Agenda Item 2.3.2a
Appendix 1

GIG CYMRU NHS WALES | Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

EVOLVING OUR CLINICAL MODEL

Stakeholder Briefing Document

Collaborating on Change

Version 0.5
September 2024

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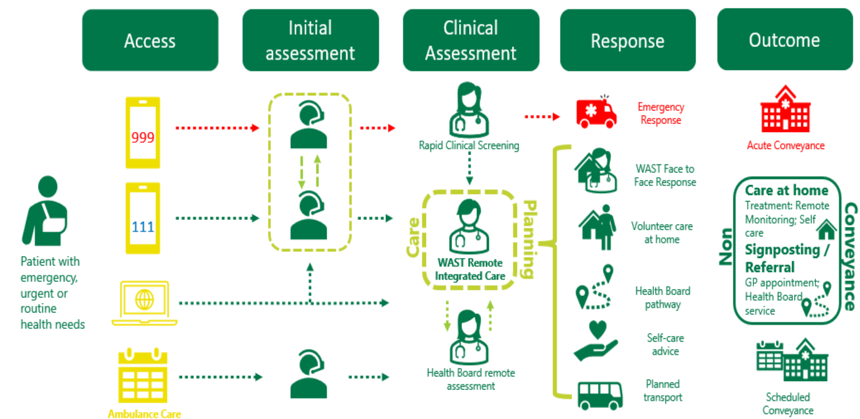
Executive Summary

With patients continuing to come to avoidable harm, evolving evidence for changes in clinical practice and increased opportunities arising from digital developments, the Welsh Ambulance Services University NHS Trust (WAST) is working with commissioners and partners to evolve its Clinical Services Model across all its services to ensure that patients get the right care and advice, in the right place, every time.

This briefing document has been developed to share these proposals and seek support from Welsh Government and commissioners to continue the journey of working collaboratively to develop and implement the new model.

A high level visual of the model is set out in Figure 1 below.

Figure 1 – Overview of proposed Clinical Services Model



The new Clinical Services Model will be characterised by:

- **Clinical leadership** – there will be increased clinical input, earlier in the call cycle and throughout the patient journey. Clinicians will be actively involved in decision making on the right pathway for each patient as part of a care planning process. A new ethos of personalised care will be introduced.
- **Connectivity** – systems, processes and people across the Trust will be increasingly connected so that patients get the right care, irrespective of their point of access.
- **Choice** – A greater range of response options will be created for those patients who need a face-to-face assessment, designed to enable more patients to be treated safely at, or closer to home and to avoid unnecessary conveyance to an Emergency Department. An emergency ambulance response will no longer be the default option.
- **Collaboration** – Increased effort will be put into working with commissioners at national and local level, with commissioners confirming the appropriate care pathways for their patients and making them available for WAST clinicians to refer into.

A **Rapid Clinical Screening** service will be introduced for the majority of 999 calls, immediately after the call handler stage. This rapid review of the clinical information obtained in the call will allow the Clinical Navigator to prioritise those calls that need an ambulance dispatch and conveyance to hospital. The majority of calls will be flowed into the Remote Integrated Care Service.

The **Remote Integrated Care Service (RICS)** brings together clinicians who currently support 111 and 999 calls into one service. They will undertake more thorough clinical assessments for those patients flowed into their service and, in partnership, will create a personalised care plan that meets the patients' specific needs. They will be able to deploy volunteers to the patient's home for an eyes-on assessment and to take basic clinical observations to support remote clinical decision making. Where it is appropriate, they will be able to easily access Health Board clinicians who can undertake a more specialist assessment using locally agreed pathways.

As well as providing more patients with self-care advice, they will have access in the future to a greater range of response options as part of the **Urgent Community Response** service. Whilst some of these response options will be provided by WAST, others will be provided by Health Boards, and there will be much greater collaboration at a national and local level to ensure access to the right Health Board pathways.

The enhanced clinical oversight, together with the ability to use volunteers to monitor patients at home for short periods, will enable WAST and partners to schedule or plan the responses for many more patients, bringing a greater sense of order to the urgent and emergency care system.

The benefits for patients will include:

- Fewer instances of serious avoidable harm;
- Reduced waits for an ambulance for those that need it most;
- Better care outcomes as they get the right service at the right time in the right place to meet their needs;
- A feeling of confidence as their care is planned with them;
- Fewer frustrations as they are seamlessly navigated through the complex health system, regardless of their access point.

The benefits to the system will include:

- Fewer patients with unmet needs making their own way to hospital Emergency Departments;
- Getting the most acutely unwell to hospital quicker, improving potential for positive outcomes and reduced length of stay;
- More patients being treated at home by WAST who will not then require onward referral;
- Developing the ability to safely hold / monitor some patients at home for a short period e.g. overnight until community services are available. This allows for increased scheduling of urgent care;
- Appropriate primary care/community pathway being identified by Health Boards for more patients, avoiding the need for an Emergency Department attendance
- Improved value across the system, with improved outcomes for patients as they receive the right care from the right place, first time, every time.

The benefits to our staff will include:

- Development of new roles and career paths, including portfolio and rotational careers;
- Fewer overruns for frontline response staff;
- Fewer distressed call-backs for call handlers;
- Emergency Department staff freed to see only those patients that need their services.

This will mean that staff benefit from an improved work experience with potential to positively impact levels of stress, sickness absence and turnover.

As a result of this evolution of our model, we will need to refresh the ways in which we monitor service delivery, performance and outcomes for patients. Our proposal is that we review the broad Red, Amber and Green categorisation and consider a more nuanced, clinically relevant set of categories and measures. This supports the recent recommendation arising from the Health and Social Care Committee's scrutiny of WAST which suggested that an assessment should be undertaken of the red response target.

The evolved model will take time to fully develop, test and implement, and a series of phases of implementation are planned, supported by ongoing evaluation, with some elements being in place for this winter.

Capacity is available within WAST to resource those elements which are being implemented this year, including Rapid Clinical Screening. Further discussions will continue with commissioners as plans are finalised for 2024/25 and 2025/26.

1. Background and History

The services provided by WAST were previously commissioned through the Emergency Ambulance Services Committee, a joint committee of the seven Health Boards in Wales who had responsibility for planning and securing sufficient emergency and non-emergency ambulance services for the population. Since April 2024, this responsibility has passed to the newly established Joint Commissioning Committee which has additionally taken on responsibility for the commissioning of 111 services.

