluate models of care for the delivery of pre hospital thrombolytic treatment to coronary heart disease patients, is notable.

What are CHI's conclusions about Welsh Ambulance Services NHS Trust? *continued*

The development of first responder schemes is now commonplace. However, the trust has been successful in building schemes with the police and fire services as well as GPs, voluntary organisations and community volunteers.

The trust has a colleague support service, run by staff to help and support peers.

What, if anything, did CHI find that the rest of the NHS can learn from?
The trust has reduced the need for staff to travel long distances by using video conferencing.

The trust has a research and development function, known as the pre hospital research unit, developed in partnership with University of Wales College of Medicine, which has been successful in gaining a high profile nationally and internationally.

What are the key areas of action that the trust needs to address to improve its clinical governance systems?

CHI expects the trust to review all aspects of this report. Here we highlight areas where action is particularly important or urgent.

- The trust must take action to address and implement a broader vision of clinical governance across the organisation. The trust needs to set out its strategic direction for clinical governance and must underpin this with strategies for all areas of clinical governance. This must include routine consultation with all grades of staff, patients and partners to ensure that clinical governance is fully integrated across the organisation.
- The trust should reconfigure its clinical governance committees and structures to ensure they are fully integrated with the operational management structure ensuring clarity of accountabilities for clinical governance at all levels of the organisation.
- The trust needs to set up a programme of education to help staff from board level down to ensure that clinical governance is fully integrated and understood throughout the trust.
- The trust should review the amount of dedicated time for clinical leadership at a strategic level.
- The trust must take urgent action to broaden its strategic approach to clinical risk management, ensuring the risk register captures the actual clinical risks inherent in its day to day operations and that these are rigorously monitored.
- The trust needs to increase its use of clinical and non clinical information and to develop routine and exception reporting to ensure that policies are implemented and that there is informed change.
- The trust must promote a culture of openness where clinical governance activities lead to monitoring, dissemination and learning through measurable improvement.

What is it like to be a patient of Welsh Ambulance Services NHS Trust?

In this section we report what we observed and what patients said about their experiences, through surveys or directly to CHI. We also look at what the trust's data can tell patients about the services they provide.

Many things can impact on a patient's experience of their local NHS service. These may include the outcome of their treatment, whether the vehicles and facilities were of good quality and whether they and their relatives or carers were treated with respect.

Are patients treated with dignity and respect?
CHI found a caring and positive attitude towards patients at all levels of the organisation. Positive comments were received from patients and carers about the way in which they are cared for by staff from the emergency medical service and patient care service. Many partner organisations also commented favourably about the way in which patients are treated.

What did CHI find out about how the trust's services are organised?
The trust is reviewing its delivery of pre hospital care, which comprises the emergency medical service and the patient care service.

A number of new grades of staff are emerging from the existing baseline of care assistants, technicians, paramedics and helicopter services. These include, for example: the intermediate tier vehicle staff dealing with inter hospital transfers and providing a first responder service; the rapid response vehicles responding to potentially life threatening calls; and the evaluation of five paramedic practitioners carrying out detailed clinical assessments with a view to referring patients to alternative treatment centres. The trust has also established a number of first responder schemes across Wales working in partnership with the police and fire services, voluntary organisations and community volunteers.

CHI has concerns about the effectiveness of deployment plans to support dispatchers allocating the most appropriate response to an incident. The range of deployment options has become more complex since the trust has introduced new working practices with differing clinical skills amongst staff. CHI was given examples of some inappropriate working practices including: maintenance of cover in urban areas at the expense of rural cover; double technician crews working together; intermediate tier staff being used to routinely respond to 999 calls; and a failure to deploy first responders. CHI is further concerned that deployment of staff is not routinely monitored across all grades of staff and types of call.

Can patients get appropriate access to the services?
The patient care service has been subject to criticism during CHI's review from patients and members of staff at all levels of the organisation.

Concerns relate to the management of outpatient appointments and, in particular, late arrivals for appointments and long waits to get home after appointments.

Patients do not understand the new criteria implemented by hospital trusts and former health authorities by which patients qualify for care services. The lack of a consistent approach to the carriage of wheelchairs, walking frames and personal belongings was also a concern.

What is it like for patients of the Welsh Ambulance Services NHS Trust? *continued*

Some managers raised concerns that in some areas emergency vehicles are regularly used for routine patient care work.

CHI is aware that, as it is phased in over the next two years, the trust's agenda for improvement through its review of the patient care service will overcome some of these problems.

However, CHI is concerned that the phased project for patient care services and the review of the emergency medical service has not yet taken full account of the impact of impending contractual changes in other parts of the NHS, for example the likely impact of GPs no longer providing out of hours cover, which will have an effect on their services.

How good are the standards of vehicles and facilities?
Significant investment has been made in both the accident and emergency and patient care service fleets. The trust has a fleet management system that allows tracking of MOT test and servicing schedules. Many vehicles have been fitted with ramps to reduce manual handling and lifting. CHI saw some vehicles that had been adapted to carry wheelchairs, hospital beds and incubators. Vehicles are mainly clean, tidy and well equipped. The introduction of new staffing levels and therefore the increased availability of personnel in some areas has led to concerns that these improvements have not been balanced against the availability of vehicles and equipment.

CHI visited rural and urban ambulance stations across Wales including each of the control rooms, the national ambulance training college and two of its regional training schools, each of the regional headquarters, the trust's headquarters and some of the accident and emergency and outpatient departments at hospitals that patients are conveyed to. Trust premises are variable with some providing purpose built facilities while other provide a poor working environment. The results of a health and safety inspection are due and the trust is expecting to have to address a number of issues.

