National Assembly for Wales
Audit Committee

Ambulance Services in Wales Inquiry

July 2009

The National Assembly for Wales is the democratically elected body that represents the interests of Wales and its people, makes laws for Wales and holds the Welsh Government to account.

An electronic copy of this report can be found on the National Assembly's website
www.assemblywales.org

Further hard copies of this document can be obtained from:
Audit Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

Tel: 029 2089 8617
Fax: 029 2089 8021
Email: Audit.Comm@wales.gsi.gov.uk

National Assembly for Wales
Audit Committee

Ambulance Services in Wales Inquiry

July 2009

Ambulance Services in Wales Inquiry

Contents

Annexes

Audit Committee Record of Proceedings 21 January 2009	Annex 1
Audit Committee Record of Proceedings 11 March 2009	Annex 2
Audit Committee Record of Proceedings 30 April 2009	Annex 3
Audit Committee Record of Proceedings 4 June 2009	Annex 4
Audit Committee Record of Proceedings 18 June 2009	Annex 5
AC(3) 08-09 (p1) Unison – Ambulance Services in Wales	Annex 6
AC(3) 08-09 (p2) British Paramedics Association – Ambulance Services in Wales	Annex 7

Committee Membership

Jonathan Morgan
Chair
Cardiff North
Welsh Conservative

Lorraine Barrett
Cardiff South and Penarth
Labour

Mike German
South Wales East
Welsh Liberal Democrats

Janice Gregory
Ogmore
Labour

Lesley Griffiths
Wrexham
Labour

Irene James
Islwyn
Labour

Bethan Jenkins
South Wales West
Plaid Cymru

Huw Lewis
Merthyr Tydfil and Rhymney
Labour

Nick Ramsay
Monmouth
Welsh Conservative

Janet Ryder
North Wales
Plaid Cymru

Chair's Foreword

Since the National Assembly for Wales voted in favour of an inquiry into the Welsh Ambulance Services NHS Trust in July 2006, the Audit Committee has taken a keen interest in the performance of the Ambulance service. But despite two Committee reports on the underperformance of the Trust, the Committee is not convinced that progress is being made and remains unhappy with unscheduled care provision.

The Trust has undergone a transformational change in recent years that has gone some way to modernising the delivery of pre-hospital care in Wales but further improvement is still needed.

The Committee is concerned that targets designed to ensure a prompt response to emergency 999 calls are not being met consistently and at times, performance falls well below the required level. The Committee is also concerned that performance has been adversely affected by the Trust's efforts to make efficiency savings. Further concerns relate to the bullying culture evident in the Trust which is undermining the achievements of staff and must be addressed as a priority.

But the Ambulance service does not work in isolation. Lengthy delays to handovers at accident and emergency units can mean that paramedics are queuing with patients in corridors and unavailable to answer 999 calls. For the patient in an A&E Department a lengthy wait is unacceptable. For the patient in the community awaiting a response to a 999 call, the situation could be fatal. It is of the utmost importance that the NHS in Wales works to improve the process from the 'front door' to the 'back', with joined up working and intelligent systems that have both the capacity and the tenacity to enable staff to provide first class care.

This report examines the pre-hospital care provided by the Welsh Ambulance Services NHS Trust and the handover process when paramedics transfer the care of a patient to hospital staff. The Committee has previously made recommendations about delayed transfers of care which occur when patients are discharged from hospital, and will be examining other aspects of the patient journey in future reports. It is hoped that the Welsh Assembly Government will take the opportunity of the forthcoming re-organisation of the NHS to modernise the delivery of care across the whole system. However, the re-organisation should not be seen as the solution in itself and work on improving the performance of the Wales Ambulance Service NHS Trust must be carried out in earnest.

I would like to thank the witnesses who gave evidence to this inquiry. The passion and dedication of those individuals was apparent throughout and the Committee is grateful for their time and efforts.

Jonathan Morgan,
Chair, Audit Committee

Introduction

1. The Welsh Ambulance Service NHS Trust is the frontline provider of pre-hospital unscheduled care in Wales. The all Wales service responds to emergency 999 calls in order to save lives and provide emergency care to patients. The Audit Committee commends the dedication and hard work of all staff of the ambulance service who strive each day to ensure that the patients they see receive the care they need.

2. However, concerns regarding the Welsh Ambulance Service NHS Trust have been ongoing for sometime. Accusations of bullying and poor morale were coupled with poor performance against the Trusts performance targets. In times of particular pressure, the already overstretched service was brought close to breaking point with reports of ambulances queuing outside emergency departments and patients waiting for unacceptably long periods for an emergency response.

3. In July 2006, the National Assembly for Wales voted for an inquiry into ambulance services in Wales, to be led by the Auditor General for Wales. The Auditor General for Wales published his report on the inquiry in December 2006. The inquiry concluded that there were longstanding and severe problems throughout the Welsh Ambulance Service NHS Trust. In March 2007, the predecessor Audit Committee reported on its own investigation into the issues.

4. In June 2008, the Auditor General for Wales reported on his follow up review into the Ambulance Services in Wales. That review found that although there was evidence of positive improvements in the Trust since December 2006, some difficult problems remained. These problems were judged by the Wales Audit Office as symptomatic of the process of transformational change. The Audit Committee report of October 2008 reflected this view and recognised that although there was a need to make rapid and sustained progress, it would take time to deal with some of the organisational and systemic challenges that faced the Trust.

5. In December 2008, the Welsh Assembly Government responded to the Audit Committee report. The Audit Committee considered the response in January 2009 and sought advice from the Auditor General for Wales.[1] The Committee was concerned that progress was not being made quickly enough with regard to the issues highlighted in its earlier reports. It decided to seek further evidence from Paul Williams, Director-General of Health and Social Services and Accounting Officer in the Welsh government, and Alan Murray, Chief Executive of the Welsh Ambulance Services NHS Trust.

6. The Auditor General for Wales issued his report 'Ambulance Services in Wales – further update to the National Assembly for Wales' Audit

[1] AC(3)-01-09 (p2), (p3)

Committee' ahead of the Audit Committee meeting on 11 March 2009, in which Paul Williams and Alan Murray gave evidence to the Committee.

7. On 23 April, the Auditor General for Wales published his report 'Unscheduled Care – patient handovers at hospital emergency departments'.

8. Following consideration of the report on handovers,[2] the Audit Committee launched an inquiry into ambulance services in Wales in order to examine the wider issues effecting performance of the trust.

9. The Committee took oral evidence from:

16 March 2009

- Alan Murray, Chief Executive, Welsh Ambulance Service NHS Trust
- Tim Woodhead, Director of Finance, Welsh Ambulance Service NHS Trust
- Paul Williams, Director-General of Health and Social Services, Welsh Assembly Government
- Simon Dean, Director of Service Delivery and Performance Management, Welsh Assembly Government

4 June 2009

- Dave Galligan, Head of Health, Unison Wales
- Tina Donnelly, Director, Royal College of Nursing
- Andrew Evans, Professional Officer, Royal College of Nursing
- Professor Malcolm Woollard, Chair of the College of Paramedics

18 June 2008

- Jon Falcus, Directorate General Manager, Wrexham Maelor Hospital
- Judith Rees, Deputy Directorate General Manager, Wrexham Maelor Hospital
- Meredith Gardner, Directorate Manager, University Hospital of Wales
- Jennie Palmer, Senior Team Leader Nurse, Emergency Unit, University Hospital of Wales
- Alan Murray, Chief Executive, Welsh Ambulance Service NHS Trust
- Tim Woodhead, Director of Finance, Welsh Ambulance Service NHS Trust

[2] AC(3)-06-09 (p2)

- Paul Williams, Head of Health and Social Services, Welsh Assembly Government
- Simon Dean, Director of Service Delivery and Performance Management, Welsh Assembly Government

10. Written evidence was also received from Professor Malcolm Woollard and Dave Galligan.

The eight minute standard

11. The Welsh Ambulance Service NHS Trust has a target to respond to category A immediately life threatening calls within eight minutes at least 65 percent of the time. From March 2005 – April 2007 the target eight minute response was achieved 60 percent of the time.

12. Earlier reports on the ambulance trust had shown a trend towards improvements in performance against the eight minute standard. The overall annual performance figure rose from 55.8 percent in 2006/07 to 62.3 percent in 2007/08.[3]

13. However, performance by December 2008 had dipped to just 47.6 percent.[4] In March, Alan Murray told the Committee that this alarming dip in performance was partly due to a reduction in numbers of frontline staff in order to make required efficiency savings of £17 million a year.[5] He also told the Committee that the dip in performance was partly due to a 90 percent increase in lost ambulance hours due to delayed handovers at hospital emergency departments at that time.[6]

14. The Committee noted the increase in hours lost during handovers at emergency departments with concern. There is a real need to reduce the number of hours that patients and crews are spending waiting for handovers to hospital staff. While ambulance crews are delayed at emergency departments they are unavailable to respond to other 999 calls. The issues surrounding such delays are discussed in detail later in this report.

15. The Committee understands the need for the ambulance service to make efficiency savings and applauds any public body that strives to secure better value for money for taxpayers. However, the number of unfilled vacancies for emergency medical staff has clearly contributed to reduced standards of performance from the essential public service and is likely to have done further harm to the already damaged morale of ambulance trust staff.

16. On 18 June, Alan Murray told the Committee that staffing levels in the south east, where there had been a particular deficit, have now improved. He also stated that the trust was training '*an unusually high number of people at the moment, both on EMT and on Paramedic courses'*. He also assured the Committee that funding to

[3] Auditor General for Wales, *Follow up Review – Ambulance Services in Wales*, June 2008, paragraph 1.4
[4] Auditor General for Wales, *Ambulance Services in Wales – Further update to the National Assembly for Wales' Audit Committee,* March 2009, paragraph 1.2
[5] Record of Proceedings AC(3)-04-09 [15]
[6] Record of Proceedings AC(3)-04-09 [16]

recruit and train staff was now in place. [7] The Committee welcomes this progress.

17. At the meeting on 11 March, Paul Williams told the Committee that the prolonged cold snap and Christmas period added to the difficulties faced by the ambulance services in December 2008 as patient numbers rose and departments started to '*wind down'* for the period[8].

18. The Committee does not accept that seasonal effects on performance cannot be better predicted and managed by the National Health Service as a whole. **The Committee recommends that the Welsh Assembly Government ensures robust plans are in place in all NHS trusts to ensure that predictable seasonal variations in supply and demand are better managed during the winter months 2009/10.**

19. By January 2009 performance had increased significantly to 57.8 percent and on 18 June, Alan Murray told the Committee that since March 2009 the ambulance service had consistently met the 65 percent target for responses within eight minutes.[9] The Committee welcomes this improvement in performance against this critical target and hopes that performance will not drop below this level but will be improved over the coming months in a more consistent manner.

20. Alongside appropriate staffing levels, it is vital that shift patterns match demand. Staff rotas were first identified in the Auditor General's 2006 report as a priority for improvement[10]. In June 2008, the Auditor General's report stated that there had been particular problems in Cardiff where '*the Trust has had greater problems changing rosters in line with its demand analysis[11].'* **The Committee notes that the staff rota review in south east Wales is still pending. It notes Alan Murray's decision to await the outcome of the efficiency review before making a final decision on rotas but would urge him to bring this issue to a conclusion as soon as possible.**

Rapid Response Vehicles

21. Rapid Response Vehicles (RRVs) are single staffed emergency response cars intended to provide a fast response to emergency 999 calls. RRVs are equipped to enable their paramedic drivers to

[7] Record of Proceedings AC(3)-09-09 [162-164]
[8] Record of Proceedings AC(3)-04-09 [21]
[9] Record of Proceedings AC(3)-09-09 [167]
[10] Auditor General for Wales *Ambulance Services in Wales*, December 2006, p162
[11] Auditor General for Wales *Follow up Review – Ambulance Services in Wales*, June 2008, paragraph 2.8

provide emergency care to patients. They are not able to transport patients to hospital.

22. When RRVs respond to an emergency call they are followed, when necessary, by a double staffed ambulance capable of transporting patients to hospital. The target response times for the arrival of the double manned unit following the RRV are 14, 18 or 21 minutes depending on whether the area is urban, rural or sparsely populated.

23. There have been incidents where a double staffed ambulance has taken considerably longer than the target time to arrive at the scene in order to support the RRV paramedic and facilitate onward travel of the patient to hospital.

24. In his written evidence to the Committee, Professor Woollard stated that '*The College is most concerned about the clinical risks to Patients requiring emergency transportation arising from prolonged management on scene by single-staffed Rapid Response Vehicles (RRVs) and also the attendant pressure and psychological risk to RRV paramedics when ambulance transportation is delayed*.'[12]

25. During oral evidence, Professor Woollard argued that there is a '*perverse incentive in the performance targets'*[13] which can mean that once an RRV is on scene, follow up ambulances are diverted elsewhere to meet the eight minute target for other 999 calls. This will inevitably lead to longer delays for the patient awaiting onward travel to hospital and delays for the RRV paramedic who is required to provide prolonged management of the health condition on scene.

26. Alun Murray agreed that a delayed ambulance response resulted in clinical risks to patients who needed to get to hospital quickly. He also agreed that there were psychological risks to RRV paramedics who were tasked with prolonged management of a patient on scene. He assured the Committee that in order to eliminate those risks, the ambulance service had improved its performance in this area and was now meeting the 14, 18 or 21 minute target 92 percent of the time[14].

27. The Committee was pleased to hear that performance in this area had improved but notes with concern Professor Woollards' comments on what he sees as a 'perverse incentive in the performance targets.' When setting performance targets, the Minister has made it clear that targets exist to improve patient care. The Committee notes Alun Murray's assurances that the Welsh Ambulance Service is putting '*equal emphasis on getting follow-up ambulances to the scene within the 14, 18, and 21 minute standards*.[15]' **The Committee asks the Welsh Assembly Government to provide an update detailing**

[12] AC(3) 08-09 (p2) College of Paramedics: Ambulance Services in Wales, paragraph 11
[13] Record of Proceedings, AC(3)-08-09 [39]
[14] Record of Proceedings AC(3)-09-09 [149-153]
[15] Record of Proceedings AC(3)-09-09 [153]

response times of the ambulance service. This should include figures for the Christmas period which has been problematic in the past and should be provided by the start of February 2010.

Transport of patients by other emergency services

28. The Committee was concerned that there have been several incidents of other emergency services transporting patients to hospital. Such incidents have occurred when an ambulance was unavailable, typically coinciding with periods of lengthy handovers at emergency departments.

29. From October to December 2008, South Wales and Gwent police reported 89 incidents in which they transported patents to hospital; an average of 30 incidents per month.[16] Paul Williams told the Committee in June that the Joint Emergency Service Group identified 59 incidents in January 2009 and 65 in February 2009 of patients being transported to hospital by other emergency services[17]. 23 such incidents were reported to the group in March 2009.[18]

30. In January, the Minister for Health and Social Services instructed the Welsh Ambulance Services NHS Trust to set up a taskforce to deal with the issue.[19]

31. Alun Murray told the Committee that both formal and informal processes for managing performance in this area have been agreed with the four emergency services in the problematic south-east Wales area.[20] He also stated that '*significant progress'* had been made with only 4 reported incidents from 1 to 18 June.[21]

32. The Committee would no more expect the police or fire service to undertake the medical care of patients than it would expect paramedics to extinguish a fire or arrest criminals. It notes the efforts of the ambulance service to minimise incidents of this nature but is nevertheless troubled by Alan Murray's qualification of the figures as they stand. He told the Committee that some incidents were '*more serious than others'* for example, when another emergency service has had to step in because of '*ambulance control taking too long to answer the phone'.*[22] Regardless of the reason, other emergency services providing cover for the Welsh Ambulance Services NHS

[16] Auditor General for Wales, *Unscheduled Care: Patient handovers at hospital emergency departments*, April 2009, paragraph 1.21
[17] Record of Proceedings AC(3)-09-09 [244]
[18] Auditor General for Wales, *Unscheduled Care: Patient handovers at hospital emergency departments*, April 2009, paragraph 1.21
[19] Record of Proceedings AC(3)-09-09 [244]
[20] Record of Proceedings AC(3)-09-09 [246-249]
[21] Record of Proceedings AC(3)-09-09 [245]
[22] Record of Proceedings AC(3)-09-09 [246]

Trust damages the reputation of the Welsh Ambulance Services NHS Trust and erodes public confidence in Welsh emergency care provision. Care should be taken to ensure that such incidents are eradicated altogether. **The Committee recommends that the Welsh Assembly Government closely monitors the effectiveness of the new formal and informal performance management processes to ensure that the number of reported incidents is quickly and consistently reduced.**

Intelligent targets

33. The Committee has heard from a number of witnesses that the targets by which the ambulance service response and handover times are measured are not foremost in the minds of clinical staff when dealing with patients.

34. Jennie Palmer told the Committee that '*Patients have to be at the centre of every journey. In some respects, the 15 minute target for ambulances has taken away from patient focus.*'[23]

35. Judith Rees told the Committee that '*We tend not to talk about the targets, but about the safety issues on the floor and what is best for the patient – the targets will take care of themselves if we do that properly.*'[24] She added '*it is the care that they give to patients and what is happening to those patients that is most important to staff. They are not driven by the target in that sense; they will not see patients according to who has been waiting the longest and therefore might breach a target, but according to who is the sickest.*'[25]

36. Professor Woollard told the Committee '*Although I think that response time performance targets are important because otherwise you would have no constraints on service provision, the other thing to say is that they are overrated as a measure of clinical effectiveness. It is certainly true to say that if we get to a patient within seven minutes and 59 seconds and they die, that is a success and is counted as a success because we met the only measurable performance target, but if we take eight minutes and 1 second and the patient in cardiac arrest is successfully resuscitated and goes home to live a normal life, that is considered as a failure. Clearly, that is ridiculous*'[26]

37. The eight minute target set by the Welsh Assembly Government is intended to improve patient care. However, a system which classes a successful clinical outcome from a response which breaches the eight minute target as a failure and an unsuccessful clinical outcome

[23] Record of Proceedings AC(3)-09-09 [13]
[24] Record of Proceedings AC(3)-09-09 [15]
[25] Record of Proceedings AC(3)-09-09 [22-23]
[26] Record of Proceedings AC(3)-08-09 [40]

from a response within eight minutes as a success seems perverse. Equally, to prioritise the handover of a patient close to breaching target as opposed to one with greater clinical need would be senseless and recognition of this has led clinical staff to 'tend not to talk about the targets'. Although targets are a necessary performance management tool, they must be intelligent enough to recognise that to improve performance, the efficiency of the whole system must be considered.

38. Dave Galligan told the Committee that '*Some work is being done in England currently, and I believe that some is being done across the UK on trying to produce a more qualitative measure, rather than be dictated to by the time.*'[27]

39. **The Committee recommends that the Welsh Assembly Government assesses the studies that are being carried out into qualitative targets and considers amending the quantative targets currently in place, depending on the outcomes of those studies.**

Advanced Paramedic Practitioners

40. In 2002, the Welsh Assembly Government funded an advanced paramedic practitioner pilot scheme. The two year pilot provided funding for 5 paramedics to undertake training on the Practitioner in Emergency Care programme at the University Hospital of Wales[28]. The training was designed to provide greater flexibility in pre-hospital care allowing early assessment of emergency patients and access to alternative pathways of care where appropriate. The scheme changed the patient pathway for 60 percent of the patients seen by the specialist paramedics.

41. The pilot is estimated to have cost £259,000 and the business case put forward by the Welsh Ambulance Services NHS Trust in September 2004 indicated that the new model of care 'significantly reduces the pressure on emergency ambulance resource, whilst contributing extensively to reducing the number of unnecessary attendances at A&E'[29]. The pilot scheme reduced the number of patients taken to hospital by 46 percent which meant the ambulances were free to attend other emergency calls and full-capacity pressures at hospitals were relieved. Another 14 percent of patients attended hospital using an alternative mode of transport to an emergency ambulance.

[27] Record of Proceedings AC(3)-8-09 [117]
[28] Note from Paul Williams on the Advanced Paramedic Practitioner Scheme paragraph 4
[29] Note from Paul Williams on the Advanced Paramedic Practitioner Scheme paragraph 10

42. However, 'there was no formal review process undertaken by the Welsh Ambulance Service NHS Trust or Health Commission Wales.'[30] **The Committee finds it unacceptable that the Welsh Assembly Government should allocate such a significant sum of money to the scheme without requiring a formal review of the outcomes achieved and recommends that future pilot schemes are subject to a full review as a condition of funding.**

43. Despite the lack of any formal review, the Welsh Assembly Government supported the continuation of the scheme based on the initial evidence provided in the Welsh Ambulance Services NHS Trust business case in 2004.[31] However, the Welsh Ambulance Services NHS Trust and Health Commission Wales were unable to agree funding for the continuation of the scheme and so it was discontinued from September 2005.

44. The Welsh Ambulance Services NHS Trust has now returned to this approach.. Alan Murray told the Committee that specialist practitioners are currently being trained who will focus on home resolution[32]. These specialists will be employed initially at a lower scale that the advanced paramedic practitioner but may have the opportunity for further development. The Committee is concerned that despite recognising the benefits of such a scheme in 2004, the opportunity to progress this new model of care was missed by the Ambulance Services NHS Trust and Health Commission Wales, effectively delaying progress in this area by 5 years.

45. A new triage scheme is currently underway in ambulance control that has seen more intelligent triage lead to a two thirds reduction in the number of category C calls being referred back to 999 ambulances. This scheme, like the advanced paramedic practitioner scheme has made a dramatic difference to the number of calls requiring either hospital attendance or a 999 ambulance response. However, the nurse led triage scheme is not in place on a full time basis due to a lack of funding.[33]

46. **The Committee recommends that every effort is made by the Welsh Assembly Government, Health Commission Wales and the Welsh Ambulance Service NHS Trust to drive forward schemes like the specialist practitioner scheme and the Nurse led triage scheme. Such schemes will go some way to modernising the provision of unscheduled care and should improve patient care and deliver sustainable efficiency savings for the future.**

[30] Note from Paul Williams on the Advanced Paramedic Practitioner Scheme paragraph 7
[31] Note from Paul Williams on the Advanced Paramedic Practitioner Scheme paragraph 18
[32] Record of Proceedings AC(3)-09-09 [206]
[33] Record of Proceedings AC(3)-09-09 [203]

Handovers

47. A handover occurs when ambulance crews arrive at a hospital emergency department and transfers the care of the patient to hospital staff. The handover period starts when ambulance crews arrive at the hospital and record their arrival on data terminals situated in the emergency department. The crews then stay with the patient until they are able to give a verbal handover to hospital staff and provide them with a written patient record. Hospital staff will then complete the handover process by recording the handover on the data terminals. The ambulance crew then clean and re-stock their ambulances before notifying ambulance control of their availability for another call.

48. The target time for handover of a patient is no longer than 15 minutes. Another 5 minutes is allowed for cleaning and restocking the ambulance. The total ambulance turnaround time is therefore 20 minutes.

49. The Auditor General's report 'Unscheduled Care – Patient handovers at hospital emergency departments' highlights that in 2008, delays in handover resulted in ambulance crews losing nearly 30,000 hours at emergency departments beyond the 20 minutes turnaround time targeted.[34]

50. The delays meant that patients were kept waiting either in ambulances outside the hospital or in the corridors of the emergency department. During that time, patients remained in the care of the ambulance crews.

51. Lengthy delays can have a devastating effect. Patient care is compromised because, as Professor Woollard told the Committee '*the delay to handover is clinically significant'*[35] and as long as paramedics are waiting with one patient in a hospital corridor, they are unavailable to help another patient who has made a 999 call for help.

52. Professor Woollard also told the Committee that ambulance crews who are providing protracted care for patients in a hospital setting are '*undertaking a role for which they are not trained*[36].' Paramedics are trained to give emergency care to patients in a community setting. They are not trained to care for patients over a long period of time in a hospital setting where the equipment is unfamiliar and the patients condition may change, thus altering the care they need. Paramedics are restricted in the drugs they may administer and caring for a

[34] Auditor General for Wales, *Unscheduled Care: Patient handovers at hospital emergency departments*, April 2009, paragraph 10
[35] Record of Proceedings AC(3)-08-09 [110]
[36] Record of Proceedings AC(3)-08-09 [12]

patient in pain whilst being unable to relieve their suffering can have psychological effects on the ambulance staff as well as an obvious negative impact on patient care.

Data terminals

53. In order to monitor the extent of delays in handovers of care, data terminals were installed in all emergency departments ready for use in September 2008. However, due to technical problems experienced in November, the data terminals were not in full use until December 2008. The data terminals consist of a touch sensitive screen which records the time of arrival of ambulance crews waiting to handover and the time that handover is complete. The screens also give details of ambulances which are enroute to emergency departments.

54. The Auditor General's report states that '*some staff were resistant to using the screens'*[37] Those giving evidence to the Committee's inquiry concurred with that observation. Ms Rees told the Committee that '*when the nurse's priority is the patient on the trolley, the screen is not such an important thing'*[38] and Ms Donnelly told the Committee that '*the patient comes first and the paperwork comes second*.'[39]

55. Ms Palmer felt that the reluctance to use the data terminals partly stems from '*the design of the terminals and the design of the data collection. It was not really designed with users in mind – or the service to some extent.*'[40] Mr Murray explained that *'the screens had to be designed in such a way as to interface properly with our computer aided despatch system, so there was not a lot of choice about how they were designed and there were constraints.*'[41]

56. Ms Palmer told the Committee that the software installed on the data terminals could be problematic and that the data captured during a recent shift contained a 26 percent rate of error[42]. There have been reports of 'ghost jobs,'[43] which show ambulances as waiting at one hospital when they are actually at another, and occasions when more than one ambulance has attended an incident but only one patient is taken to hospital. On those occasions, or when the ambulance crews have not 'clicked' to say it has arrived, the software will not allow nurses to 'complete' the handover on screen.

---

[37] Auditor General for Wales, *Unscheduled Care: Patient handovers at hospital emergency departments,* April 2009, paragraph 15
[38] Record of Proceedings AC(3)-09-09 [59]
[39] Record of Proceedings AC(3)-08-09 [104]
[40] Record of Proceedings AC(3)-09-09 [55]
[41] Record of Proceedings AC(3)-09-09 [256]
[42] Record of Proceedings AC(3)-09-09 [115]
[43] Record of Proceedings AC(3)-09-09 [119]

57. Professor Woollard suggested that '*the only reliable way to gather data...is to have an automated system. If the system requires human intervention in a high-pressure environment, it will inevitably be inaccurate and it will fail, because paramedics' and nurses' focus will be on the patient, and not on a bit of hardware.'*[44]

58. Ms Rees told the Committee that in her experience the '*manual system* [for recording handover times] *shows a different level of performance compared to the screen. That gives a truer reflection of the 15-minute handover, which is the important bit, namely caring for the patient within 15 minutes, not having the time to press the screen.'*[45]

59. Although monitoring performance is a first step towards improving it, the Committee is unconvinced that the data terminals are fit for purpose. The requirement for staff to divert their attention away from patient care in order to manually input the data on terminals that are considered badly designed and unreliable by the staff seems to a poor use of staff time. **Given that 'a truer reflection' of handover times is recorded in clinical notes, the Committee urges the Welsh Assembly Government to revisit the issue of data collection in emergency departments and consider alternative approaches to measuring performance such as using samples of the data gathered in clinical notes. This would also reduce the burdens on staff in an already high-pressure situation.**

Handover targets

60. Ms Rees told the Committee that '*it is the care that they give to the patients and what is happening to those patients that is most important to staff. They are not driven by the target in that sense; they will not see patients according to who has been waiting the longest and therefore might breach a target, but according to who is the sickest*.'[46]

61. This sentiment was reflected by many of the witnesses who gave evidence to the Committee's inquiry. Indeed, Ms Palmer told the Committee that '*In some respects, the 15 minute target for ambulances has taken away from patient focus*.'[47] She explained that '*deciding which patient should have the priority of care is a very difficult decision for any nurse to make.'*[48]

62. Mr Falcus stated that '*My only slight criticism of a 100 percent target is that, if you miss it by one patient, you have missed it, whereas with*

[44] Record of Proceedings AC(3)-08-09 [112]
[45] Record of Proceedings AC(3)-09-09 [59]
[46] Record of Proceedings AC(3)-09-09 [22-23]
[47] Record of Proceedings AC(3)-09-09 [13]
[48] Record of Proceedings AC(3)-09-09 [20]

the 95 percent target you can have clinically appropriate breaches and you do not make inappropriate clinical decisions around the target.'[49]

63. The Committee would be concerned to hear of any cases where the need to meet targets had been considered to be more important than clinical judgement of the patients needs. The targets for handover were intended to improve the patient experience and release paramedics quickly to enable them to respond to other 999 calls. However, the patient should be at the centre of the process, rather than the target.

64. Ms Rees stated that '*We tend not to talk about the targets, but more about the safety issues on the floor and what is best for the patient – the targets will take care of themselves if we do that properly.'*[50]

65. The prime focus of both ambulance crews and hospital staff is on what is best for the patient. In the case of handovers, it is best for the patient to be handed over swiftly and efficiently to hospital staff. This ensures that the patient in the hospital receives appropriate care and the patient in the community awaiting an ambulance response gets that response quickly. The main barriers to swift handovers are not attitudinal and cannot be overcome by setting targets. Barriers to swift handovers come in the form of capacity issues, patterns of accessing services and bed management across the whole of the NHS system.[51] **The Committee recommends that the Welsh Assembly Government relieves frontline staff of this focus on target compliance instead placing the responsibility with a named individual in both A&E Departments and elsewhere in the wider healthcare system. Staff must be supported to provide what is best for the patient based on clinical needs whilst managers prioritise the wider issues that create a barrier to swift handovers.**

Making best use of resources

66. Ms Gardiner told the Committee that '*There has been a long standing culture in which there has been an acceptance that patients can wait. That needs to change.*'[52] Although work is ongoing to ensure that patient flow is as efficient as possible, there are times when delays in emergency departments have been seen as inevitable. Patients do not arrive at emergency departments in a steady flow and there are times when an emergency department can experience high volumes of patients arriving at once. Those patients will experience delays not

[49] Record of Proceedings AC(3)-09-09 [93]
[50] Record of Proceedings AC(3)-09-09 [15]
[51] Auditor General for Wales, *Unscheduled Care: Patient handovers at hospital emergency departments*, April 2009, paragraph 22
[52] Record of Proceedings AC(3)-09-09 [103]

necessarily because of any fault in resource planning but because of the nature of unscheduled emergency care.

67. Hospitals have rapid escalation plans in place for such times. These are designed to enable hospitals to react to increasing pressures and minimise the effects of those pressures for the patient.

68. However, the Committee was surprised to hear that when a hospital is under such pressure and has declared itself as at 'red' status, and therefore at full capacity, ambulances still take patients to that hospital and suffer the inevitable wait. Tina Donnelly suggested that better partnership working in the management system might result in patients being taken elsewhere to a 'green' status hospital.[53]

69. Mr Murray cited a system of capacity management used in Surrey that was successful. **The Committee recommends that the Welsh Assembly Government explores the possibility of creating a clear and transparent capacity management system that directs emergency patients, when it is clinically safe to do so, to the hospital best placed to deal with that patient rather than to the closest hospital which may be at full capacity.**

Ambulance officers

70. As well as improving patient care, the handover target was intended to release ambulance crews from hospital as soon as possible to allow them to respond to other 999 calls. During periods of particular pressure, ambulance officers have been used in hospitals to receive patients from ambulance crews. The ambulance officer will receive patients from several ambulance crews at a time, releasing those crews to tend to other patients in the community. The ambulance officer will then give on-going care to the patients left in his or her care until such time as the handover to hospital staff can take place.

71. The Committee has several concerns relating to this practice. Patients handed over to ambulance officers will be made to await handover to hospital staff in corridors. This has serious ramifications for the privacy and dignity of the patient and also creates clinical risk. A two stage handover from the paramedic to the ambulance officer and then from the ambulance officer to hospital staff, creates an unwelcome opportunity for vital information to be lost. This could lead to serious errors in assessing the clinical needs of a patient.

72. Professor Woollard described paramedics in the hospital environment as '*fish out of water*.'[54] Their training prepares them to administer emergency care to people in the community and placing them in a

[53] Record of Proceedings AC(3)-08-09 [135]
[54] Record of Proceedings AC(3)-09-09 [86]

hospital setting to care for patients over a period of time puts pressure on the paramedics and does not deliver the best care for the patient.

73. The ambulance officers tasked with taking care of the patients is often a manager which creates further pressure on managerial capacity. As the Auditor General's report on patient handovers points out, 'while ambulance trust senior managers are working as additional operational resource at emergency departments, they cannot work on sustainable solutions across the whole system that might prevent unnecessary delays in the longer term.'[55]

74. Furthermore, the practice is harmful to the reputation of the hospital. As Ms Donnelly pointed out to the Committee '*a high proportion of the patients who are sitting and waiting in accident and emergency...wonder about the clinical care provided when they see patients, three abreast, in a hospital corridor waiting to be seen*.[56]

75. The Committee recognises that the practice of transferring care to an ambulance officer goes some way to relieving the pressures on the ambulance service during times of high pressure. However, it sees the practice as an unsatisfactory solution. The detrimental effect the practice has on the patient experience, the reputation of unscheduled care provision and the paramedics themselves should be motivator enough to find an alternative solution to this problem.

76. **Furthermore the Welsh Assembly Government needs to explain whether the handing over of patients to an ambulance officer is how they envisaged the handover target working or whether the expectation was that patients would be discharged into the care of the accident and emergency department's clinical team. Although the use of ambulance officers will free up ambulance crews to respond to other calls, patient care is at best no worse than that given by ambulance crews during delayed transfers of care. At worst, patients are being put at risk by this practice as one officer receives patients from several ambulance crews at a time.**

77. Recommendations elsewhere in this report should go some way to reducing the need for ambulance officers to be used in this way, but the Committee recognises that until sustainable improvements are made across the healthcare provision system, there could be times when an ambulance officer could ease the situation for ambulance crews. **The Committee therefore recommends that the Welsh Assembly Government ensures that all partners are working together to ensure that ambulance officers are given the best possible support when caring for patients in this manner.**

---

[55] Auditor General for Wales, *Unscheduled Care: Patient handovers at hospital emergency departments*, April 2009, paragraph 2.31

[56] Record of Proceedings AC(3)-08-09 [94]

Consideration should be given to creating an appropriate area in which paramedics caring for patients awaiting handover can easily access emergency equipment and oxygen. Further consideration should be given to providing nursing staff to such an area in times of predicted high demand. This would enable the hospital to liaise with the ambulance service more effectively and would provide for ongoing triage of patients in order to clinically prioritise their handovers.

Restocking

78. After the handover process has been completed, ambulance crews have 5 minutes allocated to clean and re-stock their ambulances. The Auditor General's report on patient handovers states that some crews felt the target was unrealistic and that 'where crews required replacement drugs, they are sometimes delayed in waiting for a nurse to become available who can open the emergency department's store of medication.'[57]

79. The Auditor General's report also states that crews are delayed by having to walk around the emergency department in search of replacement backboards, braces or bedding and in some cases will 'get back on the road without these pieces of equipment.'[58]

80. Ambulance crews should not have to attend calls without the equipment they need because of confusion over the location of supplies in the hospital departments. **The Committee recommends that each accident and emergency department creates a specific area for the storage of medication, bedding, protective clothing and other equipment vital to the ambulance crews in order to eliminate lengthy re-stocking delays. These areas should be fully accessible to ambulance crews so as not to divert hospital staff from patient care.**

Sharing best practice

81. Throughout the NHS in Wales and the UK, work is being undertaken to improve unscheduled care provision. While the Committee recognises that there may not be a 'one size fits all' solution to the challenges that exist, there will be lessons to be learnt from others successes and failures in this field.