In 2015, WAST and its commissioners implemented a new Clinical Response Model. The intention was to provide a more clinically focussed service by prioritising people who would most benefit from an immediate response and allowing more clinical discretion for other calls so that not just the speed but type of response was matched to patient need.

Time based response targets were retained only for those with immediately life-threatening conditions (65% of Red calls responded to in 8 minutes) with a range of clinical indicators used to measure outcomes for other patients.

A full evaluation of the new model was carried out by the University of Sheffield and published in early 2017 and confirmed that moving to the new model had been the appropriate and the right thing to do, with no new risk to patient safety and no serious safety concerns.

The evaluation suggested that further refinement to the model could be considered, including:

- a need to review the call categories outside Red, with a concern that the Amber category was too large and not sufficiently discriminatory in terms of prioritising patients with high acuity illness, and that for some calls this was resulting in unacceptably long waits;
- providing alternative response options for more calls, acknowledging that this would require changes in infrastructure, workforce profile and training;
- the scope to increase hear and treat and see and treat if the right pathways were in place that allowed and supported confident and safe clinical decision making by clinicians in the clinical hub or at scene with a patient.

2. Changing Landscape

Since the Clinical Response Model was introduced in 2015, there have been significant changes across a range of factors that influence and impact the provision of our service.

Population Growth

- The population of Wales continues to increase and is expected to increase by circa 4% by 2030 to 3.23 million (PHW Stats).
- The greatest growth is in the over 65 age group which is projected to increase by over 170,000 people aged 65 and over, from 680,000 in 2023, to a peak of around 850,000 in 2044. This level of projected growth is coupled with a continued increase in the proportion of the population who are economically inactive. With over 50% of current ambulance demand generated by the over 65s age group, the projected population growth signals a significant increase in the future demands placed on the NHS and ambulance service.

Increasing Demand and Changing Patient Case Mix

- There has been a significant increase in the number and proportion of calls categorised as Red (immediately life threatening), from 4-5% of all 999 incidents in 2017 to over 15% currently (see Fig 2). High-priority calls can monopolise resources as they attract multiple vehicle attendance, potentially leaving less critically ill patients without a timely response.
- Over many decades the 999-case mix has changed with the greatest proportion of calls for urgent health care needs related to an older, frail population with multiple long standing chronic diseases (se Fig. 3). The ageing population presents unique challenges for health services. Older adults often require more frequent and complex medical interventions due to chronic illnesses such as diabetes, heart disease, and respiratory conditions. These conditions can exacerbate emergency medical needs, necessitating timely and specialised care.

Figure 2. Breakdown of 999 activity by Call Categories (November 2017 to present).

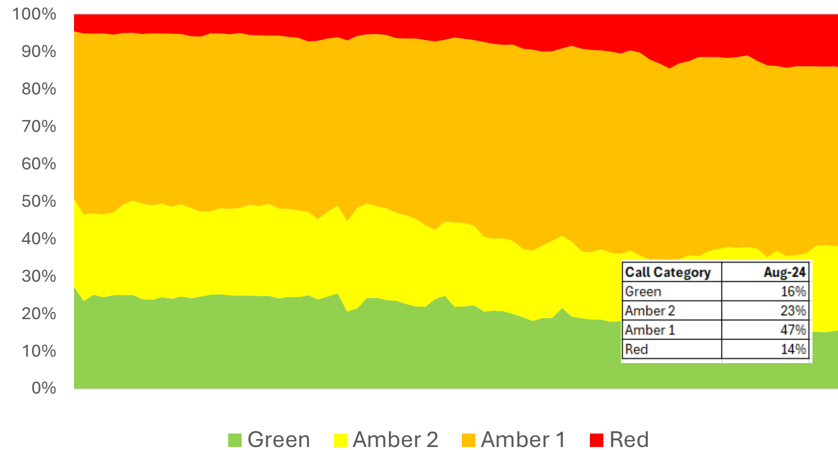
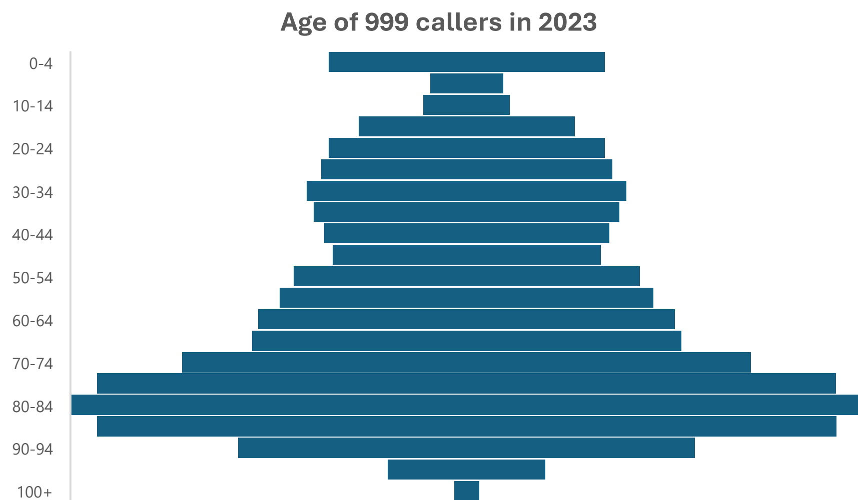


Figure 3. Breakdown of 999 calls by age group (2023)



System Pressures

- Pressures across the wider health and care system have been exacerbated due to increasing patient demand, staff vacancies and financial pressures impacting service delivery. This has resulted in the system becoming gridlocked, with severe challenges discharging patients home or into social care, depleting bed availability, placing greater pressure at the front door.
- As a result of these pressures, the system has seen record levels of hospital handover delays, depleting frontline ambulance capacity. Up to 40% of ambulance capacity can be lost each day as a result of hospital delays.

'Emergency access to healthcare is in crisis. Unmet need in primary and community care, as well as low capacity in hospitals and social care, has left emergency health services gridlocked and overwhelmed'

(House of Lords Public Services Committee Sep-22)

Workforce Challenges

- There are significant numbers of clinical vacancies across NHS Wales. Coupled with high staff absence and challenges retaining staff, this impacts on the ability of many organisations to provide accessible and timely care across both planned and urgent and emergency care.
- These challenges also impact WAST, with sickness and turnover at higher levels than we would want. Whilst there is a robust ability to recruit across the paramedic profession, it is more difficult to recruit to some clinical groups.