What do the figures show about the trust's performance?
It should be noted that Welsh Ambulance Services NHS Trust has to meet different response time standards to those required of trusts in England. The range of clinical situations identified as needing a category A response is also agreed differently with the Welsh Assembly Government.

In 2002/2003 the trust was targeted with reaching 50% of category A life threatening calls within eight minutes and 95% of all calls within 14, 18 and 21 minutes according to its service classification of urban, rural or sparsely populated areas. Across Wales it achieved figures of 52% and 89.1% respectively. Figures show that these targets were reached despite a 9.3% increase in calls across Wales compared to the same period the previous year.

The trust informally set itself a 55% standard and the figures for the last quarter of 2002/2003 show that six out of 22 unitary authority areas achieved a 55% standard in eight minutes with an overall range between 37.6% and 74.3%. These areas were Conway, Wrexham, Denbighshire, Cardiff, Flintshire and Newport. A similar calculation for 95% of all calls within 14, 18 and 21 minutes show that only three areas, Conway, Wrexham, and Denbighshire, all in North Wales, achieved the standards with the overall range between 78.1% and 97.8%.

The current aim for Wales is that 60% of category A life threatening calls must have a response within eight minutes. This is an all Wales average for the month March 2004 and 95% of all calls

What is it like for patients of Welsh Ambulance Services NHS Trust? *continued*

must have a response within 14, 18, 21 minutes according to its service classification of urban, rural or sparsely populated areas.

In order to achieve this, each of the 22 unitary authority areas has been set a percentage category A performance improvement target by the trust based on last year's outcome to at least bring them up to a 50% baseline of performance.

The trust is working in partnership with NHS Direct to transfer certain categories of call but the timetable for achieving this is yet to be agreed.

CHI has had concerns about the way in which response time data has been collected and managed by some ambulance trusts in England. CHI subjected the Welsh extract of data provided to the same analysis and found no evidence of manipulation.

Unlike other categories of calls the trust has witnessed a marked decline in the number of requests for GP urgent journeys, but has still not reached its target of 95% of all urgent journeys arriving no more than 15 minutes later than the requested arrival time. In 2002/2003 it achieved 78.8%.

What areas of the patient experience should the trust consider?

- The trust must ensure that full account of the impact of impending contractual changes in other parts of the NHS is adequately planned for within the patient care service and emergency medical service reviews.
- The trust should work with its partners to implement the aspects of its patient care services review that will facilitate extended patient care services operating times, thereby reducing the waiting times encountered by patients for hospital transportation.
- The trust should ensure that as it increases its range of services it makes adequate provision of equipment and vehicles to maintain safe minimum levels of service.
- The trust should revisit its deployment plans in all areas to ensure equality of access to services for all patients.
- The trust must ensure clear guidance is available to all staff regarding the appropriate deployment of all grades of staff and this should be checked through routine monitoring and exception reporting.

What is CHI's assessment of the trust's systems for patient, service user, carer and public involvement?

This section describes how patients can have a say in their own care and how they and patient organisations can have a say in the way that services are provided.

What is CHI's main assessment?
The trusts' structures and processes for patient, service user, carer and public involvement are at an early stage of development. Greater emphasis is being given to this area of work.

CHI's assessment = i

What are CHI's key findings?
The trust is developing accountabilities and structures for patient, service user, carer and public involvement (PPI). The board lead for PPI is the chief executive who delegates responsibility to an executive assistant. Accountabilities for PPI are not embedded in regional structures.

There is no formal committee structure supporting PPI but the trust is defining terms of reference for a patient experience committee. The board discusses PPI although it is mainly through complaints and compliments monitoring.

The trust has a strategic framework for PPI and a memorandum of understanding between itself and the Association of Welsh Community Health Councils.

The Association of Welsh Community Health Councils has also established a group drawn from local community health councils' liaison committees across Wales to discuss strategic issues with the trust. Members from this group and other community health councils attend the public trust board meetings.

The trust states that it aims to ensure that patients and the public are fully involved in decisions concerning the delivery and planning of services. However CHI found that there is very little actual patient and public involvement and CHI is not clear how the trust plans to resource this new agenda.

The trust has other important partnerships through its first responder schemes, the air ambulances, air sea rescue and mountain rescue.

Information such as the annual report, trust board minutes and some policies are widely circulated and also posted on its website and the recently introduced intranet. Public documents are produced bilingually in line with the trust's Welsh language scheme.

There has been some PPI input into the development of policies such as the code of conduct, consent, race equality, management of records, recognition of life extinct and child protection.

The trust has recently introduced a core induction course that deals with customer care issues. However these issues are not revisited during refresher training. Some thorough ongoing monitoring of customer care work is undertaken in control rooms but there is little evidence of systems to assess for this in the emergency medical service or patient care service.

Members of staff told CHI about many activities that they take part in locally to support PPI but these are not necessarily communicated and coordinated as part of an overall PPI approach.

What is CHI's assessment of the trust's systems for patient, service user, carer and public involvement? *continued*

The trust has a Welsh language scheme and has some Welsh speakers. A dial up interpreting service for other languages is available in control rooms and headquarters. Operational staff carry a multilingual emergency phrase book.