[57] Auditor General for Wales, *Unscheduled Care: Patient handovers at hospital emergency departments*, April 2009, paragraph 2.36
[58] Auditor General for Wales, *Unscheduled Care: Patient handovers at hospital emergency departments*, April 2009, paragraph 2.36

82. The Committee was told that the emergency services collaborative was a very good way of sharing best practice but that it is no longer operating.[59] The Committee considers that in a time of such pressure and change, a national forum such as this in which to share best practice and learn from less successful endeavours is vital.

83. **The Committee recommends that the Welsh Assembly Government develops a national forum in which staff from all NHS trusts can share good practice and drive positive changes forward and learn from the experiences of others.**

Addressing geographical variations

84. In June 2008, the Auditor General's report stated that '*While performance has improved in each region since December 2006, performance has been falling consistently in the South East region since April 2007, while there has also been a drop in Central and West Wales. Since February 2007, there has been an upward trend in North wales, which already had the highest levels of compliance with the eight minute standard'*[60]

85. In March 2009, the Auditor General reported that '*significant regional variations* [in performance] *remain with particularly serious problems in some localities'* although figures for January 2009 showed that '*the variability in performance between the different localities reduced significantly with improved performance in all but two localities*.' [61]

86. On 18 June, Mr Falcus told the Committee that the Wrexham Maelor Hospital has '*a medical admissions unit and surgical admissions unit with around 40 beds.'*[62] Ms Gardener told the Committee that in the University Hospital of Wales in Cardiff there are '*about 26 trolleys in our surgical assessment unit and a further 22 in our medical assessment unit.'*[63] Considering that the size of the population served by each hospital differs vastly, it seems illogical that the departments are so similar in size. Indeed, the similarity in size of the two departments would suggest that an assessment of capacity needs across NHS Wales should be undertaken as a matter of priority.

87. Given the geographical and demographical differences between north, mid and south Wales, it is unsurprising that the challenges for provision of emergency care should differ between localities. However, the differing needs and challenges of all areas of Wales

[59] Record of Proceedings AC(3)-09-09 [131]
[60] Auditor General for Wales, *Follow up Review – Ambulance Services in Wales*, June 2008, paragraph 1.17
[61] Auditor General for Wales, *Ambulance Services in Wales – Further update to the National Assembly for Wales' Audit Committee,* March 2009, paragraphs 1.6 -1.7
[62] Record of Proceedings AC(3)-09-09 [44]
[63] Record of Proceedings AC(3)-09-09 [45]

need to be clearly understood in order to eliminate the postcode lottery associated with unscheduled care. The greater capacity issues associated with major tertiary city-centre hospitals are in danger of being seen as an excuse for poor performance in some regions. On June 18, Paul Williams told the Audit Committee that '*it may simply be that insufficient attention has been given to the fact that the design of the accident and emergency department needs to be radically overhauled.*'[64]

88. Mr Williams also told the Committee that '*the issue for me is whether the commissioners and the providers are ensuring that there is sufficient capacity and expertise within the accident and emergency departments to ensure swift handovers*.'[65]

89. **The Committee recommends that work is carried out to establish whether there is sufficient capacity at accident and emergency departments to ensure swift handovers. Urgent work should be carried out to ensure that, where possible, capacity in each hospital is appropriate to the population it serves.**

90. **The Committee recommends that business cases to re-design those emergency departments most in need of modernisation are given the full support of the Welsh Assembly Government and the Strategic Capital Investment Board.**

Staffing levels at emergency departments

91. Mr Falcus stated that '*Over the last few years, we have identified that physical capacity is not necessarily the key to this – it is also about the standard, competence and seniority of the decision makers and staff within your departments. The more senior staff that you have at the front door, the more you are able to turn around the demand that is coming through it'*[66]

92. Ms Gardner told the Committee that '*The Royal College of Emergency Physicians has recently created guidelines on the exact numbers of medical staff in the department and, unfortunately, we fall short.'*[67] While the Committee recognises that Wales is not immune to the staffing shortage affecting the UK, and notes the dependence on staff from other countries, it should be recognised that no amount of targets or incentives can make up for a lack of staff. Senior staff able to treat and discharge patients will relieve pressure on other areas of the emergency department in the same way that specialised paramedics who can discharge patients at the scene will help to free up capacity in the system.

[64] Record of Proceedings AC(3)-09-09 [242]
[65] Record of Proceedings AC(3)-09-09 [265]
[66] Record of Proceedings AC(3)-09-09 [44]
[67] Record of Proceedings AC(3)-09-09 [46]

93. **The Committee recommends that the Welsh Government works with the UK Government in order to tackle the staffing shortage and thereby improve capacity and performance in emergency departments.**

94. **Consideration should also be given to revising the staff structure in emergency departments to provide for a greater level of senior staff. These staff should be able to treat and discharge or refer patients independently, thus freeing up capacity elsewhere in the department.**

The staff experience

95. The Committee was told by Dave Galligan that *'everyone in the ambulance service...feels under pressure constantly and continually, no matter what their grade or rank'*[68] Professor Woollard felt that for ambulance staff, '*it's not an issue of low morale – it is an issue of poor mental health among many ambulance workers'*[69]

96. Concerns were expressed that bullying is '*becoming a bit cultural in some areas'*[70] of the ambulance service and that 'staff feel powerless'[71] when dealing with the pressures of delayed handovers. Providing emergency medical care to sometimes very sick patients is in itself a very difficult and stressful job. The additional stress placed on staff by bullying and applying pressure for staff to change what they are powerless to change is unacceptable.

97. Work is now underway in the Welsh Ambulance Services NHS Trust to implement new measures recommended by the NHS Centre for Equality and Human Rights. A staff charter is being developed which will make clear what the relationship between manager and staff should be and will set out the staff's rights and responsibilities. Staff were invited to have an input into designing that charter and Alan Murray told the Committee that they have had '*hundreds of responses from staff who wish to be engaged in the process*.'[72] It is encouraging that staff are so keen to be involved in the process which should go some way to stamping out bullying in the trust. However, the Committee remains disappointed that progress has not been swift in this area given that the bullying culture was recognised in the 2006 report by the Auditor General for Wales[73].

---

[68] Record of Proceedings AC(3)-08-09 [127]
[69] Record of Proceedings AC(3)-08-09 [53]
[70] Record of Proceedings AC(3)-08-09 [45]
[71] Record of Proceedings AC(3)-09-09 [19]
[72] Record of Proceedings AC(3)-09-09 [222]
[73] Auditor General for Wales, *Ambulance Services in Wales*, December 2006, paragraph 2.208

98. The fact that so many staff are keen to get involved with the development of the charter shows the level of support for change within the trust. The Committee finds it unacceptable that although a bullying culture was identified as early as 2006, the staff of the Welsh Ambulance Services NHS Trust are still experiencing problems. **The Committee recommends that the Welsh Ambulance Services NHS Trust drive forward the changes necessary to stamp out bullying in the trust and to ensure that hard working, dedicated staff have the support they need to deliver a first class service. The Committee further recommends that the Welsh Assembly Government provides an update to the Committee as soon as practicable on the results of the staff survey.**

WAST financial position

99. Funding for the Welsh Ambulance Services NHS Trust comes from the commissioning body, Health Commission Wales. The level of funding is based on what the service needs to provide the service and is reduced by the amount of efficiency savings it is required to make. Some efficiencies are made by streamlining processes, others are made by changing the way the service is provided. Discussions regarding the level of funding needed to deliver ambulance services in Wales have been ongoing between the Trust and the Health Commission but are yet to be resolved.

100. In addition to the funding it already received, the Trust estimated that it would need a further £9 million of funding in 2008-09 to enable it to adhere to new response time targets in force from April 2008. However, the Trust and Healthcare Commission Wales have been unable to reconcile their differing views on the level of additional funding required to meet the targets and so agreed that a benchmarking efficiency review should be independently carried out in order to inform future discussions. The review was due to report in mid-March[74] but is now expected to have reported by the end of June[75]. In the meantime, the ambulance service lacks clarity on its financial position.[76]

101. Dave Galligan told the Committee that the lack of clarity regarding the financial position of the trust had resulted in '*disbelief and incredulity among the staff*.'[77] The recent reduction in the number of frontline staff was a direct response to the need for efficiency savings, although funding has now been provided to bring staffing levels back up. It is unsurprising therefore, that staff are concerned by the financial situation of the trust.

[74] Auditor General for Wales, *Ambulance Services in Wales – Further update to the National Assembly for Wales' Audit Committee,* March 2009, paragraph 1.34
[75] Record of Proceedings AC(3)-09-09 [185]
[76] Record of Proceedings AC(3)-09-09 [183]
[77] Record of Proceedings AC(3)-09-09 [147]

102. The Committee welcomes the decision by the Welsh Ambulance Service NHS Trust and Health Commission Wales to be guided by an independent efficiency review. **The Committee asks the Welsh Assembly Government to provide an update to the Committee on the findings of that report and the resulting level of funding agreed by the Trust and commissioning body as soon as those decisions have been made.**

Re-organisation of the NHS

103. The forthcoming re-organisation of the NHS will provide an opportunity for very positive changes to be made across the whole of the care system. Paul Williams told the Committee that '*for the first time, I am seeing plans coming through that not only identify the need for investment in hospitals but are thinking fundamentally about the whole unscheduled care package and how it fits into general practice and community care.*'[78] The Committee is disappointed that despite the longstanding problems relating to emergency care provision, such issues are only now being considered.

104. Nonetheless, the Committee welcomes the Welsh Assembly Government's commitment to improving unscheduled care in the reorganised NHS. Changes already made in Cardiff and the Vale NHS Trust as a result of that commitment have resulted in a 50 percent reduction in handover delays. **The Committee looks to the Welsh Assembly Government to ensure that full support is given to sharing the good practice that has resulted in this improved performance.**

105. It is clear that unless issues regarding capacity, patterns of accessing services and bed management across the whole of the NHS system are addressed the unscheduled care system will continue to be placed under pressure to breaking point. It is essential for both the users and providers of the service that the systems currently in place are looked at creatively in order to enable staff to deliver the a first class service. **The Committee urges the Welsh Assembly Government to ensure that the opportunity to modernise unscheduled care during the forthcoming NHS re-organisation is fully realised and that NHS trusts are given the support they need to address the problems they face creatively and collectively.**

[78] Record of Proceedings AC(3)-09-09 [208]

Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Archwilio
The Audit Committee

Dydd Mercher, 21 Ionawr 2009
Wednesday, 21 January 2009

Cynnwys
Contents

Aelodau Cynulliad yn bresennol
Assembly Members in attendance

Lorraine Barrett	Llafur Labour
Eleanor Burnham	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Chris Franks	Plaid Cymru The Party of Wales
Janice Gregory	Llafur Labour
Lesley Griffiths	Llafur Labour
Irene James	Llafur Labour
Bethan Jenkins	Plaid Cymru The Party of Wales
Huw Lewis	Llafur Labour
David Melding	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives

Eraill yn bresennol
Others in attendance

Dr David Blaney	Cyfarwyddwr Datblygu Strategol, Cyngor Cyllido Addysg Uwch Cymru Director of Strategic Development, Higher Education Funding for Wales
Jeremy Colman	Archwilydd Cyffredinol Cymru Auditor General for Wales
Paul Dumblebee	Swyddfa Archwilio Cymru Wales Audit Office
Ian Gibson	Dirprwy Bennaeth, Uned Llywodraethu Corfforaethol, Llywodraeth Cynulliad Cymru Deputy Head, Corporate Governance Unit, Welsh Assembly Government
Yr Athro/Professor Phil Gummett	Prif Weithredwr, Cyngor Cyllido Addysg Uwch Cymru Chief Executive, Higher Education Funding Council for Wales
Dr Dennis Gunning	Cyfarwyddwr Dysgu Gydol Oes a Sgiliau, Adran Plant, Addysg, Dysgu Gydol Oes a Sgiliau, Llywodraeth Cynulliad Cymru Director for Lifelong Learning and Skills, Department for Children, Education, Lifelong. Learning and Skills, Welsh Assembly Government
Yr Athro/Professor David Hawker	Cyfarwyddwr, Adran Plant, Addysg, Dysgu Gydol Oes a Sgiliau, Llywodraeth Cynulliad Cymru Director, Department for Children, Education, Lifelong Learning and Skills, Welsh Assembly Government
Gill Lewis	Swyddfa Archwilio Cymru Wales Audit Office

James Verity	Swyddfa Archwilio Cymru Wales Audit Office

Swyddogion Gwasanaeth Seneddol y Cynulliad yn bresennol
Assembly Parliamentary Service officials in attendance

John Grimes	Clerc Clerk
Abigail Phillips	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 9.30 a.m.
The meeting began at 9.30 a.m.

Ymddiheuriadau a Dirprwyon
Apologies and Substitutions

[1] **David Melding:** Good morning everybody, and welcome to the meeting of the Audit Committee, the first of 2009. I wish everybody a happy new year and a productive one in terms of audit responsibilities.

[2] I will start with the usual housekeeping announcements. The proceedings will be conducted in English and Welsh. There is a slight change—when Welsh is spoken the translation is on channel 2. For the hard of hearing, the proceedings can be amplified via channel 0. Please switch off all electronic equipment. We do not anticipate a routine fire drill this morning. Should the alarm go off please follow the ushers' instructions to leave the building safely.

[3] There are no apologies or substitutions. Irene James may be delayed due to caring responsibilities that she has. I am confident we will see her later.

[4] I welcome Mike German to his first meeting of the Audit Committee. We look forward to your contributions Mike, and your participation in our work.

9.31 a.m.

Cydweithio Rhwng Sefydliadau Addysg Uwch
Collaboration Between HE Institutions

[5] **David Melding:** The Auditor General for Wales's report will be discussed, and it is an important topic. As well as being valuable in its own right, higher education is recognised as having a number of wider socio-economic benefits. However, the higher education sector in Wales is facing a number of challenges, including increased international competition.

[6] The Assembly Government have a clear policy of encouraging greater collaboration between universities in Wales and, in some cases, favours mergers. However, the powers of the Government and of the Higher Education Funding Council for Wales to direct universities are limited, given the constitutional independence of those institutions. These are some of the issues that we will be exploring this morning. We have a number of witnesses. It will be quicker if they introduce themselves formally now, starting with Professor David Hawker, who is one of the principal witnesses this morning.

[7] **Professor Hawker:** I am David Hawker, director of the Department for Children, Education, Lifelong Learning and Skills for the Welsh Assembly Government. I joined the department last August, so I am very much a new boy and enjoy working here. The topic that

we are discussing today is crucial to the future of Wales, not just for our education system, but for Wales as an economy.

[8] **Professor Gummett:** Good morning, I am Phil Gummett, chief executive of the Higher Education Funding Council for Wales. I have my colleague Dr David Blaney with me. Chairman, is it in order if my three colleagues sitting behind me slide forward a note from time to time, to ensure that I inform the Committee properly?

[9] **David Melding:** I am sure that you are properly briefed, but unless I see something disruptive I am unlikely to comment on it.

[10] **Professor Gummett:** Thank you.

[11] **Dr Blaney:** I am David Blaney, director of strategic development at the Higher Education Funding Council for Wales.

[12] **Dr Gunning:** I am Dennis Gunning, I am director of skills, higher education and lifelong learning within David Hawker's department.

[13] **David Melding:** Welcome, gentlemen. Some of you are well acquainted with the operations of this Committee and the way we work. We have agreed a range of questions that cover the various issues, and establish or build on the evidence within this report. We can then issue our own findings. We will work around the Members, and I may ask someone to come in with supplementaries. Some of the questions are to all the principal witnesses, some are to one or the other. If you attract my eye and have something that adds to the evidence, I will bring you in as necessary.

[14] I will start with my general question. Please do not drill into too much detail, as that will be done as the session progresses. Professors Hawker and Gummett, can you state your general reaction to the auditor general's report?

[15] **Professor Hawker:** First of all, we welcome this report. It gives us a balanced view of how the reconfiguration collaboration fund has operated—its successes, some of the barriers and problems that it has encountered, and some helpful suggestions for the way forward. What we need to bear in mind are the remarks that the Chair made earlier. Higher education institutions are autonomous. Neither the Welsh Assembly Government nor HEFCW can direct autonomous institutions to do what they do not want to do. What we can do is explain policy direction to them, and use funding levers to try to ensure that, where we do have an influence, it supports the direction in which policy needs to go.

[16] The process of investing through the fund was very much a process of dialogue between institutions and groups of institutions to try to look at how they can collaborate more effectively together, academically, in research and in administration. The report clearly bears out our own view that there have been some successes but that, equally, there have been some issues. Those are largely down to a number of things concerning institutional autonomy and, in some cases, relationships, vision and purpose. One of the conclusions in the report about the need to look at wider levers to effect change is a valid point, as is the issue of clarity and transparency. I will leave it there for the time being and invite your questions.

[17] **Professor Gummett:** We welcome the report. It is an important area, one that we take seriously, and it occupies a lot of our time in the funding council. It is pleasing to see a number of positive comments in it. It is salutary to see a number of more critical comments. It is important to recall why this fund was established in the first place, as David Hawker has reminded us. It is not because collaboration is thought to be good in itself; it is thought to be an important means to the end of improving the performance of the higher education sector.

That is the goal toward which we are striving. I believe that we have made progress in that direction, and I look forward to supporting that proposition in the detailed questioning. I accept that there is more to do, as indicated, and we have already begun to act in light of the report. I will be happy to elaborate as we proceed.

[18] **David Melding:** Thank you for your introductory remarks.

[19] **Janice Gregory:** Good morning. In my question, I will refer to paragraph 1.3, and then move on to paragraph 1.4 to 1.22. Paragraph 1.3 states that £38.5 million had been dispersed from the fund by the end of March last year. Paragraphs 1.4 and 1.22 set out the benefits accrued from the merger and collaborative projects supported by the fund. Professors Hawker and Gummett, do you think that the fund has delivered value for money, and could more have been achieved?

[20] **Professor Hawker:** Thank you for the question. It is always a difficult one to answer when you ask whether a particular investment has given value for money. Sometimes the benefits of that investment are not immediately apparent from the outcomes of the work. Looking at what it has done, certainly the three substantial mergers that have been achieved would not have been achieved without that investment. The support that HEFCW was able to give through the fund was absolutely crucial. Those three mergers are all important steps forward for the higher education system as a whole in Wales. The other collaborations that have produced a benefit need to go further, and will produce further benefit in the future. The point about the investment is that it has triggered a new way of thinking, in institutions working together. It is a slightly difficult question to answer from that point of view, but I think that the answer is positive in terms of how it has got the sector moving.

9.40 a.m.

[21] **Professor Gummett:** Similarly, judging value for money on a matter where the benefits will come over a lengthy period of time depends on the point at which you stop the clock and have a look. It is reasonable to say already that where we have done one significant evaluation—on one of the oldest of those processes, although only four and a bit years, namely the merger of Cardiff University and the University of Wales College of Medicine—the outcome of the independent evaluation was extremely positive. It showed that much of the targets were passed or surpassed.

[22] If you look at the overall record since the fund began to operate, we have now had three mergers. That includes the HE/FE one between the University of Glamorgan and Merthyr Tydfil College of Further Education. We have got significant activity in south-west Wales, referred to, that is possibly unique—I do not know of anything like that anywhere else in the UK. We have had a quite modest rationalisation of subjects in the Swansea area as well as between Swansea and Cardiff. We have had a fairly significant amount of research collaboration—that is probably where most of the activity has taken place, other than the mergers. There has been some Wales-wide activity, such as on Welsh-medium provision and pay modernisation.

[23] In terms of value for money, interestingly, yesterday I was at a meeting with the chief executive of the Medical Research Council. We were discussing the future of medical research in Wales and what can be done to improve it. The theme of the meeting was collaboration, and how we can achieve a greater capture of grant funding from the Medical Research Council by encouraging more collaboration between the main players in medical research in Wales. He spoke in relation to the recently published results of the periodic review of research—what we call the research assessment exercise, which takes place every so often and is a major review, subject by subject, in all universities. One point that he made, quite unsolicited, was that people in the Medical Research Council and in the London universities

who regard themselves as dominant in the field of neuroscience had noted the performance of Cardiff and other Welsh universities. He said that people at University College London 'gasped', since they regard themselves as absolutely the top dogs in that area.

[24] In terms of your question, that is an area in which we invested a few years ago, by bringing together Cardiff, Bangor and Swansea universities in a Welsh Institute of Cognitive Neuroscience. It is always hard to prove cause and effect with such matters, but it was, nevertheless, encouraging to hear that statement about the dominance of Wales in that field, contrary to the expectations of many others.

[25] **Darren Millar:** One of the issues raised in the report is that the fund was established, in part, to deliver significant administrative efficiencies through collaborative working. Paragraph 1.27 says that the only project that has been designed specifically to deliver administrative efficiencies was the south-west Wales higher education partnership project. Despite that, there have been some efficiency savings through some of the other projects. That can be seen in other paragraphs.

[26] Professor Gummett, given that that was one of the specific issues flagged up to be looked for as an outcome through the fund, and one of the main reasons why it was established, why have you not done more to look for opportunities and to encourage applications to the fund for this specific sort of efficiency saving?

[27] **Professor Gummett:** I can see absolutely why the report says what it says and is phrased as it is. Other than one or two very small things, it is indeed the case that, under this fund, this is the only significant project taken forward where the headline statement explains that its purpose is to secure administrative savings. However, embedded within other projects, there is a great deal more aimed at securing administrative savings; it is just that people are not shouting about it and selling it in those terms. One reason for that is that using administrative savings to sell a new approach is not necessarily the most successful way of getting academic communities to rally around it.

[28] To take an example of a recently secured restructuring, what we are calling 'a strategic alliance' has taken place between the Royal Welsh College of Music and Drama and the University of Glamorgan. Again yesterday, in a conversation with the principal of the college, we were hearing about the state of play with their exciting plans for capital development on North road, where a new concert hall and other facilities will be built. We have been clear for some time that the college was in a difficult competitive position, because many conservatoires across the UK were re-equipping in all sorts of ways and ours was not, and that is a significant issue when it comes to attracting students. When considering how to help to move this forward, we faced an essentially administrative problem—and I would say that it related to administrative capacity rather than administrative savings.

[29] With a very small-scale higher education institution—and in saying that, I mean no disrespect to anyone involved—it is a bit like rebuilding a school or major capital development within one, in that it happens only once in a blue moon. It is therefore not surprising if the authorities in the school do not have a lot of experience of doing that. What we have been looking for is a way of placing a much stronger administrative arm around that college, so what is now being taken forward is very manageable indeed. For Glamorgan university, what we are talking about is not difficult.

[30] We now have a position in which the administration of the college is, essentially, in the hands of a much larger operating unit and administrative cash savings will come from that. However, I would contend that the more important thing is that it is now possible to significantly improve performance by being able to take forward a very important project with real safety, which we would previously have been unable to do.

[31] I could go on. If you look at Glamorgan university and Merthyr Tydfil College, which was a college that was not without its difficulties, you see that they are now running on a very different basis. I could say that what is going on between Lampeter and Trinity College, Carmarthen is similar, because it is significantly driven by the need to address very important administrative issues.

[32] I am sorry that this is a slightly lengthy answer, but the other thing that I would say, which takes me back to my starting point, is that selling significant change using the message that it will bring administrative savings is not an easy way to mobilise the troops in a higher education context.

[33] There are a lot of other things going on that are addressing administrative savings, so the question of which is the best way to address them and which channels are the most appropriate becomes a live one. For example, in Wales, we have the Wales International Consortium, which does a great deal of collective work on international student recruitment. Previously, that was not the case; it was done individually by institutions, and not as well as it needed to be. Separately from this fund, we have brought the institutions together and, for several years, we and they have co-funded a unit that does a lot of the preparatory work and marketing. Although cause and effect are hard to prove, the evidence suggests that international recruitment has gone up dramatically since that group was in place.

9.50 a.m.

[34] There is also the Welsh Higher Education Brussels office. Again, instead of each institution going in individually, we have an organisation that does it on behalf of the whole sector. We do a lot UK wide to seek administrative savings, and so it is not through collaboration solely within Wales. The student recruitment process or the IT infrastructure—a massive operation—is done on a UK-wide basis, with significant savings made in comparison with doing this individually. I could say more.

[35] **David Melding:** I suspect that the Member wants to say more, so I will give him the opportunity to do so.

[36] **Darren Millar:** I am afraid that you seem to be quite complacent about this and yet, as the report indicates, there may be significant opportunities to make savings on the back-office functions. I appreciate that, within other projects, savings are coming forward, and the report contains examples of those, but, given that this is a low-hanging fruit for some of the institutions to grasp at, should you not be doing a better job to try to sell this? I appreciate that you are saying that this is not a sales pitch, but, while that might be easy for some academics to grasp, I find it astonishing. It seems straightforward—merge some back-office functions, make some savings, and invest them in education and learning. Why can they not grasp that, and why are you not doing a better job of selling it?

[37] **Professor Gummett:** I hope I do not appear complacent, as I certainly do not feel complacent. My response would be that the fruit hangs lower in certain areas. It is easier to mobilise the troops if you say, ‘We will improve our research performance by working together with others, and, by the way, we will make some administrative savings while we are doing that’, than if you say to them, ‘We are having a wholesale campaign to reduce our administrative costs’. That is just how it is. People will be more excited about the possibility of improving their research performance or their delivery of teaching than they will be about being told to make administrative savings. We will get there; the only question is which route we take.

[38] **Darren Millar:** I would simply suggest that, if savings are being made, it will be

possible to invest them back into research facilities anyway. It would seem to me that you can still sell that message on the back of back-office function and administrative savings. However, I think that you have made your point.

[39] **David Melding:** I would say from the chair that you did give a long answer to the initial question, but a lot of the examples that you cited were not related to the fund. They were about the culture of HE rather than the actual use of this fund to encourage that sort of collaboration.

[40] **Professor Gummett:** I agree that they were not. The point that I was trying to make was that there are other ways to skin this cat. Given that this fund is limited, we have to prioritise. We have many more proposals than we can afford to take forward, so the question will always be which are the most cost-effective and appropriate in raising performance. That is the main point.

[41] If you look in detail at our criteria—and let us take for example a research collaboration—you will see that we ask about administrative savings. It is an explicit element of the proposal. We will be asking them how they intend to save money and what they will do as a result of that saving. It is in the process, but we are coming at it from a different direction. We are also doing a lot of other things about administrative savings, although I will not give you further examples. The question relates to the balance of priorities within the overall portfolio.

[42] **David Melding:** Right, we will move on.

[43] **Lorraine Barrett:** Thank you very much. This is a question to Professor Hawker. Paragraphs 1.29 and 1.30 suggest that the fund can only be used to support projects in collaboration within the HE sector, despite the potential benefits of higher education institutions collaborating with bodies from other sectors. I am thinking particularly about the Assembly Government's 'Making the Connections' commitment here. Could you say something about why support from the fund was limited to collaboration between HE institutions rather than looking at other opportunities, as suggested in paragraph 1.30? This relates particularly to the merger of the University of Wales, Newport's libraries with those of the city of Newport, and the merger of various NHS bodies with other HE institutions.

[44] **Professor Hawker:** Yes, this is very much the flavour not just of the month but of the year. We are definitely moving closer to cross-sectoral and cross-regional collaboration, which brings together the benefits of a number of different areas of work into a whole. This has been growing and, when the fund was first initiated, that message was probably not as strong as it is now. You are right to pick up on it, and we are looking to broaden the scope of the criteria for the use of future funds of this nature so that we target exactly that. It is valid in relation to where it comes from.

[45] It demonstrates an evolution in thinking, not just within the educational sector but across a number of areas of public service. We know that the benefits of cross-sectoral collaboration far outweigh the institutional silo mentality that has characterised things in the past. I welcome this as a development and a step in the right direction, but you are right that that needs to be made more explicit in the criteria than it was in the first place, perhaps. I wonder whether my colleague, Dennis Gunning, would like to say something about the transformation programme, launched at the end of last year for the post-16 sector as a whole, which touches on higher education.

[46] **David Melding:** The point on the criteria was quite interesting. Let us focus on that.

[47] **Lorraine Barrett:** Yes, I was going to ask whether you would be amending the

criteria and whether you will make it clear to HE that you have done so and are allowing this.

[48] **Dr Gunning:** I might touch on that, Chair. I have a meeting next week with the council of the Higher Education Funding Council for Wales, at which we will discuss the transformation agenda.

[49] **David Melding:** This is the subject of another question, so let us stick to the criteria for cross-sectoral approaches.

[50] **Dr Gunning:** The other point worth mentioning is that collaboration is emerging between FE and higher education institutions particularly, and we encourage that. There are discussions around the proposed university for the Heads of the Valleys, relating to structural collaboration. Changes taking place that you will have heard about involve the Welsh College of Horticulture, as its assets are being transferred to Deeside College and Glyndŵr University. That is again, structural.

[51] There are also large numbers of collaborative arrangements at a curriculum level. The University of Glamorgan works very closely with a whole range of FE colleges on curriculum development. A further example would be Airbus UK's collaboration with Deeside College and Glyndŵr University, which provide very high-level training for Airbus. The climate has moved on since we set up the criteria, and these things now happen as a matter of course, so it is appropriate that we now review them.

[52] **Michael German:** May I move onto the next section and look at an area in which the collaboration fund has not achieved the objectives that you set? While I am aware of the background covered in the report, the back end of paragraph 1.33 contains some implicit criticism that the fund was not perhaps best used to achieve the objectives originally set. I am not certain whether the new strategic collaboration board receives funding from this fund or whether it comes from the internal pot of the Welsh Assembly Government, but I wonder whether Professor Hawker could tell us what the current state of play is. What are the strategic collaboration board's objectives, what will it seek to achieve, and what progress has been made?

[53] **Professor Hawker:** I will field that one to Dennis.

[54] **Dr Gunning:** You are absolutely right. This is an example of the use of the fund not achieving the objectives that we would have liked it to. It is also a good example—and the report picks this up—of the balance between strategic collaboration for Wales as a whole and the interests of individual institutions. It is a difficult balance to strike.

[55] As far as the current position is concerned, you will be aware that we set up a new board recently to return to the issue and see whether we could make progress. We appointed Professor Deian Hopkin, the vice-chancellor of London South Bank University, to chair that board. The board is made up of the vice-chancellors of the three institutions and representation from the department, with Deian Hopkin in the chair. A number of proposals for collaboration are now being discussed by the councils of the three universities, particularly a proposal on shared services, which takes us back to the administrative issues that were mentioned earlier, a proposal on collaboration on the university of the Heads of the Valleys, which is something that has already happened, but we are encouraging further collaboration on what is described as a social learning space, which is about sharing facilities—particularly access for students to IT—and collaboration on a campus in Barry.

10.00 a.m.

[56] So, there are specific proposals that have come from that board that are now being

developed and discussed by the councils. We have not funded those, in that they remain proposals, although we have funded the board for their meetings. If there are proposals that emerge from that discussion that need lubrication funding, if I can call it that, we would be very interested to look at that. What we are looking for now from the institutions is a business case for each of those proposals.

[57] **Michael German:** There is some interest here in the methodology that you have used to trigger and develop collaboration. The fund did not work, it was probably too directive, too centralist, and now you are looking at something more organic. You have excluded HEFCW from that board—perhaps you will explain why—and now you have returned to what Professor Gummett was just talking about, namely development that has come from the institutions themselves. Would that have been a better model to have followed in the first place and why have you excluded HEFCW?

[58] **Dr Gunning:** It might well have been. In a sense, it is a case of being wise after the event, but having reviewed the situation in south-east Wales, though we are very conscious of the fact that the first round did not achieve much progress, we felt it was worth another go. It is one of the most pressing areas for progress and an obvious one to tackle.

[59] As for membership of the board, we discussed this internally and felt that a very small board, comprising largely of vice-chancellors of the institutions, would recognise the need for progress and come up with suggestions on how to make progress. So, we kept it effectively as a vice-chancellors board, but with Deian Hopkin, a very well recognised vice-chancellor, as a neutral chair. You are right, it is an alternative approach and, who knows, if we had had other examples where the fund was not a sufficient incentive, we would have had to try other ways to make progress.

[60] **Michael German:** Presumably you would choose the fund if you find progress being made in this way.

[61] **Dr Gunning:** That is possible. Equally, there are things that we might fund ourselves from the Department for Children, Education, Lifelong Learning and Skills. We will discuss that with Phil and come to the best conclusion as to how to fund them.

[62] **Professor Gummett:** On the exclusion of HEFCW—picking up directly from Dennis—to the extent that what emerges from this initiative is proposals to the reconfiguration and collaboration fund, we will be having to act upon those according to our normal processes. Therefore, it is arguably better that we are not part of this developmental process, because if we were, we would be making judgments on proposals to which we were party.

[63] **Michael German:** Let us move to the next section of this report, which deals with the merger between Lampeter and Trinity College. This is a different approach, it has resulted in collaboration at a high level, but will result in a development that is still the smallest in Wales. Is small a problem, or can you live with small?

[64] **Professor Hawker:** We can live with small if small is also efficient and provides value for money. There is nothing against small per se, but there is obviously an issue of critical mass and of maintaining and retaining quality. There is also the issue that Phil referred to earlier of the capacity to carry out large, strategic investment programmes and so on. It is not that small is necessarily wrong, but you need to recognise that with small size comes all those issues. You have to be credible in the way you deal with those issues.

[65] What we do not want is for the Welsh HE sector as a whole to go backwards in relation to international competition because it is based on a lot of very small units. If those

small units can collaborate effectively, and if they are high-quality units in their own right, they have a strong future. We also have to look, in the context of south-west Wales, at what Lampeter and Trinity have to offer and whether that offer makes sense in its own terms, as a self-standing institution independent of anything else. Clearly, the picture may change and there needs to be ongoing collaboration with the other HEIs in that area and indeed other HEIs across Wales that offer similar things—especially Welsh-medium higher education, which is a particular issue—and we need to look at those ongoing collaborations. On institutional autonomy, small does not necessarily mean bad. We need to look critically at the ability of those institutions to thrive.

[66] **Michael German:** Does HEFCW have the same view?

[67] **Professor Gummett:** Yes. This is a subject we are giving a lot of attention to at the moment, not least because of the responsibility we took upon ourselves to provoke the situation we now find ourselves in. Having become concerned with the situation at Lampeter, having agreed with the university that we would send in consultants to look at strategy and management, having had the conclusions from that and then having seen the governing body at Lampeter take some very rapid decisions about its senior management and then move into discussion with Trinity College Carmarthen, where we now have a very active discussion under way about the feasibility of merger, it is something that is very much at the front of our minds.

[68] It would still be a very small institution, you are right, but it is a step forward; we are moving in the right direction. It would not be the smallest in the UK, by any means, it would be a similar size to Winchester, Chichester and York St John—these are thriving institutions in England of a similar scale to what a combined Lampeter/Trinity College would be. Nobody is raising any questions that I am aware of about the viability of those institutions. So, if well managed and all the things David said, it should be okay. The other thing that we are saying to both Lampeter and Trinity, recognising that it will still be a very small institution, is that we want to see proposals that show how that new university would operate within the framework of the south-west Wales partnership.