- The frontline workforce is bearing the brunt of the pressures in the system, with fatigue and stress impacting the health and wellbeing of our people. For our frontline ambulance staff, this manifests itself in reduced numbers of patients seen each shift and long shift overruns. For our control centre staff, pressure comes from being unable to dispatch resource to distressed and unwell patients.

3. Current Context and Situation

The operating context for the Trust remains challenging. Despite the best efforts of colleagues to improve care, the increasing demands and impact of system pressures has meant that we cannot respond as quickly as we would want to those who call us. We know that there are many patients who have a very poor experience of care and that some come to avoidable patient harm.

Delayed ambulance response to 999 calls in the community

The timeliness of ambulance response to attend calls in the community has continued to deteriorate. Fig 4 shows the number and proportion of Red calls attended within 8 minutes, a key national performance target, and Fig 5 highlights the response times for Amber 1 category calls.

During the period Aug-19 to Mar-23 over 75,000 patients had an ambulance response time or wait over 6 hours. In December 2022 over 1,800 patients waited over 12 hours for an ambulance response. These long delays cause avoidable patient harm, de-conditioning, and very poor patient experience.

Figure 4. Number and % of Red Incidents Attended within 8 minutes

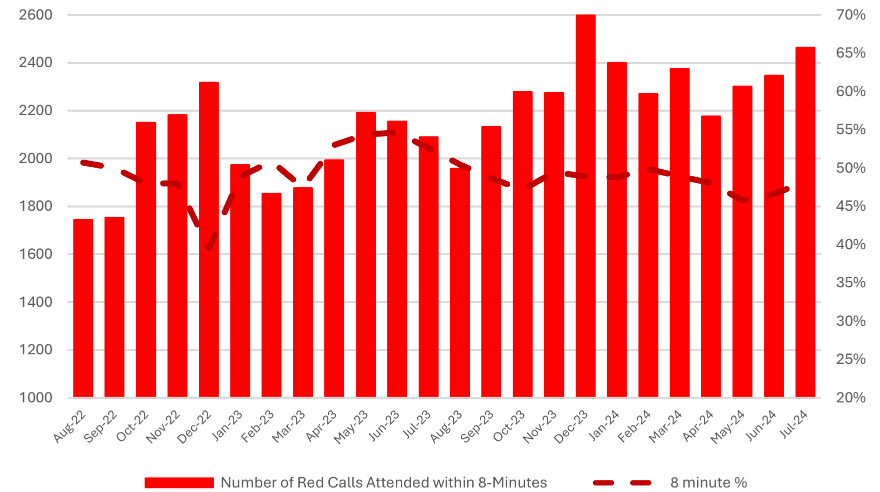
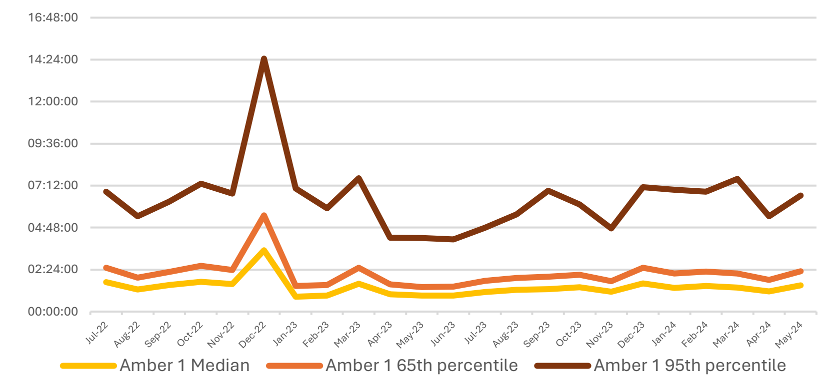


Figure 5. Amber 1 Response Times

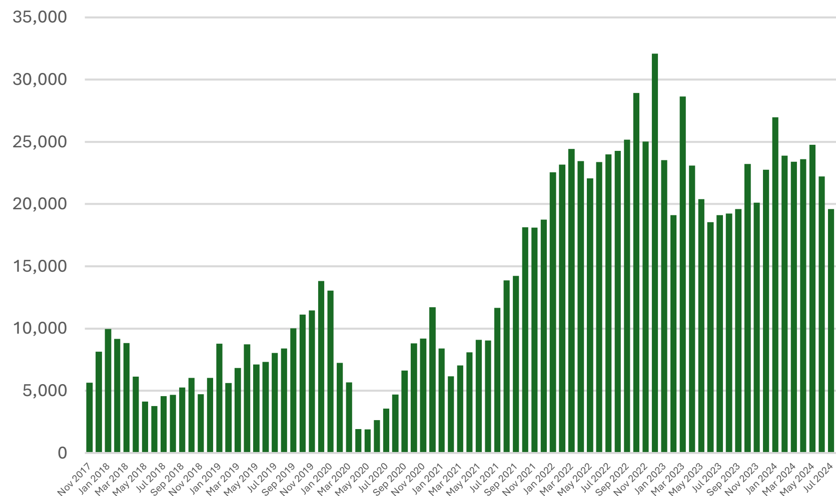


Delays receiving definitive care in hospital following conveyance

The challenges of hospital handover delays in Wales are well documented. WAST has seen the number of lost hours dramatically increase from circa 3,000 lost hours per month in 2015 to over 21,000 in 2023.

Whilst this places huge pressure on ambulance capacity to attend calls in the community, for the patient this can mean exceptionally long delays in the ambulance waiting to be admitted into the Emergency Department.

Figure 6. Pan Wales Hospital Handover Lost Hours (Nov 2017 to present)



Patient waits of 6 to 8 hours are common, with some patients waiting over 12 hours. Extensive delays outside the hospital, coupled with the potential delay waiting for the initial ambulance response in the community is leading to avoidable harm. This is especially evident for our most vulnerable and frail elderly patients, who are at risk of avoidable harm due to multiple factors including pressure damage, acute kidney injury and deconditioning.

An Association of Ambulance Chief Executives report, 'Delayed Ambulance handover: Impact assessment of patient harm', published in 2021, indicated that 1 in 10 patients waiting over 60 minutes for handover would come to 'severe harm'.