A process is available for anyone wishing to make a complaint or comment about the trust. The number of complaints is reported to be falling but the trust is not reaching its resolution targets, nor is it clear how telephone and verbal complaints are reported.

The trust has limited evidence available on improvements as a result of PPI activities. The main source of information comes from complaints. Outcomes are discussed within trust committees but these are not clearly disseminated to staff. Staff said they would like to see the final letter sent to complainants by the chief executive.

The trust has recently conducted a user survey for both the emergency medical and patient care service. An initial summary of results was available at the time of CHI's visit but full analysis is awaited.

The trust is beginning to share some learning about PPI activities through its website, intranet, *Siren* and *Insight* magazines.

The trust provides some support to staff in developing skills in PPI but activities are not coordinated or widely available through structured programmes of learning. Staff are, however, encouraged to learn Welsh and this is widely available through structured programmes of learning.

What areas of patient involvement should the trust consider?

- The trust should strengthen its structures and accountabilities for PPI, including further consideration of how patients can be included.
- The trust must broaden its strategic framework and define an action plan with associated accountabilities and timescales for the delivery of PPI.
- The trust must work towards coordinating PPI activities with assurance processes to support policy implementation.
- The trust needs to develop a framework whereby the whole organisation can learn and improve as a result of PPI.
- The trust should define a training programme to cover all aspects of PPI. This should be made available to all staff.

What is CHI's assessment of the trust's systems for risk management?

This section describes the trust's systems to understand, monitor and minimise the risks to patients and staff and to learn from mistakes.

What is CHI's main assessment?
The trust has made progress in risk management in relation to setting up systems and processes. However some key clinical risk management and incident reporting issues require further progress. Further work is required to develop links with clinical governance.

CHI's assessment = ii (a)

What are CHI's key findings?
The trust's strategy for risk management sets out clear accountabilities. However CHI is concerned that these are not fully understood by staff at all levels of the organisation. There was particular confusion about staff responsibilities for clinical and non clinical risk.

Extensive committee structures exist for a number of risk management activities but they lack clarity in terms of reporting and coordination. The trust has identified this in its current clinical governance action plan.

The board regularly discusses risk issues raised by its sub committees.

A risk strategy clearly documents a desire to create a risk adverse culture and improve risk scores against the Welsh risk management standards. Scores are self assessed but subject to some external verification. There is limited patient involvement in risk management.

The trust has developed a risk register by running workshops and including a variety of staff representatives and lead managers. However a lot of the trust's attention has focused on non clinical risk. The trust has concentrated on managing the risks within the Welsh risk management standards but has not recognised other significant clinical risk outside these standards. Clinical risk management systems are immature and have caused the trust to be reactive to incidents on a number of occasions.

The trust has a process for risk assessment linked to the risk register, although risk assessment training has not been widely cascaded. Examples of clinical risk assessments undertaken include medicines management, infection control, equipment evaluation and the standardisation of drug protocols.

The trust's process for risk management is coordinated nationally and the trust has been left vulnerable to some potential risk. For example, the trust has not yet achieved a cultural shift in the staff's willingness to report incidents and near misses and this has led to trust discussions about potential under reporting.

CHI found staff to be knowledgeable about risk management issues but found that some staff lack confidence in reporting incidents due to fears of a negative reaction from management.

The trust has prioritised and introduced some specific measures to control and reduce some significant risks. Examples of this include policies and training packages directed at emergency medical staff to support lone workers, dealing with violence and aggression and manual handling.

What is CHI's assessment of the trust's systems for risk management? *continued*

However CHI has serious concerns about systems failures, which could still allow significant levels of unmanaged risk. Staff cited examples including inappropriate deployment of staff and vehicles, failures in communications systems, cases where patient safety has been compromised, including protracted turnaround times and failures in policy implementation.

Analysis of incidents, complaints and claims is carried out corporately but lessons learnt are not widely shared or discussed with patients, public or staff. The trust bought a database system to make the analysis and reporting of trends faster, but the introduction of this system has been slow. There is limited overall evidence of improvements to the quality of care resulting from risk management. A few isolated examples were found including the benchmarked control of infection indicators and moves towards driver refresher training through the operational based driving assessor scheme.

Staff say that they rarely receive feedback in response to reported incidents.

The trust's training needs analysis identifies 26 risk related needs. An action plan has been drawn up and shows that much of the training is expected to be completed by the end of 2003/2004. Some risk management issues are now discussed as part of the recently introduced core induction course.

The Welsh risk management standards are regularly reviewed for progress. The trust needs to define broader performance indicators to capture other areas of risk in conjunction with the Welsh Risk Pool.

What areas of risk management should the trust consider?

- Accountabilities for clinical and non clinical risk need urgent clarification and dissemination across the trust.
- The trust needs to urgently broaden its risk register to ensure all risk management issues are captured and assessed. The trust must have comprehensive action plans in place, and actively monitor these.
- The trust needs to urgently implement its policies and develop ways to ensure that incidents are reported and investigated in an appropriate manner.
- The trust must develop effective systems to ensure that all learning from risk management is captured and fed back to staff within an open and supportive environment.
- The trust should complete its programme of risk management training including staff from all levels of the organisation, while anticipating and planning for future needs.
- The trust needs to develop further risk management indicators focusing on clinical risk, incident reporting and feedback.

What is CHI's assessment of the trust's systems for clinical audit?

This section describes how the trust ensures the continual evaluation, measurement and improvement by health professionals of their work and the standards they are achieving.