[69] **Lesley Griffiths:** I will refer specifically to Glyndŵr University. As the report states, it has not entered into collaboration or merger with any other HE institution and has not been able to engage in any of the projects supported by the fund. Some have suggested that, because of its geographical position, it could collaborate with an institution over the border in England. How realistic do you think that is, given that we are a devolved nation?

[70] **Dr Gunning:** I pay tribute to Glyndŵr, because, from the position that it was in a few years ago to where it is now is a real sea change; the vice-chancellor, Mike Scott, has made significant progress on a number of fronts and it is now in a position where, with university status and a collaborative spirit, it has the possibility to be free-standing. We would have no problem with cross-border collaboration—we welcome that—and there are examples elsewhere of that happening, but we would have to say that Glyndŵr would want to be sure that it is self-standing in Wales as well and that collaboration is about enhancement, not about survival.

[71] One way forward that we are encouraging it with is in the context of the Welsh College of Horticulture, where it is one of the partners with Deeside College. It is interesting because that gives it access to the discussion between the four FE colleges in north-east Wales under the transformation agenda. We have the possibility of four high-quality colleges strongly connected to the local university and, given that that university has a strong mission towards vocational and applied higher education, there really is an exciting prospect there for north-east Wales. Not only is there a very vibrant and carefully linked strategic vocational mission, but also, geographically, a very powerful entity. The example that I gave earlier of

Deeside and Glyndŵr linking with Airbus UK, one of the biggest employers in Wales, gives them a very exciting future.

[72] **Lesley Griffiths:** Leading on from that, do you think it is capable of standing alone? The link with Airbus UK is one reason it might be able to survive so well.

10.10 a.m.

[73] **Dr Gunning:** It is strongly linked to the last question—with the transformation agenda, we are trying to discourage higher and further education institutions from seeing themselves as being in a little box of their own. There is a strong case for small institutions, FE or HE, if they are going to be small, to be very well connected. That means connected to employers, to further education and to schools so that there is a sense of a local size beyond the university itself and it will create a catchment area for the university. The university will still want to attract students from across the UK and internationally, but having a strong home area is crucial for a university like Glyndŵr, and it is approaching that position. For Wrexham, being a university town will be a very satisfactory outcome.

[74] **Professor Gummett:** May I start by endorsing what Dennis said about the achievements at Glyndŵr? Now that it has a university title, it is in a much stronger competitive position than previously. One of the worries was over the title of the institute. The title was fine when it was established, but it has become increasingly surrounded by English institutions—Mike Scott once told me he has 12 English HE institutions closer than his nearest Welsh neighbour. It is in probably the toughest competitive environment, geographically, of any higher education institution in Wales. Having university title is very important because it puts it on the same footing, in status terms, as the University of Chester, which again was not a university until relatively recently.

[75] Going forward from that position, if the issue of cross-border collaboration arises, the position is reasonably straightforward. We have had discussions with the Higher Education Funding Council for England and have talked this through in relation to another case where there has been dialogue between two universities, one on each side of the border. We are very clear that we see no structural impediments. We have legislative requirements to abide by, but those do not present barriers. We can only fund higher education activity in Wales and the English council can only fund higher education activity in England, but we can each fund our own institution in a collaborative arrangement so that the funding is properly applied within the legal frameworks within which we operate. If, in so doing, the whole is greater than the sum of the parts, fine—we see no structural impediment to working across the border.

[76] I might add that there is now a range of cross-border activities—not involving us, interestingly—but some universities, particularly Cardiff and Swansea, latterly, have announced two or three collaborative activities with universities in Bristol, Bath and Exeter in particular. Those are drawing upon various forms of UK funding and have encountered no particular problems. The key things are good, sound ideas and a demonstration of the benefit that will come from the investment that could be made.

[77] **Lesley Griffiths:** How viable do you think it could be as a stand-alone university?

[78] **Professor Gummett:** It is tough and it is going to get tougher, because of that very competitive environment. However, it has survived a long time in that competitive environment without university title and if it is well managed and stays nimble and agile, it is better placed than it was. It will continue to need nimble, agile, skilful leadership in order to survive, but that is true of other institutions as well.

[79] **David Melding:** May I just clarify one point? I infer that you are saying that

institutions across the border could not merge—that would not be an appropriate model—but that they could do anything else. They could share back-office functions—administration, recruitment, payroll, even teaching and research—but there would still have to be some institutional identity at, let us say, Wrexham. How far could it go if it really worked?

[80] **Professor Gummett:** It would be an interesting challenge, would be the short, but also quite serious, answer to that question. The prospect has not arisen, so I freely concede that it is not something to which we have given serious thought. We have been giving serious thought, however, to the prospect of a very substantial integration of elements, rather like in some of our research collaborations within Wales, but across the border instead. We do not see any problem with that.

[81] On one level, I think that it would be possible to have a cross-border institution. We would have to think carefully about how we manage accountability, about the flows of funding from the Welsh Assembly Government and from the Department for Innovation, Universities and Skills in London. With ingenuity and care, I do not see why we could not manage that.

[82] **David Melding:** Dr Gunning has been indicating that he wishes to come in.

[83] **Dr Gunning:** It was on an entirely different point, on Glyndŵr University.

[84] **David Melding:** In that case, I will bring you back, but we will first move to Dr Blaney.

[85] **Dr Blaney:** The key to this is to secure good-quality provision for north-east Wales, and the institutional structures that underpin that is a separate issue, although closely related. The key, however, is to get good provision for the communities of north-east Wales, as for the rest of Wales. If that gives us difficult structural challenges, we are all for trying to address those.

[86] **David Melding:** Those were tentative but quite helpful answers. Let us return to Dr Gunning.

[87] **Dr Gunning:** I was going to say, building on my earlier comment about connectedness, that Glyndŵr University is also connected through the University of Wales network and so, given the changes in that network, I imagine that Glyndŵr will play an important and growing role in the University of Wales. We look forward to its being very active there.

[88] **Chris Franks:** I now move on to part 2 of the WAO report. I refer specifically to paragraph 2.7, where there is significant criticism of the assessment criteria, which came from three post-1992 institutions. Has the Higher Education Funding Council for Wales been applying different criteria to applications to the fund by rejecting applications that do not fit with the Government's view that the three institutions should be merged?

[89] **Professor Gummett:** On the contrary. The reservations that appear to have been expressed by the institutions, as reported here, arise precisely because we have been applying the Assembly Government's policy, not because we have not. I would maintain that we have been applying consistent criteria—within the limits of human judgment. We have a panel and a process, and we work extremely hard to try to be consistent. We have an independent member who has no vested interest in anything in Wales to help us, and we take independent advice and so on.

[90] In respect of the three in south-east Wales, there is a particular dimension to this.

Following the attempts at merger between the University of Glamorgan and the University of Wales Institute, Cardiff and the ending of that process in 2003, as you will see in summary in the report, we conducted an audit review of what happened. We then commissioned work by Professors Bull and Cooke to look at the prospects for south-east Wales, and they made various recommendations. In the context of the discussions after that report was published, there was a clear statement from the First Minister that he expected the three institutions in south-east Wales, by which he meant Glamorgan, UWIC and the University of Wales, Newport, to plan their futures together. I think that I have it verbatim and I could send it on for the record, if you wish. Therefore, whenever we have had proposals from any of those three subsequent to that point, we have always asked how they satisfy the requirement that they plan their futures together.

[91] This is why I say that we have been applying Assembly Government policy. It is arguable whether that is adding further tests to those institutions that do not apply to others. I can see why they might say that. That point apart, we have been applying exactly the same criteria to them as we have to everybody else.

[92] **Chris Franks:** So, why has it not happened?

[93] **Professor Gummett:** Why has what not happened?

[94] **Chris Franks:** Why have they not merged?

[95] **Professor Gummett:** With respect, that is a different question.

[96] **David Melding:** That is slightly subjective.

[97] **Professor Gummett:** We have been applying the criteria to the proposals, and the point that has been made in paragraph 2.8 was that we have been criticised for applying different criteria. We are saying ‘No, we are not’.

[98] **David Melding:** I think that you have said that you are applying different criteria.

[99] **Professor Gummett:** In that one regard.

[100] **David Melding:** It was a very clear answer**.** Do you want to pursue that point with Professor Hawker?

[101] **Chris Franks:** Yes, please. Is the Assembly Government still totally committed to the tripartite merger?

[102] **Professor Hawker:** Between the three institutions, do you mean?

[103] **Chris Franks:** Yes. For the sake of clarity, I am talking about Glamorgan, UWIC and Newport.

[104] **Professor Hawker:** When this process began, that is how the Assembly Government saw it: it wanted to see a merger of the three institutions. Clearly, that was not going to happen, for a number of reasons. The board that has now been set up is to ensure that, short of institutional merger, which can be done only by the individual boards agreeing to it, the three post-1992 institutions in south-east Wales will work very closely together in collaboration on academic work, research and regeneration activity as well as on administrative support. That is the thrust of the policy at the moment. If they subsequently came back to us and say, ‘Yes, we would like to bring about a merger’, we would be happy to look at that further, because that is where we started from. It is not, however, the Assembly Government’s position to

instruct autonomous institutions to merge. We can persuade and discuss and look at the issues with them. We can encourage them to work very closely in collaboration, and we can have all those discussions about critical mass and mission and so on, which are essential, but we cannot tell them to merge.

[105] **Chris Franks:** No, I understand that. Can I tackle the question of money? Presumably, the Assembly Government is a substantial funder. There is a phrase, 'He who pays the piper plays the tune', so why is the Assembly Government not being more assertive?

[106] **Professor Hawker:** The Assembly Government can use its funding to support closer joint working on projects that take Wales forward. It is treading a fine line between something that is philosophically and mission-based to something that requires a particular institutional solution. We have to be very careful not to cross a line that impinges on the proper decision-making of properly constituted governing bodies. Having said that, yes, we have funding that we want to apply to help them to move towards much closer collaboration. I think, however, that that is as far as we can go in policy terms; otherwise I suspect we would be stepping over a line that we should not be stepping over.

10.20 a.m.

[107] **Chris Franks:** Okay. Is there an element of the institutions protecting their turf? Is there an element of their putting their interests above those of the students?

[108] **Professor Hawker:** That is a difficult question to answer. There is always a temptation in any organisation to close in and protect what you have. The whole thrust of our policy is to make them open up, work collaboratively and realise that the threats are more real if they close up than if they open out—in all sorts of ways. We are having that discussion, but we are working with people who occasionally feel threatened, and we need to work through that.

[109] **Darren Millar:** This question is directed at Professor Gummett. An issue with any bid that comes forward to the fund is that it takes time, resources and a great deal of effort from the institutions involved to prepare their applications for submission. One issue that the auditor general has, rightly, picked up on is that lots of the institutions are suggesting that there is very little feedback on what constitutes a successful bid and why certain bids are rejected. They say that there is insufficient communication when a bid has been successful about the components that made it successful, and there are all sorts of problems communicating back to the institutions some of the lessons learned where a bid has been implemented and is now in the operational phase. Do you recognise that that is a problem that needs to be addressed? If so, what are you doing to address it so that, in the future, we do not find that a great deal of time, resource and effort has been lost?

[110] **Professor Gummett:** I recognise that we can do better to explain what has happened and what we require. The report is quite positive about the explanations that we give about what we require. There are some very positive statements about the preparatory phases. The comments were more about what happens after decisions have been made. I accept that we can do a better job there. As for extracting lessons and so forth, we have built a programme of evaluation into all these projects. So far, that applies only to two—a plant has to have a little time to grow before you can pull it up and look at its roots. We have done two so far and, when we have published the results of more of those, it will then be appropriate to look at the general lessons emerging from them. With only two so far, however, and with very different characters, it is too early to do that.

[111] We give a lot of advice about what we require and the report is reasonably positive about that. The concerns are about clarity over the complete list of what has been funded. I

accept that, until recently, that has not been easily available. It has all been public information, but I agree that it has not been easily available in one place, so you could not easily go to one place and ask to see a list of everything. It is now available on our website. We have already acted in response to the concerns expressed in the report. We have looked at the material on our website in light of information about what has and has not been funded, and also to give clarity about what we are looking for in a good proposal and the indicators of a poor proposal. We have gone to some trouble to lay this out. As an illustration, we have a table on our website that specifies the criteria—they have always been in the public domain, as we have had public circulars out. All the institutions have them and they have always been on our website in an identifiable location. As well as these criteria stated in formal terms, we have now published a list of things that we would find reinforcing and positive and a list of things that we would find negative and undermining. For example, under the list of what is undermining, we say:

[112] 'A bid for funding with no real sense of strategic priority to all partner institutions'.

[113] In other words, some seem rather more committed to this than others, and it is not very compelling if we see that. Another is:

[114] 'No real sense that proposal will deliver greater benefits than partners operating individually, as a limited partnership or as a loose network'.

[115] That has been a characteristic of a number of the proposals that we have either rejected absolutely or sent back, with the invitation to come back to us, if they want to, having done further work. The further work, however, would need to satisfy us in respect of that particular point, namely that what would be achieved by it is more than could be achieved by getting on with working together in a loose partnership without any further action or funding from us. Quite a number have been like that, and we have said that we are not sure what the value added is from it, which is why we are not prepared to take it forward. We have not necessarily rejected it, but we have said to them, 'If you want to, come back,' but, very often, they do not.

[116] **Darren Millar:** The auditor general mentions the fact that you make available the broad criteria and you encourage people to make applications, but suggests that there may not be specific examples of the sorts of projects that might make successful bids, and that perhaps that is why there was an issue of clarity with some of the institutions that provided evidence to the auditor general. You say that you have taken action and that you have improved your website, for example. Are you now finding that you are receiving better-quality applications, or are you still rejecting the same number of applications? I appreciate that they may be few and far between but are they, by and large, of better quality?

[117] **David Melding:** The fund has been going since 2002, has it not?

[118] **Professor Gummett:** Yes.

[119] **David Melding:** So, presumably, some experience has been built up.

[120] **Professor Gummett:** Yes, but this report has not been published for very long. We have had to think about what to do and we have done it. Not very much time has elapsed, so the honest answer has to be that it is too soon to say. Perhaps in a year's time or so, we will have a better sense.

10.30 a.m.

[121] **Darren Millar:** However, you have focused purely on developing the web materials,

so that people are able to access information and data about how to make a good quality application that is likely to be successful, rather than disseminating information in any other ways.

[122] **Professor Gummett:** We find that this is one of the most effective ways to disseminate information to universities. We make sure that vice-chancellors' offices and central offices know that that is where the material is. People regularly walk up to me and my colleagues at all kinds of meetings and say, 'We're thinking of starting such-and-such, is this something that could be considered?'. We will talk about it very informally, then say to them, 'Here is where you get all the information in one convenient place'. It is a very important mechanism for communicating with institutions. I do not mean to underplay it in any way at all. I would contend that putting it there is actually putting it in a very helpful place.

[123] **Dr Blaney:** The other dimension, when it comes to sources of advice, is talking to the officers at HEFCW. The report indicates that that mechanism is working effectively. We would expect—

[124] **David Melding:** At the pre-application stage, the report says that you are not in anything like as good a shape.

[125] **Dr. Blaney:** The point is about helping institutions to understand how to frame a good application. The most effective way of doing that is to have an iterative process with us, talking about their ideas and exploring those. They do indeed do that very effectively. It is important for a number of reasons: not only for them to understand what we are looking for, but also for us so to get a round understanding of what their proposal is about and where it sits contextually. We have had dialogue in the past where we have received expressions of interest that are far from convincing, but the problem has been not the project or the proposal but the way in which it is written. Having a dialogue is the most effective way of moving these things forward.

[126] **Darren Millar:** In addition to the web-based data that you have now made available—which seems to be a step in the right direction—what have you done to address the points in paragraphs 2.11 and 2.12, where four institutions said that they were unclear what constituted a bid that HEFCW would recommend to the Assembly Government? In paragraph 2.12, six of the nine institutions that answered the relevant questions considered the feedback that they received about unsuccessful applications to be either poor or very poor. They are pretty damning statements. What are you doing to give direct feedback to institutions that make a bid that is unsuccessful?

[127] **Professor Gummett:** We talk to them about it. I am interested in the opinion in 2.12, which says to me that we are going to have to talk more directly and, in some cases, possibly be a bit less polite when we give our feedback. If I would plead guilty to a particular charge, when I look at some of the feedback that we have given, it is that we have been too polite. So, I think that we sometimes need to be much sharper in what we say about the reasons why.

[128] There is a complex point to be made when it comes to talking about rejections. We do not reject vast numbers outright, in the sense of saying, 'Never darken our doors again'—although there are some in that category and at different stages. However, very often what we say is, 'We are not convinced by that proposal; if you want to come back, the kinds of issues that you have got to be able to satisfy us on are the following'. We can redouble our efforts to try to clarify what we are saying when we say these things and we will do that. Very often, things stop there and institutions decide that it is too difficult. After all, one of our criteria is that we want to see significant structural change. We do not want a loose coalition. If I take research as an example, we do not want people in two or three universities carrying on doing what they were doing before but with a little bit—

[129] **Darren Millar:** However, the question is how you relay that message back to the people making unsuccessful bids. What is clear from the auditor general's report is that that is not happening at the moment, and that you need to clarify and sharpen your message to make sure that it hits the mark. I think that you accept that, from what you say, but you have not yet planned any specific action to deliver it.

[130] **Professor Gummett:** Yes, I have planned specific action, with respect—

[131] **David Melding:** To be less polite.

[132] **Professor Gummett:** To be less polite and much more direct in what we say. That is the specific action. I cannot think what else to do, other than be as plain as we can.

[133] **David Melding:** We can reflect on that. The facts have been established.

[134] **Professor Gummett:** If I may refer to paragraph 2.11, because the question was also about that, it is, in a sense, the discussion that we were having a few minutes ago, with the addition of Lampeter to the list of those that are not content with us. I do not find it hugely surprising that those whose proposals we turned down are not very delighted with the arguments that we gave to them.

[135] **David Melding:** Thank you, we will move on. Huw Lewis, you have the next question.

[136] **Huw Lewis:** Thank you, Chair. My question arises from paragraphs 2.17 to 2.24, which are all about the range of barriers that exist in terms of further collaboration in the HE sector. I am sure that you will agree that it is worrying reading. What occurred to me, while reading it, is that I have a great deal of sympathy for the work that you are undertaking, because, in many cases, you are herding cats, are you not? This is the feeling that I get, after six years of operating the fund and the rate of progress that we have seen. Without having to read between the lines of the report, it strikes me that the received opinion and the psychology of many of the institutions is a primary problem. If you have a refusal even to accept, on the part of most institutions, that there is such a thing as a Welsh HE sector—they are not comfortable with that idea—we really are starting from a problematic starting point.

[137] Furthermore, do you not think that the fund, in that context, is operating as a carrot, and that we do not have any kind of stick in terms of encouraging collaboration? What would you advise the Welsh Assembly Government to do? You have a HE sector that is in denial about its contribution to the Welsh public realm while, at the same time, it is happy to trouser the money from the Welsh public realm. It strikes me that this report has winkled out something rather fundamental, in that there is a dislocation, which has been the case for a minimum of six years, between the primary, fundamental aim of the Welsh Assembly Government and its desire to see HE serving the Welsh public and the attitude of HE itself towards that strategic priority. It has not moved forward.

[138] **Professor Hawker:** It is slightly difficult for me to answer that question, because I have only just recently arrived. The perception that I have is that a lot of good work has happened but, on the macro or strategic level, it has fallen short of what the Welsh Assembly Government really wanted to see happen. It raises the question, which is one of the recommendations in the auditor general's report, about the funding lever that we have through this fund. It is quite small compared with the generality of the core funding that the university sector receives. We need to look at how we apply the core funding in terms of the missions of individual higher education institutions being aligned with the strategic direction in which the Welsh Assembly Government wants to move. We will have to have some discussions about

that with Phil and his colleagues in the light of this report. I think that you have put your finger on a very important issue; it is something that we clearly need to address.

[139] **Dr Gunning:** To be fair to the institutions, they are in an interesting position in the sense that their governing bodies are charged with being dedicated to the interests of the institution, if I can put it that way. Therefore, we have a delicate balance, and want to work with the institutions as a sector. Higher Education Wales—the collective body for universities—works closely with us and with Phil and his colleagues. I discovered the original 'Reaching Higher' document in a filing cabinet today, which discusses the purpose of reconfiguration and collaboration. It states:

[140] 'We envisage a multitude of inter relationships…a series of networks of excellence',

[141] but talks about not being prescriptive. We are trying to work with institutions, particularly where they see a shared objective, and seeking to develop a sense of trust between them.

10.40 a.m.

[142] In some fields, for example in attracting international students, they continue to be very competitive, but getting them to work together, whether on shared services, as Phil mentioned for south-west Wales, or on things like research—for example, the Institute of Biological, Environmental and Rural Sciences that has been set up between Bangor and Aberystwyth universities—is slow. It is about building trust between institutions when they work together, to the point that they will then contemplate further moves.

[143] **David Melding:** Professor Gummett indicated that he wishes to respond to Mr Lewis's forceful point that splendid isolation is somewhat eroded by the public purse.

[144] **Professor Gummett:** It does feel like herding cats; if you have not seen the video, then Google it, because it is a treat.

[145] There are two points to make on this. First, I would, with respect, go back to what I said at the beginning, which is that there has been progress. I listed the kinds of things that have happened in Wales and I could sharpen that a little bit by saying that I do not know of any region in England that has done as much in the past five or so years by way of collaboration, integration and merging between institutions as has happened in Wales; I say that in all seriousness. If anyone could show me a region of England that has done more than we have seen in Wales in the past five years, I would be grateful to be informed of it. So, it is not fair to say that there has not been progress. It is perfectly reasonable, on the other hand, to say that we might have wished to have seen more, but, relative to the UK, and certainly to England, there has been substantial, significant progress.

[146] Secondly, what is said in paragraph 2.22 needs some unpicking. I do not deny for a second—indeed I recognise—some of the statements here about rivalry and so forth, which is right. When some people say that they are unwilling to acknowledge the existence of a Welsh HE sector, I suspect that what they mean is a Welsh HE sector that is distinct from the UK, by which they mean that the market in which they work is a UK market. So, it is problematic if you are operating in that market to see a sort of wagons-in-a-circle, Welsh sector that is somehow distinct from the UK sector. That does not mean, on the other hand, that they are not responsive to local agendas; there is plenty of evidence that they are responsive to local agendas. We could develop that point.

[147] Finally, came the question of sticks and carrots, and if the carrot is not big enough or is not working, what about the stick? We have another important process going on at the

moment, which is the Jones review of the future of higher education in Wales. None of us can know what will emerge from that when the report is produced at the end of March, which I believe is now the deadline, and we cannot know what the Assembly Government reaction to it will be later on in the year. It would be surprising if it were not the case that part of that process would be to try to develop steps towards specifying more clearly the relationship between what the higher education sector delivers for Wales and the money that it gets from Wales. I do not doubt that it is possible to make that case, but there is a tension here in relation to the positioning of the Welsh higher education sector within the UK framework. That tension centres on having to demonstrate that the money that comes from the Welsh purse is being used in ways that are responsive to the aspirations of Wales. However, every pound that is spent in that way must also be spent in a way that maintains the competitiveness of those institutions on the UK platform—if not wider. There is a tension in managing that, and I suspect that some of the language was probably not very adroitly chosen by institutions in speaking to the persons doing the review and that has come forward in this way.

[148] **David Melding:** I will now go back to the Member. I know that some witnesses feel that they could add a bit more; we will not leave this sensitive area until you have had the opportunity to respond further if, after Huw's supplementary question, you still want to add something.

[149] **Huw Lewis:** I think that these are honest answers. I acknowledge—as we all would—that there has been progress. However, many of us, as Members, would continue to be alarmed at the level of cosiness surrounding the debate. There is, among all the institutions that I can think of, an absence of any sense of urgency in putting these things right. I take on board the point you make about us outstripping the regions of England in terms of this way of working, and that is a good thing. I would also say, 'So we should be.' There is a problem of institutions understanding the reality of devolution and what it has meant; it still has not dawned on them. We should be aiming for a mentality in the higher education community that is more akin to that in the Scottish HE sector than to any of the regions of England. That does not disbar us, or them, from fighting on a UK platform in terms of competition. The Scots are doing very well, and they have had this mentality for 100 to 200 years. It goes back quite a while. So, part of the problem here is that we have an HE sector that is living in a pre-1999 universe, while Government has moved on.

[150] **Dr Gunning:** Phil mentioned that the Minister set up the review of higher education in Wales with Merfyn Jones in the chair. The review has looked at the developments in Scotland, which I think are very interesting. They are also considering the issue of carrots and sticks, or stick-shaped carrots, or whatever combination we might put together. Your question is at the heart of why we needed to refresh 'Reaching Higher' as a strategic document. I do not want to pre-empt a later question but it is interesting that, having issued the transformation document as one of the follow-up actions to the review of the skills strategy for Wales, we are now discussing potential mergers with a number of further education colleges. So, sometimes a new strategic document does trigger a new level of discussion and debate on these issues. Clearly we hope that the Jones review will do that.

[151] **David Melding:** Do any other witnesses want to respond to the very direct charge that you are too complacent on this agenda? The Minister said, in 2004, that you could start to use the core grant to accelerate this process and get institutions to think about it seriously, but it has not happened yet.

[152] **Professor Gummett:** First, this is a very serious discussion and we take this point seriously. I recognise the undertones of the 'pre-1999' charge. I am not trying to deny that, but I also think it is fair to say that there has been a lot of movement, and also that the picture is patchy. It varies from one institution to another, and from one part of an institution to another part. However, that is not to say that there is not more to do. That is where the Jones

process will be important, because one of my hopes is that what ultimately emerges from it is a very clear statement of what the Assembly Government requires from higher education, against which we can then map delivery. I do not think that we are as clear as we could be about that, and that is partly why we have these discussions—because we sometimes talk across each other, in terms of what people think is being delivered compared with what particular expectations there are. Hopefully, we can improve on that.

[153] Secondly, in relation to Dennis's reference a moment ago to the agenda for transforming education and training, part of the evidence that will decide whether or not higher education institutions have moved on will depend on precisely how they respond to that document. I know that colleagues in the department, and we ourselves, are collecting information from institutions about how they intend to respond to it. I can say that there is significant activity being proposed by higher education institutions in relation to that agenda. Therefore, that seems to be an indication that we are moving on to a post-devolution Wales.

[154] Thirdly, Chair, I turn to your important reference to the requirement on us to use our core grant. We have been doing that—I will explain how in a second—but I must make the preparatory point that we have always to be conscious of balancing our existing commitments to students, particularly within institutions. When we alter funding, we do not want to do it too abruptly. That is not to say that we must not change it, but if we do it too abruptly it could be quite destabilising. Using small institutions—which we discussed earlier—as an example, that sort of behaviour can cause serious problems for them. If we shift funding around rapidly, they will not have time to plan how they can deal with it, bearing in mind that a full-time undergraduate degree lasts three years.

10.50 a.m.

[155] So, what have we been doing with our core grant? We have been gradually moving funding. The numbers are small but they are beginning to pick up a little, and we are moving towards the establishment of a strategic development fund. That fund has been driving some of the other activity that I referred to earlier—some of the collaborative things, for example, and some things within individual institutions. It was that fund that we used, for example, to support what was then the North East Wales Institute of Higher Education, and is now Glyndŵr University. The fund was used to get it to the point where it was given its degree-awarding powers. Things were taking longer than we hoped and we were concerned about its competitive position, so we took a deliberate strategic decision that something needed to be done to strengthen certain aspects of the institution. We do a number of things with that fund, and the intention is to continue to increase it, but in ways that do not destabilise existing provisions. There is a balance to be struck in this. However, I would say we have moved—modestly, I concede—in that direction.

[156] **David Melding:** Huw, do you want to come back on that?

[157] **Huw Lewis:** No, I think that we have explored the issues quite well.

[158] **Chris Franks:** I would like to follow on from Huw's comments about the effective spending of our limited resources. I have been looking at the histogram on page 15 of 'Collaboration between Higher Education Institutions', which shows institutions' income in 2006-07. I was intrigued to see relatively small figures for the University of Wales, Newport, and for the University of Wales Institute Cardiff. However, there is what I would call a 'substantial spend' for University of Glamorgan. Is it not the case that Glamorgan can see that, sooner or later, it is going to be able to swallow up these institutions? So, why go for a merger? Also, are these two institutions afraid that they are going to lose out? I am not talking about the students, but the senior staff. They are going to lose out, so they will resist and, the whole time, we are spending public money without giving priority to the students in this very

small geographical area. Looking at the map on page 14, it can be seen that these three institutions are very close together. You have already been advised by one Member that you need to be more robust. Is your lack of robustness letting down our students?

[159] **Professor Gummett:** Your question presumes that it is, but the substantive question here is about the relative scales of these three institutions. First, it is a matter of fact—and public record—that the University of Glamorgan has supported the proposition of a merger. It is not opposed to it. It is the only one of the three that has said that it is prepared to move, but it wishes to move quickly and not go into lengthy deliberative processes. That has been its position for several years. From its perspective, it has not wanted to get caught up in processes of debate that might or might not lead somewhere. It has said that very plainly. It is the other two that have reservations.

[160] Reference was made earlier to autonomy, but the other thing that I think is important here is the question of judgment. There are governing bodies that have legal responsibility for managing these institutions, and the question here is one of judgment and vision. Reasonable people can differ in the view that they take when they are presented with the facts about the changing world around them. That is the situation we find ourselves in. Our concerns about the issues of scale here are to do with the capacity of the higher education sector in Wales—and I do use that phrase myself—to remain competitive. Part of what that means is that they have to be innovative, and part of what that means is that they must be able to afford to take risks. Not everything will work. Our concern about the institutions to the right-hand side of that histogram is that they have much more difficulty in taking risks, because the consequences of something going wrong, of a new scheme not working, can be much more significant.

[161] I would say that what we are doing is offering a vision and an awareness of threat. However, the governing bodies of the institutions are perfectly within their rights to respond to us by saying, ‘What is wrong with what is happening at present? Are we in financial difficulties? No, we are not. Are we failing to recruit? No, we are recruiting fine. Are our students getting jobs? Yes, they are. So what is wrong with us as an institution?’ I am trying to give you a sense of the nature of the dialogue. We might say to them, in shorthand language, ‘You are okay now, but look 10 years down the line.’ That is the nature of the discussion, and that is where we can have different views. That is why this is such a difficult area to move forward in. Reasonable people are taking different views.

[162] **Bethan Jenkins:** I want to pick up on that particular point. I have missed some of the debate because, unfortunately, I had to pop out. You have said that other regions are not working together as strongly, but I wonder whether that is the case. Obviously, in the rest of the UK, there are different funding formulae. Therefore, different universities do not have to work together as much because they compete against each other. That is what is happening worldwide. So, does that not contradict what the Welsh Assembly Government is trying to propose in saying, ‘We want you to work together, but the main reason we want this is that you are not competitive enough in the global market’? If that is the main concern, do you believe that you should change the funding formula across the board to reflect that agenda? Also, should you be frank with the universities and say, ‘The reason we are doing this is that we need to make sure we can market you around the world as an institution’? This is what you need to do to reach your aims. It seems to me that this pot of money is working in a silo on its own and not reflecting what is happening in the rest of Wales. You are not being honest about that reality.

[163] **Professor Gummett:** We cannot argue, on the one hand, that we are not making progress and that the reconfiguration fund is not making a difference, and then on the other hand say, ‘It is only because we have that in Wales that we are doing things, and that is how we explain the relative lack of reconfiguration activity in the regions of England’. Either it is

having an effect or it is not.

[164] More importantly, we are saying those things. It is also the case that these things are happening in England and, quite dramatically, in Scotland. Huw Lewis rightly made the point that there has been a lot of movement in Scotland in terms of research collaboration, but not in mergers. The penny is increasingly dropping within universities across the UK, and it has certainly dropped in Wales. You see it happening in England, but in more modest ways. For many purposes, institutions have got to increase their scale. That may mean mergers, or it may mean other forms of relationships. They are recognising that fact and beginning to do things about it. My earlier contention was that I think we have made more progress than any region of England, but that is not to say that we have done all that we could or all that we need to do.

[165] You talked about honesty. I would say, in all honesty, that we are giving that message very plainly. For example, a question was asked earlier about south-east Wales. We have had two meetings with the governing bodies of those three institutions, and we have clearly laid out our view of their position. We also hold annual sessions for the governors of higher education institutions. They are essentially training sessions for new or relatively new governors. One of the things we do in those sessions is to give them what we see as the facts of life about higher education in the UK, and what the competitive position is for Wales. This report has the implicit challenge, 'What more could we do?' One of our further responses to that is to ask ourselves, 'What more can we do to get across to governing bodies information that will help them to understand better—better than, in our view, some of them do at present—precisely what the realities are?' This is so that they can be better informed as they make difficult judgments about what is the best thing to do for the future of their particular institution.

11.00 a.m.

[166] **Bethan Jenkins:** The final question touches on what was said earlier on partnerships with people outside the HE sector. Paragraph 2.27 refers to the announcement by the Welsh Assembly Government on encouraging local providers and post-16 education providers to be included in the collaboration process. This question is to Professor Hawker: to what extent did the recently announced proposals to encourage increased collaboration between all providers of post-16 education effectively supersede the narrower proposal of the reconfiguration and collaboration fund, which only supports collaboration between HE institutions?

[167] **David Melding:** Professor Hawker deferred to Dr Gunning earlier before I deprived him of his hour of fame, but it has now arrived.

[168] **Professor Hawker:** Indeed. Would you like me to hand straight over? This comes back to what I said earlier.

[169] **Dr Gunning:** The new proposals complement rather than replace the current ones—I think that that is the correct way to describe it. I welcome the chance to mention again the transformation agenda because it comes from a need to fundamentally rethink how we deliver post-16 education, or indeed post-14 education.

[170] Briefly, there are two challenges: creating the breadth of pathways needed to support 14 to 19-year-olds under the new 14-19 learning pathways programme. We do pretty well on academic pathways for young people, but we do much less well on vocational pathways and we need to transform that.

[171] The second challenge, as you will all know from the statistics, is that people in employment in the future will largely be those who are in employment at present because we

have diminishing numbers of 14 to 19-year-olds. So, there is an enormous challenge to upskill and retrain the existing workforce. The layout of providers at the moment is not ideally suited to that. We need much more choice for students and much less duplication of provision—there is a lot of duplication where providers in close proximity to each other offer the same courses. That needs to be addressed. In the future, we do not need individual excellent providers, because we are quite well-off in that regard in Wales, but excellent networks of providers, planning and working together. If that happened, and we have been talking a great deal about the money available in the system, we would put more of our resources into the classroom rather than into running administrative units. So, transformation is about saying to schools and the FE and HE sectors that they need to lift their game and work together to provide for the needs of an area.

[172] The reason I said 'complement' in relation to higher education is because, as Phil mentioned earlier, the sector has a wider mission, UK-wide and internationally, but it also has a great responsibility locally to work with schools and the FE sector to support the pathways for young people, which will get us to where we want to be. It will be essential that Merfyn Jones, in his review of HE that will soon be reporting, takes account of this new agenda, which brings schools and the FE and HE sectors closer together. They will always be distinctive, but that does not stop them collaborating for the future of Wales.