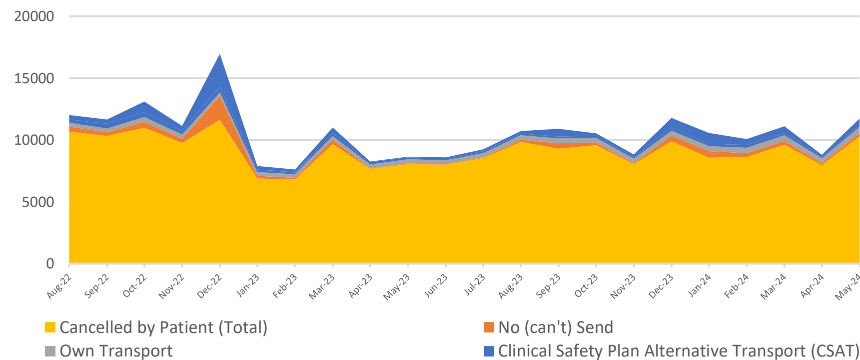
Patient needs are not being met

The Trust has seen an increase in the number of patients who ring 999 and then take the difficult decision to make their own way into hospital. The reasons for this are due to delays and long waits in the community for an ambulance response, or where the Trust applies its Clinical Safety Plan during periods of high escalation where ambulance capacity is severely depleted, and patients are advised to make their own arrangements to hospital as there is no ambulance available.

There are currently around 10,000 patients per month whose needs are not currently being met as shown in Fig 7 below. Up to 20% of all cancellations come from patients presenting with chest pain or falls. This can result in patient harm, poor experience and there have been reported serious incidents where severely unwell patients have been found to be in cardiac arrest in the hospital car park having been transported by a family member. There are missed opportunities to meet the needs of some patients at home or in the community if there had been a timely ambulance response and Welsh Government has prioritised deconditioning as an area of focus for the NHS.

Without data linking routinely available across patient pathways, there is no hard evidence which identified where these patients go to access care, but it is assumed that they will attend an Emergency Department.

Figure 7. Number of Patients with Unmet Care Needs



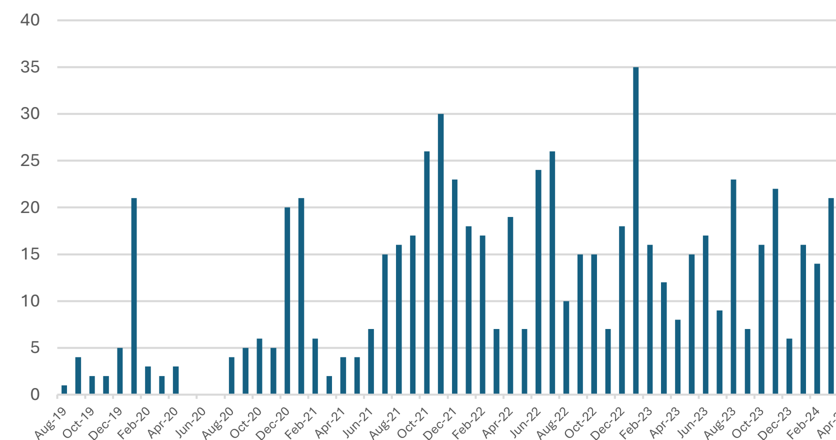
Serious Adverse Incidents

The heightened levels of pressures and risk being managed across the system can be evidenced in the number of reported Serious Adverse Incidents. Following a notable reduction in reported SAIs during 2019/20, in part as a consequence of reduced demand during the height of the Covid-19 pandemic. The number of reported SAIs has increased, ranging from 8-20 SAIs reported per month.

Prevention of Future Deaths (Regulation 28)

Over the last 12 months the Trust has been issued with a total of 13 Prevention of Future Death reports by HM Coroners. A significant proportion of the Regulation 28 reports issued make reference to delayed ambulance response times and handover of care delays as causal factors. Over recent years the Trust has seen an increase in the number of reports issued by HM Coroner following inquests where it has been deemed that further avoidable deaths could happen, if preventative action is not taken.

Figure 8. Serious Incidents referred to Health Boards



Patient Story

The patient story overleaf records the upsetting experience of a patient who sadly passed away due to waiting over 6 hours for an ambulance response. This story is unfortunately not unique. Many patients and their families across Wales have experienced long delays waiting for an ambulance response and have sadly come to harm or have passed away. This story demonstrates the devastating loss because of the challenges facing the ambulance service and wider NHS to deliver safe and timely emergency care across Wales. We have also heard from a

number of families about how the impact of feeling helpless as they watch their loved ones suffer has significantly affected them.

‘She would be alive today if help had reached her sooner’

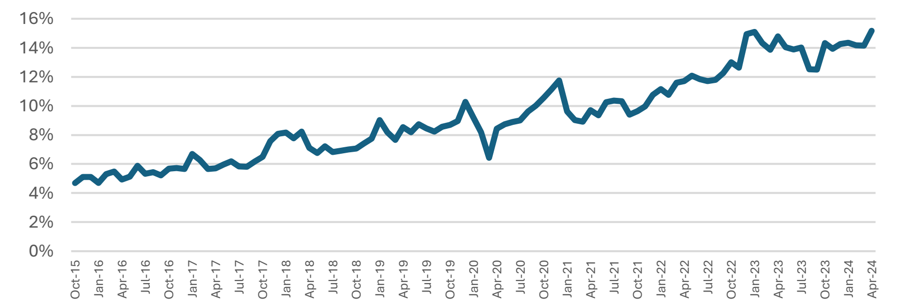
Video link: [If this happened to you - YouTube]

4. Changes and Improvements since 2015

The Trust has continued to adapt, evolve and improve services to benefit our patients, our people and the wider system, and has taken a proactive approach to acting, including;

- Undertaking a collaborative review of demand and capacity in 2019 leading to the commissioning of around 400 additional front-line staff over 3 years, designed to meet increasing demands;
- Improving the efficiency and effectiveness of funded capacity through reductions in sickness absence levels, implementation of new rosters pan Wales and reducing multiple attendance rates;
- Doubling the number of clinicians working within the clinical contact centres and the number of calls managed remotely without the need for conveyance to hospital (Fig 8);
- Increasing the types of clinicians and practitioners responding to patients in the community such as Advanced Paramedic Practitioners (APPs), falls responders, community welfare responders and specialist palliative care paramedics;
- Collaborating with Health Boards to design and deliver alternative care pathways such as those to Same Day Emergency Centres;
- Embedding joint ways of working with Health Board clinical teams as part of co-located multi-disciplinary teams (APP Navigator);
- Introducing the Cymru High Acuity Response Unit (CHARU) service to deliver high quality outcomes for the most acutely unwell patients;
- Rolling out the national 111Wales service with a new clinical system for call handlers and clinicians, designed as a gateway to services for patients with urgent care needs.