What is CHI's main assessment?
Clinical audit is in the early stages of development and must be integrated with the other areas of clinical governance.

CHI's assessment = i

What are CHI's key findings?
The trust has partially developed accountabilities for clinical audit that are not fully integrated strategically or operationally. The medical director is the board lead with daily activities managed on a secondment basis by the national clinical audit manager. The clinical operations officers have the potential to support the incorporation of clinical audit operationally but their structure is not integrated enough to enable this at present.

In the absence of an audit committee, the clinical governance lead group reviews audits periodically. The audit lead and the medical director prioritise audit. Some audit discussions are captured within other forums but this limits the trust's opportunity to have properly structured clinical audit discussions and to coordinate audit activity across the trust. While clinical audit is represented by the medical director on the clinical governance committee, CHI considers that the committee would be strengthened by including the national clinical audit manager as a member to ensure clinical audit methodological issues can be progressed.

The trust does not have a clinical audit strategy but has a clinical audit annual plan. There is a process for ratification of the plan but the plan itself is not driven by a set of agreed criteria based on connections with other parts of the clinical governance agenda or the trust's long term aims. Activities are not linked to other clinical governance initiatives, with the exception of some clinical effectiveness activities. There is some evidence of partnership working, particularly on the implementation plan for tackling coronary heart disease in Wales.

Resources have been allocated to clinical audit. Those resources have been committed to patient care record scanning and its dedicated team, and the secondment of the national clinical audit manager. It is not clear how the remaining money is allocated to support the development of clinical audit.

Some significant audit of specific conditions has been conducted but the audit of new models of responding to emergency calls has not been adopted as an integral part of the programme.

Involvement in the UK myocardial infarction national audit project and a trauma audit with the trauma audit and research network is noted. Some all Wales internal clinical audit and reaudit have been undertaken including looking at patients with chest pain, patients with head injury, treatment of suspected spinal injury, patients with asthma and patients in cardiac arrest. CHI found evidence of some other audit type activity within the trust including first responders and some control of infection benchmarks. Clinical audit is largely conducted from the clinical audit office with limited staff or patient participation. Some staff members have been seconded for short periods of time. The impact of this activity has influenced some staff training programmes but its impact on staff is not

What is CHI's assessment of the trust's systems for clinical audit? *continued*

widespread. Staff told CHI that the current clinical audit programme is inhibited by the backlog of patient care records. They also raised concern about data quality and the inaccuracies of their outputs. Analysis is restricted to processes rather than more extensive auditing of the quality of care.

CHI heard about the trust wide centre of excellence for advanced medical priority dispatch, although CHI is concerned that reaccreditation has been deferred in some centres while staff are retrained on new software following control room mergers.

Some clinical audit outcomes are disseminated through refresher training and a recently introduced *Insight* magazine. However the systems and processes in place do not effectively support the dissemination of outcomes, learning and improvements to ensure changes in practice. CHI is concerned that the clinical governance lead group has not shared some audit results because of their concerns over poor compliance by crews and poor data quality, missing an opportunity to effectively manage audit difficulties and share learning from mistakes.

Few members of staff could describe how clinical audit has led to any change in their practice. Many staff have limited knowledge of clinical audit and commented that involvement only extends to the clinical operations team checking that they have completed the correct fields on their patient care records.

Clinical audit training for staff is mainly available to those attending undergraduate and postgraduate degree courses.

A baseline of clinical care was established through performance indicators in 2002 but the work appears to have ceased.

What areas of clinical audit should the trust consider?

- A clinical audit strategy with a prioritised clinical audit plan must be developed which involves all staff groups at all levels of the organisation, as well as patients and other stakeholders.
- The trust should consider its approach and commitment to clinical audit and must strengthen its delivery of clinical audit throughout the organisation.
- To secure confidence in the outcomes of clinical audit projects priority must be given to the collection of reliable clinical data that has been quality assured.
- All clinical audits must be openly disseminated. Outcomes must be discussed and debated with staff to facilitate understanding, learning and changes to practice.
- The trust needs to define various training packages for clinical audit that are proportionate and appropriate to all staff groups within the organisation.
- The trust should progress its work on clinical performance indicators.

What is CHI's assessment of the trust's systems for clinical effectiveness?

This section is about the way the trust ensures that the approaches and treatments it uses are based on the best available evidence, for example from research, literature or national or local guidance.

What is CHI's main assessment?
The trust has made progress in developing systems and processes to support clinically effective practice, especially in research. Some of the committee structures struggle to deliver, while others still require further development. Systems for improving the quality of care through systematic learning are not yet fully developed.

CHI's assessment = ii (a)

What are CHI's key findings?
Accountabilities for research are clear and led by the medical director, but other areas of clinical effectiveness are less well defined and integrated across the trust.

It appears that the trust is operating two clinical effectiveness structures. The first is the more traditional ambulance service approach through paramedic steering committees, of which there are three across Wales. One has not met for a considerable time, and the other two committees are struggling to deliver their original remit and are not engaging clinicans and staff, although the trust has recognised this and is trying to revise their sphere of activity. The second structure is emerging through the clinical governance structure, and shows the potential to support the trust's direction on clinical effectiveness. However, this is not fully developed. The trust needs to work towards integrating both structures to ensure the effectiveness agenda is met. CHI is also concerned that the continuity between both structures is undermined by significant levels of non attendance at meetings.