[173] **Bethan Jenkins:** So, do you think that there will be change beyond 2010 and would you include some of the core funding, potentially from the new student finance measures that the Minister will put in place?

[174] **Dr Gunning:** There are some interesting changes, for example, to FE funding that were presaged in 'Skills That Work for Wales'. It talks about investing in a sector priorities fund so that some of the money will be directed towards particular employment sectors and not just in global terms. We must still have an element of global funding because we can never predict wholly accurately—I think that Stalin tried and failed—all the local demand from every employer. Merfyn Jones, in his review of HE, must consider whether that type of approach, where there is a little more direction towards key sectors, might be appropriate in HE, and we look forward to his recommendations.

[175] **David Melding:** Thank you. That concludes the questions that we wish to put to you this morning. We are grateful for your help with this inquiry and for the evidence that you have provided. You will all be sent a transcript of the evidence to check it for its accuracy. I always emphasise to witnesses that you cannot change anything that you have said, but if there is an error in the transcription, you will have a chance to put that right.

11.04 a.m.

Ystyried Ymateb Llywodraeth Cynulliad Cymru i Adroddiad y Pwyllgor Archwilio 'Adolygiad Dilynol—Gwasanaethau Ambiwlans yng Nghymru'
Consideration of the Welsh Assembly Government's Response to the Audit Committee Report 'Follow-up Review—Ambulance Services in Wales'

[176] **David Melding:** Jeremy, you have given us advice. Jeremy's letter is before us. Do you want to emphasise anything? It is quite a serious subject and your letter raises some quite profound issues.

[177] **Mr Colman:** Thank you very much, Chair. I will begin by making a statement that will be well known to members of the committee, but which I should say for the record. In advising the committee as I have, I am of course not taking any particular view on how the outstanding issues relating to the Welsh Ambulance Services NHS Trust should be resolved,

such as what its revenue budget should be for this year or what capital programmes should be approved. I have no opinion about that as the Auditor General for Wales.

[178] We are in a situation in which the Assembly Government's response, although it has accepted all the recommendations of the committee, is not entirely satisfactory. The reason that I say that it is not satisfactory is that subsequent to the Audit Committee's hearing another committee of the Assembly took evidence from Alan Murray, and that evidence and the subsequent developments—or maybe I should say 'the lack of some subsequent developments'—suggest that this committee might wish to seek further information from the Assembly Government about matters that were of concern back in July and which still seem to be uncertain.

[179] The first of the four that I mention in my letter is the budget for the current year. It is very late in the current year and it is not clear whether the Assembly Government has agreed a revenue budget this year for the ambulance trust. Secondly, a number of business cases for capital expenditure have been presented, and Ann Lloyd's evidence in July more than suggested that the Assembly Government would be seeking an early decision on those. However, those business cases are still outstanding, as the response makes clear. Thirdly, there is the issue of efficiency savings. I would never say a word against public bodies in Wales seeking efficiency savings, but I think that it is a matter for concern that the Assembly Government's reply makes quite a lot of possible efficiency savings from fuel prices. We all know that fuel prices go up and down quite a lot, and if the ambulance trust is to make savings whenever the price goes down, the question then arises about what is to happen when the price goes up. That is an issue on which further information might be helpful. Finally, everyone understands—certainly members of this committee understand—that handover times at accident and emergency departments, particularly in Cardiff and Newport, are a serious problem. The Assembly Government has announced targets for handover times, but the response is not very detailed on what specific actions need to be taken to help the ambulance trust to achieve those targets.

[180] I am sorry that this is rather a long remark. Finally, I draw attention in my letter to what you might call some longer-term issues, where it is not clear that short-term action has been taken that would be helpful. Those longer-term issues are to do with culture, the spatial plan and, to use words from the Assembly Government's response, 'intelligent targets'. The Assembly Government's response clearly recognises—it might be 'rightly recognises'—that the culture of the ambulance trust is an area that needs to be improved. This committee drew attention to that issue. Changing the culture of an organisation is not something that you can do overnight and everyone understands that too. However, equally, if you do nothing, it will never change. There could be a question about what action should be taken and what action is being taken that will have beneficial effects on culture. On the spatial plan, the Assembly Government's response accepts the recommendation about the need for the ambulance trust to be much more closely involved in the spatial plan, but it was very thin on detail. Finally, on intelligent targets, who could be against a concept called 'intelligent targets'?

11.10 a.m.

[181] What it means in this context is that the performance of the ambulance trust, particularly with regard to emergency services, is intimately connected to the performance of the rest of the NHS and, to some extent, social services. An intelligent target is one that takes account of the fact that, for improvement to occur, the whole system needs to work more effectively. The question is: what action has been taken to promote effective working through the whole system?

[182] Some of these matters will be covered in a study that I currently have under way on the subject of unscheduled care. The Assembly Government's response refers to that, and the

ambulance trust is working with us, as is the Assembly Government. Relatively soon, the committee will have an opportunity to look at the topic of unscheduled care. The question now is whether, in advance of that—it is still some months away—the committee wishes to seek further assurance from the Assembly Government.

[183] **David Melding:** The auditor general's response is weighty and considered, and it is significantly more qualified than some of the Government's past responses to our report. I suggest that our secretariat and the Wales Audit Office prepare a draft letter that covers these points for me to send on behalf of the committee, perhaps with the proviso that some of the points may come under the work on delayed transfers of care. I feel that further action is required. I am not one to suggest that we write to the Government again on minor matters, and I am not sure that I have done this before on Members' behalf. We can usually pick these issues up in six or 12 months of their being brought to us if we need to, but I feel that a more immediate response is called for on this occasion.

[184] **Darren Millar:** I suggest that, given the auditor general's response and the continuing concerns about many of the matters raised in our report, and given that the Assembly Government has accepted that there were problems, as this matter is of such concern to Assembly Members and members of the public, we ought to have another evidence session to which we can invite witnesses and cross examine them on the outstanding issues rather than simply write a letter. That would be far more useful to us. Given that some work in this regard is ongoing, the evidence session can be used to feed into that with regard to unscheduled care issues. That would be a far more satisfactory arrangement than to send another letter highlighting concerns.

[185] **Janice Gregory:** I do not know that I totally support Darren's call for another evidence session, as that would delay the process even more, whereas a letter would reach the Welsh Assembly Government quicker.

[186] I want to get something off my chest. I understand what Jeremy is saying about it taking a long time to change the culture of an organisation. We should say that those who work at the coalface of the ambulance service, those who are delivering services on the ground, are doing a tremendous job, but they are clearly hamstrung by decisions that are taken higher up the chain. The ambulance service cannot just say, 'Nothing to do with us, ref. We didn't do this; this is not our fault'. The culture in the ambulance service should have changed by now, given that we have been discussing this issue under subsequent Ministers for health, and we are still at the stage when Alan Murray is still saying, 'It's nothing to do with me. It's the Welsh Assembly Government's fault'. I am not saying that there are not difficulties in that regard, but it is unfair to shift all the blame onto the Welsh Assembly Government because of the budget or anything else.

[187] Before Christmas, I made it my business, as did other Assembly Members, to speak to paramedics. Some changes could be made in the ambulance service that are not quite cost-neutral but which will not have the huge financial implications that we are led to believe that they will have. There needs to be a very rapid change in the senior management of the ambulance trust. With respect to Jeremy, I do not see that that is reflected in his letter.

[188] **David Melding:** On the latter point, Janice, I have allowed you to get it off your chest.

[189] **Janice Gregory:** Thank you, David.

[190] **David Melding:** Although we were very tactful in the way that we put it, our report thought the reverse—we thought that the leadership was in quite good shape and that there would be a danger if there was instability at the leadership level. Jeremy has reflected what

the committee agreed at that time. Politically, this issue has moved on somewhat, and those particular questions have been taken out of our realm. I am not denying that it is appropriate for certain fora in the Assembly to look at that political question. From the evidence that we have received, we have come to a settled view, so I am keen that we do not chase that issue.

[191] I do not want rebuttals at this point, but does anyone have anything to add on how we will progress, given the correspondence from Jeremy? I see not.

[192] **Darren Millar:** I think that Janice has made some very valid points about the issues within the service, and there are questions that need to be asked of Alan Murray and his executive team. If Members are content for a further evidence session to be held, perhaps we could include not only representatives from the Assembly Government but also from the trust, so that we could get a balancing of views. We are not here to necessarily criticise one side or the other but to get the best possible service going forward for the people of Wales, and that is what it must be about. A further evidence session would help us to get that.

[193] **David Melding:** Janice, you started your remarks by saying that you did not think that a further evidence session was necessary immediately.

[194] **Janice Gregory:** Yes.

[195] **David Melding:** Is that still your view?

[196] **Janice Gregory:** If we were going to rehash what we have already done, there would be no point, but if we were going to drill down further, as Darren suggested, I do not know. Given the questions that we asked last time I do not know that the answers will be any different. We would have to ask a completely new set of questions based on the report or on how we feel that things stand on the ground. That will be a question for you, Chair.

[197] **David Melding:** Jeremy, do you wish to give further advice at this stage?

[198] **Mr Colman:** If I may, Chair. Janice Gregory has got there before me. If the evidence session is to be disciplined, it would have to be on the basis of some type of document. You can have your evidence session and your letter, because we could draft the letter in the form of a document that could be the basis of an evidence session. As usual, we would suggest a briefing for the committee to focus the line of questioning on the outstanding issues, such as those to which I have drawn attention.

[199] **David Melding:** It is possible that the response to the letter may be entirely satisfactory to the committee, but I am not sure whether we say in the letter that we may want to take further evidence on these issues, depending on the nature of the reply.

[200] **Mr Colman:** That is not what I was proposing, but that is an option. It is just an option, but I was proposing that the committee could decide to hold an evidence session and that the letter would say that, and also mention the issues in which it was interested in exploring.

[201] **David Melding:** It appears that there are two options. One is that I write on behalf of the committee on the issues of concern and, subject to the reply, we hold an evidence session if we feel that it is necessary, or we could write to the Government saying that we want a further evidence session on the points listed. What are your thoughts on this, Lorraine?

11.20 a.m.

[202] **Lorraine Barrett:** You should write the letter first. We cannot slot in an evidence

session immediately, anyway, so I would suggest that we wait for a reply and base our decision on that.

[203] **David Melding:** That would be the first option, to write and wait to see the nature of the reply, before committing to an evidence session.

[204] **Michael German:** I want to clarify something regarding the role of this committee. We have heard Jeremy's concerns, and the committee is here to investigate such concerns. I thought that we needed Alan Murray to answer on those issues as well as the Government. Writing to the Government is fine, but we will only receive the Government's response. I interpreted Jeremy's original suggestion as being that he would write a letter, to which you would add your signature, Chair, but it would basically be a letter from Jeremy describing the issues of concern that he has laid out to us, and we would invite the Government to respond and to answer questions that we would also ask the ambulance trust to answer. That is what I thought.

[205] **David Melding:** We are focusing on the Welsh Assembly Government's response. I suspect that it can refer, as necessary, to Alan Murray, and we would have to decide, if we had a further evidence session, whether we would want him there. We now need to choose from two reasonable options. The first is to write to the Government, but wait to see the nature of its reply before committing to an evidence session, and the second is to write and say that we want an evidence session, and give the Government the details why, so that it can respond. I would like further indications from Members. Your response was that we should commit now to an evidence session, Mike, was it not?

[206] **Michael German:** That was my view, on the basis of what Jeremy said.

[207] **Irene James:** We need both the letter and the evidence session. It is as simple as that. I think that we must have Alan Murray here, so that we can look with him at the questions that Jeremy has raised that need to be resolved.

[208] **David Melding:** I am getting slightly confusing signals. It now seems to me that we are saying that we want to take further evidence. Therefore, we will take the path that Jeremy originally suggested. It will be a substantial letter, however, because it will serve as the document that we will use as a basis for our evidence session, but we will say that we will be seeking further evidence. Thank you for that guidance.

11.23 a.m.

Cynnig Trefniadol
Procedural Motion

[209] **David Melding:** I propose that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 10.37(vi).

[210] I see that there are no objections.

Derbyniwyd y cynnig.
Motion carried.

Daeth rhan gyhoeddus y cyfarfod i ben am 11.23 a.m.

The public part of the meeting ended at 11.23 a.m.

Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Archwilio
The Audit Committee

Dydd Mercher, 11 Mawrth 2009
Wednesday, 11 March 2009

Cynnwys
Contents

Aelodau Cynulliad yn bresennol
Assembly Members in attendance

Lorraine Barrett	Llafur Labour
Michael German	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Janice Gregory	Llafur Labour
Lesley Griffiths	Llafur Labour
Irene James	Llafur Labour
Huw Lewis	Llafur Labour
Jonathan Morgan	Ceidwadwyr Cymreig Welsh Conservatives
Nick Ramsay	Ceidwadwyr Cymreig Welsh Conservatives
Janet Ryder	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Jeremy Colman	Archwilydd Cyffredinol Cymru Auditor General for Wales
Simon Dean	Cyfarwyddwr Cyflenwi Gwasanaethau a Rheoli Perfformiad, Llywodraeth Cynulliad Cymru Director of Service Delivery and Performance Management, Welsh Assembly Government
Ian Gibson	Dirprwy Bennaeth, Uned Llywodraethu Corfforaethol, Llywodraeth Cynulliad Cymru Deputy Head, Corporate Governance Unit, Welsh Assembly Government
Gill Lewis	Swyddfa Archwilio Cymru Wales Audit Office
Alan Murray	Prif Weithredwr, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Chief Executive Officer, Welsh Ambulance Services NHS Trust
Rob Powell	Swyddfa Archwilio Cymru Wales Audit Office
Paul Williams	Pennaeth, Adran Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cynulliad Cymru Head, Department for Health and Social Services, Welsh Assembly Government
Tim Woodhead	Cyfarwyddwr Cyllid, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Director of Finance, Welsh Ambulance Services NHS Trust

Swyddogion Gwasanaeth Seneddol y Cynulliad yn bresennol
Assembly Parliamentary Service officials in attendance

John Grimes	Clerc Clerk
Abigail Phillips	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 9.31 a.m.
The meeting began at 9.31 a.m.

Ethol Cadeirydd
Election of Chair

[1] **Mr Grimes:** Good morning, ladies and gentlemen. I welcome you to the Audit Committee meeting. As Members will be aware, a number of changes have been made recently to the membership of the committee, as a consequence of which David Melding, who was committee Chair, is no longer a member. Therefore, the first item of business is to elect a new Chair.

[2] **Michael German:** I nominate Jonathan Morgan.

[3] **Lorraine Barrett:** I second the nomination.

[4] **Mr Grimes:** Are there any other nominations? As there are none, I declare Jonathan Morgan duly elected Chair. Congratulations.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[5] **Jonathan Morgan:** I am delighted to have joined the Audit Committee, as is Nick Ramsay. We should place on record our thanks to David Melding and Darren Millar, who served as members of this committee, with David as Chair since 2007, for their contribution and commitment to the work of the committee.

[6] The usual housekeeping arrangements apply. The committee operates bilingually, so participants are welcome to speak in Welsh or English. Headsets are available for translation. I remind everyone to switch off mobile phones, pagers and BlackBerrys. I have not been informed of a fire drill scheduled for this morning, so if the fire alarm sounds please follow the advice of the ushers.

[7] I have received an apology for absence from Bethan Jenkins. Janice Gregory may not be able to join us, because she serves on one of the legislation committees, which is sitting this morning. She may join us later.

9.33 a.m.

Adolygiad Dilynol—Gwasanaethau Ambiwlans yng Nghymru
Follow-up Review—Ambulance Services in Wales

[8] **Jonathan Morgan:** The committee will be aware that the Wales Audit Office has produced an expanded version of its letter from the Auditor General for Wales, which the committee considered at a previous meeting. That report has been provided to Members, along with a briefing and suggested questions. Before we move to our questions, I ask the witnesses to identify themselves for the record.

[9] **Mr Dean:** I am Simon Dean, director of delivery in the Department for Health and

Social Services.

[10] **Mr Williams:** I am Paul Williams, director general of the Department for Health and Social Services and chief executive of the national health service in Wales.

[11] **Mr Murray:** I am Alan Murray, chief executive of the Welsh Ambulance Services NHS Trust.

[12] **Mr Woodhead:** I am Tim Woodhead, director of finance for the Welsh Ambulance Services NHS Trust.

[13] **Jonathan Morgan:** It is a pleasure to welcome the four of you to the Audit Committee this morning. We will proceed with the questions, because there are a large number of questions that Members wish to ask you this morning. I will start.

[14] Looking at paragraphs 1.1 to 1.17 of the auditor general's report, I will ask Alan Murray first, why has performance dipped so alarmingly in the second half of 2008? Is the downturn in performance against standards a sign of things to come?

[15] **Mr Murray:** There are two major reasons for the downturn in performance, the first of which is that, in order to come in on our £136 million budget, we have to make strategic change and efficiency savings of £17 million this year. While we have made the majority of that from non-emergency medical service staff pay, we had no alternative this year but to make some of those savings from EMS staff. That resulted in a reduction in EMS staff this year.

[16] The second major reason is the increase in extended hospital turnaround times. Between March and December of last year there was a 90 per cent growth, almost a doubling, in the ambulance unit hours that we lost at the front doors of hospitals. Is it a sign of things to come? I am happy to say that, this month, as of midnight last night, we are in the sixty-fifth percentile of our category A eight-minute standard for the whole of Wales. Seventeen out of 22 local health board areas are above the sixtieth percentile equity standard, and the remaining five are above the fiftieth percentile. We are doing that chiefly by two means. Since Paul Williams took over as chief executive of the NHS, he has emphasised the priority of shortening turnaround and handover times for ambulance crews. That has begun to have an effect, and we can measure that. That is one reason why our performance has improved. The other is that we are replacing the full-time equivalent posts that we did not fill. We are doing that this year using non-recurrent funding.

[17] **Jonathan Morgan:** Looking at figure 1 in the report, the drop in performance in December is quite marked in comparison to virtually all of the previous figures, going back to April 2004. Between April 2004 and December 2006 there was a fluctuation of performance on category A calls between 55 and 60 per cent. However, since January 2007 there has been an even greater fluctuation. What is it about the period since January 2007 that makes the figures so markedly different to the previous trend?

[18] **Mr Murray:** In March 2007 we introduced our performance management framework, and from then until November 2007 we were consistently above the sixtieth percentile standard. In December 2007, Members will recall that we had an unofficial overtime ban. That was part of the evidence that was given at the last hearing. That overtime ban caused a sharp dip in performance, which we restored to some extent in January, through until the early spring. The reason for the sharp dip in December 2008 is different. Between 28 November and 8 December we had a period of very cold weather, and there was a sudden upsurge in activity of 16.5 per cent, almost overnight. That subsided after 8 December, but it left a legacy in terms of increased rates of illness. People with chronic conditions, who

normally manage them well, became emergency cases, and that in turn caused further blockages at the front doors of hospitals. There were other issues, such as the outbreak of norovirus in north Wales, which also caused us problems—it was the first time that we had had a problem with extended turnaround times in north Wales. The result, measured in hospital delays, was that, between December 2006 and December 2008, looking at those two months, there was just over double the number of extended hospital delays of more than 20 minutes. There was a loss of ambulance hours as a result of those hospital delays.

9.40 a.m.

[19] **Jonathan Morgan:** Question 2 is to Paul Williams. As the new chief executive of the NHS, have you undertaken an assessment of the performance of the ambulance service in the second half of 2008? Is cold weather in December, which is somewhat predictable, a justification for a poor performance in that period?

[20] **Mr Williams:** We have regular performance management meetings with the trust. When I took over, I was concerned about the performance, which had dipped. It looked to me as if there had not been a pattern of sustained improvement, so that was not acceptable. As a result of that, I took an immediate interest in this and stepped up the performance management, but I also had discussions directly with the ambulance service, because, as Mr Murray indicated, it was perhaps spending too much time on reigning in the financial problem and was not accelerating the service improvement and efficiency gains, which should happen at the same time to achieve a balanced position. I was able to help with some non-recurring resources. I think that there were just not enough crews on the ground in the south east, for instance, so we quickly started to resolve that, albeit on a short-term basis. I also took a particular interest in accelerating some of the business cases that you might refer to later. I was also of the view that, because of the particular problems in the south east, we needed to do several other things, one of which was to ensure that we had maximum operational experience on the ground, so we put a very senior operational manager in.

[21] On the comments that Mr Murray made about the cold weather, we have endured probably the coldest prolonged snap for a considerable while and, if you look at the evidence, you will see that it is clear that the incidence of strokes and heart disease problems increases in cold weather. The surge of 16 per cent in December was not just experienced in Wales; we were already experiencing December-type problems early in England, particularly on the borders, where similar difficulties were being experienced. After the first cold snap came the second wave of people needing to get into hospitals, then you have the Christmas period, when the hospitals tend to wind down to some extent and discharge arrangements, particularly in terms of getting support from social care, tend to be a little more difficult, so the system starts to block up. Then we had the further cold prolonged snap in January, which has exacerbated issues. So, I am hoping that, although one swallow does not make a summer, now that the cold snap has moved on, we will see improved performance because of some of the short-term measures that we have put in place.

[22] **Huw Lewis:** I would like to take a look at the variation in performance in terms of turnaround and response times across Wales. It is clear from figure 3 in the auditor's report that, in some parts of Wales, there is a consistent above-target performance—and by 'target', I mean 60 per cent of category A calls receiving a response within eight minutes, and so on—but that, in others, the performance is consistently and considerably below target. Figure 7 shows that 12 per cent of patients experience a turnaround time of over an hour in an area like Torfaen. I understand that going over an hour is so bad that there is no breakdown of figures for such a time; turnaround times could be over two or three hours—we do not know. Why is there this completely unreasonable variation—as I am sure that you would accept—in performance across Wales? Are we talking about a particular intractable problem connected to Gwent and the Royal Gwent Hospital?

[23] **Mr Murray:** We have commissioned an analysis that shows that, for every 24 ambulance hours that we lose in a given day in the Royal Gwent Hospital, our performance in the whole of south-east Wales dips by 6 per cent. There is a very close correlation between those two. Clearly, there are other factors and correlation does not necessarily imply causation. However, the correlation is very strong. It is particularly notable that the most improved trust in Wales for turnaround times in the last two weeks has been the Royal Gwent. Simon Dean can probably give more details about that, but I know that the trust has taken on a new consultant. It has brought in an experienced locum consultant who has worked with accident-and-emergency-department flow issues such as this in Bristol. It has revived its rapid assessment and treatment team, which gets patients off ambulance stretchers, turns the ambulances around and gets them back out onto the street again.

[24] Since that improvement has taken place and since we have had more people out on the road, there is not a locality in Wales where the figures are under 50 per cent. Even in Monmouthshire, it is currently 52 per cent. That is a significant improvement compared with where it was. I accept that more significant improvement is required, but it has demonstrated that, if we can get our crews out and if we can turn them around quickly at hospitals, we can improve performance. From the beginning of March to midnight last night, we have improved our performance.

[25] **Mr Williams:** I would like to add to that, Chair. When I undertook the second stage work, it was clear to me that the turnaround times were being lengthened by, perhaps, the hospital trusts not giving enough attention to this field. So, in January, I asked for comprehensive plans from the local health boards, the hospital trusts and the Welsh ambulance service for each health community, to tackle an unscheduled care agenda by considering all systems and particularly to address the turnaround times. It seemed, unfairly, that the ambulance service was suffering from a lack of attention in this area. I am pleased to say that my colleagues in Gwent have taken this on board very seriously. The issues that Alan Murray mentioned—the additional consultant staff, improved reception areas and a rapid assessment team—have made a difference. So, I would like to thank my colleagues in Gwent for taking this on board. We will be pursuing, with equal vigour, these joint plans in other parts of Wales.

[26] **Huw Lewis:** I am a little unclear as to when the reforms that you are talking about swung into action. When will the figures show whether they have led to the improvement that you are trying to engender?

[27] **Mr Williams:** I felt that it was fairly reasonable to ask for an eight-week turnaround time for the plans, although the plans to achieve the target have already been determined. So, there has been a little bit of a tussle. These are not new plans; these are things that need to be done to achieve our targets. However, there is more focus on the important issues that need to be addressed. So, it is simply the fruits of the first part of that work, which is feeding through particularly in Gwent, which had the highest turnaround times and probably needed the greatest amount of attention.

[28] **Huw Lewis:** I am still a little unclear. When did the clock start ticking for the eight-week turnaround time?

[29] **Mr Williams:** The eight-week turnaround time?

[30] **Huw Lewis:** You mentioned an eight-week turnaround time.

[31] **Mr Williams:** I asked in January for the end of February.

[32] **Huw Lewis:** The end of February?

[33] **Mr Williams:** Yes.

[34] **Huw Lewis:** When will the figures be made public?

[35] **Mr Williams:** It depends what you mean. I am not saying that there will be new figures; I am saying that the plans are being considered at the moment. The figures are still the targets that need to be achieved. My point was that there is an indication in the figures for February and early March that that performance is feeding through.

[36] **Mr Murray:** I can give an illustration on that, Chair. Last March, when the Royal Gwent Hospital was doing particularly well, we were losing under half of a 12-hour ambulance shift per day at the front door. That grew until, by December, we were losing around two and a half 12-hour shifts per day. It is now down to one per day and dropping. So, that gives you some idea of the magnitude of the improvement and of the magnitude of the problem for us.

9.50 a.m.

[37] **Huw Lewis:** Chair, could I just come back—

[38] **Jonathan Morgan:** Lesley Griffiths wanted to ask a supplementary question first. Is it specifically on this, Lesley?

[39] **Lesley Griffiths:** Yes; thank you, Chair. On what you said about Gwent, why has the trust not engaged with hospitals to improve services?

[40] **Mr Murray:** We have been meeting them regularly and in the case of the Royal Gwent, my executives and I have been meeting the interim chief executive of Gwent Healthcare NHS Trust and his executives regularly over the last few months, to see how it can improve its performance and what we can do to help it. One example is working with GPs to agree admissions slots for patients whom we currently describe as urgent and GPs would prefer to describe as same-day admissions. Some cases are urgent and need to be brought in within the hour, but some can be phased throughout the day so that they miss the peaks of emergency activity. We have already done some things such as moving the times of our discharge vehicle to help the hospital improve its discharge process and to clear beds so that people coming into accident-and-emergency departments can be admitted. The trust itself has also been doing many other things.

[41] We have been prioritising because some trusts have not been giving us a problem, although, even those trusts have been having difficulty over the last few months. So, we have been prioritising the bigger hospitals such as the Royal Gwent Hospital, University Hospital of Wales and Morriston Hospital; we have been working with those. I should add that I am meeting the chief executive of Gwent Healthcare NHS Trust and his team this afternoon.

[42] **Jonathan Morgan:** Before I ask Huw if he wants to pursue this issue, Mike wants to come in on this.

[43] **Michael German:** I want to pursue Huw's issue because I need clarity for the record. Huw asked you a question and we did not get a clear answer. Huw asked Paul Williams about the eight-week turnaround time on getting plans to you, and if I understood you correctly, you asked for those plans either at the end of January or the beginning of February, in which case, the clock has not stopped ticking yet. Can we be clear about when you asked for those?

[44] **Mr Williams:** I asked at the beginning of January and they were due to be with me at the end of February. I have received the first cut of those plans and we are currently working through them.

[45] **Michael German:** So, all the plans were with you by the beginning of March.

[46] **Mr Williams:** Yes.

[47] **Huw Lewis:** So, we are still in the situation where you may have the plans, but none of them have been implemented. We are still where we were in terms of the Royal Gwent in particular.

[48] **Mr Williams:** I am not struggling with the question, but to get some of this in context, I have asked for action plans; they are not detailed, grandiose plans. I have asked for a set of actions on a whole-systems basis that will ensure that all the organisations are achieving the targets that we have set them. Some of those things only required small attention to detail in order to be achieved. Others, such as recruiting staff, take longer. I will hold each of those organisations to account until I am fully satisfied that those plans are practical. It is a question of simple performance management.

[49] **Huw Lewis:** But we are still where we were in terms of the practical reality on the ground, are we not?

[50] **Mr Williams:** No, I am sorry, we are not; we are seeing a significant step change in behaviour in the Royal Gwent.

[51] **Mr Murray:** I hope that I have made it clear that the plans have started to be implemented. They are well under way in some trusts, particularly in those that were giving us the biggest problems. For example, in Gwent, we have agreed that we will put six extended-scope ambulance practitioners in Newport to work around the clock and to see patients who, potentially, do not need to be admitted to hospital and to resolve their conditions at home. They will help keep people with long-term conditions at home and help them manage those long-term conditions in order to avoid bringing them into hospital. So, that is how we are taking the next step from simply managing the processes inside the hospital to looking wider at the whole system.

[52] We also have a joint ambulance, GP out-of-hours services, and an NHS Direct centre at Vantage Point House in Cwmbran, covering the whole of south-east Wales for ambulance services and NHS Direct, and covering Gwent for out-of-hours services. We are doing a pilot at the moment. We are already using nurses to triage 999 calls to avoid ambulance responses where we can do so safely, and that has had some success. We are now conducting a pilot on how we can include the Gwent out-of-hours GPs in that approach, to give an added layer of triage and governance. That will also, hopefully, provide more appropriate alternatives to admission to emergency units for more patients in Gwent. The plans are already well under way in Gwent.

[53] **Lorraine Barrett:** I am a little confused now, Chair. I would like to take part of Huw's question on the eight-minute response time, because we concentrated more on the turnaround, which was the bigger part of my next question. I think that some of my questions on turnaround times have been answered. Am I right?

[54] I do have one question that you could expand on. Paul Williams, I have a question here about known problems in certain hospitals and performance that has not improved on turnaround times and handover times, but I think that you have covered that.

[55] **Mr Williams:** If the committee is struggling with why trusts and local health boards are not tackling these things with the necessary vigour, then I share its frustration. It may be a product of how the quasi market operated, but I am now focusing on a more collaborative approach to ensure that targets are achieved. That may be worth exploring. The organisations are in no doubt, since I took over, as to what I expect them to do.

[56] **Lorraine Barrett:** Mr Murray, you started talking about the GP out-of-hours service and the nurse triage system. Do you have anything more to say about collaborating with other partners in the wider system to resolve the issues with turnaround times? Also, should you add in longer turnaround times when analysing demand and deploying resources?

[57] **Mr Murray:** I will take the second part first, and then deal with the first part.

[58] If you examine the way ambulances queue at the front doors of hospitals, adding ambulances really just adds to the queue. The only way to resolve that is by ending the queue, or at least by reducing it to manageable proportions. There will always be something of a queue. I was at the University Hospital of Wales's accident and emergency department yesterday, where I saw four emergency ambulance crews arriving together. There is nothing that you can do about that. I watched the staff manage those patients very efficiently, but you will inevitably get a queue under those circumstances. What I am talking about is the avoidable queue. Adding ambulances does not resolve the problem, it just adds to the queue.

[59] The first part of your question was on the collaborative work that we are doing with other parts of the NHS. We have now identified a number of priority areas, that is, what we see as our seven priorities for the development of the modernised unscheduled care system. We are engaged now in all seven health communities' unscheduled care project boards. I have to say that having seven health communities, rather than 22 sub-communities, is making life much more manageable for us, because we can actually resource that. We are regularly engaging with those communities.

[60] Our priorities have been recognised and reflected in the unscheduled care plans, and we are making progress faster in some areas than in others, and I guess that that is by choice, because we have to prioritise the development and implementation of these schemes, as we cannot move forward on all fronts at all times.

10.00 a.m.

[61] I have mentioned two areas in particular. One is Gwent, where, as I said, we are planning to put in six paramedic practitioners to provide round-the-clock admission avoidance and to find more appropriate alternatives to accident-and-emergency department admission for patients who dial 999. As I have said, in Vantage Point House we are playing the GPs into that, at the point at which the call is taken. In Powys, we have just agreed that we will put a number of extended-scope practitioners in there as well. Powys Local Health Board is paying the start-up costs for that, and it is considering paying the differential costs of operating band 5 paramedics to band 6 practitioners. The focus of that will be on helping them to keep three safe and reliable minor injuries units available, and on doing admission avoidance work, particularly with older patients, where it is often more appropriate to look after them outside the hospital.

[62] We have also refocused our paramedic continuing professional development on home resolution. We started with two particular conditions, namely hypoglycaemia—low blood sugar and diabetes—and epileptic convulsions, both of which can often be resolved at home. So, we are focusing our ordinary paramedics—if you want to call them that—on doing home resolution work and keeping patients at home. We see that as part of our contribution to the modernisation of unscheduled care. Vantage Point House is a very big part of that

contribution.

[63] **Lorraine Barrett:** On the eight-minute target time for category A calls, we have previously discussed turnaround and handover times; I am trying to keep them separate. However, do the turnaround times impact on the ability to achieve the callout target, generally speaking?

[64] **Mr Murray:** As I said, we have done a regression analysis to look at the impact of delayed turnarounds at the hospital that gave us our biggest problem, namely the Royal Gwent Hospital, on category A eight-minute performance across the whole of the south-east region. This is reasonably blunt, and it should not be taken as absolutely accurate, but for every 24 ambulance unit hours per day that we lose at the front door of the Royal Gwent, we lose six percentage points against our eight-minute standard across the whole of south-east Wales.

[65] **Jonathan Morgan:** Janet, is your question on this particular point?

[66] **Janet Ryder:** Yes, Chair. Can you confirm that? It sounds as if many of these issues stem from how cases are managed when patients arrive at the hospital, and you are being measured against someone else's performance. To what extent do we need to address that? How can we ensure that that turns around so that your ambulances are released to do the jobs that they need to do, and why is it not happening?

[67] **Mr Murray:** It returns to why I have called for these plans. There was not the co-operation and collaboration that there should be in terms of the seamless handover to release the vehicles back onto the road with their crews. You may well ask why, but I do not know why different parts of the system see their priorities differently in one national health service. That is why I have asked for these plans, and I have mentioned it to the Chairs at recent meetings that I have attended I want it to be seen as a joined-up system.

[68] The other point that we need to explore, particularly in terms of Royal Gwent, University Hospital Wales and Morriston hospitals, is that they are major accident-and-emergency centres. They receive complex cases, and cases will often come in unscheduled in a batch as a result of major road traffic accidents. Those cases are more difficult to legislate for, and we need to recognise that. However, there is much room for improvement and we are not working as seamlessly and in as joined-up a way as we need to be, and that is where I am placing my attention at the moment.

[69] **Janet Ryder:** Whose job is it to drive through that seamless delivery of service? Is that your job?

[70] **Mr Murray:** Ultimately, I am responsible for everything, so the answer is 'yes'. The system tended to be much more at a distance with commissioners and providers, and we would manage performance through the regional offices. However, this is a very important issue in terms of the quality of care of our nation, and I am giving it the highest priority. It is not just about the patient experience within accident-and-emergency departments. If we do not have effective unscheduled care management it impacts on the rest of the system in terms of scheduled care. It is a major component of the way in which we need to improve how we do things at present. I am absolutely clear about that.

[71] **Michael German:** I refer to paragraph 1.18 of the auditor general's report, particularly bullet points 1, 2 and 4. I will start with the rota review in bullet point 4 and work backwards. We have had previous reports from the auditor general about how shift patterns did not match demand patterns. Bullet point 4 states that this is still a problem. Was there something wrong with the review? Did it not throw up the right answers, or was the original

analysis wrong? Why is the issue in bullet point 4 still there?