Figure 8. Hear and Treat rate (Oct 2015 to April 2015)



5. Why the time is right to change

Despite the efforts, in collaboration with our commissioners and health partners, to deliver a range of service improvements initiatives, ambulance response times remain below performance expectations. It is recognised that whilst these initiatives have delivered improvement, the visible gains have been limited due to the increased pressures across the system. Without these changes in place, it is likely that ambulance performance would have deteriorated further.

Incremental improvement is not enough to mitigate the current level of avoidable harm and wider challenges. Furthermore, it is widely accepted that the traditional ambulance model of care is not fit for purpose to meet the current needs of the population or for future generations.

It is therefore proposed that WAST, in partnership with its commissioners, undertakes the next phase to evolve its Clinical Services Model, building on the foundational changes put into place in 2015 as part of the then 'new Clinical Response Model'.

Our strategy 'Delivering Excellence' sets out our ambition to move away from the 'traditional' ambulance model of care that primarily focuses on clinical logistics and hospital conveyance to a future where the ambulance service is the gateway to access urgent and emergency care across Wales, resolving a greater proportion of episodes of care in the patients home (or close to home), whilst only dispatching an ambulance and conveying patients to hospital whose needs cannot be safely met in the community or another part of the system.

Working across such a complex and interconnected health and care system, in order to maximise the impact and benefits for our patients, we want to broaden our thinking and adopt a more holistic service model that realises the true benefit of integrating our core services (EMS, NHS 111 and NEPTs).

6. Our Founding Principles for Change

Reducing Harm and Improving Patient Care

As described in the earlier section, we are facing a burning platform in terms of the increasing level of clinical risk in our communities and the avoidable harm and poor clinical outcomes for our patients due to the challenges providing a timely ambulance response.

The primary reason underpinning the decision to evolve our Clinical Services Model is to improve clinical outcomes and reduce the clinical risk and harm in our communities. We aim to provide a safe and timely service, for all of our patients who receive the 'right care or advice, in the right place, every time'.

Delivering the Duty of Quality

The proposed Clinical Services Model seeks to specifically respond to and address the legal expectations set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020, including the Duty of Quality to create a culture of 'quality', focussed on 'improving the quality of health services and outcomes for the population on an ongoing basis'. The tables below provide a short summary to describe how our work seeks to address the six quality domains.

Safe	We will provide a safer service by prioritising patients most in need. By enhancing clinical decision-making earlier in the call process, we can better determine individual patient needs and ensure the right service to resolve care episodes safely.
Timely	Improving the way we identify clinical need will allow us to tailor clinical services based on patient need. This will mean that we are better able to protect finite ambulance resources to respond to those most in need quickly, whilst providing timely remote based care with individualised care plans for patients who present with less urgent health care need.
Effective	Our primary goal is to deliver the best clinical outcomes for our patients. To achieve this, we are adopting a Clinical Services Model that accurately identifies each patient's needs. Through personalised care planning we can tailor the right care and advice to meet those needs.
Person-centred	By improving our use of clinical information, we can determine the best service to meet each patient's individual care needs earlier in their pathway. Adopting a care plan approach will ensure a more tailored and personalised outcome for each patient until their care episode is safely resolved.
Equitable	A Pan Wales solution is being adopted to ensure an equitable level of service is available to the whole population across Wales.

Efficient	Clinically informed decision-making will ensure the right decisions are made to meet patient needs, avoiding unnecessary touchpoints or responses that do not align with those needs.

Embedding the Principles of Prudent Healthcare

The principles of prudent healthcare fully align with the aspirations of our approach to develop and implement our future model of care.

- Our approach seeks to learn the key lessons and through meaningful collaboration and involvement with our people, service users and the wider system to design a model of care that is fit for purpose for future generations;
- The model is predicated on ensuring that we care for those who contact us with the greatest need first.
- Adopting greater clinical decision-making and interrogation of clinical information earlier in the call cycle we can make the 'right' decisions for the patient.
- Taking a more holistic approach to integrate our core services, we are seeking to remove any inappropriate 'variation' or 'duplication' to best meet the patient and the system's needs.

Responding to our Strategic Drivers and Commissioning Intentions

The strategic direction set out by Welsh Government puts forward a clear vision to shape the future provision of health and social care services in Wales. The vision is centred on improving the health of the population, tackling health inequalities and preventing poor health. It describes a future state that focuses on 'health, wellbeing and prevention', where care is provided at home, or as close to home as possible, supporting self-management.

At the core of the decision-making process to evolve the clinical services model, we have fully considered our role in supporting the strategic direction of NHS Wales, alongside the specific objectives included in the 'Strategic Commissioning Intentions' and the 'Six Goals' Programme for Urgent and Emergency Care.

WAST recognises that we have an important role to play, working across the system, as a commissioned service, to support the delivery of this strategic direction. The objectives of our model, fully aligns to the strategic direction, with the greatest emphasis upon:

- Providing and managing more care closer to home or in the community;
- Locking in a shift of care closer to home, managing and resolving more activity upstream along the 5-step ambulance model;
- Reducing unnecessary conveyance to hospital;
- Adopting a whole system approach, recognising that the ambulance service has a more fundamental role to play integrating and supporting the system.

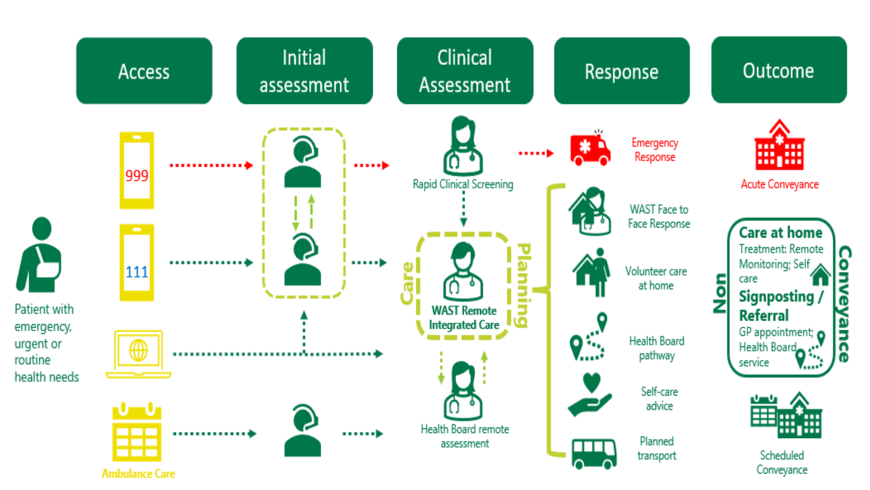
7. Evolution of the Clinical Services Model

WAST has engaged extensively with its clinicians and other staff across the organisation and with commissioners to design a further evolution of the Clinical Services Model, acting within its control to reduce avoidable harm and unmet need and ensure that patients receive the right care and advice, in the right place, every time.