The trust has established programmes of work for clinical effectiveness but these are not driven by clearly defined strategies or plans. The effectiveness agenda is weighted towards research with less focus on staff development and implementation of evidence based practice. However some clinical effectiveness activities are becoming integrated within training programmes and through the clinical operations structure.

The trust has established some strong partnerships and some patient involvement is achieved through representation from the community health councils. Some external resources have been secured for clinical effectiveness activities but these are mainly through the research arena.

The clinical governance lead group has compiled a significant number of clinical goverance policies and procedures. Through its pre hospital emergency research unit the trust has worked in partnership with the Joint Royal College Ambulance Liaison Committee to strongly influence the development of UK national evidence based and best practice clinical guidelines. These have been adapted locally by a small sub group of the clinical governance lead group for applicability in Wales. However, the processes used to achieve this lack clarity and endorsement from other clinicians supporting the trust.

The clinical governance policies and procedures and the amended clinical guidelines have been distributed across the trust. Staff express concern and difficulty in understanding the reasoning behind some of the clinical changes expected from their practice. The senior clinical operations officers, together with the national clinical audit officer, have undertaken some robust evaluation of

What is CHI's assessment of the trust's systems for clinical effectiveness? *continued*

models of delivery for pre hospital thrombolysis to support the implementation plan for tackling coronary heart disease in Wales. Training to support this development is underway.

The trust is showing commitment to the development of a small number of clinically effective staff. This is a positive step. The trust has supported the development of the operational based assessor structure which is beginning to impact on practice and has the potential to play a significant role in closing the loop for dissemination and adoption of effective practice. However, the role needs further evaluation. The trust has also been proactive with its partners in developing undergraduate and postgraduate degree courses in pre hospital care and developing an emergency paramedic practitioner scheme.

Access to clinical effectiveness resources including critical appraisal training is restricted. Some guidance is offered to staff through the clinical governance procedures manual but the majoriy of staff do not have access to library or internet resources unless visiting training centres or locality ambulance stations. Resources are made available to staff working in the pre hospital research unit and to students on courses.

Clinical effectiveness activities are not fully linked to a mature clinical audit system to facilitate robust performance monitoring.

What areas of clinical effectiveness should the trust consider?

- The trust must clearly define its accountabilities and structures for clinical effectiveness.
- The trust must set out a clear strategic direction for a balanced programme of clinical effectiveness work.
- The trust must set up systems of assurance to ensure policy development is implemented systematically by frontline staff.
- Staff must be supported and involved in practice developments to facilitate understanding of the changing clinical environment within which they are operating.
- Resources and training need to be made available to help staff develop new clinical and analytical skills.
- The clinical effectiveness programme should link closely with clinical audit to monitor performance.

What is CHI's assessment of the trust's systems for staffing and staff management?

This section covers the recruitment, management, and development of staff. It also includes the promotion of good working conditions and effective methods of working.

What is CHI's main assessment?
The trust has worked hard to introduce all Wales employment policies and procedures but inconsistent implementation has led to slow progress. It is proving difficult to create a culture within which clinical governance can flourish.

CHI's assessment = ii (c)

What are CHI's key findings?
Strategic accountabilities for staffing and staff management are designated to the director of personnel and training who is the board lead and manages a number of supporting posts. CHI found much less clarity in the operational structures where competing operational and clinical functions are not fully integrated to produce clear lines of accountability.

Personnel issues are dealt with through a number of national and regional joint consultative groups and forums with representation from the various unions but there is no single committee with a unified view of personnel issues. While the board receives regular reports on staffing issues, the range of information available is limited and has a tendency towards future position papers rather than monitoring the impact of current policy implementation.

A draft strategy was under discussion at the time of CHI's visit. The trust has a workforce plan linked to the changing workforce programme, which is externally reviewed twice a year. CHI was unable to find evidence of a workforce profile linked to organisational development and succession planning.

Although the trust has an all Wales employment contract, many staff have opted to remain on old terms and conditions which means they are being managed from a baseline of 13 different contracts. This causes difficulties for managers and hinders the development of a single trust culture. A lot of work has been undertaken to introduce all Wales policies and procedures including some flexible working options. However, inconsistent application of these policies has contributed to a sense of frustration and a lack of equality amongst the trust's workforce. CHI was particularly aware of staff concerns in relation to the inconsistent application of the policies on promotion and secondments, sickness, discipline and equality of opportunity.

The trust has introduced a corporate induction day and staff have further induction dependent on their employment route. Appraisal is emerging within the managerial tiers with about 45 managers appraised to date. Clinical supervision and mentoring schemes are also being developed through the operational based assessor schemes although assessors are not given any protected time to fulfil this role. Some clinical staff groups remain without clinical supervision. A process exists for paramedic registration, driving licence and police checks but CHI is not assured that this process is robustly administered across the trust.

Although there is some good practice relating to local devolvement of rotas, they are short term in nature and not linked to a framework supporting the trust's longer term strategic needs. Many control staff commented on high turnover, staff shortages and the trust's dependence on undefined

What is CHI's assessment of the trust's systems for staffing and staff management? *continued*

secondments. All grades of staff told CHI that the trust has developed a culture of reliance on overtime. This culture has led to sickness, inconsistent deployment patterns relying on a mixture of inappropriate skill mixes and outdated practices including difficulty standing staff down for meal breaks.

The trust has addressed issues of staff safety and introduced a lone workers policy, a booklet on personal safety and conflict management as well as training in some aspects of personal safety. CHI received mixed feedback on relationships between staff and managers across the trust. While there are some superb examples of respectful, progressive team working some staff also spoke of a few disappointing examples of bullying and harassment, lack of respect and poor team working.