[72] **Mr Murray:** I agree with the wording of the auditor general's report, which states that many shift patterns were changed to achieve a better match two years ago but that some now need further work. In the review that we started a few weeks ago we found that, essentially, all of the shift rotas in north Wales were a good match to demand and that they did not need a review. Some minor adjustments were needed to some of the rotas in central and west Wales but, by and large, the original review had actually produced a good match with demand. In south-east Wales, most of the localities had shift rotas that matched activity well. The major exception to that was Cardiff, which needs some significant re-working. At the time of that review, we did not have a substantive regional director in charge in south-east Wales and the job of introducing the shift rotas was delegated to an interim director. He did a very good job. However, clearly, he was not ultimately our choice for that job. There was, let us say, some mismatch there, mainly in Cardiff, as a result of the way that these rotas were put in. It would be unfair to say that there was a major mismatch across the region. Most of the localities were fine, but, clearly, Cardiff was very important to us.

[73] We have an efficiency review under way at present, which was jointly commissioned by us and Health Commission Wales. We have held the rota review for a brief period. On 19 March, we should have a draft of that efficiency review, so we do not have to hold for very long. We want to see what the effect of the efficiency review recommendations will be on rotas generally. We do not want to change rotas now and then have to change them again later.

[74] **Michael German:** Okay. I will now turn to the first and second bullet points. I will start by identifying the amount of cash that is in the shortfall. In cash terms, what is the shortfall to fulfil bullet points 1 and 2? Secondly, how much non-recurrent funding, which in my language means stopgap funding—money that will come once and once only—have you received to plug that gap? My third question, which is to Paul Williams, is where will the rest of the money come from in years to come, if it is non-recurrent funding this year?

[75] **Mr Murray:** To bring the staffing back to our pre-strategic change and efficiency plan establishment—

[76] **Mr Woodhead:** It is 66 staff, approximately £4 million, which is the gap that we currently face. The non-recurrent funding is approximately £4.7 million. Therefore, you can see the similarity between the two. Effectively, we have been able to get some of the staff back in by utilising non-recurrent funding when it was made available to us. That has led to some of the improvements that Mr Murray has been highlighting for the end of this year. The gap that we currently face in terms of our staffing and getting us back up to the previous pre-strategic change and efficiency plan staffing level is approximately £4 million.

10.10 a.m.

[77] **Mr Murray:** As far as next year is concerned, we are relying on the efficiency review to demonstrate what we need. It has been well-evidenced that we have not been able to agree with Health Commission Wales on what we need to achieve sustainable compliance with the standards. We have agreed to sign next financial year's annual operating framework on the basis that we are both committed to implementing in full the recommendations of the efficiency review. We have, effectively, asked an independent party to come in and tell us what we need. So, as for the answer to the second part of your question, that has to await the imminent recommendations of the efficiency review.

[78] **Michael German:** There are two obvious questions stemming from that, before Paul gives us his view on how he will manage to fill that gap for next year. First, when did you

receive the non-recurrent expenditure that you just mentioned—the £4.7 million? How quickly are you able to staff up as a result of receiving that funding? Presumably, you will give those staff a contract. Will that be for one year, because you do not know where the funding for the next year is coming from? Will they be on permanent contracts, and so have the expectation that they will be working in the ambulance trust for the following year?

[79] The second question, related to what you just said, is that it seems to me that you are in some sort of dispute procedure, as I call it—if you do not agree, put it another way—with Health Commission Wales on whether you can make efficiency savings to match the amount of money that is available without touching front-line services and affecting your targets. That seems to be what you just said, and it is a worrying scenario. What are the principal elements of the dispute or difference between yourselves and Health Commission Wales, which you have asked the independent body—and perhaps you could identify that body for us—to resolve?

[80] **Mr Murray:** The funding came in—

[81] **Mr Woodhead:** Sorry, may I answer this? The funding came in at the end of December. It was then that we were given the go-ahead. So, effectively, it kicks in for the last three months.

[82] **Mr Murray:** I should say where the funding comes from. The majority is made up of fortuitous savings on the Airwave programme caused by delays occasioned by the programme itself, not by the trust. We have also had £300,000 from Health Commission Wales, and we are getting that on the basis of £100,000 per month from January to the end of March. Health Commission Wales has said that it will continue that funding into the new year until we get our automatic vehicle location and mobile data systems up and running.

[83] We are offering permanent contracts to new staff, but it takes a while to recruit people. We have plans in the coming year, and in the current year as well, to recruit and train 36 ambulance technicians—that is the basic emergency medical service grade—to train 36 paramedics, and to recruit a further 36 intermediate staff for our high-dependency service. They will have to be given permanent contracts, so there is a degree of risk involved, and we acknowledge that.

[84] As to the nature of the disagreement between ourselves and Health Commission Wales, we had some negotiations with HCW last year for the current financial year's annual operating framework, and we put together a package valued at £13.6 million.

[85] **Mr Woodhead:** Yes, it started at about £13.6 million.

[86] **Mr Murray:** Through a process of negotiation with Health Commission Wales, that was brought down, by agreement, to just over £9 million. However, in the final analysis, Health Commission Wales told us that it could not give us anything, but that it still expected us to meet the standards.

[87] **Michael German:** Sorry, could you repeat that last sentence? I did not quite catch it.

[88] **Mr Murray:** It said that it could not give us anything, but that we were still expected to meet the standards. That is the basis of the disagreement, and we have decided to take it further. We have made a positive step in agreeing to bring in outside analysts to do this efficiency review, and to tell both of us where we were right or wrong in our calculations.

[89] **Michael German:** When will they report?

[90] **Mr Murray:** The report is in two parts. The first is about what we need to achieve sustainable, safe, effective performance in the current situation, when unscheduled care has not yet been modernised, and the second part is about what we would need in a modernised, unscheduled care system. The first draft of the first section of the report is due on 19 March.

[91] **Michael German:** What about the second part?

[92] **Mr Murray:** That depends on how much reiteration is required. They are aware that they have to do this quickly, because next year's annual operating framework depends on it. We should have something final by April.

[93] **Michael German:** Mr Williams, you have about heard the dispute that is going on. You have to plug the gap. What do you anticipate will happen post April, which is not that far away, in the ambulance trust's budget?

[94] **Mr Williams:** This goes back to my introductory remarks that we have to be sure that the assumed efficiency savings that are there to be had will be achieved against an assumption that the budget is adequate. Some of those assumptions have not yet been taken out of the system. We have talked about improving rotas, and more work is being done on that. There is more work to be done on matching supply and demand, and we have done some work that suggests that 39 per cent of category A incidents could be classed as category C, so there is an issue there. We have also looked at reducing sickness and other absence, and at reducing turnaround times. We have not yet talked about the benefits of the automatic vehicle location system, which is calculated to give another 5 per cent of savings. So, we first need to ensure that the standing assumptions are fully implemented, as they will give us the outcomes that we are looking for.

[95] In the longer term, there is the benchmarking exercise that Health Commission Wales and the trusts are currently working through to see whether the assumptions about baseline budgets are standing up to comparisons, particularly with England. If all that does not come into play, I will have to look at the competing priorities in the total budget. There is a long way to go before we can think in those terms, but we are planning ahead and anticipating issues. The situation changes: demand changes and technology changes, and all these things put pressure on budgets.

[96] **Michael German:** I just wanted to be absolutely clear on this. We are talking about a budget from the coming 1 April.

[97] **Mr Williams:** Yes, but we manage in-year issues, and that is part of the normal way in which the health service has to flex to deal with competing demands, priorities and new developments as they arise. However, first and foremost, you have to ensure that you are getting value for money from what has already been allocated.

[98] **Janet Ryder:** The report mentions the three capital business cases that were made, and when Ann Lloyd, the previous head of NHS Wales, came before us, she said that there would be a short timescale for the Assembly Government's consideration of those capital cases. Mr Williams, why has it taken so long to request and approve the various capital strategies, and when will they finally be approved?

[99] **Mr Williams:** I understand that the business case for the automatic vehicle location system, which is the first important one, was submitted back in April. There was a fairly long dialogue between Welsh Assembly Government officials and the trust about whether it was fit for purpose, and there was also an issue for the commissioner about whether the revenue implications could be funded. A resolution on that did not come to pass until November. As far as the Welsh Assembly Government is concerned, we took three weeks to turn the case

around. We do not have a problem with the Assembly Government turning a business case around once it has been properly signed off. We did it very rapidly: in three weeks, as I said. We might need to understand more fully why it took so long to get the detail sorted out, and that is where we need to be accelerating things. Clearly, I cannot approve business cases until I am comfortable that they have been clearly signed off.

[100] **Janet Ryder:** However, some are still outstanding, are they not?

10.20 a.m.

[101] **Mr Williams:** The second one was in regard to the estates and I understand that the estates strategy was also submitted in April. There was a lot of discussion on the potential to release redundant properties to help to fund some of the capital programme, and on the detail of the plan. When I took over the portfolio, I quickly became concerned about the development at Wrexham, because that is an exciting opportunity for joint planning with the other emergency services. So, I took measures to establish a framework contract, and to provide external consultants who could develop the business plan. We have accelerated that and are still waiting for further information from the trust. As far as the Assembly Government is concerned, we are accelerating the business plans.

[102] The final business case is on the ambulance replacement programme. My officials were reluctant to approve any further investments until they had an overarching and wide-ranging vehicle replacement programme. That has only just been submitted, and we are currently working through it. Once we are satisfied, I have no problem in turning the business cases around in a matter of weeks.

[103] **Janet Ryder:** So, are you saying that you are happy that there was a short timescale, as with the assurance that was given and as indicated to you?

[104] **Mr Williams:** I am happy with the length of time that business cases are before me, to give me the comfort that I require. They are turned around. One question that you might want to address to Mr Murray is whether the trust has had enough management time to think the strategic issues through, given all that it has been doing. That may be a feature of the fact that the trust is under a lot of pressure and it needs to sift the important strategic issues from the operational issues. That is where there have been some difficulties.

[105] **Janet Ryder:** I will just ask Mr Murray whether the trust has contributed in any way to those delays.

[106] **Mr Murray:** Every time we submit a business case, we get a series of questions back to answer. Sometimes, those questions require us to reiterate the case, that is, to draw it up anew. Tim can probably fill us in on the timescale for that.

[107] **Mr Woodhead:** Yes. We would often have a timescale of around three weeks to a month to reply to an initial set of questions. In the business case for the vehicles, there was a supplementary set of questions, some additional information was then requested about our longer term plans, which we provided, but there was then a request for an overarching fleet strategy, and we have just provided that. There have since been questions on the fleet strategy, which we are about to respond to, and will do so by the end of this week. So, you can see the procedure of scrutiny that the capital cases go through. It ensures that the trust will respond, and I believe that we have responded to all the requests that we have had. However, clearly, we have to respond to all the questions before any funding can be released.

[108] **Mr Murray:** I would agree that there was major issue with the automatic vehicle location system business case. It was not that there was a delay in responding to the questions;

we responded to them, and dealt with them, fairly quickly. The major outstanding issue was that £900,000 per year of revenue was required to pay for licence fees and system updates, and to cover all the usual costs of acquiring a major system. There was a major debate between us and Health Commission Wales as to how that would be funded. In the end, we resolved it by agreeing that we would pay half of it and Health Commission Wales would pay the other half, which means that we have another £450,000-worth of efficiency savings to find as a result.

[109] **Jonathan Morgan:** I will just ask a question as a point of clarification. You said that you had to deal with Health Commission Wales and decide how that revenue funding would be covered. How long did the discussions—and I do not want to use the word 'dispute'—go on for before the issue was resolved?

[110] **Mr Woodhead:** It went on for some months. Without looking at the details, I would estimate that there was about two to three months' worth of debate.

[111] **Mr Murray:** The Assembly Government was in the position of having to demonstrate a business case's affordability to approve it. We could not demonstrate the affordability of the AVLS business case, because we were in discussion with Health Commission Wales about how the revenue consequences would be met.

[112] **Jonathan Morgan:** Before I bring in Simon Dean, I have a quick question for Alan Murray. You have experience of other ambulance trusts in Britain. What is your analysis of the processes that we go through here in comparison with the speed at which business cases are approved in the other trusts of which you have experience?

[113] **Mr Murray:** They have been mixed. We have had some delays in getting business cases approved recently. However, when we submitted the business case for £16 million for new ambulances shortly after I arrived, that business case was approved very quickly. That enabled us, over a six-month period, to bring a large number of new ambulances on stream. So, some of our business cases have been approved very quickly; others have not been approved as quickly.

[114] **Mr Dean:** I was heavily involved in a number of these business cases and chaired a number of meetings, so I thought that it might be helpful for me to comment on this point. There are two levels of questioning about business cases. The first is on the fine detail, so on the technical issues of a business case. The major issue that we had last year was the strategic fit, namely how all these things fitted together into a coherent strategy for the development of the ambulance service. It was difficult for the Minister to consider business cases for replacement vehicles for the estate without being clear about the strategic shape of the trust. The Minister requested a strategic statement from the trust, which has taken a while to get to a stage at which it is nearly in a condition to be approved.

[115] On the AVLS business case, Mr Williams mentioned a few moments ago the performance improvement that that business case would generate. The 5 per cent figure that has been agreed with the trust as the required improvement in performance emerged only quite late in the discussions about the business case, as I recall. So, the affordability issues and the payback for the £900,000 of investment took a little time to become clear. The key issue from our point of view is how all these specific business cases fit together to deliver a strategic plan for the trust as a whole. That is a key contextual issue, which is very important.

[116] **Janice Gregory:** Mr Murray, it is good to hear you say that your business case for the vehicles was approved very quickly. I have heard what you and Tim have said—and I am sorry for being late; I was in another committee meeting—but it seems to me that you are like other organisations that request funding from the public purse. Paul has talked about the

management structure and whether there is capacity within it to deal with the issues. Hopefully, we will discuss that later, as I have a particular interest in your management structure. We all work with people who have to make business cases to the Assembly Government for funding. Surely, in doing so, you try to pre-empt the questions and try to answer, or include within your business case, questions that could arise. I know that it is sometimes like wishing that you had a crystal ball, but I do not think that you can then be unhappy or critical if you are asked by the Welsh Assembly Government to clarify things in your business case. If Assembly Members were scrutinising this, I know that they would be very unhappy if any Minister just wrote out an Assembly Government cheque for £9 million without ascertaining whether the structure was in place to support that investment. The press has made much of the timescale and the fact that things have been waiting for approval, but there is an issue that perhaps you should have been a bit more savvy, if I may say so, when submitting your business case and pre-empting the questions that could have come back.

[117] **Mr Murray:** We are not unhappy to receive questions and we deal with them quickly and turn them around quickly when we get them. We understand that that is part of the process. We are fully aware that we are fishing in a lake of limited capacity, if you like, and there is an opportunity cost for someone else for every £1 million of investment that we get. I have been in the public sector for 34 years and I have been involved in many capital developments, so I am fully aware of that and I am aware of the Treasury's 'The Green Book' requirements. That is not an issue for us. Would you like me to deal with the issue of management capacity?

[118] **Janice Gregory:** I do not know whether we have the time.

[119] **Jonathan Morgan:** If we have time later, we can refer to it. However, I am conscious that we have other questions.

10.30 a.m.

[120] **Irene James:** I want to look at paragraphs 1.27 to 1.30, which give details of the Assembly Government's request that trusts produce an overarching and integrated strategic plan. Both the auditor general's and the Audit Committee's reports on ambulance services highlighted the importance of rapidly addressing the historic lack of effective capital investment in the trust. Why has it taken so long to request an overarching and integrated strategic business case?

[121] **Mr Dean:** To give you an idea of timescale, the overarching strategic statement was requested last June from the trust. We have seen a couple of drafts of that, one in November, and we have provided comments, but are still awaiting the final version from the trust. So, the responsibility for setting a strategic direction for the organisation must rest with the trust rather than with the Welsh Assembly Government.

[122] **Irene James:** This was first highlighted in the auditor general's report in December 2006, and you are saying that it took that long for it to come through from the trust.

[123] **Mr Murray:** I think that the reference in the auditor general's report was to 'Time to Make a Difference', which was approved by the trust board in December 2006. We began to implement that in January 2007, so there was a major strategic review of the trust at that time, as I think that a reading of the auditor general's original report will confirm. That was occurring at the time that the report was being developed and it shaped many aspects of the report's recommendations. So, there is recognition in the Welsh Assembly Government and in the trust that we are two years into 'Time to Make a Difference'. A number of assumptions that we made in that strategy, such as the speed of modernisation of unscheduled care, have not proven to be accurate, so there is a need to review that. We have now had authorisation

from the Welsh Assembly Government to take the advanced draft of the document to our own staff for consultation, and we will do so as quickly as possible.

[124] **Irene James:** I was about to ask when that strategy would be provided and you have just said that it will be provided as soon as you can do so.

[125] **Mr Murray:** No; we are ready now to go out to consultation with our staff and that will happen within the next few weeks.

[126] **Irene James:** Why has it been necessary for the Assembly Government to ask you to produce it? Why did you not just produce it yourselves?

[127] **Mr Murray:** As I say, we did produce a strategic document in 2006, namely 'Time to Make a Difference', which was approved by the board in 2007. Members were part of the external consultation process on that. We are talking about refreshing and updating that strategy, so we are not working without an overarching strategy at the moment; we are simply refreshing and updating that strategy in the light of changes to our strategic policy.

[128] **Mr Williams:** I wanted to hang back in terms of the history here. What we do not want is yet another strategy. However, we want the various excellent documents that the auditor general has produced and 'Time to Make a Difference' to be joined up. The question is: why are we not making enough headway as quickly as we would all want? We need a stock-take in terms of where we are and a well sequenced and co-ordinated set of actions, bringing the strategic and operational issues together, particularly in terms of the people in the organisation. If I were driving this forward, I would start by asking myself why we are not moving more quickly in terms of the organisation's culture. This comes back to the pressures that trusts have been under. We have to start with clear leadership at the board level and the board needs to indicate the strategic and operational issues. We also need stable management and experts in human resources, information and communications technology and finance. We need to develop this culture of engagement, team working and problem solving in the trust and we need good middle management. I do not think that the middle management is operating as effectively as it should. I would like greater emphasis on management at a regional level. This brings us back to your earlier point about partnership working, because we do not only have partnerships with the trusts and the LHBs, we also work with the emergency services and the local authorities. I think that it would help if we were to emphasise the regional structure and elements of the stable management platform, and then we can get into a much more exciting time of change. For me, a key element that is missing in the strategic plan is around people management and developing a new positive culture.

[129] **Lorraine Barrett:** I would like to ask a question about the £300,000 that Health Commission Wales agreed to provide as stabilisation funding, on the basis that the trust would fund the other £300,000. Will Paul Williams tell us on what basis the £300,000 was to be provided by Health Commission Wales? Do you think that that will deliver sustainable improvement?

[130] **Mr Williams:** May I defer that question to Simon? He has been involved with that in detail.

[131] **Mr Dean:** I chaired the meeting between the ambulance trust and Health Commission Wales that brought about that position. The discussion in the meeting was that the ambulance trust should be able to achieve 62.4 per cent within its existing resources. On how that performance could be improved going forward, the automatic vehicle location system is a key contributor, with the business case committing the trust to achieving a 5 per cent improvement in performance following the implementation of the AVLS. That business case has now been approved, but there is a six-month lead-in time between approval and the

system being live, so the question was how could that financial gap be covered in the interim, and that is where the £600,000 came in. The discussion was, essentially, that the cost would be shared between HCW and the trust on a non-recurring basis, pending the introduction of the AVLS system.

[132] **Lorraine Barrett:** Can Alan Murray say whether that will deliver sustainable improvements or is it just short-term funding to improve headline performance figures?

[133] **Mr Murray:** The position that we are in at the moment is that we are waiting for the efficiency review to come through. I think that we have settled on that as a way of avoiding the kind of we-said-they-said discussion that we have had with Health Commission Wales. So, it is probably best that we wait for the outcome of the efficiency review. If that review tells us that we can be more efficient and that we do not need any more money, we are signed up to delivering that because the review is not just going to tell us what we need to do, it is going to tell us how the standards can be achieved. On the other hand, if the review says that we cannot be more efficient—it is never true to say that an organisation cannot be more efficient, but, if it says that, at this stage, it is not efficiency that is required, but investment, Health Commission Wales has signed up to that.

[134] **Mr Dean:** I would like to add that the efficiency review question came up at the meeting that I just mentioned. In fact, I asked for there to be an agreed joint methodology to ensure that both parties were signed up to a view about efficiency and benchmarking. The context of that discussion was the savings requirement on the trust going forward, as opposed to current performance levels, as I indicated a few moments ago. So, the baseline position, plus the improvement that the AVLS system will allow the trust to achieve means that the trust is committed to achieving a performance above 65 per cent—67 per cent—across Wales. So, the issue about the efficiency and benchmarking review is what it says about further savings and efficiencies in the years to come.

[135] **Janet Ryder:** A number of issues that need attention were highlighted in the report. Some of the issues have been touched on, but some of the others, like the need to provide ongoing reductions in sickness absence, have not. We have talked about turnaround times and matching supply and demand. Mr Murray, what is the trust doing to deliver in response to the issues that were highlighted in the original report?

[136] **Mr Murray:** One of the priorities in our management development programme was the management of sickness absence for first-line and middle managers. That was one of the earliest programmes that we delivered. I recognise that it says in the auditor general's report that only 31 per cent of our managers have undertaken that training, however, our new human resources director—we now have a substantive HR director, I am pleased to say—has recognised and said as much to the auditor general, that not all the training that has been undertaken by our managers has been entered into the system.

10.40 a.m.

[137] The system therefore shows that only 31 per cent of managers have gone through this training. Jo Davies, our HR director, is auditing that, and she will report to the executive management group next Monday what the actual figure is for each of the different elements of the management learning programme that we have embarked on. That was one of the initial focus areas for the management learning programme.

[138] We have also been refreshing return-to-work interviews, and we have been beefing up our HR function so that it can better support managers in managing sickness. We have put in a new information system called Promis, which feeds the electronic staff record for us. We have all of our emergency medical service staff and most of our main patient care service

staff on that system now. That system records sickness absence in a way that is accessible to the local manager. If I was the local manager, doing a return-to-work interview with a member of staff, I can look on Promis to see how many days and how many episodes of sickness that individual has had, and that will then inform how I deal with the individual.

[139] Our sickness absence figures are on a downward trend at the moment. I tried to get you the most up-to-date figure before I came in today, but even from the auditor general's report, I think that you will see that the trend is downward. It needs to come down still further and faster, and that is something that we are focusing on at the moment.

[140] **Jonathan Morgan:** I will just bring Janice Gregory in at this point, because we have gone into the issue that she was going to raise to do with management. Janice, do you want to ask a question about this now?

[141] **Janice Gregory:** Thank you, Chair. Alan, we have heard what you have said, but the reality is that fewer than half of your managers have attended any training. If we go back to earlier conversations about the perception, people are convinced that there is an issue with your management structure. Do you think that the trust has effective leadership in place, and are the managers and the middle managers doing their job as they should? Please tell us, as a committee, what you can do to ensure that your managers receive adequate funding and that that does not encroach on operational issues. There is a massive issue here to do with how you deal effectively with your middle management structure. How do you ensure that they take on adequate training and that that trickles down through the rest of the service?

[142] **Mr Murray:** At our most recent staff survey, we recognised right away that there was an issue with the trust's middle and first-line management. We still have some issues with senior managers, because at that time we did not have a substantive regional director for south-east Wales. We advertised, we offered the post and then, for reasons that I will not go into, the appointment did not happen. We appointed an interim regional director in the south east for six months. We told him that we would give him six months to show what he could do, and in the meantime, we advertised for a substantive director. We made the appointment to that post in May of last year, so we have only had a substantive director in south-east Wales since then. That has an impact on the quality of middle management, and on the ability to mentor and develop middle management.

[143] As soon as we got the staff survey, we put together a staff survey action plan, we appointed a modernisation manager in our HR department, James Moore, who has been leading that in conjunction with our staff side, and we have been making progress with the MSLP—I cannot remember what the 'S' stands for, but it—

[144] **Janice Gregory:** Skills.

[145] **Mr Murray:** The management skills and learning programme—I am deeply ashamed that I forgot that. It is a management skills and learning programme for all of our first-line and middle managers. We have been proceeding with that as fast as we can. You say that the majority of our managers have not accessed that, but the fact is, as Jo Davies has admitted, we do not know how many of them have accessed it. For example, all the managers in the clinical directorate have been through some form of training and development, and all have had personal development reviews, but none of those reviews have been put into the system. We know that there are other parts of the service where people have accessed the modules, but they have not updated the system. So, Jo is doing an audit of that and she will be reporting to our executive management group on Monday. We anticipate that the percentage of people that have actually accessed the programme will be considerably higher than the percentage currently recorded as having accessed the programme.

[146] **Janice Gregory:** That is not a good admission for you to say that the trust does not know how many managers have accessed this particular training. In light of the deficiencies that exist at the moment in the service, it is an admission of inefficiency that you do not have this information on the system and at your fingertips so that you, as the person in charge, can access it to see where the deficiencies are. If this training is so important, your managers should know exactly who has and has not undertaken the training. I know that we are getting into the micromanagement of it, but we all know about the good work that the people are doing on the ground. They took my 16-month-old grandson into hospital the other day, so I have nothing but praise for your staff. However, there is an issue about managers accessing the training that you provide for them and which, I assume, that they are expected to undertake. It is not an either/or situation: you say 'You will undertake this training because you need it so that we can run the service efficiently'.

[147] **Mr Murray:** They are required to undertake the training, but I will make a couple of points in response to your question. First of all, I must accept the criticism that everyone should be on the system, but we have only just appointed a human resources director, and Jo is working her way through a backlog at the moment. She jumped onto this issue very quickly, and, as I said, she will report on Monday on what the actual position is. The second thing is that the emphasis on performance over the last few months has been such that managers have been working operationally, and because of the extended hospital delay problem, we have had managers in the corridors of accident-and-emergency departments. I think that Tim can give a number for that.

[148] **Mr Woodhead:** There are approximately 10 managers working various shifts in accident-and-emergency departments. The cost to the trust is around £350,000 to £400,000 for that work, which tries to mitigate some of the problems with hospital delays.

[149] **Mr Murray:** If you talk to ambulance staff, they will say that they have never seen so many managers. They used to complain that they never saw managers, but now they are complaining because they see too much of them. So, managers are working operationally, and they cannot divide their time infinitely. I am sure that that has caused some delays in their ability to access the learning and skills programme. As far as not having the training on the record is concerned, it is something that Jo Davies is putting right.

[150] **Jonathan Morgan:** Janet, do you want to come back on this before we move on to Nick?

[151] **Janet Ryder:** I will move on from the issue of sickness levels, because two other areas were highlighted that the trust needed to address. We have talked a lot about the improvement in time-loss because of long turnarounds and some of the issues that may stem from that, which may be issues outside of your control. However, are you satisfied that the trust is doing everything that it can to improve long turnarounds? If not, what more can the trust do?

[152] **Mr Murray:** One can never say that one is doing everything—there may be things that we have not thought of. However, we have worked assiduously with the trusts that give us the major issues. I even commissioned a consultancy review in 2007 in partnership with the chief executives of those trusts to look systemically at what was causing the queues at the front doors, what we are doing in the ambulance service that is causing problems, what is happening in accident-and-emergency departments, what is happening further into the hospital, and at the back door of the hospital that is causing those problems? That review was published in December 2007, and I can give one example of where it worked well, namely the former Swansea NHS Trust, where the chief executive picked it up and implemented its recommendations, and we had a significant reduction at that point in the number of delays at Morriston Hospital. It goes back to competing priorities within the trusts. As far as whether

we have done everything that we can is concerned, we have done everything that we can think of.

10.50 a.m.

[153] **Janet Ryder:** So, you are satisfied that improvements now lie in the hands of the hospital trusts.

[154] **Mr Murray:** They largely do, but if they identify anything that we are doing that adds to their problem, we will quickly work with them to fix that. One of the things that we need to work on is that it is estimated that, across the whole of the UK, anything up to 60 per cent of people who are brought into accident-and-emergency departments are discharged without in-patient care. You can imagine that someone with a broken wrist needs to be in an accident-and-emergency department and will be discharged, but a large number of people do not need to be in an accident and emergency department in the first place. We need to reform the entire unscheduled care system to create new care pathways to keep those people out of accident and emergency departments.

[155] **Mr Williams:** That is why I was keen to engage the local health boards, and primary care in particular, in this whole debate. A task and finish group is currently working on this, with Alan's support, which suggests that some 39 per cent of category A calls should be category C calls. There is a lot more work to be done here. At the moment, the system is pushing far too many people into ambulances and from ambulances into accident and emergency departments. So, it is a whole-system issue that we need to address, and that is what the new reorganisation must tackle as part of thinking about different ways of delivering services.

[156] **Nick Ramsay:** I want to ask Mr Murray about paragraphs 1.51 to 1.54 of the report, and figure 13—it is the part on page 24 that is headlined:

[157] 'Overall progress has been slow because of operational pressures and a lack of clear focus and prioritisation'.

[158] The paragraphs mention the problem with the introduction of clinical team leaders—positions that were a way of addressing cultural and morale issues in the trust. Why are the majority of clinical team leader positions still unfilled and why will it take so much longer to address this than you seemed to suggest the last time that you gave evidence to the committee?

[159] **Mr Murray:** I find this a difficult area, and it is embarrassing in many respects, because I feel strongly about the team leader programme, which I introduced to the UK ambulance service in the 1980s, when I was in Belfast. So, I feel strongly about the need for clinical team leaders. I have appointed them in each trust that I have worked in, without the issues that we have had here. The first issue was that, because of the protection that was offered to existing supervisors, only about 10 of them applied for clinical team leader positions. That left us in a potentially unaffordable position, in which we would have two significant groups of band 6 staff—one group being the clinical team leaders, and another large group being the former paramedic supervisors, who would be working as operational paramedics and still being paid as supervisors, because of the protection arrangements. So, we put forward an alternative, namely that we would review the qualifications of the existing paramedic supervisors, and that we would slot those with the requisite qualifications into the team leader positions, and develop and performance manage them to ensure that they were capable of doing the job. Unfortunately, we were unable to reach an agreement with the staff about that. They disagreed strongly with that suggestion. We now have to run the development programme first and, when people have been through the development

programme, slot them into the team leader positions. That will take much longer than we had anticipated.

[160] **Nick Ramsay:** Do you have any idea of the timescale that you are talking about? I notice that the problem with filling the posts is uneven across Wales—the south-east is more of a problem than the north, for instance.

[161] **Mr Murray:** I am reluctant to say that this is another south-east problem, because everything gets laid at the door of the poor old south-east. The north already had a number of clinical team leaders in post, and that is why it is not a problem for them. It is an issue in the south-east, the central region and the west, where there were no team leaders. It will take us most of this year to work our way through that, and having twice given dates by which the problem was going to be resolved, I am extremely reluctant to tie myself to another date. Unfortunately, this will be a gradual process.

[162] **Mr Woodhead:** I would expect to see some incremental improvements as these people complete various modules of the training and enhance their skills, becoming able to deliver more of the programme.

[163] **Nick Ramsay:** May I draw your attention to paragraph 1.56, which talks about the management review reporting on 25 March 2009? On the back of that, do you have the right people, both in terms of capability and capacity, to manage the trust? It could be said that you do not, and that that is why you are undertaking the review.

[164] **Mr Murray:** There are management capacity and skills profile issues at the top of the trust. One of the things that we jointly recognised with the Welsh Assembly Government is that we need someone at executive director level taking responsibility for strategic development. That is one of the issues that we are considering in our current management review. I am reluctant to go into too much detail about the discussions that we have had, because we will be going out to consultation with affected parties at the beginning of next month—I think that it starts on 9 April. It would unfair to them for me to go into more detail now, except to say that we recognise that there are areas of weakness in our team that we need to address.

[165] **Nick Ramsay:** I would like to put that question to Paul Williams as well, regarding the managerial capacity within the trust to deliver on the challenges that you face.

[166] **Mr Williams:** As I said earlier, there is no doubt that we have not progressed as quickly as we would like, and there have been challenges across the piece. We can concentrate on that now that we have improved the board itself by the addition of two non-executive directors, both of whom will have particular skills that we needed, one in finance and one in IT, and they will strengthen the board at a non-executive level. There will be strength in numbers, because I also want them to take on a champion role for each of the regions, perhaps including some kind of pastoral responsibility, going around the stations and looking at what is going on. I will be working closely with Alan and his senior team, and I am delighted that we have brought in an experienced HR director. We need to bolster his team with some more general management skills and support, so that we can divide the strategic and operations issues, particularly the issues around workforce flexibility and engagement. If we can get those things right, then we can move forward more rapidly than we have in the last couple of years.

[167] **Lesley Griffiths:** I will just ask a supplementary question on that. Given your comments on the clinical team leaders—that you did not take the staff side with you—I would like to ask why. Was it because they did not think that they had an adequate support structure in place?

[168] **Mr Murray:** No. I have to be careful about how I put this. They probably felt that some of the supervisors would drown in the role of team leaders, and it might not be fair to them.

[169] **Lesley Griffiths:** Looking at the continuing work on unscheduled care, the Welsh Assembly Government has initiated an intelligence target project. Do you have too many projects running simultaneously? Is there too much emphasis on the current targets applying to unscheduled care, particularly ambulance response times and accident-and-emergency department access?

11.00 a.m.

[170] **Mr Murray:** I will deal with the ambulance response-time target first. The eight-minute standard is a clinical standard, and it is about providing effective, life-saving care to people who are having life-threatening emergencies, therefore it is very distressing when that target is not achieved. Having said that, as Paul Williams has already said, we include too many people in that A category. We have been doing some work with the medical priority consultants that develop our call categorisation system to improve the way in which we ask questions of callers—sorry, this is almost throwing your own words back at you—looking at asking supplementary questions. For example, when we ask, 'Is the patient breathing normally?' and the answer is 'no', we should ask, 'Is he breathing normally for him?' and the answer might be 'yes', because that person could have had emphysema for 30 years, so the answer to that first question would always be 'no'. In the old questioning regime, that would automatically be upgraded to a life-threatening emergency. So, we are adding supplementary questions and are retraining our call takers. The results of that are already apparent, because the percentage of the 999 calls that we categorise as A, as potentially life threatening, has gone down from 42 per cent to 32 per in recent weeks, and there is a continuing reducing trend. So, yes, that standard is very important, but it is very important to our staff and to other road users, for example, that we are not responding with lights and sirens for patients who really do not it. So, the specificity of our call categorisation is very important. When we get to the B category, there are 14, 18 or 21 minute ninety-fifth percentile targets depending on population density—it is 14 minutes for an urban area, 18 minutes for a rural area and 21 minutes for a sparsely populated area. That is about getting the ambulance to the patient to transport him or her to hospital. Taking patients out of the ambulance response population is very important too, because it means that we can save our emergency ambulances for the life-threatening emergencies and that we do not bring as many people through the front door of the hospital. So, the standards are fine up to a point, but the way in which we manage our caseload determines how relevant they are.

[171] **Lesley Griffiths:** Mr Williams, do you think that there is too much emphasis on the current targets that apply to unscheduled care?

[172] **Mr Williams:** No, I do not think so, but the emphasis needs to be on intelligent targets to ensure that we are tracking the whole system through. Perhaps Simon would like to come in on this, because he is doing some work on intelligent targets.