A high level visual of the evolved clinical model is shown in Figure 9, with its characteristics set out below:

- **Clinically led** – there will be increased clinical input, earlier in the call cycle and throughout the patient journey. Clinicians will be actively involved in decision-making on the right pathway for each patient as part of a care planning process.
- **Connectivity** – systems, processes and people across the Trust will be increasingly connected so that patients get the right care in the right place, irrespective of their point of access (digital, 111, 999, ambulance care).
- **Care Planning:** We will adopt a personalised care planning approach for all patients, providing robust clinical oversight of the patient throughout their episode of care until their needs are resolved and case closed with the ambulance service.
- **Choice:** A greater range of response options will be created for those patients who need a face-to-face assessment, designed to enable more patients to be treated safely at home and to avoid conveyance to an Emergency Department.
- **Collaboration:** Increased effort will be put into working with commissioners at national and local level, with commissioners confirming the appropriate care pathways for their patients and making them available for WAST clinicians to refer into.

Figure 9 – Overview of proposed Clinical Service Model



8. Key Features of the Model

Rapid Clinical Screening

Description:

Rapid Clinical Screening is a new service which will see 999 calls being reviewed by a senior clinician (Clinical Navigator) during or immediately after the initial call handling stage to determine the most suitable service to meet the patient's need. Based on the clinical information available, the clinician will either decide to place the patient on to the ambulance dispatch queue or flow them into the Remote Integrated Care Service (RICS) for a remote clinical assessment. **High acuity, life-threatening calls will be excluded from screening, receiving an immediate ambulance dispatch**.

The call handlers use the Medical Prioritisation Dispatch System (MPDS) which is a structured protocol system used by the Trust to prioritise and allocate emergency medical service (EMS) resources. MPDS is highly effective at identifying and prioritising life-threatening conditions, however it has limitations with the standardised questions and categories potentially not capturing the nuances of every emergency, leading to potential over-triage (assigning higher priority than necessary) or under-triage (assigning lower priority than necessary). This clinical review provides a mechanism for a more nuanced and personalised approach.

Key Features:

- **Prioritisation of Life-Threatening Emergencies:** Rapid Clinical Screening ensures that cardiac and respiratory arrest (immediately life-threatening) incidents receive urgent attention and immediate ambulance dispatch.
- **Early Clinical Review:** Experienced clinicians conduct an early review of all other calls to assess the need for immediate or urgent ambulance dispatch. In particular, this will mean that patients who have historically been in the large Amber 1 category will have their call clinically assessed much sooner and will allow those that need an ambulance and conveyance within this group to be identified quickly – this might include strokes, chest pain patients and frail older patients who have fallen and are vulnerable.
- **Efficient Resource Utilisation:** By clinically evaluating each call, this process aims to prevent unnecessary ambulance dispatches, ensuring that resources are available for those in critical need.
- **Improved Patient Care:** This approach ensures patients receive the appropriate level of care, either through immediate dispatch or by guiding them to a thorough remote clinical assessment to establish the best clinical pathway.

Benefits:

- Clinically informed decision making to confirm requirement for an immediate ambulance dispatch, protecting resources for those most in need.
- More patients safely managed away from the ambulance response stack.
- More patients have their needs met via Remote Integrated Care Service or Urgent Community Response.

Remote Integrated Care Service

Description:

The Trust already provides a level of clinical health care remotely through the Clinical Support Desk and the NHS 111 Wales service. The **Clinical Support Desk (CSD**) is a specialised service composed of experienced paramedics and nurses who, among a range of other responsibilities, remotely assess a proportion of 999 activity. The service has demonstrated an increase in consult and close rates as clinical capacity has expanded with more patients receiving timely clinical advice and resolution of their issues without needing an ambulance dispatch. However, this has included increasing the numbers provided with alternative means to attend an Emergency Department (e.g. via a taxi), and further work is required to consider the overall impact on the healthcare system.

NHS 111Wales is a 24/7, free, easy-to-remember service designed to provide comprehensive non-emergency medical support and advice to the public. Following initial triage from our call handlers, calls are directed to the remote 111Wales clinical team including nurses and paramedics who conduct a more detailed assessment. Depending on the assessment, individuals receive medical advice, self-care instructions, or referrals to appropriate services, such as out-of-hours GPs, pharmacies, or urgent care centres.

If the situation is deemed an emergency, the service seamlessly coordinates with emergency ambulance services to dispatch an ambulance or direct the caller to the nearest emergency department.

The integration of the Clinical Support Desk and NHS 111Wales and the creation of one Remote Integrated Care Service (RICS) presents an opportunity to enhance the efficiency, effectiveness, and patient-centeredness of non-emergency medical services. By combining the strengths of both services, the integrated model can optimise resource allocation, improve patient outcomes and streamline access to healthcare.

Leveraging the clinical expertise of paramedics and nurses from the Clinical Support Desk can enhance the capability of NHS 111Wales to manage complex cases remotely, reducing unnecessary ambulance dispatches and emergency department visits. The now unified remote clinical decision-making software solution (Emergency Communications Nurse System (ECNS)) ensures that calls are clinically assessed with a consistent and comprehensive approach.

By permitting an appropriate pathway connection regardless of the point of access (999 or 111) would allow RICS clinicians to direct patients to the most appropriate level of care more effectively. Integration facilitates smoother transitions between different levels of care, ensuring that patients are referred to the right service promptly and efficiently.

The remote clinicians will be supported by a team of Community Welfare Responders who will attend patients in the community and provide them with relevant observations, enhancing clinical decision-making. The ability to schedule ongoing support visits to repeat observations or provide elements of care may also allow patients to be

safely held at home until a scheduled appointment with the appropriate community or hospital service. The use of remote technology and personal wearables will also be explored in the future.

The clinicians will undertake care planning, tailoring the care to the specific needs of the patient, and will take responsibility for each patient until care is able to be passed to another organisation.

The Remote Integrated Care Service will develop very strong links and pathways with Health Board remote clinical teams, for example in flow centres or hubs, and it will be expected that additional clinical advice will be secured seamlessly for those patients that need it.