The trust recognises that communicating with staff is problematic due to its geographical spread and has started work on a communications strategy to improve this situation. The trust does not always maximise the use of its operational structure as a means of communication with staff and instead it relies heavily on its national and regional consultative fora as a means of communication.

There is limited evidence of the trust providing feedback to staff, although some work on flexible working, work life balance and violence and aggression training has been undertaken as a result of risk assessment and the national staff survey. However, a number of staff are unaware of the staff survey.

Communication with staff is inconsistent despite the trust starting to make use of web based tools and media such as the staff magazines *Insight* and *Siren*.

The trust has a range of formal and informal support structures including occupational health, a 24 hour counselling line and a colleague support scheme for staff. Staff welcome these. However, some have difficulties accessing occupational health providers.

The trust has worked hard on monitoring and reducing its sickness absence rates through a combination of improved performance monitoring and an increased expectation of managers to adhere to policies.

What is CHI's assessment of the trust's systems for staffing and staff management? *continued*

What areas of staffing and staff management should the trust consider?

- The trust must clarify accountabilities for staff management throughout the organisation and further consider how it can speed up progress towards a unified contract of employment.
- Line managers must be responsible for the clinical performance of staff, based on effective monitoring and feedback systems.
- The trust must ensure it has a clearly defined strategy in place that provides a workforce profile. This must be clearly linked to a regular assessment of how demand patterns are changing and that it reflects the effectiveness of different and more varied response options, changing employment law and training needs within an organisational development plan.
- The trust must define processes to test and ensure that its personnel policies are being implemented consistently and equitably across the trust.
- The trust's dignity at work policy must be rigorously implemented.
- The trust must ensure all staff are involved in feedback and dissemination of key policy advancements and learning. Steps must be taken to implement the communications strategy as soon as possible.
- The trust should work with partner organisations to increase access to occupational health consultations.
- The trust must extend its range of performance indicators for staffing matters.

What is CHI's assessment of the trust's systems for education, training and continuing personal and professional development?

This section covers the support available to enable staff to be competent in doing their jobs, while developing their skills and the degree to which staff are up to date with developments in their field.

What is CHI's main assessment?
The trust's approach to education and training is going through a period of transition, which embraces some aspects of clinical governance. New structures are not fully integrated operationally and have not been evaluated for their effectiveness, causing staff to express confusion and concern. CHI is concerned that some staff groups have not received their mandatory training.

CHI's assessment = ii (c)

What are CHI's key findings?
Accountabilities for education and training are clearly set out at board level and through the national ambulance training manager whose responsibilities encompass all clinical training, organisational development and moving and handling. The new accountabilities for operational based assessors and operational based driving assessors, which are jointly managed by training and clinical operations teams, provide an opportunity to integrate training within the operational management structure. However this approach is in its infancy and requires further development.

CHI is concerned that there is no dedicated forum for the discussion and monitoring of education and training, but several disjointed committees. This has led to a lack of cohesiveness between committees.

The trust devotes a lot of time and effort to education and training but its work is not embedded within a current strategy and lacks clear links with workforce planning, personal development plans and full integration with clinical governance.

Significant partnerships are in place between various universities, healthcare providers and other emergency services. These should be further harnessed by linking them to the committee structures supporting education, training and clinical governance.

The trust has started to redefine the roles of some of its workforce to meet its operational and geographical demands. This has required the development of new grades of staff to support the operational delivery of training as well as new grades of staff to deliver some aspects of pre hospital healthcare.

The operational based assessor scheme predominately supports this, and is welcomed by staff. However some managers and operational based assessors express concern about the lack of clarity about the range of responsibilities and authority associated with the role. CHI is also concerned that there is not a clear programme for staff that sets out when work based assessments are likely to take place. Staff are unaware of plans to work with their assessors.

The trust is beginning to map the process of organisational development through personal development plans for senior managers. However locality ambulance officer roles remain focused on administrative tasks and have not yet developed a focus on clinical performance.

What is CHI's assessment of the trust's systems for education, training and continuing personal and professional development? *continued*

New course designs are beginning to embrace some aspects of clinical governance, for example paramedic refresher training and the intermediate tier patient care service training. However CHI is very concerned that there have been many competing demands for education and training so that some staff groups, including patient care services and emergency medical technicians, have received little or no training, especially for some mandatory aspects of their work.

The trust has invested in the professional development of staff primarily but not exclusively through the pre hospital care Bachelor of Science degree and paramedic practitioner programme Master of Science degree. While the availability and uptake of these courses is welcomed by CHI, many staff express concern that these courses have been developed at the expense of mandatory and continued professional development and claim that they are accessible only to a minority.

CHI found little evidence of evaluated learning and dissemination across the trust, although a recent external verification conducted by the Institute of Health Care and Development praised the trust's training processes. A good practice example of a training programme leading to evaluated change is the administration of aspirin which was initiated as a result of a clinical audit project showing low compliance followed by training and reaudit showing improvements in compliance.

The trust has an interim policy with guiding principles on how to select and provide support to staff during times of study. Staff criticise the inequitable way in which this policy is administered with particular reference to the requirement to make up hours lost through study. Staff also express concern about the difficulty of accessing some courses only run in the north or south of the country and the implications of this for them. The trust acknowledges this and is beginning to address this.

What areas of education and training should the trust consider?