[173] **Mr Dean:** This links back to the earlier points. It is about how we connect all of this together and look at the patient experience through the whole of the journey through the healthcare system, how we ensure that there are appropriate methods of treating people so that people who do not need the services of an accident and emergency department are offered an alternative. We will need a responsive service, there is no doubt about that, so, to my mind, there will always be a response-time target, but that cannot be the be-all and end-all. We have to connect this together so that hospital-based staff understand the importance of turning ambulances around quickly when they arrive at hospital to free them up to help manage the

next patient in the pathway. We need targets that are increasingly focused on clinical outcomes, and we need to look at pathways for people with emphysema, for example, or how we manage people who have had a fall and have different targets for different types of care that are much more sensitive to what is relevant to the individual person. So, there is a lot of work to do, and it is exciting work. To my mind, there would always be a response component, because the ambulance is often the first contact with the health service, and it is an important triaging and signposting service. So, I think that response time is critical, but we are doing work to refine the targets across the whole pathway.

[174] **Lesley Griffiths:** Do you think that it is reasonable for the ambulance service to be judged each month against a single figure for category A response-time performance?

[175] **Mr Murray:** No, I certainly do not think that it is reasonable for it to be judged against a single figure. As we refine our triage process at the point at which we receive the call and when we are face to face with the patient, we need to be measured against appropriateness targets. For example, NHS Direct is measured on what is referred to as endpoint dispositions, that is, the percentage of patients that it referred safely and appropriately to a non-urgent GP appointment, a pharmacist, self-care and so forth. I think that that is a guide to the kind of standards that we need to develop for the whole unscheduled care system. The ambulance service is a major component of the unscheduled care system.

[176] **Lesley Griffiths:** Do you think that it is reasonable, Mr Williams?

[177] **Mr Williams:** It is the start. Targets are about touching the top of the pyramid and having the ability to drill down within them. There are other targets that we look at within the ambulance service—we have talked about sickness and absence, for instance—that could be a factor in why we are not meeting response times. We need to look at these things in the round, and that is the issue. There is always going to be criticism about targets. I think that the use of intelligent targets is appropriate but we need to understand what lies behind these figures.

[178] **Jonathan Morgan:** The final question is from me. I want to take you back to the beginning very briefly for a point for clarification. In the answer that you gave to Huw Lewis and to Mike German about the plans that you had requested in January, which have been submitted and that you are now considering, bearing in mind that more than two years had elapsed between the auditor general's first report in December 2006 and the point at which those plans had been requested, had the Assembly Government made any other requests to those health bodies for similar plans in the intervening period?

[179] **Mr Williams:** I will refer that question to Simon.

[180] **Mr Dean:** The short answer is that we have been engaging with the national health service on seeking to improve performance in unscheduled care on a continuous basis with trusts individually and collectively. I have chaired a number of meetings involving colleagues from the ambulance trust, colleagues from Cardiff and Vale NHS Trust, and the same with Gwent. We have asked for plans, which we have had. Much of those plans has been implemented; this is about going up another gear, looking for the next level of activity, keeping the focus and pressure on, and seeking continuous improvement.

[181] **Jonathan Morgan:** Thank you. I thank the witnesses for attending this morning.

11.07 a.m.

Ystyried Ymateb Llywodraeth Cynulliad Cymru i Adroddiad y Pwyllgor Archwilio 'Y Senedd'

Consideration of the Welsh Assembly Government's Response to the Audit Committee Report 'The Senedd'

[182] **Jonathan Morgan:** As you will recall, the Audit Committee report was published on 5 November 2008. We have received the responses. There is a response not just from the Assembly Government, but from the Assembly Commission. This consideration has been somewhat delayed because the Assembly Commission's report was late in coming back to us, but we now have both sets of information. I will ask the auditor general to provide an assessment of the Government's response to the committee's report and then give Members a chance to express any particular views that they have beyond that.

[183] **Mr Colman:** Both responses are extremely positive and as my letter to your predecessor shows, there is clear evidence of acting upon a very important recommendation, which is to transfer the learning of a largely successful project into other projects. Richard Wilson, who gave evidence to the committee, is now in charge of a number of major Assembly Government projects. Transferring the person who has developed the learning is a real way of transferring the learning, and I think that the committee was very impressed with Mr Wilson's evidence.

[184] My letter also refers to the fact that we are currently undertaking an exercise across the whole of public services in Wales looking at good practice in estate management and buildings management, therefore, we will be drawing further lessons from that.

[185] In short, we had a very positive response and clear evidence of action to transfer successful learning from this building to other buildings.

[186] **Jonathan Morgan:** Thank you. Are there any views from committee members? I see that there are none, so I assume that we are content.

[187] **Irene James:** We are content, but cold.

[188] **Jonathan Morgan:** I am not sure what the temperature in this room is.

[189] **Lorraine Barrett:** It is the price that we pay for sustainability.

[190] **Jonathan Morgan:** Absolutely.

11.10 a.m.

Cynnig Trefniadol
Procedural Motion

[191] **Jonathan Morgan:** I propose that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 10.37(vi).

[192] I see that the committee is in agreement.

Derbyniwyd y cynnig.
Motion carried.

Daeth rhan gyhoeddus y cyfarfod i ben am 11.10 a.m.
The public part of the meeting ended at 11.10 a.m.

Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Archwilio
The Audit Committee

Dydd Iau, 30 Ebrill 2009
Thursday, 30 April 2009

Cynnwys
Contents

Aelodau Cynulliad yn bresennol
Assembly Members in attendance

Lorraine Barrett	Llafur Labour
Michael German	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Janice Gregory	Llafur Labour
Lesley Griffiths	Llafur Labour
Irene James	Llafur Labour
Bethan Jenkins	Plaid Cymru The Party of Wales
Jonathan Morgan	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Chair of the Committee)
Nick Ramsay	Ceidwadwyr Cymreig Welsh Conservatives
Janet Ryder	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Gillian Body	Swyddfa Archwilio Cymru Wales Audit Office
Jeremy Colman	Archwilydd Cyffredinol Cymru Auditor General for Wales
David Francis	Hyrwyddwr Cymru gyfan ar gyfer mynd i'r afael â thrais ac ymddygiad ymosodol yn erbyn staff y GIG yng Nghymru All-Wales Champion against Violence and Aggression against NHS Wales staff
Ian Gibson	Dirprwy Bennaeth, Uned Llywodraethu Corfforaethol, Llywodraeth Cynulliad Cymru Deputy Head, Corporate Governance Unit, Welsh Assembly Government
Sheelagh Lloyd-Jones	Cyfarwyddwr Adnoddau Dynol, GIG Cymru Director of Human Resources, NHS Wales
Rob Powell	Swyddfa Archwilio Cymru Wales Audit Office
Paul Williams	Pennaeth, Adran Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cynulliad Cymru Head, Department of Health and Social Services, Welsh Assembly Government

Swyddogion Gwasanaeth Seneddol y Cynulliad yn bresennol
Assembly Parliamentary Service officials in attendance

John Grimes	Clerc Clerk
Abigail Phillips	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 9.29 a.m.
The meeting began at 9.29 a.m.

Ymddiheuriadau a Dirprwyon
Apologies and Substitutions

[1] **Jonathan Morgan:** Good morning. I welcome Members to the National Assembly's Audit Committee. On housekeeping arrangements, I remind everybody that we operate bilingually, so participants are welcome to speak in Welsh or English. Headsets are available for translation and amplification.

[2] I remind Members to switch off mobile phones and BlackBerrys. If the fire alarm goes off, the ushers will instruct people on the best course of action to follow.

[3] We have received one apology for absence this morning from Janice Gregory, who is unwell. There are no other apologies or substitutions to note.

9.30 a.m.

Trais ac Ymddygiad Ymosodol yn y GIG: Swyddog Cyfrifyddu
NHS Violence and Aggression: Accounting Officer

[4] **Jonathan Morgan:** This is our second evidence and review session on the Auditor General for Wales's report on NHS violence and aggression. The committee will remember that it resolved on 25 February to launch an inquiry into violence and aggression within the NHS. On 25 March, the committee took evidence from the Royal College of Nursing, Unison, the Crown Prosecution Service, and the Association of Chief Police Officers. Today is the last planned evidence session for this inquiry.

[5] We have witnesses with us this morning, but, before asking them to provide an opening statement, I ask them to identify themselves for the record.

[6] **Mr Williams:** Good morning, Chair. I am Paul Williams, director-general for health and social services and chief executive of the NHS in Wales.

[7] **Ms Lloyd-Jones:** I am Sheelagh Lloyd-Jones, director of human resources for the NHS in Wales.

[8] **Mr Francis:** I am David Francis, chair of the Cardiff and Vale NHS Trust and the Minister's lead on the violence and aggression taskforce recommendations.

[9] **Jonathan Morgan:** Thank you very much. Before moving to the questions, is there any opening statement that you wish to make?

[10] **Mr Williams:** Yes, if I may. First, I am pleased to note that the Wales Audit Office report has noted an improvement in the management of violence and aggression in trusts in Wales. In 2007, the Minister for Health and Social Services announced the establishment of a ministerial taskforce to recommend a range of issues to improve the protection of NHS staff, and specifically to address three key elements related to violence and aggression: incident reporting, the prosecution of perpetrators, and support for the staff who are the victims.

[11] It is further encouraging to see that the Wales Audit Office has identified and recognised specifically the actions that were identified by the ministerial taskforce, and the work undertaken to bring these recommendations forward under the leadership of Mr David

Francis. I am delighted that David is with us here today to support me.

[12] In the wider context, the World Health Organization declared violence to be a leading worldwide health problem in 1996, but successive reports have failed to halt the growth of that global phenomenon. Healthcare workers who have face-to-face contact with the general public are considered to be at a particularly high risk of physical assault, with nurses at four times the national average risk.

[13] While the numbers of serious physical assaults across the NHS appear to be stabilising, the trend has continued to increase in the number of reported incidents. Although the numbers are clearly of concern, the increased reporting level enables NHS employers to understand the problems faced by staff and the issues that need to be addressed to combat the problem.

[14] In Wales, 7,800 incidents of violence and aggression were reported in 2007-08, and the incidents have apparently fallen in 2008-09 to just fewer than 6,950. However, I think that we have to treat those numbers with some caution because of reporting. From the data available, we see that the figures for Gwent indicate that 40 per cent of all incidents of violence and aggression resulted in injury to a member of staff. Some accident and emergency departments report that almost all violence and aggression was related to drugs or alcohol: it was 100 per cent in the North West Wales NHS Trust, 64 per cent in the Gwent Healthcare NHS Trust, and 69 per cent in the Hywel Dda NHS Trust.

[15] As you know, Chair, we are now moving to a major period of change. It is important that, during these significant changes, the management of violence and aggression continues to command the highest priority. You will have noted that, on 23 April, the Minister for Health and Social Services announced a number of new initiatives to help to protect NHS staff. They include a 12-month trial of closed-circuit television and developing services for lone workers. We have allocated resources to support both those initiatives, and the Minister has again stated that violence and aggression against staff is totally unacceptable and that she is determined to stamp out such behaviour.

[16] From my point of view, I am supportive of the work that the Wales Audit Office has done in the area. We have been able to demonstrate some progress, although further concerted action is required to achieve a major step change in the behaviours and attitudes of that section of our society who verbally abuse or physically assault healthcare workers. As the employer, NHS Wales must continue to minimise the risks, provide support and, when an assault occurs, see that the perpetrator is brought to justice.

[17] **Jonathan Morgan:** In paragraphs 1.1 to 1.5, the auditor general's report points to the fact that staff are reluctant to report all but the most serious offences. How do you intend to ensure that there is a change of culture among staff within the NHS so that they feel more comfortable and willing to report the offences as they occur?

[18] **Mr Williams:** That is an important issue. First and foremost, we need to improve awareness in general. The methods of reporting have not been easy, and so we can simplify the form—soon to be implemented. We are also offering web-based reporting to minimise the paperwork involved. We need to demonstrate some action on the ground by giving improved feedback on the results of reporting incidents, and by taking preventative measures. Investing in closed-circuit television, for instance, is an example of that. There is also the matter of the aftercare, and we may want to talk particularly about the role of the caseworker. Better analysis of information will also help us to deal with the root causes. I would underline the support of the employers at this point. Having a board champion regularly reporting to the board makes sure that staff are aware that the matter is at the top of the agenda. Those are the issues, but there are others. We hope to see an increase in convictions to demonstrate that we

are all terribly serious about this matter and that it is unacceptable.

[19] **Jonathan Morgan:** Moving on to a question for David Francis, in 2006, it was recommended that security staff take over the responsibility of incident reporting. Your Government says that that recommendation is being discharged. I wonder whether there has been any progress on that, as it was also suggested to us as a possible option in previous evidence. Should there be a change in where the responsibilities lie for reporting an incident?

[20] **Mr Francis:** Chair, there is no doubt that we can make some improvements in the training and the focus for security staff across Wales, but it is a bit of a complex mix at the moment in that some are employed within and some are contracted staff. There is some work to be done there.

[21] As for whether the reporting should be done by the security staff, I do not think that it is as simple as that. The key for success here is to ensure that line managers take responsibility alongside the member of staff. There will be occasions when security staff members could assist in the recording, although we may want to think that through a little more carefully. Their role would be better focused on being there and helping to manage the incident. I am not saying that it is not a role for them, but I would not want to absolve line management of the main responsibility. That is my suggestion.

[22] **Jonathan Morgan:** Okay, terrific. Thank you.

[23] **Michael German:** May I just look at paragraphs 1.6 to 1.12? The general picture is one of progress being made, but, in paragraph 1.12 in particular, we are given the impression that not all the health trusts have picked up on the new reporting system. We have also heard from the British Medical Association that there are no centrally collected figures for violence in primary care. Could you give us some indication of what progress is being made and of why it has taken so long to get everything in line so that we can get some robust figures and that we know what the situation is currently? Without knowing where we are, it is difficult to know how much action to take.

[24] **Mr Williams:** Maybe I could start, Chair. I have picked up on a pattern in the reports, which is that we do have patchy performance across Wales. The multitude of organisations that we have seen in the past has caused some difficulty in what I would call ‘universalising’ the best practice. Organisations had different definitions, different methods of collecting and analysing the data, and they have not always given us the priority that we would expect to be given. What we saw was that around 50 per cent of the organisations made progress or significant progress, and the others had a lot more to do.

9.40 a.m.

[25] We can talk about the progress that we have made, particularly since the recommendations of the report were considered by David Francis and his taskforce and we separated out what needed to be done by the employers. We now have employers’ action plans, and I am pleased to say that, when they were requested by David Francis, they were all submitted on time, in February. We are now going through those again.

[26] The new local health boards will be established in October, and 50 per cent of the new local health boards are already implementing this, with the others committed to implementing it by October. We will have seven boards, with each board having, for the first time, a workforce director as a main board member, a champion, and a performance management system. We can dwell on the past—and, as I said, the results are patchy—but there is now a robust system in place. We have the reinforcing comfort of a much more streamlined process and systems to ensure that we move forward significantly.

[27] **Michael German:** Is it therefore the position that, from October, there will be uniform reporting? Will the figures that come in be robust for the whole of Wales, rather than parts of Wales and for secondary care only? If so, it would be good to acknowledge it, but what is the position in respect of primary care?

[28] **Mr Williams:** I will ask Sheelagh to give us some of the detail, if I may, since she deals with that on a day-to-day basis. However, it is my understanding that we have agreed the common definition, we have a new set of codes, we have a method of collecting them into the Datex system, and we will be in a position to interrogate those data and give you a response that you have never been able to have previously, given how it was. Looking from a community-wide basis, Sheelagh may want to say something about primary care, where there is still more work to be done.

[29] **Ms Lloyd-Jones:** As Paul says, within secondary care, we anticipate that we will be able to analyse and monitor data across Wales certainly from October. In primary care, the situation will not be so easy, as I do not think that they have Datex as the NHS trusts do. However, if we are now creating local health boards, that is a key action for us: to look at how we get the same data across the health service so that we can monitor and understand what is going on and where.

[30] **Michael German:** Given what you have just said, how can we be certain that the figures that you have had in the past six months are robust enough, given that they have come from only a part of the health service as a whole?

[31] **Mr Francis:** I will come in there, if I may, Chair. The answer is that we cannot say that they will be totally robust. Among the first measures that we took in taking the taskforce's recommendations was to recognise that we had to expand quickly and engage with primary care; hence the early meetings with Richard Lewis of the BMA. That work is ongoing now, recognising the independent status of primary care. We are intent on building up that picture, but it is work in progress.

[32] **Mr Williams:** Could I just supplement that? It is an important question. We need to differentiate between primary care, with the remit of independent contractors and GPs, and the vast majority of community staff, such as community nurses, health visitors, community mental health workers, who are part of the trusts. I am not belittling primary care contractors and their staff, but the vast majority of staff are working in the community, and those data are collected within the trusts. All the trusts, apart from one or two specialist trusts, are integrated. We are not referring only to hospital employees.

[33] **Michael German:** From what you have just said, even in secondary care, we get only part-reporting across Wales. We cannot be certain that the responses that you are getting from part of the healthcare service, in secondary care, reflect the other part. It is 50/50, from what you are saying. We do not have a full picture for Wales here.

[34] **Mr Williams:** I do not think that it is 50/50.

[35] **Michael German:** If I remember correctly, you said earlier that 50 per cent of the health trusts were now reporting.

[36] **Mr Williams:** Yes. Sorry, I thought that you meant 50 per cent of staff in the community—

[37] **Michael German:** No, 50 per cent of the secondary care health trusts are reporting, and 50 per cent are not.

[38] **Mr Williams:** What I said was that 50 per cent of the trusts are probably in the higher quartile of performance reporting training. By October, we will have all seven new organisations complying with our requirements, and 50 per cent of those are already doing so.

[39] **Michael German:** I get the picture.

[40] **Irene James:** I want to look at paragraphs 1.13 to 1.15, which state that all trusts have now have appointed a violence and aggression champion. In the auditor general's report of 2005, he said that a senior member of staff was already responsible for tackling incidents of violence and aggression. Mr Francis, what will be different about the new champions, compared with the senior member of staff who was previously responsible for violence and aggression?

[41] **Mr Francis:** I cannot comment on the 2005 senior member of staff, but, on the current position, I can say that we felt it important to link the need to have clear plans that we could use to hold people to account and to measure progress locally, with having a named board attendee, a director, taking the lead. We felt that that was important. What we have now, which I feel is robust, is a named individual working to a clear plan with clear timescales, who can be held to account. I am not saying that that was not the case in 2005, but I am not able to comment on what it was like at that time, I am afraid.

[42] **Irene James:** Is anyone able to comment on what it was like before? If not, is there some way that we can have information?

[43] **Ms Lloyd-Jones:** The key difference is that the champion is a member of the board. That demonstrates to everyone that the board is taking first interest in the topic. A senior person does not necessarily indicate an executive member of the board. So, it is on the board's agenda.

[44] **Janet Ryder:** Paragraphs 1.16 to 1.19 say, as we have heard, that the Government does not have reliable data on the number of incidents of violence and aggression. However, they do show that there has been an increase in the number of serious incidents reported to the health service authorities. Mr Williams, do you know what is behind the increase in serious assaults and acts of violence?

[45] **Mr Williams:** I alluded to drugs and alcohol, and they seem to be the major factor, according to the information. We have looked at the information and, on the nature of the assaults, punches and kicks seem to be the main offenders, along with being struck with an object. People who are clearly under the influence are at least confused if not outright malicious. That is the issue that you really need to address, because there are other illnesses that can cause people to become confused, so you need to differentiate between them. While those ill people might still inflict a serious injury, their intent might not be the same as that of someone who is under the influence of drugs or alcohol, and who has heightened levels of aggression. I think that it is an issue that we have to deal with as a problem for society, as well as protecting our health workers.

9.50 a.m.

[46] **Janet Ryder:** That could explain some of the incidents, and why it is happening, but when it comes to the reporting of it, there has been an increase in the number of serious incidents being reported. Unfortunately, it has been the case, among many professions in the health service, that they accept a certain level of violence, in some cases, as you have alluded to, because of the illness that people are presenting with. It does not make it right, and it is not acceptable, but many staff have accepted that. For them to report it, it becomes a very serious

incident. Do you know what has led to that increase in the reporting of serious incidents?

[47] **Mr Williams:** We would hope that it is because of the efforts that we have been putting in. We have to be careful about zero tolerance, because there are cases where, clinically, there may be a good reason. It may be difficult to justify and we have to train people to deal with it, but, where we have society not respecting healthcare professionals and their job, that is where we have to be very robust in saying, 'This is not acceptable'. It is not right that healthcare workers just accept this as part of their day-to-day work, another pressure that they have to endure. It has to be unacceptable; we have to draw the line. I am hopeful that, because those messages have been coming out, people are now coming forward and recognising that the board, their managers and colleagues are supportive of them in this. It is a cultural issue. It may have crept in over the years in terms of less respect for healthcare professionals, but I think that we all agree that it has gone too far. We have to put all those measures in place now to ensure that it is eradicated in healthcare in Wales.

[48] **Janet Ryder:** Mr Francis, we have heard very clearly that it is a complex picture, but how soon will Government have in place the right strategies, the right initiatives, the right training and the right support to give a true picture of how violence is panning out across the NHS?

[49] **Mr Francis:** With the local plans, which are a national template, we already have that framework in place. It depends, then, on which aspect we look at. If we look at training, I think that that will probably take some time, because we have the focus on modules C and D, which you may want to discuss later. We are very much dependent upon the ability to analyse the data, which, as Mr Williams has said, will come in later this year, in terms of our confidence in being able to use it. Then, depending on which aspect of the action plans you were to look at, we have clear timescales set against various actions, so that, at any point, we could report on the progress against whichever element we are interested in. I am not sure whether you are looking at a specific issue, but, because it is such a broad series of actions, there will be different timescales for different elements.

[50] **Janet Ryder:** Could you give us a picture now, across the NHS, in which you would have confidence, or do we have to wait for some of those initiatives to kick in? If so, when do you anticipate that happening?

[51] **Mr Francis:** I could give you each plan, which could aggregate up to a situation in which I am confident that I know when I expect each employer to reach a certain stage in the action plan. In that respect, yes, I am confident that I can tell you what has happened and what we intend to happen over the timescales agreed. What I could not do now is say—well, the trouble is that, in the action plan, there are 26 actions, some of which are related, some of which are independent and, as we go through the year, we will be adding to that. So it very much depends which part of the progress you would want me to report on.

[52] **Janet Ryder:** So you are not in a position yet to give us a complete picture across the NHS.

[53] **Mr Francis:** I am not understanding the question.

[54] **Janet Ryder:** When will you be in a position to pull all those action plans and all those strategies together to give us that picture across the whole NHS?

[55] **Mr Francis:** I have got the action plans, which I could put on the table now, or bring in the next day or two, to show you, in each of the communities, the actions that we have agreed and the timescales that we have agreed against them. They do aggregate up, but it is not that simple. Let us take, for example, readiness in terms of the passport scheme. There

will be different elements and each employer will be at a different stage, but I could bring the plan that would show you by what date we have agreed that they will reach that standard we have asked for.

[56] **Janet Ryder:** Would you be able to tell us where each of them were against that, so that we could get that picture?

[57] **Mr Francis:** Yes.

[58] **Mr Williams:** Yes, on a makeshift basis.

[59] **Lorraine Barrett:** I have a question that, Dave Francis, you could have asked yourself a little while ago. Are you working with the police on what is behind the increase? Jonathan and I know that there are all sorts of reasons why, in the big cities, there are assaults and acts of violence. Are you working with licensing authorities, such as in Cardiff and Swansea and Newport? I guess that the majority of serious acts of aggression are drink-related and drug-related. So there is the police, the licensing authorities and you; are you working together? Is it the case that it is ambulance staff, on the front line, who bear the brunt of that? Are you doing some work on trying to defuse such situations? This relates to the work that Professor John Shepherd did—I do not know whether we will be taking evidence from him. Is any work being done on that and on how you can defuse the situation and deal with it before it gets to the hospital? It is an issue for ambulance staff and police and others to work on together. I am just trying to get a picture of whether you are all working together to try to resolve an element of the violence and aggression.

[60] **Mr Francis:** I think that I got most of the questions out of that. The answer is ‘yes’; we are working closely with the police and other agencies. I will give you some examples. You mentioned ambulance and accident and emergency departments: we recently did a joint-agency process-mapping exercise with the police, ambulance service and local authorities, tracking a sample incident kicking off in a town or city centre. Ambulance staff attended first and we then tracked that right through to the doors of the accident and emergency department and then through the hospital. That work was undertaken on 1 April and today’s steering group meeting will be agreeing that a task and finish group will pick up on the recommendations. We had support from the University of Glamorgan in doing that work. That is one example. Part of the local action plans are to ensure that employers link with community safety partnerships and have discussion on risk assessments for the threat of violence against NHS staff and, if the risk assessment stands scrutiny, to ensure that that is built into their action plans.

[61] I met with John Shepherd last week and had a discussion with him about the work that he is doing. At a high level, you will be aware that we are close to concluding the memorandum of understanding with the chief constables and I can also throw in that essential and pivotal to this joint work is the work that we are doing on case management minimum standards. The memorandum of understanding is one thing, but they very often just sit on a shelf, but this case management work will give life to that local relationship.

[62] **Mr Williams:** If I may just supplement that, Chair, I think that the work of the community safety partnerships is terribly important and the wider partnership agenda needs to be developed under local service boards. As Lorraine said, we need to look at the whole picture, to see whether we can address the way in which licensing is conducted and improve amenities or facilities within town centres and the night economy. We are looking at the possibility of drop-in centres to take some of the pressure off the main accident and emergency departments, so that some of those who are the worse for wear can be dealt with in different ways. On the ambulance side and CCTV, we are also going to have a pilot scheme for some crews and vehicles going out of Blackweir in Cardiff to ensure that ambulance

colleagues feel fully engaged within this initiative.

10.00 a.m.

[63] **Bethan Jenkins:** It has already been alluded to, but I want to ask about the passport scheme for training of staff and the fact that the report suggests that some people are still not receiving the basic training to which they are entitled. We also had evidence from the Royal College of Nursing that non-registered healthcare support workers were not receiving support from their managers to take up that training. How many staff out there still need to receive the basic, minimum training? Can you expand on what the hindrance is to them accessing that training?

[64] **Mr Williams:** I cannot give you the number of staff who have still not had the training, because that comes back to one of the questions from your colleague earlier in regard to the fact that we have less than perfect implementation. If I can start with the experience of my own previous trust, in Abertawe Bro Morgannwg, in module A, we had 100 per cent of staff who were trained, and, when I left, we had reached about 87 per cent on module B. There are difficulties and David wanted to discuss the more challenging issues on modules C and D.

[65] The reasons are interesting. Providing training across the board, and particularly in these areas, is proving difficult in terms of releasing staff and making staff available, because of service pressures. There are also records of maybe a 40 per cent did-not-attend rate, so that, when you put the sessions on, staff do not turn up. Obviously, you cannot leave it there, so we have introduced things like an e-learning package so that some staff do not need to leave their desk or their ward, but clearly, there is a lot more to do here. I think, from my own experience, that it has to be linked back into performance management. In dealing with this, at board level, we would regularly see the number of staff who were trained, we tracked it and that was passed down the system as an essential element. Clearly, this has not been given the same priority elsewhere. We have a lot to do. I would expect that we can now capture much more accurately the number of staff we need to cover and we need to be consistent in the approach. I do not know whether Sheelagh would like to come in with any further detail on this.

[66] **Ms Lloyd-Jones:** Yes. It will be our intention, with the new health boards, to ensure that, in the performance management framework, we will be getting information around training and all information around violence and aggression. Paul alluded to the fact that, in Abertawe Bro Morgannwg, we got 100 per cent of staff through the basic module A; that was by linking it to induction. It was part of their induction programme to the organisation that staff went through that. As to how one works out which staff need further training, it is linked to the risk assessment in the area in which they work. It is a moving programme, so the figures you have one day might not be the right figures the following day. It is about ensuring that every organisation has a training strategy around these areas and means by which they monitor performance. That is what we will be ensuring.

[67] **Bethan Jenkins:** I note the progress that you are making on this, but do you think that it may be putting people at risk, especially in modules C and D? If module D is not being implemented in psychiatric units, are staff being put at risk, unnecessarily, because of the lack of action in implementing the modules that seem to me to be necessary in dealing with this issue?

[68] **Jonathan Morgan:** On the back of that, have you prioritised certain staff? It seems clear that if you have staff working in fairly intensive environments where patients or patients' families might pose a potential threat to a member of staff, prioritising that training for key groups would be essential.

[69] **Mr Williams:** Certainly from my experience, where we had high-risk areas, like a medium secure unit, there was significant training. Obviously, this is all about avoiding the incident, breaking away and only using some form of restraint as a last resort. This is a very difficult and somewhat controversial area, where we are looking for advice from directors of nursing services, in particular. It is an area that must be addressed. However, I think that you will find that, in areas of high risk, most trusts will have addressed this, because there are other reinforcers in the system here. The Health and Safety Executive has been coming in and looking at how effective trusts have been. The risk pool and Healthcare Inspectorate Wales have also been looking at it in terms of quality standards.

[70] **Mr Francis:** May I just add to that? It is important not to leave the committee with the impression that no training whatsoever in modules C and D is taking place. We need to link it, as Mr Williams said, to the fact that risk assessments are taking place every day and training is taking place. The issue is, with passport being a national standard, recognising the need to revisit modules C and D because of the complexities on either break-away or the restraints and holds, which is some of the work that will be taken forward as soon as possible.

[71] **Bethan Jenkins:** I note that, but the report says that, at the time of the launch of the passport scheme, it did not contain any guidelines for the delivery of module D. How can you square that with the fact that this is not actually happening on the ground with risk assessment analysis?

[72] **Mr Williams:** I can only give my own experience and I think that David is absolutely right to qualify what I was reporting back to you. In my own organisation, we had a significant amount of time invested in the approach to training in break-away techniques and, as they used to be called, control and restraint. However, there are different views about how appropriate those techniques are. The difficulty we have had is agreeing on an appropriate set of guidelines for Wales, because there are different views about this, professionally. However, I do not want to give the impression that nothing is happening.

[73] **Bethan Jenkins:** Will there will be national guidelines on this? Surely, if it needs to implemented across the board and streamlined, a national guideline will be necessary.

[74] **Ms Lloyd-Jones:** Work on that is ongoing at the moment, in collaboration with the University of Glamorgan, where there is a professor who used to work for Bro Morgannwg and who is renowned for his understanding of this area of work. We hope that, within about three months, we should get something.

[75] **Jonathan Morgan:** Before we proceed, could I just ask for one point of clarification? Sheelagh Lloyd-Jones, you mentioned earlier that, as part of the restructuring of the NHS, you will be ensuring that information on training is collected as part of the performance management framework. I am assuming that, at the moment, that does not happen, or certainly not to the extent that it should. What level of data, and what level of reporting, do you expect of NHS trusts currently? Or is it that they are not required to report on how many staff are actually trained, in a variety of training—not just on how they handle difficult situations? Is there no requirement at all on the NHS to report to you and to the Assembly Government on how staff are trained in a variety of areas?

[76] **Ms Lloyd-Jones:** In terms of training, there is, I think, within what is known as the annual operating framework, a requirement to report some information, certainly around incidents. I do not think that we have a robust enough requirement to have detail about all the training that is taking place. That is something that, as we sort out the passport scheme, will be part of the performance management framework. However, within organisations—Paul has alluded to where we worked, within Abertawe Bro Morgannwg—as part of local

performance management, we would expect to have detail of training being reported.

[77] **Jonathan Morgan:** Did the passport scheme stipulate that NHS trusts had to report back to the Assembly Government as to what proportion of staff was being trained?

[78] **Mr Williams:** I might have to take the lead on that question, if I may, Chair. Coming back to the earlier evidence, clearly I could not report on the number of trusts that had reached a high level of compliance, or had not, without that information being provided to the Welsh Assembly Government. Obviously, we have that information, but what it demonstrates is that 50 per cent of the organisations were not reporting up. There is an awful lot of work to do there, clearly.

[79] **Jonathan Morgan:** The point that I am making is that there was no requirement put on the NHS trusts to report, but some were reporting a level of success, because you obviously have some figures.

10.10 a.m.

[80] **Mr Williams:** There was a need or a requirement to report, because otherwise we would not have the figures. The issue for me is why poor performance was not picked up in performance management. In the comprehensive plans that we are putting together by October, these issues will be addressed. I will certainly expect to have this information available to me through my suite of performance indicators.

[81] **Jonathan Morgan:** We are, in essence, as a committee, auditing how policy translates into practice, and I am always conscious of the role of this Audit Committee. Could we—and I am happy to receive a letter from you—have an outline as to whether the passport scheme had any requirement built into it? I assume it did not although you say that you know about some of the trusts. I suspect that those trusts might have just reported it as they thought it was part of their natural role. Clearly, you do not have that full picture. As we are auditing current and past performance, obviously we do not know how the new system of performance management framework will operate when it is up and running towards the end of this year. It would be quite useful from our perspective to know what the requirements were in detail, in order to see what has happened and what is currently happening.

[82] **Mr Williams:** I will send a report on the detail, Chair. In my understanding, it was a requirement. We have reports from the Welsh risk pool going back as far as 2005, 2006 and 2007, and from Healthcare Inspectorate Wales on levels of compliance. I think that it is probably an issue of compliance, not reporting, but we will check on the detail.

[83] **Nick Ramsay:** Can I ask Mr Williams about the design of hospitals and improvements in this design, and specifically the introduction of CCTV? You mentioned this in one of your earlier answers. I understand that it is ongoing on four trust premises on a pilot basis. When will this pilot scheme be up and running and how long do you anticipate it running for?

[84] **Mr Williams:** First and foremost, this is not new. A number of trusts already have closed-circuit television and the issue is whether it is sufficiently sophisticated, particularly when looking at good evidence for prosecutions. The trial will be on high quality closed-circuit television. We will be starting that in the next two or three months, and we should be in a position to report back by late autumn.

[85] **Nick Ramsay:** Secondly, to Mr Francis—and Mr Williams might want to comment as well—will it work?

[86] **Mr Francis:** I am confident that it will work, as long as we are linking the results of the CCTV pilots with some effective case management, and that we link everything up. The Minister has already made it very clear that she does not expect to have money spent on CCTV pilots if everyone is not linked up to make sure that all their processes support that investment. I am confident that it will very much help the prosecution process.

[87] **Nick Ramsay:** Do you think that the investment in higher quality will directly improve the rates of dealing with cases of aggression?

[88] **Mr Francis:** I think that it will certainly improve the evidence we have available to take to the police. It will also act as a significant deterrent. We have not started what is on the blocks in terms of an awareness raising campaign. Once we are confident of that, we can start putting these pieces together and I think it will make a difference.

[89] **Jonathan Morgan:** During the last evidence session, in discussion with Chris Woolley, the chief Crown prosecutor and the chief constable of the South Wales Police, we were told that there were concerns about the technical ability of the current CCTV systems in our hospitals. I think reference was made to three, or possibly four, of the systems being evidentially capable, and the rest of them simply were not. I appreciate why there is a pilot scheme being done now because there is clearly some sort of deficiency. Do you think that has been the principal problem in the way in which you have interacted with the police and the Crown Prosecution Service, and that the level and ability of CCTV to monitor what has happened in our hospitals has simply not been up to scratch?