The full integration will take place over the next 2 years, and the Trust will take the following immediate steps in support of integration:

- There is now unified remote clinical decision-making software solution in place for both CSD and NHS 111 Wales. Unification can be taken further with both services operating the same queue management software and with a single electronic directory of services.
- Management and support structures will be reviewed to bring functions together wherever possible, including but not limited to line management arrangements, training and education and clinical audit. Fostering strong communication, shared learning and collaboration between the teams will enable cohesive service delivery and continuous improvement.

Through strategic implementation and continuous improvement, this integration can become a cornerstone of modernised healthcare delivery in Wales.

Key Features:

- **Care planning approach**: Remote clinicians in RICS will adopt a care planning approach and will take ownership of patients through the episode of care until the episode is closed or until responsibility for care is safely passed to another organisation.
- **Clinical information supporting decision-making**: RICS clinicians will undertake remote patient consultations and request further clinical information in order to develop the care plan. Access to the Welsh Clinical Portal (WCP) will enable the clinicians to access historical clinical information about the patient to help inform the right clinical decision to meet the patients' individual needs.
- **Partnership with Health Boards remote clinicians**: There will be clear pathways for flowing more complex patients to Health Board-delivered Clinical Hubs for a remote consultation with a Health Board multi-disciplinary team.
- **Wider range of response options and dispositions**: Outcomes for each episode might include:
    - Holding the patient safely in the community, supported by Community Welfare Responders or remote technology;
    - Consult and Close: Care needs met e.g., self-care;
    - Consult and Refer: Care needs met by a referral to another service e.g., GP referral;
    - Consult and Dispatch a Community Response: a scheduled urgent care response arranged in the patient's place of residence, e.g., APP appointment.

Benefits:

- Safer service as patients will have a dedicated clinical care planner overseeing the care journey;
- Clinical information informing the right care approach;
- Increase in the number of patients whose care needs are met remotely;
- Reduction in proportion of calls which require emergency ambulance dispatch;
- Reduction in proportion of calls which require hospital attendance;
- Increased utilisation of community resources.

Urgent Community Response

Description:

There are a range of community responses which WAST already deploy with its commissioners and partners, including a national Falls Response Service, increased numbers of Advanced Paramedic Practitioners (APPs) and specialist Palliative Care Paramedics.

WAST will work alongside Health Boards to develop additional types of response that meet the needs of specific patient groups and will consider how these responses could be scheduled and planned according to acuity.

Work is underway to grow the number of APPs, but also to test the ability to schedule APP visits to patients in their own home who require an urgent (on the day) face-to-face clinical assessment. APPs will receive a planned appointment list to attend for that shift, with the benefits being:

- Increased utilisation of APP clinicians;
- Increase in the number of patients whose needs are safely managed and resolved at home or in the community;
- Reduction in hospital admissions.

In addition, WAST will be implementing a robust clinical model to support the safe and timely management of patients presenting with a mental health concern. Mental Health Practitioners (MHPs), alongside a non-mental health member of staff, will provide a tailored face-to-face clinical response and support in collaboration with the remote MHPs. The benefits will be that:

- Patients receive more specialist and tailored care from the most appropriate clinicians.
- MHPs expertise will also for a full range of mental health pathways to be accessed and utilised.

9. WAST and Health Board collaboration

Whilst much of what is proposed in this model is a series of actions that are within WAST's gift to undertake, improving outcomes for patients within our care, we are not looking to duplicate current services or develop services that would normally be expected to be commissioned or delivered through Health Boards.

We are seeking to complement Health Board services when patients contact WAST with urgent or emergency care needs and ensure that these patients are appropriately transitioned to the most effective pathway, as agreed and determined by Health Boards. In part, the success of this model will be to safely reduce the trajectory for emergency hospital admissions and do so in a way that reduces the level of harm being experienced by patients and their families/carers.

We are therefore seeking to work collaboratively with Health Board colleagues to develop a seamless approach to stream the 'right' patients to the most effective Health Board service. This could be flowing patients from RICS into a Health Board delivered remote Clinical Hub or via a direct care pathway via the DOS.

Health Boards are responsible for the commissioning of all services to meet their patients needs, and a key feature of this model is that they will continue to be responsible for the identification of the most appropriate pathways of care.

10. Performance Framework

The evolved Clinical Services Model will retain a focus on those most in need of an immediate face-to-face response, but there will be some differences in how calls are categorised and the ways in which an appropriate level of response is captured and measured. Consideration is being given to moving away from the current colour coded categorisations as these large categories are not reflective of the more nuanced needs of patients.

This links closely with the recommendation from the Health and Social Committee's recent report following its scrutiny sessions on WAST. It recommended that the Welsh Government and the NHS Wales Joint Commissioning Committee should assess the red response target (that 65 per cent of life-threatening calls receive an emergency response within 8 minutes) to provide assurance that it continues to be appropriate, given that this target has not been met since July 2020.

Work on this element of the model has been developing at pace through a series of workshops including commissioner representation. A summary of some of the emerging considerations is included here in this briefing document.

Call categories could include:

Arrest, for cases of cardiac or respiratory arrest, requiring immediate, high-priority intervention. There will be an immediate dispatch (including computer system driven auto-dispatch functionality) with the fastest possible response. There is the potential to move to a system of measuring performance according to the Chain of Survival, which include time to recognise a cardiac arrest, time to start CPR, time to defibrillator / ambulance personnel on scene and time to hospital.

Emergency, for immediately life-threatening situations that demand rapid, skilled intervention and transport to secondary care. An ambulance would be dispatched as soon as possible (including by computer driven auto-dispatch functionality), with a need to attend the incident as soon as possible with a backstop type performance measure being 90% attended within 20 minutes.

Urgent, for cases where clinical intervention is necessary to improve patient outcomes or prevent deterioration. An ambulance response would be required within one hour.

For patients flowed into the RICS service, there will be a range of categories based on assessed acuity, which will determine a range of appropriate call-back times. Call-back time measures are already in place for 111 patients who require clinical assessment, and this new performance model will see this extended to all patients (999 and 111) who require clinical assessment.

Once an assessment has been completed, a personalised care plan will be agreed with / for the patient. Where a face-to-ace assessment is required, the RICS clinicians would be able to use the 3 response

categories as set out above, if agreed, but could also have in addition 2 further response categories:

Non-Urgent, for cases that require clinical attention but are not time sensitive. A response will be provided within 2 hours by a clinically determined WAST clinician / WAST response / non WAST healthcare professional.