- The trust needs to clearly define the range of duties and the managerial authority of the operational based assessors and operational based driving assessors with regard to clinical performance. This role must link with the locality ambulance officers.
- The trust must develop an education and training strategy that embraces all aspects of the trust's education and training remit, including closer links to the clinical effectiveness agenda.
- A full training needs assessment must be undertaken to determine the range of training required within the trust, to help prioritise and to assist in monitoring the uptake of training.
- Urgent action must be taken to bring mandatory training up to date for all staff.
- The trust must develop methods of evaluation to assure itself of the implementation of learning and dissemination across all staff groups.
- The trust should monitor its application of the study leave policy to ensure equity.
- The trust should develop performance indicators to track progress.

What is CHI's assessment of the trust's systems for using information?

This section describes the systems the trust has in place to collect and interpret clinical information and to use it to monitor, plan and improve the quality of patient care.

What is CHI's main assessment?
The trust has inherited an information, communication and technology (ICT) infrastructure that was not designed to support an all Wales ambulance trust. Integration has been slow and this has contributed to the underdevelopment of the trust's ICT infrastructures supporting clinical governance.

CHI's assessment = i

What are CHI's key findings?
The director of finance has accountability for ICT. Structures are in place but are underdeveloped in terms of supporting the development of clinical governance.

The trust discusses a limited range of clinical information issues at the board, the executive group and clinical goverance committee. Discussions rarely make specific links to improving the quality of care by using information effectively. There is very little continuity of attendees between the ICT and clinical governance committees, which limits the pace of development.

The trust's recent clinical governance action plan outlines the need to develop an up to date information strategy linked to clinical governance. Current plans focus on investments in infrastructure and operational systems rather than information needs and use.

There is little evidence that users, patient and partners are involved in defining information needs. ICT staff told CHI that meetings are frequently cancelled, that they feel detached and that their technical input is not valued.

The service and financial framework recognises the need for investment in ICT.

The trust has made some progress with the implementation of some integrated ICT systems. Policies are in place to support and safeguard the use of information but CHI has significant concerns about compliance and data quality.

The trust produces reports from its control and business systems to monitor limited areas of clinical and non clinical performance. However throughout CHI's review, staff gave examples of information that they felt contained inaccuracies. Minutes from meetings provided by the trust also show discussions taking place about poor data quality. Discussions rarely focus on audits of data and how to improve data quality.

CHI understands the difficulties facing the trust from the collection of data from multiple systems and notes that the trust is working towards a uniform system of reporting data in each of its control rooms. However CHI is concerned about the impact of the current inaccuracies on information production and the trust's decision making processes.

Staff showed varied awareness of the trust's information security policies regarding data protection and Caldicott guardianship. CHI observed some good practice involving the secure management of patient care records but also observed a number of breaches involving these and training records.

What is CHI's assessment of the trust's systems for using information? *continued*

The trust covers a huge geographical area, which makes communication with staff and partner organisations difficult. Staff frequently spoke of radio black spots giving rise to poor radio contact. There are also poor infrastructures to support communication. The majority of ambulance stations do not have access to personal computers, or web based communications. Internal communications at most stations are reliant on the diligence of locality ambulance officers posting hard copy information onto station notice boards. Staff express concern about not seeing vital information in a timely manner. Managers encounter similar problems but one innovation to improve this for managers is the introduction of video conferencing.

There is some evidence of the use of information to change practice, for example the use of deployment plans following a report commissioned by the Welsh Assembly Government from the Operational Research in Health consultants. Other information includes response time reports, complaint and sickness monitoring, advanced medical priority despatch and some first responder audits, and there are some examples of the use of some clinical audit data to inform training programmes and changes to clinical guidelines.

Key documents and messages are disseminated through a variety of means including policies, procedures, the clinical guideline manual, the internet, the intranet and the trust's two staff magazines. However, the trust has no systematic way of ensuring that information has been received by staff. Only one region promotes its regular staff meetings.

The trust provides limited training and support to staff using ICT. A small minority of staff are given IT training on some business and off the shelf software packages. Limited analytical support is provided.

There is little use of routine performance indicators. There are no clinical quality indicators.

What areas of using information should the trust consider?

- The trust needs to establish effective ways to link ICT and clinical governance systems in order to define how improvements in the quality of patient care can be achieved through the use of information.
- The trust must urgently develop and implement a clear strategy for the use of ICT.
- The trust must urgently put systems in place that test and assure the trust it is using robust clinical and non clinical data. This should be linked to a system of information governance.
- The trust must continue to develop and monitor methods to communicate regularly with its staff and partner organisations about the quality of the clinical services it is providing.
- The trust must develop training to support staff in the use of ICT and the development of analytical skills.
- The trust must introduce the use of performance indicators to help assure itself of progress in all areas of clinical governance.

What is the trust's strategic capacity for improvement?

This section describes the ability within the trust to monitor and improve the quality of patient care.

What is CHI's main assessment?
In view of the exceptional range and complexity of the issues the trust has had to address since its inception in 1998, it is a credit to the trust that it has begun to develop the clinical governance agenda over the last 28 months. However, many areas of clinical governance are still underdeveloped and not integrated within the mainstream activities of the trust. The barriers to full integration need removing to achieve further progress.