[90] **Mr Francis:** It may be an element, Chair, but I would not class it as the principal problem. One of the things this pilot will do is focus everyone's mind on the purpose of CCTV and how it fits into the overall process. There may well be examples of CCTV not having been used correctly in the past and not having been monitored properly. This is about getting the process and the equipment right to move on.

[91] **Jonathan Morgan:** I have the evidence in front of me. The chief constable said that of the 17 hospitals that have CCTV, only three have cameras that are of good enough quality to use their footage as evidence. I appreciate it is how you use the system, where you position cameras, how you record and monitor them. Ultimately, she said that the quality of that CCTV in all but three of them was not evidentially capable of helping to lead towards a prosecution. Do you accept that?

[92] **Mr Williams:** Yes, obviously. I would just comment that trusts that have used closed-circuit television over the years, in general terms, have probably not invested in catching up with technology because they are putting their money into healthcare. We now recognise that we have a situation which has reached intolerable levels in some places, and we are now saying that we have to divert money from front-line healthcare into closed-circuit television. The issue is that the health service has had to react to a problem that it is now facing in society. I make no bones about it—it means diverting money from front-line healthcare investment.

[93] **Lorraine Barrett:** I am looking at paragraphs 2.14 and 2.15—lone workers and the worker tracking system that was first suggested in 2004 but, as we understand it, has still not been implemented. The chief constable also told us that Airwave—the new national digital communication system being used by all UK police forces—is used to protect police and ambulance staff, as well as RSPCA staff. She also said she did not know whether the NHS kept an intelligence database in order to share information on high-risk individuals. Why has there been so little progress in obtaining the all-Wales lone worker tracker system? We can all think of midwives and district nurses who put themselves at risk by going into people's homes, not knowing what is behind the door. Do you have the funds to procure this system? I

wonder if Mr Francis could say something about learning lessons from the police and other emergency services to protect staff working on their own or in high-risk environments?

[94] **Mr Williams:** Some trusts have piloted systems to support their lone workers, but there have been some difficulties in determining a system that is effective. This is not just in Wales, but also in England. During our work and research we were able to discover that England is now identifying a system and going through a procurement process, but that is only after evaluation. We took the view that we would have a framework contract with England, rather than going through our own process and procurement. As soon as our English colleagues have completed that process we will be in a position to similarly award tenders on that framework contract. This year we have set aside between £350,000 and £500,000 to implement that.

[95] **Mr Francis:** If I could just pick up on the other part of that question—there is no doubt that we can learn from the police and that is why we are working closely with them. Scheduled in the relatively near future is another part of this process mapping—which I mentioned earlier—to look at the lone worker position and, again, to ensure that we have a minimum standard of protocols across Wales. Having a system is one thing, but if we do not have the protocols in place and know that we will get the response that we need, when it is needed, it would not bear out the investment.

[96] Airwave is not as simple as was suggested. It may be relevant for front-line ambulance staff but I am not sure that it would be the answer for lone workers. If I could pick up the other part of the question about the intelligence database—you are absolutely right, there is not an efficient link-up yet. Again, that was part of the process mapping work of 1 April. The steering group that I chair has information sharing as a standing agenda item and there will be a group looking at that because a significant amount of work is needed. Ambulance workers know things that accident and emergency departments do not and vice versa. We need to link that up as quickly as we can.

10.20 a.m.

[97] **Mr Williams:** Just to expand, if I may, on my response in case I did not make myself clear. On the appropriateness of the device, obviously, a device which is appropriate for a uniformed police officer may not be the same for a district nurse or a mental health worker in an informal setting. We have to be sensitive to what we are doing, which is providing care for people, but at the same time providing appropriate protection for our staff. There are issues about the appropriateness of the device.

[98] **Lorraine Barrett:** I was thinking about the Suzy Lamplugh Trust, and the lessons learnt from that situation about people going into homes alone. Is there a system in place for lone workers in the NHS, to ensure that someone—a line manager or the surgery who have their list for the day—to know where an individual is at a particular time, and how practical would such a system be?

[99] **Mr Williams:** I do not think that you would find a sophisticated system, but there are risk assessments and information is passed between colleagues, management, and organisations.

[100] **Lorraine Barrett:** I think there is still a bit more work to be done on lone workers. You can think of all sorts of scenarios, but there are practicalities involved as well.

[101] **Jonathan Morgan:** If we move to part three of the report—it states in paragraphs 3.1 and 3.2, that when the auditor general first reported, security staff were not always available to help with incidents and security staff did not always manage them satisfactorily. This question is for Paul Williams—has there been any increase in the numbers of trusts that employ security guards and is the quality of the service they provide adequate?

[102] **Paul Williams:** I do not have the numbers of staff employed as security guards. I do not think that we collect that information so I would have to discover that for you. It has been very much an issue for trusts as to how they want to deploy security. Some have contracted out although, increasingly, that is not the case. We would have to look at that for you. The importance is of giving our front-line staff comfort in relation to physical security, through better design or the presence of support within the department. That should be constantly risk assessed within each trust to ensure that they have the appropriate level of cover. There will be different approaches to reflect different circumstances.

[103] **Jonathan Morgan:** David, do you think that the lack of dedicated security teams causes real problems?

[104] **Mr Francis:** I would not say that it causes problems, Chair. The issue is that, at the moment, security staff across Wales will have different job descriptions and different levels of training—some will be in-house, some will be contracted. There is no such thing as a generic security staff member. The difficulty, when we look into this, is that we can look at accident and emergency as a classic place where you would want security staff, but incidents of violence and aggression happen across the hospital. There are many stories of security staff having to run from one department to another. It is the early stages, but work is being undertaken to look at the training, the standards, and whether it would make sense to have an all-Wales approach. I know that the chief constable mentioned accreditation, and I am interested in pursuing this with her, perhaps on a broader field. I am sorry, Chair, the answer would not be to say that we will just have security in accident and emergency waiting for an incident to happen, because of that flow across the hospital and in the grounds.

[105] **Mr Williams:** As you will know from the report, certain trusts have been able to either provide facilities for police such as a room or accommodation, and some have police coming in on a regular basis. There are various approaches here, and it is an important area where we need to look at best practice and have some consistency. As I said, it varies from organisation to organisation, in different parts of the country, from proximity to urban or rural environments and so on.

[106] **Bethan Jenkins:** How can you qualify saying that many of the trusts do not use security staff that are contracted out? We had evidence from the Royal College of Nursing or the British Medical Association, saying that there were a large number of security guards who were working at supermarkets during the day, then coming into work in the evening and not knowing what to do or how to deal with situations. Is that not an argument for streamlining?

Mr Williams: Yes it is. The point I was making is that, in line with the ‘One Wales’ commitment, we are using staff who are contracted out less and less. However they are employed, they must have good guidelines and training. It would be indefensible if we had people coming in from another job, moonlighting, with no idea how to conduct themselves within the policies and guidelines of an organisation. I would hope that is not the position. There is still more work to do on this because the issue facing trusts is a question of balance. The more staff they employ in security, the more money is taken away from front-line services. However, they have to balance that with protecting their staff. It is a constantly shifting situation that needs to be risk assessed. However that risk assessment is executed, we need to make sure that the staff who are there are operating against good guidelines, are trained and are appraised to ensure that they are complying with those guidelines.

[107] **Lesley Griffiths:** At our last evidence session there was a conflict in some of the information that was given. The trust and staff representatives said that there was difficulty getting the correct response and attendance from police, while the chief constable said she felt that her staff were constantly in accident and emergency departments, particularly at weekends. Mr Francis, with your former hat on, why do you think there have been problems in securing the right assistance from police in hospitals?

[108] **Mr Francis:** I would not accept that, as a totality, we do not get the right response from the police. One of the difficulties is that the answer lies in the middle somewhere. We often get a very good response from the police and then, on occasions, we will have police officers who are run ragged and have many calls waiting. They will attend, deal with a flare-up, feel they have dealt with it and move on. You may then have a classic situation where the NHS staff will be left with a situation which will either flare up or has not been properly defused. That leads to this difficulty and confusion. At the risk of sounding boring, the answer lies in much closer working between health organisations and the police, and an approach of jointly owning the incident. That is what we are pushing forward on a case management approach so that we can get away from police blaming health organisations, and health organisations blaming the police. We jointly own the problem and that is certainly accepted on the ground with the police.

[109] **Mr Williams:** All this work is being done through senior managers sitting down with colleagues in the police and the other agencies, discussing wider issues. From that, an enormous amount of benefit and understanding starts to flow. There really needs to be support in the community partnerships in this area.

[110] **Lesley Griffiths:** In relation to the memorandum of understanding that is due to be signed by the Welsh Assembly Government and the police, we were under the impression that was going to be signed last week. Mr Francis, I think you just mentioned that it was going to be signed shortly. Mr Williams, why is there so much delay in the signing of this?

10.30 a.m.

[111] **Mr Williams:** It has not been intentional. The issue has been around the discussion and getting the organisations together. I would not want to give the impression that nothing has been happening in the meantime. This should be the final brick in the wall, as it were, because there has been significant improvement. I know that David has been engaged in part of these discussions.

[112] **Mr Francis:** I need to take some of the responsibility for this, because a draft document was available as long as a year ago. When I was appointed, I took a look at it and asked whether we could revisit it as I felt that it was far too broad for what we were trying to do in focusing on violence and aggression against NHS staff. The delay is partly my fault, therefore—if there is fault. As Mr Williams has said, we are now close to finalising that agreement, which we will then take forward.

[113] **Lesley Griffiths:** A year is a long time.

[114] **Mr Francis:** I cannot argue with that, but it has taken some discussion. Again, I do not want to give the impression that we were at different ends of the spectrum, but one of the issues that we needed to work through was that of private prosecution, which links to the CPS

MOU, because that is a very difficult issue for both the police and the CPS. In the earlier documents, there was an idea that, 'If the police will not do anything, we will take on a private prosecution'. The emphasis that I have been putting on this is that, if we gather the evidence properly, private prosecutions should become the exception. I hope that makes sense. That was where some of the discussion and delay was: working through whether private prosecution was appropriate or not and how to get the relationship with the police and the CPS right.

[115] **Lesley Griffiths:** Can you give us any indication of when it will be signed?

[116] **Mr Francis:** I cannot, but it is just a question of logistics now and getting some busy people together to finish that off.

[117] **Lesley Griffiths:** Given that there is concrete evidence that where police are present in any departments there is a decrease in the number of incidents, why do we not have a more general police presence in hospitals?

[118] **Mr Francis:** The type of cover that we would need in order to ensure protection was costed at about £9 million plus per year. That was at police community support officer rates, which throws up a problem, because they are neither trained nor employed to deal with violent incidents. So there is that element. A positive part of the answer is that, as Mr Williams mentioned, there is a police presence already. Some of the work that we are doing involves looking at the possibility for co-location on estates in the future.

[119] Sorry, I lost my track there. That work coming together will probably take us forward. I am in the process of doing another piece of work with the assistant chief constable in South Wales on hospitals in the heart of the community. So it would not be seen in terms of whether the police will call into a hospital, but, with the hospital being at the heart of the community, what it is entitled to in terms of police presence. Again, we are working through that.

[120] You will know that police officers on the streets are fairly sparse and so we need to strike a balance between them being in the hospital and them covering the streets.

[121] **Lesley Griffiths:** Do you have anything to add to that, Mr Williams?

[122] **Mr Williams:** We need to facilitate this. With regard to the hospital being at the heart of the community, we were talking about issues such as whether we can offer meal breaks for the police, for instance. If they are on patrol, perhaps they could call in and have their meals in the hospital. It is a partnership. Money will become increasingly tight for all public organisations, so are there ways in which we can complement what we are doing and, at the same time, reinforce each other's roles? I think that there is more work to be done here, but I cannot see us being able to sensibly say that we can encourage a step-up police presence of any significance in any departments because of the costs that David outlined.

[123] **Lesley Griffiths:** Okay. Thank you.

10.40 a.m.

[124] **Janet Ryder:** I want to look at the support that staff who have suffered a violent incident receive. Paragraphs 3.7 to 3.10 show that health bodies need to improve the speed at which support staff receive therapeutic support following an incident. Can you tell me, Mr Williams, what the Assembly Government is doing to improve access to support services, such as cognitive behavioural therapy and physiotherapy?

[125] **Mr Williams:** We might want to spend a bit of time talking about the role of the case worker. That needs to be available to individual members of staff from the moment the incident happens and right through. If part of that is about stress counselling, that should be provided. Also, if staff need treatment, we talked in another session about how we fast-track our staff if they need physiotherapy or any other treatment to ensure that we have an effective occupational health system. That may be a more appropriate way of dealing with some of these things than having hospital appointments. No matter what it is, for me it now has to be about the case worker, the way case workers are managed, and how the culture of the organisation insists that this happens so that people are fully embraced within the system and have that support and have confidence that any injuries will be dealt with properly, and that the prosecution that needs to taken forward will be handled in such a way that there will be a successful outcome. We have a lot of work to do here in terms of case management. I know from the various actions that I have seen in the employer's action plan that all these threads have been pulled together, including monitoring the effectiveness of the occupational health system.

[126] **Janet Ryder:** So, are you confident that the case worker will support the member of staff affected by incidents of violence and will increase the number of prosecutions by working closely with the police and Crown Prosecution Service?

[127] **Mr Williams:** Yes.

[128] **Janet Ryder:** So, you are anticipating that we will see an increase in the number of prosecutions.

[129] **Mr Williams:** Yes.

[130] **Janet Ryder:** We have had it made clear to us in evidence that there is a need for prompt feedback on incidents to staff. Mr Francis, are you satisfied that enough is being done to provide better feedback to staff, or could that be improved?

[131] **Mr Francis:** It can definitely be improved. I am not saying that it is bad—it will depend on where you are in Wales—but it can definitely be improved, and that is the purpose of agreeing, hopefully this afternoon, but certainly within the next two weeks, a minimum standard for effective case management. That will have the victim at its heart and the requirements will be along the lines of a daily review of incidents and early contact with the victim to ensure that the victim knows what is happening. There will also be regular feedback to the victim so that he or she knows what action is being taken or, if no action is being taken, why that is the case. I am confident that literally within weeks we would have those minimum standards available to you so that you can see how that is being put in place.

[132] The previous question is a good example. You asked how we would know when. In the local action plans that are in place, actions 16 and 17 specifically deal with urgent interventions in terms of psychological support and occupational health support. They are in place now in terms of the action plans and they will be tested in due course. That is an example of where a specific has already been laid out.

[133] **Janet Ryder:** So, when you get these guidelines signed off this afternoon, we will not hear again that it depends on where in Wales you are talking about. It will be common practice across Wales, and this will operate across Wales.

[134] **Mr Francis:** I am sure that you would not expect me to give a 100 per cent guarantee. What I can say is that the standards will be there and that every employer can be expected to be tested against those standards. As months go on, whether it is the Health and Safety Executive or the Wales Audit Office that will be involved, I am sure that those

organisations will take an interest in how employers are applying those standards, as will Mr Williams.

[135] **Janet Ryder:** How crucial to that process is the case worker?

[136] **Mr Williams:** The case worker is crucial. It is a massive step forward, and an innovation. Obviously, there will be a need to train and develop these individuals and to make sure, as part of the monitoring, that they are effective in their work.

[137] **Janet Ryder:** Do you have a picture of where they are employed across Wales? Does everybody have uniform cover of them or is there a lot to do to recruit staff? Is there still a lot to do to recruit case workers?

[138] **Ms Lloyd-Jones:** They will not be recruited as such; they will be people who are currently employed who are developing into this role. They will probably be people who currently work in areas such as risk management, so it will be a question of developing them to understand this new aspect. One person in an organisation that could employ 16,000 will not be able to cover what might be the load, so we have to have a group of people trained to the standard required to carry out the role.

[139] **Irene James:** I would like to look at paragraphs 3.11 to 3.15, which state that trusts have found it difficult to secure prosecutions against offenders committing violent acts against staff. The chief crown prosecutor for south Wales told us that the CPS does not routinely classify cases as being from the NHS. Mr Francis, there are around 8,000 cases of violence and aggression reported each year. Why do you think the rate of prosecution is so low? You mentioned private prosecutions, but is there another option if the case is not taken up by the NHS?

[140] **Mr Francis:** I cannot give a definitive answer to that. Part of the reason is the lack of reporting. A significant part of it will be the quality of evidence that we gather. Part of it may be that the victim may not want prosecution, because a large proportion of the 8,000 cases will be assaults or violence from patients in different settings. I would feel a lot more confident in six or nine months' time when we have the data breakdown on the areas where the assaults are taking place. My focus would be on trying to get to the bottom of how many cases warranted prosecution where we failed to take the case forward. I do not have those data at the moment.

[141] **Mr Williams:** As a broad indicator, from the earlier evidence, there is something of the order of 80 serious incidents and we would certainly need to be looking at those. I would not want to minimise any of these, but the vast majority are minor. We would need to find out, if we got 60 or 70 serious incidents, how that figure would compare in terms of the number of successful prosecutions.

[142] **Jonathan Morgan:** On 25 March, when the Royal College of Nursing came to give evidence and then later the chief crown prosecutor, along with the chief constable of South Wales Police, my colleague Nick Ramsay asked a question about the level of legal redress and touched on the issue of the type of criminal offence that is caused when somebody attacks another individual. An NHS worker is covered by the same law on assault as an ordinary member of the public. The question was put to the Royal College of Nursing as to whether or not the law should change to give nursing staff and other staff within the NHS the same level of protection as the police, or certainly for the offence to be considered the same as if there were violence against a member of the police force. The Royal College of Nursing said it thought that nursing staff and others should have the same level of protection in that sense and the chief crown prosecutor, Christopher Woolley, said there may be a case for doing that. I wondered what your view is and what the view of the Assembly Government might be.

Although this is not a devolved matter—it would be a matter for the Ministry of Justice and Department for Constitutional Affairs—do officials have a view as to whether or not the law ought to be changed to give medical staff and those working within the NHS the same level of protection as the police?

[143] **Mr Francis:** There is a case to be made as to why we should differentiate between nursing staff and the police in that regard. Equally, there is an argument against it. My focus is not on whether we should have additional powers, but whether we are using our current powers to full effect. The answer to the latter question is 'probably not'. However, I am not speaking definitively against new legislation; it is a matter of personal view.

[144] **Mr Williams:** I would tend to support that. This is not a devolved matter and we need to work with the material we have. Clearly, there is more that could be done in terms of achieving successful prosecutions.

[145] **Jonathan Morgan:** Okay, thank you. I see that there are no further supplementary questions. I thank our witnesses for attending this morning and, as usual, we will send you a copy of the transcript in a few days' time. Many thanks.

10.45 a.m.

Trefniadau Trosglwyddo mewn adrannau Damweiniau ac Achosion Brys: Gwybodaeth gan Archwilydd Cyffredinol Cymru
Accident and Emergency Handover Arrangements: Briefing from the Auditor General for Wales

[146] **Jonathan Morgan:** We have all been circulated with a copy of the report. It was published on 23 April and the auditor general advised the committee at the last meeting that the contents of this report could have a bearing on the committee's ongoing inquiry into ambulance services in Wales. I will ask the auditor general to make some introductory remarks and brief the committee on the main findings of the report. The committee has had the chance to read the report already and during the private session later the committee will need to decide under our new procedures how to proceed with this new report.

[147] **Mr Colman:** Thank you, Chair. I will say a few words to set this report in the context of our general approach to unscheduled care. My colleague, Rob Powell, will then give a little more detail about what the report shows. The history of our taking an interest in unscheduled care dates back to our first report on the ambulance services in Wales two years ago, when we found—as I think is well known—that the performance of the ambulance service in dealing with emergency response was very poor indeed and that the reasons for poor performance were not particularly related to shortage of money. The reasons for poor performance primarily were a failure to match the resources that were available to the demand for the services, which, by definition, is unscheduled demand, but that does not mean that it is unpredictable. Subsequently, last year we published a report on the management of chronic diseases, which showed that a surprisingly high proportion of acute secondary care facilities are occupied by patients with chronic diseases, who are there as a result, in many cases, of an unscheduled incident. That suggested to us that unscheduled care was an issue that bore upon the effectiveness of the whole system of healthcare in Wales. Therefore we decided to carry out a series of studies that would illuminate this important but very complex subject.

[148] The current report is the first in this new series. You could argue that it is the third or fourth, because we have done reports in the past that are relevant to the subject, but, following the decision to have a series of reports, this is the first and it focuses on what might strike you as a very small part of the whole system. It is a small part; it is an incident that should happen

within a very few minutes, with every patient taken to an accident and emergency department by the ambulance service. The report shows, however, that in an unsatisfactorily high number of cases the handover is not completed within a few minutes but can take over an hour, with severe consequences obviously for the patient, who is kept waiting, but also for the patient who is not in a hospital but is waiting for an ambulance out in the community. So this is a small part of the process but one with very important consequences.

[149] The findings of the report indicate that the Assembly Government is alive to the importance of the issue and has recognised its importance by setting a target for handover times. However, the method by which that target is measured and monitored was not very satisfactory, certainly at the time that we were doing our work, towards the end of last year.

10.50 a.m.

[150] The reasons for that are primarily to do with human factors: the ownership of the target and of responsibility for minimising handover times. It is interesting that, in the session that we have just had, there was quite a lot of talk about the ownership of issues. It is absolutely crucial, in whole-systems questions such as this, that staff recognise how their activities fit into the whole system, whoever their employer may be. That is all that I want to say by way of introduction and context. I will now hand you over to Rob.

[151] **Mr Powell:** Thank you, Jeremy. I want to talk Members through the context of the project in a little more detail and some of the main findings in the two parts of the report.

[152] You will be aware from the previous reports that we have done on ambulance services and the recent update that you considered last month that the Welsh Ambulance Services NHS Trust has lost a significant amount of time during turnarounds at accident and emergency departments. Turnaround is the time between an ambulance arriving at the hospital and becoming available to take the next call. There has been a long-standing debate as to whether the time lost arises from delays in handing over a patient to the hospital staff or whether there is a contributory element following handover that causes a delay in the ambulance crews making themselves ready to take the next call.

[153] The Minister for Health and Social Services, recognising that there is a problem, has set a new target to handle handovers, as opposed to turnarounds, and has introduced touch-screen technology at the ambulance entrance to emergency departments. This is to measure whether handovers have met the 15-minute target. Good practice across the UK suggests that turnarounds should take about 20 minutes, which is made up of a 15-minute handover plus five minutes for ambulance crews to restock the vehicle and get themselves ready to take the next call.

[154] Touch-screen technology is operated both by the ambulance crews in indicating their arrival at the emergency unit and then by the hospital staff in indicating the completion of the handover. The technology was installed in September 2008 to measure progress against the target, which came in during last year's annual operating framework.

[155] Jeremy mentioned that we are doing what we call whole-systems work on unscheduled care. So, we are not looking at one small element of the system, such as ambulance services or emergency departments; we are trying to look at the issues from the perspective of the citizen. Quite often, when one looks at a system, problems are found at the interface between different services. This report is a classic example in that respect.

[156] There are potential benefits in measuring handover times. It is probably a better indicator of the patient's experience than the turnaround target, which relates to the availability of a resource. Obviously, clinical risks increase if patients are left on trolleys or in

the care of ambulance crews, or even ambulance officers in the accident and emergency department who are there specifically to look after patients to free up ambulance staff to go back onto the road. There could be a lot of discontinuities and additional handovers that increase risks, not to mention the risks for those in the community waiting for an ambulance that is stuck at the emergency unit. If there are large numbers of ambulances outside the emergency unit or large numbers of patients on trolleys, it does not give the best impression of the operation of the whole system. In addition, it is not very good for the ambulance crews or the staff in emergency units who have to deal with that stacked-up demand.

[157] So, we decided to look at this very early on. Rather than wait a number of months for the system to work, we felt that an early spot check of the new system would be sensible. The idea behind that was to try to support the NHS in making the measurement system work, and particularly to try to reduce the impact of long delays when patients are being handed over at hospitals' front doors.

[158] Between the end of October and the middle of December 2008, we undertook two spot-check visits at each of the main emergency units in Wales. We went at different times of the day and on different days of the week for a couple of hours. We observed the handover process and looked at the data recording. We talked to a very wide range of staff, from the receptionist at the emergency unit to the front-line staff employed by the ambulance trust or the hospital, to get their views on how the system was working and the main causes of the problems.

[159] As Jeremy said, the main findings of the report were that, although there have been some positive steps towards improving handover times, patients are frequently delayed for too long outside the accident and emergency department. The data on handovers are not yet sufficiently robust to tell anyone anything more than what we already knew about turnaround times. Critically, NHS organisations need to think about the whole system. Addressing whole-system problems will probably have the biggest impact on improving handovers, as implied by the Assembly Government's strategy, 'Delivering Emergency Care Services'. They also need to measure the extent of the problem in the short term to try to improve things.

[160] Turning to the detail, part 1 of the report sets out our findings on the measurement and scale of the problem. You will be aware that, in 2008, more than 32,000 ambulance hours were lost by crews waiting to hand patients over, and which failed to meet the 20-minute turnaround target. That has direct costs: the cost of the ambulance crews' time in 2008 was about £2.4 million. There is a further cost of about £330,000 because of ambulance officers being placed in emergency units to look after patients to try to free up ambulance crews. There are also much wider indirect costs that affect response times as ambulances try to get back to where they should be. The planning of demand and job cycles tries to correct itself, because the ambulance trust works on a 1-hour job cycle from start to finish. Turnaround times of 20 minutes or more can make it very difficult to get the job cycle right again and to have resources in the right place to meet demand. That applies particularly in the more remote areas, and the report has appendices that set out the very significant impact of that in particular localities.

[161] When the system really breaks down—and we were looking at it during December 2008, which was a time of prolonged and severe winter pressures—the situation can become much worse and can quickly spiral. Figure 7 and the detailed appendix 4, which gives the situation in each of the 22 local health board areas, show that, during December 2008, the ambulance trust was taking a considerable amount of time even to allocate resources to respond to calls. In some areas, it was taking more than eight minutes even to allocate a resource to respond to a call, let alone to respond within the eight-minute target. That is a symptom of the system breaking down, and it is a very vivid manifestation of some of these problems.

[162] It is worth reminding Members that this is a very localised problem. Figure 12 shows the position of the different hospitals. You will be reminded from that that the University Hospital of Wales and the Royal Gwent Hospital experienced particular problems. Nearly 12 per cent of turnarounds in 2008 took over 20 minutes at the Royal Gwent Hospital, and it was just under 8 per cent at the University Hospital of Wales. So, it is a variable picture, and that can make the problems on particular days all the more acute.

[163] The second section of part 1 deals with an ongoing problem with other emergency services transporting patients to hospital, which is a serious issue that we first reported in our original 'Ambulance Services in Wales' report in December 2006. The Assembly Government's policy is to have an integrated emergency response, and police and fire officers have a sworn duty to protect life and to take care of people. That can sometimes lead them to decide to take patients to hospital in the absence of an ambulance to transport them. When we reported in December 2006, we highlighted a monthly average of around 11 such incidents between January and August 2006. The position that we found between October and December 2008 was quite significantly worse than that, with a monthly average of around 30 such incidents of police or fire officers transporting patients to hospital. They were predominantly incidents that involved the South Wales Police and Gwent Police, although a handful involved the fire service. It was not an issue at all in north Wales. That has all sorts of implications for the ambulance service, the patients concerned and the individual police and fire officers. If a patient dies in police custody, it will automatically trigger an investigation by the Independent Police Complaints Commission. That is obviously very difficult for officers who have done their best to do the right thing in very difficult circumstances. So, that is quite a serious issue that is contributed to by issues of handover and turnaround. The joint emergency services group is very concerned about this and has formally raised the issue with the Minister. A task and finish group is ongoing to try to reduce the impact of this.

11.00 a.m.

[164] The final part of part 1, paragraphs 1.25 to 1.47, deals with the fact that the true extent to which handover delays take place is still not clear. The terminals were introduced to emergency departments with commendable speed, but early on there were some significant problems with reliability. There were frequent malfunctions. The training was reasonably well received, but the malfunctioning led to delays in the system actually being used. That meant that people could not necessarily remember the training. There was a problem with staff knowing what to do, but not necessarily knowing why they were doing it. That probably reduced the buy-in of ambulance staff and emergency unit staff to record the information properly. They are driven by issues of patient care and patient safety. I am not sure that, in rolling out the touch screens, it was made sufficiently clear to them that getting a grip on handover delays would make a direct contribution to improving patient care. There were issues of clarity about when, in the handover process, the handover should be recorded and who should do it. Variability between different emergency units added to the lack of recording. In December 2008, which was a period of fairly unprecedented demand and winter pressures, only one in five handovers was actually recorded. Figure 13 shows the variability between the different emergency units in that respect. The good news is that, as I understand it, the extent of recording is improving. However, to get a grip on handover times, all incidents need to be properly recorded. In the report, you will see photographs taken during our spot-check visits, and there are pictures of touch screens that were not working.

[165] In the absence of robust data about handovers, the turnaround information is the best available way to measure the impact of problems at the interface between the ambulance trust and the acute hospitals. The Assembly Government and the acute trusts have some concerns about the reliability of that information. It is not validated. We think that, in the absence of any other information, it is a reasonable proxy indicator for time that has been lost. We can

certainly measure trends over time. However, the key thing is to get the measurement of handover delays accurate and robust, and a lot of work is now going on to that end.

[166] As I mentioned at the start, the key thing is to improve the operation of the whole system of unscheduled care. Part 2 sets out our findings on the extent and effectiveness of that work. The problems at the front doors of hospitals relate to problems throughout the healthcare system, and addressing those problems is likely to have the greatest impact. People must understand the range of unscheduled care services that are available and access the correct service to meet their needs rather than defaulting to the emergency unit. There are many widespread issues around the management of capacity and patient flow. Problems at the front door of a hospital often reflect issues at the back door—and you will be receiving an update on our work on delayed transfers of care in the middle of May. Issues at the back door, in relation to patient discharge, affect the front door. Bed capacity in the emergency unit was the issue most frequently cited by staff. That is affected by bed capacity on wards and the ability to move patients through the system. Flow is a key thing here, and it is exacerbated by very high levels of bed occupancy.

[167] We found that there needs to be greater vision and leadership to find joint solutions to these problems, between the Assembly Government, the ambulance trust and the acute trusts locally. They must recognise that an integrated and seamless approach needs to be taken to move patients through the system as effectively as possible. There is a lot of work ongoing on this, and there are some signs of progress. When you took evidence from Paul Williams and Alun Murray in March, they provided evidence that response times were improving. Some stabilisation funding has been given to the ambulance trust. Action plans have been developed, both to try to undertake some quick-win, short-term actions to improve things, and to deal with some of the long-term causes of this, in a longer term action plan for unscheduled care from 2009-11. If it is implemented effectively, it should help to improve the system.

[168] We found that staff are very much committed to improving handovers and to delivering good quality patient care. However, there needs to be better work by the local bodies to inspire them to record information accurately and to understand why they are doing it. There needs to be better matching of hospital resources to peaks of demand to ensure that staffing levels and the staff mix in the emergency units are appropriate to meet demand. It must be ensured that in-patient bed capacity is available to move patients through the system so that they can be admitted to the emergency unit in the best way. Handover information should be used to support better management of capacity and flow. There did not seem to be a sufficient recognition of the potential of the data terminals to help with the day-to-day management of the system, rather than using them just to record hard-nosed data. I think that greater recognition of the scope to use the terminals would certainly help.

[169] Resourcing across the system needs to be looked at in the round. As well as looking at the number of ambulance vehicles and the number of crews, there needs to be a look across the system at how much resource is available in each part of the system to move patients through in the optimum way. There needs to be much greater consistency of practice in handovers between the different units, and appendix 2 of the report provides a checklist to that end. The things listed may seem to be very obvious, which everybody should be doing, but we hope that the ambulance trust and the local emergency units will use the checklist to assess where they are and to improve their handling of the handover process.

[170] **Jonathan Morgan:** Thank you, Rob. We will now move on to questions for the auditor general, or for Rob.

[171] **Michael German:** We will come to discuss what we are going to do, perhaps, but I ask you now to look at figure 2 on page 10. I want to understand the exact starting point and the exact endpoint of turnaround, as opposed to handover, which, as you have rightly said, is

crucial to understanding this. Is the starting point of the 15-minute target the actual point at which the details are entered on to the arrival screen, or is it when the patient and ambulance crew go through the door? Sometimes, ambulance personnel are waiting in the emergency unit and they say, 'I will hold on to the trolley for you; you get going.' I have observed that many times. So, can you say with clarity where that starting point is?

[172] Secondly, have you been able to do a subtraction exercise? In other words, taking the whole timescale—from the top to the bottom—of the six stages of figure 2, can you then extract the 15-minute target and see where we are on the parts of handover that are not included in turnaround? Or the other way around.

[173] **Mr Powell:** The time recorded for the handover target starts when the screen is pressed on arrival. So, if there is a delay there, there is a risk that it would not be picked up. The report includes some photographs that indicate that there might be a wait for a triage nurse to come to receive the patient.

[174] We were not able to do the subtraction exercise. That would be very difficult in the absence of robust data, but it should become easier as the system beds in.

[175] **Janet Ryder:** To follow that question up, should the time not start from the moment the ambulance pulls up at the hospital? What would need to change to allow that? Is it your job to look at what needs to change, or where do we need to look to find out what needs to change to ensure that that happens?

[176] **Mr Powell:** Certainly, ensuring that there is a timely recording of the arrival of the ambulance through the touch screens is crucial to getting good quality information.

[177] **Janet Ryder:** You have highlighted the incident at the Wrexham Maelor Hospital. There have been very few problems of this nature in north Wales, but a problem was created by the introduction of the touch screens. You have detailed in your report that the feeling of the ambulance trust is that the nurses are there to monitor the role of the ambulance trust. How much of that tension has been created because there are two trusts involved? Was it purely about the location of the touch screen, and are there lessons to be learned from that for the other trusts?

[178] **Mr Powell:** My understanding is that the problem related to the location of the touch screen, and it was seen as belonging to the nurses in the emergency unit. Generally, this report suggests the importance of dealing with the human side of an IT implementation as well as the technical side; it is about winning hearts and minds and ensuring that everyone understands what the system is for, how it is to be used and why it is there. There has been tension in some units—Wrexham Maelor being one of them—when the implementation has not worked as well as it might have, and one side or the other feels as though their performance is being monitored. In fact, I think that the Minister's intention with this target was to get away from that, and to set a target designed to improve patient care, which fell on both organisations in recognition that this is a systems problem.

11.10 a.m.

[179] **Jonathan Morgan:** From my perspective, there are a number of issues here that certainly cause a few alarm bells to ring. The first involves the accuracy of the picture, or the true picture. Although a data terminal will record when someone touches it and will then record when the ambulance has left, and therefore provides a picture to the Assembly Government as to handover and turnaround time, there is clearly potential for a time lag between the ambulance arriving at the front door and somebody actually getting to the data terminal to record that.

[180] There is also a separate issue that certainly caused me concern when reading the report, and that involves the potential for the ambulance crew to discharge its responsibility by passing the patient over to another member of the ambulance trust. When this target was envisaged and when the policy behind it, I suspect, was drafted, the whole idea was that this involved the ambulance crew discharging its responsibility by handing the patient over to the care of the medical professionals, not, in essence, playing pass the parcel—and that is what it looks like. I am sure that that helps the ambulance crew get back out onto the road, and that was the principal reason for the target, but, ultimately, in terms of patient care, I think that some serious questions would be asked about what happens to that patient, and how long that patient stays with the other member of the ambulance trust before being examined and placed in the care of the appropriate medical professional. So there is certainly, from my perspective, a concern there.