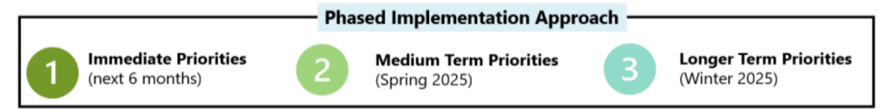
Routine, for **i**ncidents that require routine clinical care with no immediate threat to life or health. A response would be provided within 4 hours by a healthcare professional with the appropriate skills for routine patient care, potentially including community services or other specialists.

There will be a category of patients who could be kept safely at home with remote monitoring, say overnight, until a suitable community service becomes available or there is an agreed direct admission time to the hospital. Monitoring these patients will also need to form part of the performance framework.

WAST will also work with commissioners to develop further the measures of quality and harm, which will need to be measured both before and after the changes to the model, as this will be key to demonstrating and evaluating benefits to patients.

11. Phasing of Implementation

A phased approach is being adopted to take forward the transformational change to enable the successful implementation of the proposed future clinical service model.



The first phase sets out the immediate priorities to be implemented over the next six months. These priorities are outlined below and have been selected based on the need to build the foundations for the model, whilst also enacting tangible service improvement and safety measures in response to the forthcoming pressures anticipated over the winter period. The priorities include:

1. Implementation of the Rapid Clinical Screening process;
2. Testing the impact of the 111 Call Handling system (CPSS) for certain patient groups accessing services via 999;
3. Maximising the availability of existing pathways to our remote clinical workforce across NHS 111 and Clinical Support Desk;
4. Testing the ability to schedule on the day APP face-to-face clinical appointments;
5. Commencing initial work to align NHS 111 and CSD as a development towards the RICS concept;
6. Rolling out a Mental Health Response Vehicle in one part of Wales;
7. Developing proposals to change the future call categorisation process and implement first phase.

Work is continuing to develop the programme plan and key priorities to be undertaken during phase 2 (Medium term priorities up to summer 2025) and the longer-term priorities during phase 3 up to March 2026.

12. Resources

WAST's approved IMTP is underpinned by a balanced financial plan that continues our recent strong financial performance of balancing

throughout the financial year. As part of this, however, the organisation has had to commit to the delivery of a challenging savings target of £6.4m for 2024/25. This concentrates not just on savings and efficiencies but also on proactively exploiting income generation opportunities.

The overall financial plan, including an element of the 2024/25 funding uplift, has therefore allowed us to enable the implementation of the priority work streams set out in Phase 1. To deliver the priorities for Phase 1, no additional funding requirements, over and above that agreed as part of the 2024-27 IMTP process, or that contained within any current submissions for funding, are expected to be required. However, resourcing of the next phases will require discussions with commissioners as part of the IMTP planning process. This may need to include any system wide financial impact going forward.

The Trust has at pace, reviewed its internal programme delivery arrangements via its Transformation Support Office, to deliver the organisational change in a structured and planned approach, adhering to programme management best practice.

The Trust has recently undertaken a collaborative Demand and Capacity (D&C) review which substantiated the hypothesis that growing the traditional ambulance model is unsustainable and economically not viable with over 600FTE front line staff required to meet the Red 8-minute response standard. Transformed clinical models were tested and demonstrated improved value. This review will be a key piece of evidence that commissioners and the Trust will refer to and use as these proposals are developed further.

13. Risks

The programme within WAST is currently developing and finalising a full risk register. There are clearly going to be a number of risks which will require attention and mitigation.

Understanding of and support for the evolved Clinical Services Model: There will be a full engagement programme finalised in the next 2 weeks, which will include commissioners, Welsh Government, appropriate clinical fora, staff and the public. This will be discussed and shared with commissioners in due course.

Internal capacity to deliver: Internal transformation, clinical and operational capacity has been prioritised towards this programme of work. However, the pace at which the proposed changes will be made do bring some risk in this area.

Capacity within Health Boards: There has been some concern raised that this evolved model will move demand away from the front door of the hospitals to primary and community care, which are already under pressure. The intention of the model is to ensure that patients are able to access the right service to meet their needs, first time, and work will continue with Health Boards to understand and listen to concerns and clarify impacts of the changes. In addition, as outlined, the model also requires that WAST has access to appropriate alternatives to Emergency Department conveyance. There will need to be a continued and collaborative focus on this area of work.

Resources: The health service is facing significant financial pressures. As the model evolves, its is likely that there will be elements of it that required investment in WAST, and it may also be that there are periods in which there are dual running costs as elements of the model are

introduced and tested. Discussions will continue through the commissioning process on this issue.

Governance arrangements: Our clinical model has been consistently evolving over an extended period and our clinical governance framework has also continued to evolve to ensure safe service delivery. Critically, our clinical governance and risk considerations are taken in conjunction with the relative risk currently experienced by patients we are unable to respond to. Each element of the programme is considered in conjunction with a review of relevant clinical research and evidence, although there is limited evidence for the delivery model changes we are proposing.

A Clinical Advisory Group has been formed to complement our existing clinical governance and assurance processes. Membership of this group is formed from the organisation's senior clinical workforce and will play an instrumental role in maintaining focus upon patient safety and ensuring that clinical quality is maintained, developed and enhanced. The group is chaired by the Deputy Director for Nursing, Quality and Governance also has a Public Health Registrar as a member, neither of whom are directly linked into the transformation programme development, aiding objectivity within the group. The CAG reports to our Clinical Quality and Governance Group that is chaired by a Clinical Executive.

Impact on 111 services: Some concerns have been raised that these proposals may adversely affect the services provided to patients who ring 111, for example, by directing more remote clinical resource to responding to patients who ring 999. This is certainly not the intention, and we will ensure that we continue to separately monitor outcomes and response times for patients accessing services through each route so that this can be transparently monitored.

Achieving expected benefits: As with any programme of change, there will be a requirement to explicitly identify the expected benefits and monitor achievement. The transformation programme is developing a full benefits map and is also securing an external academic partner to undertake an evaluation of the changes, in line with that procured for the clinical model changes in 2015.

14. Next steps

We are seeking an endorsement from Welsh Government and commissioners of the direction of travel that this proposal sets out, together with a commitment to working collaboratively with us to deliver the changes set out, which will improve outcomes and reduce avoidable harm for patients across Wales.

Further work will be required to ensure that changes to call categorisation and measurement are agreed and understood.

Once the overall direction of travel is agreed at this level, we will work with partners to ensure that there is a robust engagement with clinicians and staff within Health Boards.

A full programme plan is in place and is available if required.