What are CHI's key findings?
On a daily basis the trust manages the delivery of pre hospital care within a framework made complex by its size, the diverse landscape, an inconvenient road and rail network, a highly dispersed population and long journeys to some hospitals. Face to face contact is also challenging to organise because the trust board and executive team members work extensively across Wales. The trust has faced and continues to cope with the complexities of its merger and the real difficulties encountered by inheriting a financial debt, poor estate including premises, vehicles and equipment, an ageing radio communication infrastructure and inadequate information technology.

The trust has had to work hard to introduce an all Wales ambulance service culture. It has had to deal with some barriers to change including staff perceptions, previous managerial structures, differing staff working arrangements and some local opposition to rationalisation, which has made it difficult to achieve economies of scale.

In the early days of the trust, decisions were taken to prioritise vehicle replacements and equipment over new information technology. These decisions were made with patients and staff in mind. However, the trust now finds itself in need of good quality information to move clinical governance forward but without the full information technology infrastructure to support this.

More recently the trust has had to deal with the uncertainties of the restructuring of the health community and the need to build new relationships brought about by the reshaping of the NHS in Wales with the introduction of local health boards and new commissioning arrangements with Health Commission Wales.

The funding arrangments under the old health authority structure created an uneven distribution of resources which has made it difficult for the trust to deliver an equitable service. The formation of Health Commission Wales should help overcome this problem, by redistributing resources equitably across rural and urban communities.

The trust feels that its financial constraints hinder its ability to fully implement a development programme to achieve a clinically focused service. In the early years of the trust significant attention was focused on ensuring the success of the merger. The trust is now at a stage of its evolution where it should be directing more of its attention to the clinical governance agenda.

The medical director is employed on a part time basis by the trust with half of this time committed to directing the clinical governance agenda. Interviewees spoke of the benefits of such leadership and a desire for increased clinical governance leadership at a strategic level.

What is the trust's strategic capacity for improvement? *continued*

A major challenge for the trust board is to complete the change of the culture of the organisation from the one it inherited which was parochial, autocratic and administrative in nature to that of a clinically focused organisation that recognises the opportunity to build an improved service that is equitable. An open, just and fair culture is essential to create such a modern service and managers need to work on removing staff perceptions that it is remote, harsh and unreliable.

There are some impressive pockets of high quality work being undertaken to support the development of clinical governance, which has involved many individuals throughout the trust. The work of the cohort of individuals in the clinical operations structure has been significant in this. These initiatives need to be integrated and spread much more widely across the organisation. The responsibility for clinical governance needs devolving to all levels of the organisation. Operational staff must be developed to ensure clinical governance is a core part of their activities.

Despite the trust outlining responsibilities for individuals and committees in key trust documents, staff report these to be unclear and CHI's evidence shows that they are not understood. This leads to uncertainty and inconsistency in decision making.

CHI supports the need for autonomy in decision making within the regional structures to support local delivery but the trust must ensure that this decision making takes place within a framework that makes certain of equity throughout the trust.

To date most of the structures for clinical governance have been developed in parallel to operations. For clinical governance to progress, these structures must be reworked and fully integrated within the mainstream activities of the trust.

The lack of an embedded strategic approach to clinical governance, coupled with poor quality information and poor monitoring of progress, hinders effective planning and leaves the trust vulnerable to substantial risk and the potential for poor quality patient care. The trust informed CHI that it is in the process of reviewing its strategic plan.

The trust must develop a consistent approach to the formation, implementation and monitoring of its strategies and policies. Ineffective systems mean that the trust is reactive to events rather than anticipating and controlling them. The trust must openly tackle the difficult issues that will emerge from better use of information and have the confidence to openly share results and enter into the debates that will inform further learning and eventually lead to improvements.

Greater transparency, better communication and further empowerment of staff would lead to a more informed decision making processes.

The trust is involved in partnership working with many NHS and non NHS organisations although it has an unstructured approach to this. Its work in developing first responder schemes with the police and fire services, voluntary organisations and community volunteers is impressive.

The trust has shown commendable flexibility in deploying staff and in tackling various boundary issues to assist other organisations facing severe service pressures in other parts of the NHS.

Stakeholders told CHI of some constructive partnership working with the trust's middle managers. However these managers are not empowered to make key decisions without reference through the

What is the trust's strategic capacity for improvement? *continued*

regional and national structures. This slows the decision making process and creates dissatisfaction at a local level.

Health community partners told CHI that the trust is not proactive in its communications with them. This is unfortunate because partners feel that the trust has developed some important initiatives that assist them greatly but they have found out anecdotally rather than through structured communications.

The trust has a close working relationship with the Association of Community Health Councils for Wales, which regularly attends board meetings and regional liaison meetings. Community health council members have also joined some of the trust's working committees.

Very little actual patient and public involvement is achieved by other means and the trust would benefit from increasing efforts to develop this.

The trust uses some information to monitor its performance but in the main a lack of clear strategy and inadequate information makes it difficult to develop an effective system of performance management for clinical governance.

There is no overarching strategy for clinical governance and strategies could only be identified in relation to a small number of the seven technical areas of clinical governance.

Further information

The CHI clinical governance review took place between June 2003 and February 2004.

This report sets out the main findings and areas for action from the review. The trust has been given a detailed summary of the evidence on which these findings are based.

The trust will produce an action plan that will be available from:

Welsh Ambulance Services NHS Trust
Trust Headquarters
HM Stanley Hospital
St Asaph
Denbighshire
LL17 0WA

or from the CHI website. The trust's implementation of the action plan will be monitored.

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Further details of CHI's work are available from:

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CHI should like to make clear that responsibility for the content of the report and its conclusions is CHI's alone.

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