[181] I wanted to raise two particular points —

[182] **Michael German:** May I come in on that? I should have asked this when I was asking my questions. Is it only the hospital staff who can touch the screen or, in other words, the trigger? If you are passed to ambulance personnel, they cannot touch the screen either, if I understand the system correctly. Is that right? Is it only the hospital staff who can touch the screen and start the process?

[183] **Mr Powell:** It varies a little bit in different departments but, in theory, on arrival, the ambulance crews will touch the screen and then, on departure, the hospital staff will usually indicate that the handover has taken place.

[184] **Jonathan Morgan:** There are two points that I wanted to raise. The first is in relation to the impact on other emergency services. You refer to the 2006 figures of 11 patients per month, on average, being carried to hospital by a different part of the emergency services, and roughly 23 such incidents being reported in March of this year. You say in paragraph 1.24 of the report that

[185] ‘The Joint Emergency Services Group has formally raised its concerns with the Assembly Government and is working to achieve a sustainable solution to these problems’.

[186] Did the joint emergency services group outline what possible solutions it was considering?

[187] **Mr Powell:** It is certainly monitoring the extent of the problem and it has had a meeting with the Minister. There is a very recent task and finish group report, as I understand it—in the last week or so—which I have not yet seen and which we will look at. We are certainly proposing to work with the joint emergency services group to monitor the trends with this in order to report back in the whole-systems report on unscheduled care later in the year, because, obviously, 30 incidents of this type is a very high number each month.

[188] **Jonathan Morgan:** Moving on to the issues that you have raised under paragraphs 1.32 and 1.33 onwards, you talk about the attitude of staff and say that

[189] ‘Some staff do not record handover times because they are resistant to additional monitoring of their activities, they are uncertain of their responsibilities or they feel the data recording takes them away from their clinical duties’.

[190] I appreciate that you spoke to staff, but did they provide any evidence of where they were being taken away from their clinical duties in order to fulfil this new responsibility?

[191] **Mr Powell:** I think that this was a general point where, if you have seriously ill patients and you are trying to care for them in the best possible way and hand them over to another service in a clinically effective way, it is quite possible that, because of the duty of care, your first priority would not be to go to a touch screen to produce some data to help with the management of the service. I think that this probably relates to the way in which the use of the screens was rolled out in terms of why that data is so important. If you had good ambulance response times and these problems at the door of the accident and emergency department did not manifest themselves, you would not necessarily need to measure how long the handovers were taking, because you could assume that the system was working well. Perhaps staff did not understand as well as they might have that, given the problems with ambulance response times and getting ambulances back on the road and the impacts on patient care when there is a delay in handover or multiple handovers, as you have just described, it is actually quite important to get a handle on the situation.

[192] **Jonathan Morgan:** I am looking now at appendix 3, which looks at the trust level data, and speaking as somebody with a keen interest in Cardiff. I am sure that Lorraine would agree with that. The fieldwork that you did shows that, in December 2008—I will just use this as an example—there was a reduction in the average number of hospital transports to accident and emergency departments per week compared with November. However, the number of hours lost in December was higher than the number of hours lost in November. So, for some reason, the number of hours lost went up and the number of average attendees at accident and emergency departments transported via ambulance went down. There is obviously an interesting interlink there between the two. I am wondering how typical this picture is, or whether it is just the picture that we have now come to expect, particularly at the University Hospital of Wales, and similar also to the problems that we have seen at the Royal Gwent?

[193] **Mr Powell:** There are many factors involved in this picture, not least discharge from hospital at the other end of the system. I think that December was a period of intense pressure on the wider NHS and, clearly, the system was struggling. However, there is, as you rightly point out, an interesting trend here with the number of patients attending at the accident and emergency department falling while the number of lost hours rose. I think that UHW, as we show earlier in the report, and the Royal Gwent are probably outliers.

[194] **Mr Colman:** This, if you will forgive me, Chair, is a mathematical point. The thing that is most important in causing lost hours is the variability of the flow. So, the fact that the number of patients being transported has gone down may not help much if the number per hour is very variable. We have had some conversations with mathematicians at Cardiff University who have shown us very clearly that, even if all the capacity is just right for the total volume of patients, you can have very long delays if the patients are so inconsiderate as to arrive randomly. [*Laughter.*]

[195] **Janet Ryder:** You have talked about the pressures that can be created because of the backlog when people are not discharged, so that the normal hospital fills up and that seeps over into the accident and emergency department. Have you made any attempt to measure cases that might show, not an inappropriate use of the accident and emergency department—because presumably the people are ill—but incidents where, because of the change in out-of-hours care by doctors, there has been increased pressure and what impact that has had?

[196] **Mr Powell:** That is very much an issue that is part of the whole-systems work that is going on at the same time as this report, which will contribute to the whole systems findings. If you can get people to access the right level of unscheduled care services, that can help to allocate the resources in a better way. When Alan Murray gave evidence to you in March he talked about 60 per cent of people who attend the emergency unit not requiring an in-patient admission, which may suggest that some of them could have been safely dealt with at another level of care, such as out-of-hours care. However, it involves how people access these

different levels of service and understand what they are for.

[197] **Jonathan Morgan:** Are there any more questions? I see that there are not. Thank you. We will defer our decision on how to proceed with this report until we discuss the matter later in private.

11.19 a.m.

Ystyried Ymateb Llywodraeth Cynulliad Cymru i Adroddiad y Pwyllgor Archwilio 'Rheolaeth Ariannol yn y GIG'
Consideration of the Welsh Assembly Government's Response to the Audit Committee Report 'NHS Financial Management'

[198] **Jonathan Morgan:** This item relates to papers 3 and 4. I invite the auditor general to introduce his assessment of the Government's response to the committee report on this subject, and we will then discuss how to proceed.

[199] **Mr Colman:** Thank you, Chair. The subject of effective financial management in NHS bodies is one that, I think, will be with us for a long time, so we never intended our report on this subject to be the last word. The Assembly Government's response is largely satisfactory, but there are still some remaining issues that, in my view, need following up. I shall certainly be following them up in our own work examining financial management in the restructured NHS from October of this year.

11.20 a.m.

[200] My letter to you records a particular issue relating to recommendation 4, where the Assembly Government's response does not seem to be consistent with the committee's recommendation, and it may be that the committee might wish to write to the Assembly Government about that. I think that it is interesting that, in the year that has just ended, for example, there was widespread expectation and forecast in December that many NHS bodies would end the year in deficit. At the end of the year, however, I understand—this is obviously to be confirmed by audit—that none of them were. It sounds like a fantastic achievement, but there were streams of payments from the Assembly Government to individual bodies towards the year-end.

[201] In our report on the financial management of the NHS two years ago we drew attention to the fact that very late adjustments—including adjustments to targets after the end of the year to which they relate—were not really conducive to sound financial management. That practice still seems to be happening—at least, I understand that it is. I conclude, therefore, where I started in response to your question, Chair, by saying that this is a subject of continuing interest that will warrant continual investigation.

[202] **Jonathan Morgan:** Are there any views before I recommend one way to proceed? I see that there are not. One option, certainly, might be for me to write to the accounting officer and set out where we require further information and clarification, and particularly to have some indication as to when the Assembly Government intends to review the initiatives that have recently been introduced to improve financial management, but also to seek clarification around recommendation 4. I think that that would be quite useful, unless there are any other suggestions as to the way to proceed. I see that there are not. Is everyone happy? I see that you are. Good.

11.23 a.m.

Ystyried Ymateb Llywodraeth Cynulliad Cymru i Adroddiad y Pwyllgor Archwilio 'Gwasanaethau Therapi Ocsigen yn y Cartref'
Consideration of the Welsh Assembly Government's Response to the Audit Committee Report 'Home Oxygen Therapy Services'

[203] **Jonathan Morgan:** This item relates to papers 5 and 6. Again, I ask the auditor general to introduce his assessment of the Government's response. I think that, on this report, the auditor general seems satisfied with the Assembly Government's response, but I will ask him to outline how satisfied he might be.

[204] **Mr Colman:** We are always a bit grudging in that respect; it is our way as auditors. In summary, yes, we think that the Assembly Government's response shows that it has taken the work of this committee extremely seriously. I do not think that there was ever any attempt to pretend that the way in which the implementation of the home oxygen contract went was anything other than really quite poor. The response of the Assembly Government is a satisfactory one.

[205] **Jonathan Morgan:** I think that that concludes that item. Thank you.

11.24 a.m.

Cynnig Trefniadol
Procedural Motion

[206] **Jonathan Morgan:** I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 10.37(vi).

[207] I see that the committee is in agreement.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11.24 a.m.
The public part of the meeting ended at 11.24 a.m.

Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Archwilio
The Audit Committee

Dydd Iau, 4 Mehefin 2009
Thursday, 4 June 2009

Cynnwys
Contents

Aelodau Cynulliad yn bresennol
Assembly Members in attendance

Lorraine Barrett	Llafur Labour
Michael German	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Lesley Griffiths	Llafur Labour
Irene James	Llafur Labour
Bethan Jenkins	Plaid Cymru The Party of Wales
Jonathan Morgan	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Chair of the Committee)
Nick Ramsay	Ceidwadwyr Cymreig Welsh Conservatives

Eraill yn bresennol
Others in attendance

Gillian Body	Swyddfa Archwilio Cymru Wales Audit Office
Jeremy Colman	Archwilydd Cyffredinol Cymru Auditor General for Wales
Tina Donnelly	Cyfarwyddwr, Coleg Brenhinol y Nyrsys Cymru Director, Royal College of Nursing Wales
Andrew Evans	Swyddog Proffesiynol, Coleg Brenhinol y Nyrsys Cymru Professional Officer, Royal College of Nursing Wales
Dave Galligan	Pennaeth Iechyd, Unsain Head of Health, Unison
Rob Powell	Swyddfa Archwilio Cymru Wales Audit Office
Yr Athro/Professor Malcolm Woollard	Cadeirydd, Cymdeithas Brydeinig y Parafeddygon Chair, British Paramedic Association

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

John Grimes	Clerc Clerk
Abigail Phillips	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 9.31 a.m.
The meeting began at 9.31 a.m.

Ymddiheuriadau a Dirprwyon
Apologies and Substitutions

[1] **Jonathan Morgan:** Good morning. I welcome Members to this meeting of the Audit Committee of the National Assembly for Wales. The usual housekeeping arrangements apply. Members can speak in Welsh or English, and headsets are available for translation and amplification. I remind everyone to switch off mobile phones, BlackBerrys and pagers. If

there is a fire alarm, please follow the advice of the ushers.

[2] We have received three apologies for absence—from Janet Ryder, Huw Lewis and Janice Gregory. There are no substitutions. I do not believe that Members need to declare any interests, so we will—

[3] **Lorraine Barrett:** Chair, could I mention that Janice is not here because she is in a meeting of a legislation committee?

[4] **Jonathan Morgan:** That is noted. Thank you, Lorraine.

9.32 a.m.

Y Gwasanaethau Ambiwlans yng Nghymru
The Ambulance Service in Wales

[5] **Jonathan Morgan:** Members will be aware that the Auditor General for Wales published a review into unscheduled care, examining the patient handovers at accident and emergency departments. The committee decided to further the inquiry by publishing a review of its own, and inviting individuals in Wales to give evidence, including those who work at the coalface in the health service. Once they have given us their views on the situation, we will take further views from those who manage our accident and emergency departments, and then conclude with an evidence session with the accounting officers.

[6] It is a pleasure to welcome today's witnesses. I ask them to identify themselves for the record.

[7] **Professor Woollard:** I am Professor Malcolm Woollard, and I am the chair of the College of Paramedics, which is the professional body for ambulance personnel. It is the ambulance equivalent of the Royal College of Nursing or the General Medical Council.

[8] **Mr Galligan:** My name is Dave Galligan, and I am head of health for Unison in Wales. I represent about 1,400 members of staff in the Welsh ambulance service, mostly in front-line services.

[9] **Mr Evans:** My name is Andrew Evans, and I am a professional officer for the Royal College of Nursing. In a former existence, I was an emergency nurse practitioner in accident and emergency for 20 years.

[10] **Ms Donnelly:** I am Tina Donnelly, the director of the Royal College of Nursing. We have members both in the Welsh Ambulance Services NHS Trust and NHS Direct, as well as accident and emergency departments.

[11] **Jonathan Morgan:** I offer a warm welcome to the four of you. We have a number of questions to get through this morning, so we will proceed with those. I will ask a general question to Malcolm Woollard, Dave Galligan and Tina Donnelly. Part 1 of the auditor general's report highlights that many ambulance hours are lost at accident and emergency departments each day. In March, Alan Murray told this committee that 12 hours are lost each day at the Royal Gwent Hospital alone. What barriers are there to consistent achievement of handover targets as a result of these particular problems, not just at the Gwent, but more generally within accident and emergency departments? We will start with Professor Woollard.

[12] **Professor Woollard:** Our major concern is that paramedics are being asked to

undertake a role for which they are not trained, by being required either to look after their own patients, whom they have brought into the accident and emergency department, for an extended period of time in an unfamiliar environment, where they are unsure of their role and the availability of appropriate equipment should an emergency occur. Worse still, individual paramedics are being asked to look after large numbers of patients with whom they will not be familiar, who they have not brought into hospital, as a temporising measure when queuing is in place. Again, that is not a role for paramedics or for the ambulance service, and we certainly feel that the responsibility of the hospital trust to provide an adequate service with adequate staffing has been shifted to the ambulance profession. Implementing that service, although it had the best of intent, is probably one of the barriers to the hospital trust getting its act together and getting its own house in order.

[13] **Mr Galligan:** I would echo many of those sentiments. It is not a new phenomenon. The figures published for December showed more than 5,000 lost hours, with a significant proportion of that being in excess of the 20 minute wait period. Until it was highlighted as crudely and bluntly as that, people could not make the correlation between that and how many crews they could see in that time. My view, pretty much like Malcolm's, is that it is not really the responsibility of the ambulance service to manage that situation. It has put in staff and resources to manage the situation, but the responsibility, in my view, lies fairly and squarely with the health trusts, which are effectively allowing this to happen. Whose performance is affected most is debatable, but the ambulance service is the one that always seems to be in the spotlight in that regard. It does not seem to work the same way for trusts, which have the majority of responsibility in this field. We do not believe that paramedics should be managing that situation in the accident and emergency departments. That is clearly the trust's responsibility.

[14] **Ms Donnelly:** I would agree with quite a lot of what has been said with regard to the ambulance trust and the measures that it has tried to put in place to work in partnership with NHS trusts. Nevertheless, we must also look at healthcare governance and clinical risk. Where patients are being offloaded to a corridor of an accident and emergency department where there is no oxygen equipment, where patients are, potentially, three abreast on trolleys—and over a period of time—that relates to a full-systems capacity issue and the management of risk. If you consider the situation with an NHS trust that is constantly at the top of its escalation policy—in other words, ready for closure at the front end of the hospital—what happens when you have an ambulance service that must respond within a given timeframe in order to meet a target when, potentially, a trust 12 miles down the road is on green or amber and could take that patient?

[15] Part of this is also due to what is being mooted with regard to the internal market, because the internal market is being done away with in the new structures of the NHS, which we support, but, nevertheless, there is the unseen market. Take the example of the ambulance trust, which must respond to those response times, going to an NHS trust to offload a patient, and the clinical staff saying that the governance of this is that they cannot bring a patient into a corridor where there is no offloading for oxygen, and the ambulance has oxygen. That is inappropriate management in governance terms, but it also demonstrates a system whereby an NHS trust down the road will potentially not take a patient because the cost will fall to the commissioners outside their area. They are, therefore, reluctant to work in partnership on assistance capacity management along the whole of the M4 corridor.

[16] So, the ambulance trust has tried to work with the NHS trusts and ask whether they can look at partnership working. What I read from that report is that it is not just about 15 minute handover times, but a full-systems approach that we need to review in relation to, let us say, the capacity issues along the whole of the M4 corridor. I have been around all the NHS trusts quite recently, and when some accident and emergency departments are at full capacity and cannot take any more, I have gone 12 miles down the road to another department

and found that there is perhaps only a 30 minute waiting time. So it is really about looking at and managing that risk across NHS provision, and then perhaps looking at who pays the cost later down the line.

[17] **Jonathan Morgan:** I have a question specifically for Professor Woollard and Mr Galligan. In March, the committee heard from Paul Williams and Alan Murray that the ambulance service trust and the Assembly Government felt that a lack of staff on the ground was affecting response times. Some £4.7 million of non-recurrent funding was allocated to the ambulance service in December of last year. That was done, apparently, to help address the situation. As a result of that, do you think that we might see more sustainable staffing levels?

9.40 a.m.

[18] **Professor Woollard:** There is still an enormous amount of tension between the requirement to make cost savings—the figure this year is £17.3 million—and the need to staff ambulances. That causes me a great deal of concern. Staff in any organisation, but particularly in the NHS, are the most expensive element of providing a service, and they are the most important aspect of providing an emergency service. If you do not have adequate numbers of vehicles that are sufficient to meet demand and distributed in a geographically appropriate way, according to that demand, there is absolutely no possibility of meeting performance targets. There is evidence from the audit report that there were unstaffed shifts, and that was, in part, to blame for the failure to meet performance targets.

[19] What is not commonly understood with regard to emergency systems is that there is a very clear cut-off point between the ability to achieve performance and the failure to achieve it. The system may muddle along, just about achieving its performance targets, but it only takes a small increase in demand or the loss of one vehicle for it to break catastrophically—it does not fail slightly; it fails catastrophically. I believe that that is what has happened in this case. I cannot answer your question specifically as to whether staffing will be improved, but my opinion is that there will be still be a shortfall, because of the requirement to make cost savings.

[20] **Mr Galligan:** I think that it has been fairly well publicised that many of the problems started in the south-east region, where, in our view, there was a self-inflicted injury of 45 vacancies. You do not have 45 people leaving overnight; a number of decisions had been taken in the south-east region, in particular, not to fill vacant posts as people left, transferred, retired or simply moved elsewhere. That was sustainable for a period, but, sooner or later, critical mass was reached, at which point it was starting to impact on performance. You filled some hours with overtime, but then ended up filling no hours with overtime, because the remaining staff were, effectively, working at capacity. Health and safety rules say that staff have to impose limits on how many hours they work. It was clear that what happened in the south-east was that there was no overtime and that there was a huge number of vacancies, which had a massive impact on performance. Most people accept that the south-east seems to be the focal point of many of the performance issues. It is not that region alone that has those issues, but the size of its catchment area probably impacts adversely on the overall performance targets.

[21] It is a little difficult to determine how that situation arose, but someone certainly made a decision not to fill vacancies, and that decision must have been taken last summer. The fairly difficult times did not start until the end of the year, but that ultimately meant that it ended up costing more because staff were being paid for overtime in order to fill gaps. It is always cheaper to fill jobs on a permanent basis than to use overtime: overtime is unreliable, unpredictable, and, frankly, quite a number of staff really do not need it, given the stress that they have in the normal day job. The problems are self-inflicted, in that regard. There needs to be better management of staffing statistics, better management and planning arrangements as

to staffing issues, and, above all, an answer as to why it was allowed to happen. The accusations are that it was to meet the region's contribution to the strategic change and efficiency plan.

[22] **Jonathan Morgan:** Staying with the issue of south-east Wales in particular, Alan Murray told this committee in March that there was a certain amount of resistance from staff to changes in the rota system. In your evidence, you indicate that much progress has been made, and continues to be made, in meeting rota requirements. How confident can we be that the situation in south-east Wales in particular has now been fully addressed?

[23] **Mr Galligan:** Frankly, I do not think that it has been fully addressed. The rota work is piecemeal; it is by locality rather than by region, and will take some time to come to fruition. I have heard criticism internally about the pace of making decisions on the staff side, even in respect of adapting to change and recognising the change agenda. There is probably still an unhealthy dependence on overtime, but the concerns relate primarily to the way in which the rotas are planned and organised. There is a system within the rota called 'relief'. I apologise if this gets a bit complicated, but if you leave relief as a vacant line on the rota, it ends up being the shifts that no-one else wants to do. It has become a bit of a battle between the expectations of the trust in relation to the rotas and the expectations of staff. I think that we are making progress, but it is slow steps and it is by locality rather than by region. With my hand on my heart, I would not like to say that there is a solution.

[24] **Lesley Griffiths:** I would like to ask you a question, Dave. We were told that there was an ongoing rota review to try to improve supply and demand. Is that ongoing?

[25] **Mr Galligan:** The rota review, as far as I am aware, is a permanent feature. The problem with supply and demand is that there are peaks and troughs. If you really wanted to match supply and demand, you would have a crew in between 7 p.m. and 11 p.m., then send them home again and bring them in between 3 a.m. and 7 a.m.. That would match the demand, but the reality would be no work-life balance and you would not get people to work such hours. Matching supply and demand is very crude. You still have crews even now going home at 2 a.m. or 3 a.m., which does not provide the greatest work-life balance arrangements, but it matches demand. The review is an ongoing feature because demand will not always be the same; it will vary. Much of the time, historic data are used to plan. I am trying to think of the exact language that they use in the service. It is 'demand analysis'. That is not rocket science, is it? It is based on past experience. However, rota planning is a bit more complex than that.

[26] **Lorraine Barrett:** I have a question for Professor Woollard and Dave Galligan. To what extent are single-staffed rapid response vehicles being used to meet response targets while avoiding committing the double-staffed ambulances to a call?

[27] **Professor Woollard:** The college, unfortunately, does not have investigative powers, so I do not have precise information on that. When I was deputy chief ambulance officer for the south-east region, when it was the South East Wales Ambulance Service NHS Trust, we looked at this in light of our own performance. We reached the conclusion that rapid response vehicles would add very little to improving the performance. For the whole of the south-east region, which was Gwent, South Glamorgan and Powys at that time, we felt that there was a need for one rapid response vehicle between the hours of 9 a.m. to 5 p.m. in Cardiff and one in the northern area of Gwent during a similar time period. We also calculated that, on average, those vehicles would do one or two calls per shift. We saw them very much as a last resort.

[28] Two rapid response vehicles are still slightly more expensive than one ambulance, but you can see that those areas are geographically dispersed. At that time, we did not have a

large number of individuals trained as specialist paramedics, who are sometimes known as emergency care practitioners, with the ability to treat and discharge people in the community or refer them to other parts of the NHS and social services. We had five in training. Because of that, we felt that most patients would still go to hospital. That was the safe and appropriate thing to do. Paramedics are not taught to see and discharge patients, their training emphasises the patients with time-critical problems. So, we saw very little value in using rapid response vehicles.

[29] Since my day, the core demand has increased, but that does not necessarily mean that the logistical demands are any different. I personally believe, as do my colleagues on the council, that rapid response vehicles are currently being overused. There is a place for them; they are no more rapid than ambulances; they are just in different places, generally speaking, so it is not because they get there faster.

9.50 a.m.

[30] From talking to my former colleagues, who staff many of these vehicles in the south-east region, I know that they spend a lot of time sitting and waiting for calls and when they get a call, they spend a lot of time with the patient, sitting and waiting for an ambulance. That is clearly not an effective use of resources. Logistics would suggest that the cheapest and most cost-effective way to resource an ambulance service is through specialised vehicles that can do everything, and not through individuals.

[31] **Lorraine Barrett:** You have answered my supplementary question on perception. My perception is that it is quicker to get a car to a location than an ambulance, but when you think about it, I suppose that that is not the case. Someone told me the other week that the life of their relative, who was having a heart attack, was saved because a rapid response paramedic arrived in time. The paramedic did whatever he had to do and stayed with the patient until the ambulance arrived around 30 minutes later. So, could that ambulance have arrived at the same time as that paramedic—we are talking about a matter of minutes?

[32] **Professor Woollard:** If an ambulance had set out from the same place as the rapid response vehicle, it would have arrived at exactly the same time. There is no evidence to suggest that a car is quicker than an ambulance. Occasionally, a motor bike might be, but we, wisely, do not use those. Interestingly, if that patient had had a heart attack, they required an urgent transfer to hospital because they needed primary percutaneous coronary intervention. They did not need a paramedic sitting with them for a long time. Paramedics can provide an excellent standard of care, but it is usually temporising and, in many cases, the patient needs to be in hospital. That is not always true, but it was in that case. They needed a transport vehicle as well as paramedics looking after them.

[33] **Mr Galligan:** I suppose much of this is about public perception. There is the visual context of rapid response vehicles attending more incidents than was the case. There has clearly been an increase in the number of RRVs. However, if you want to replace those with ambulances, then you have to double the staff involved. I have no idea of the cost of an RRV. I imagine that it is not inexpensive, but I know that the cost of a fully equipped ambulance is substantially greater. This is often about public perception in that at least someone is there, on the scene. I agree with Malcolm that, in an ideal world, we would have a fully equipped ambulance on the scene with all the necessary life-support equipment, but you are then talking about the need for two crews, not one, and the cost of an ambulance, not the cost of a car. Whether or not it is risk-taking—and I am not sure that I want to use such language—this is about trying to improve public perception and increase confidence in the ambulance service.

[34] **Jonathan Morgan:** Before we move to the next question, I think that Professor

Woollard may be able to offer a view on the costs.

[35] **Professor Woollard:** With the greatest respect to my colleague, I disagree with that view because rapid response vehicles are not staffed by specialist paramedics who can treat and discharge in the community. What such vehicles mean in practice is that the resources responding to many 999 calls are increased. For example, there is the cost of the vehicle and of the paramedic staffing it and there is the cost of an ambulance with two people on it, so, in fact, you increase the cost of responding to that particular 999 call. That is not a cost saving. In future, when the Welsh Ambulance Services NHS Trust can train specialist paramedics in adequate numbers, there will definitely be a role for rapid response vehicles. The 'rapid' in the title is misleading, but there will be a role for a single-person response vehicle and those vehicles' main responsibility will be to treat people in the community and to discharge them in the community or to arrange for their transfer to non-emergency departments.

[36] **Lorraine Barrett:** In your paper, you recommend that the use of RRVs be suspended and that all resources be focused on increasing the number of double-crewed ambulances. If that were done now before the ambulance numbers were increased, would that have a negative impact on response times? From what you say, I get the feeling that, although the rapid response vehicle is getting there, so to speak, the ambulance still has to get there. I just wondered what the impact might be on response times.

[37] **Professor Woollard:** I would hesitate to suggest that all rapid response vehicles should be suspended, but I think that there needs to be a very careful review and the question needs to be asked. It involves a reasonably complex analysis of the work cycle of the vehicle, but the question needs to be asked. If the majority of the staffing of those rapid response vehicles was translated into the staffing of ambulances so that a vehicle capable of transporting the patient arrived relatively quickly—they should be starting off at the same places as the RRVs—and was then able to transport the patient to hospital without a 40 to 50 minute wait on the scene for an additional vehicle to arrive, then it should free up resources to respond to the next emergency call. Of course, this is reliant on the patient being handed over within a reasonable period of time. So, instead of having two lots of resources tied up on the same emergency call, you have only one.

[38] **Lorraine Barrett:** You refer also in your paper to the psychological risk to the rapid response paramedics and the clinical risk to patients when the ambulance transportation is delayed. How commonplace are such delays? Do you think that there is a cultural issue? I am not quite sure where the thought might be coming from, but because the rapid response paramedic is there, is there a thought along the lines of, 'Oh, we don't need to rush the ambulance at this point; the ambulance could go somewhere else because we know that someone is with that patient'? Is that happening? Is there any evidence of that?

[39] **Professor Woollard:** Yes, I think that there is. It certainly happens in England as well. However, it is actually due to a perverse incentive in the performance targets. I would not want to criticise the ambulance service, but the performance targets essentially require that a response is provided within eight minutes for category A calls. If a rapid response vehicle is that response, the clock stops at eight minutes and then you have up to 90 minutes to provide an ambulance capable of transport. Some patients—by no means all of them; in fact, a minority—will clinically deteriorate because of that delay. However, I have to emphasise that it is a very small proportion. That may include a patient with a heart attack if there has been a delay in calling for an ambulance, a patient with a stroke, patients who are unconscious, patients who need drug therapy that cannot be provided by ambulance crews, and patients who need immediate surgical intervention, perhaps following a road traffic accident or a fall at home. They all need rapid transfer to hospital, so there is a concern there.

[40] Of course, psychologically, for the trust, if it has more 999 calls than it can handle

and it has a vehicle on scene and 999 calls that it is not able to respond to, it will send the remaining ambulance that it would like to send to the call where the RRV is to another call, where there is no resource. That is inevitable, but there is a perverse incentive built in to the current performance targets. Although I think that response-time performance targets are important because otherwise you would have no constraints on service provision, the other thing to say is that they are overrated as a measure of clinical effectiveness. It is certainly true to say that if we get to a patient within seven minutes and 59 seconds and they die, that is a success and is counted as a success because we met the only measurable performance target, but if we take eight minutes and 1 second and the patient in cardiac arrest is successfully resuscitated and goes home to live a normal life, that is considered as a failure. Clearly, that is ridiculous.

[41] **Bethan Jenkins:** I want to concentrate on the HR issues mentioned in the auditor general's report. Has morale improved or changed in response to the auditor general's report?

[42] **Mr Galligan:** In my view, it has. It has primarily improved—I will be quite blunt—because of a new director of human resources with a more progressive and partnership agenda. They have not been blessed with the best quality staff in human resources for some time and I think that they downplayed, for a variety of reasons, the value of having good human resources staff in place. However, these are small steps. I think that I said in our submission that the HR agenda really needs to be supported—in the overall context of what we are talking about, it is as important as front-line services. The HR agenda has improved and there is a positive dialogue with staff about change, whether it is about rotas or role redesign, which is the way we all anticipate that it will go in future, and that is a huge agenda.

10.00 a.m.

[43] However, when the HR department is made up of only one or two people, it really struggles with that, and it is a challenge for them to be resourced properly and effectively. However, disappointingly, there is evidence that bullying remains a problem in some areas. I am not sure whether that is because it has a macho image, but the reality is that progress on bullying has been slower than we would have liked. CEHR has been involved, but I would like to see some evidence that we are making a significant impact on improving that aspect of the human resources agenda.

[44] **Bethan Jenkins:** How seriously does management take it if that culture of bullying persists, regardless of the developments in HR?

[45] **Mr Galligan:** I think that it is taken seriously by HR, because bullying is detrimental not only to the person bullied, but to the department that that person works in, too. There are perceptions involved, which are very difficult to measure. I think that that work is ongoing, and it will take some time to reach fruition. Certainly, it needs to be highlighted and prioritised on the HR agenda, because it is not something that will go away simply because you might change some of the personalities. You have to eradicate that behaviour from the culture. I get concerned that it is perhaps becoming a bit cultural in some areas.

[46] **Jonathan Morgan:** Bethan, before we move on to Professor Woollard, I will just ask Tina Donnelly something. From the perspective of nurses who work in accident and emergency departments, bearing in mind the close working relationship between the nursing profession and paramedic staff, we know about the issue of morale among paramedic staff and ambulance crews generally, as those issues have been highlighted publicly. What is the impact of handover times and turnaround times on the nursing staff's morale? Some of the concerns expressed in the auditor general's report were to do with how some nursing staff felt that they could not get on with the job of nursing, because the patient was in limbo, which meant that they were, in essence, caught somewhere in the middle. What is your take on how

this affects the nursing staff?

[47] **Ms Donnelly:** I would like to answer the HR question, too, because I have a different view of morale in the ambulance trust from the NHS Direct workers.

[48] When we started to look at this issue, about two years ago, things were fraught between ambulance staff who wanted to offload, because they were under time pressures, and the nursing staff, who did not want to take patients who they knew would be at clinical risk by being put in the corridor. There used to be quite an exchange between ambulance personnel and nursing staff in accident and emergency departments. Nevertheless, the ambulance service has gone a long way to try to engage the clinical staff in accident and emergency departments over handover times with regard to putting a manager in place to try to smooth the transition. In addition, training has taken place with regard to the new electronic handover systems. That kind of thing has happened. There needs to be a culture of management within the accident and emergency departments that recognises that this is a team approach. While there are professional boundaries, the person in the middle of all this is the patient. It works well in some trusts, and there are those that have demonstrated that where there has been a culture shift. It is to do with the management of change and adopting a can-do approach to opportunities through the training element, which helps people to understand why ambulance staff need to offload and why clinicians need to ensure that they are offloading to a safe environment.

[49] I go back to my earlier point. The person who is held accountable is the person who is in charge of the patient at that time, and that is a healthcare governance issue. It is linked to Malcolm's point. If you are asking a clinician to take on the task of looking after a patient where the resource is not there to do so—I am talking about the oxygen, the facilities, the privacy and the dignity—then you are putting that nurse under pressure, when she or he may already be under pressure by having to deal with the patients that are already there, with numbers at the higher end of capacity, so that there just is not the capacity to deal with more in that accident and emergency department. Tempers therefore fray, and that affects a nurse's morale. If you have had a disagreement with a colleague in the morning, it sets the tone for the rest of the day, and it really is very difficult then to be able to determine the state of morale.

[50] I would like to comment, if I may, on the HR issues. We have nurses working as emergency care practitioners in the ambulance service. We have also had NHS Direct go in to the ambulance service, and they have definitely seen a different culture emerge, going from an NHS-supportive environment to one that is, I would concur with Dave, slightly bullying; I hate to use the word 'bullying', but there is quite a lot of that reported. It goes back to what we mean by morale. With regard to investment in staff who are constantly under pressure, management needs to show that it values the staff through its own performance in training staff. A high proportion of ambulance personnel have not had staff development performance reviews, and they are also not receiving the mandatory training. Therefore, there is an issue of self-worth for them as individuals, because they may feel that they always have to perform against a higher performance target, and that the trust is not investing skills in them to deliver that. So, the human resources agenda needs to start addressing, with some critical timelines involved, what we mean by 'mandatory training', and what it means to invest in your staff.

[51] There is still a culture in the ambulance service that the NHS Direct is opposite to the service, but it is now a combined trust and the management of change process has not engaged in bringing those systems together. However, we have a category C triage system in which nurses have worked, where they have potentially reduced two thirds of 999 ambulance calls going out, because they have worked together. Having participated in that working group and visited NHS Direct and the ambulance service, my understanding is that category B patients could also work very well with the NHS Direct skills set and the algorithms that

exist. So, we could define much more of what is appropriate to be taken to an accident and emergency department, because we know that the public use accident and emergency departments in many instances as a primary care centre. If we could categorise categories B and C more at the base, there will be an ongoing effect on staff morale in the clinical areas with regard to response times, because patients who need to be at an accident and emergency department will be correctly transported. That will be because that there will have been a relationship and a culture within the ambulance service trust that recognises the skill sets of both parts of the organisation. Investment in patient care must start with investment in the staff who are trained to deliver that care.

[52] **Bethan Jenkins:** Does Malcolm have anything to add to the discussion around morale in the ambulance service?

[53] **Professor Woollard:** I am afraid that it is much worse than you imagine. It is not an issue of low morale—it is an issue of poor mental health among many ambulance workers. About six years ago, in a former life, I managed the ambulance trust's research unit, which was based in the Welsh College of Medicine; it is now part of Cardiff University. With one of its professors of psychology, we undertook a review of the mental health of ambulance staff. It was an anonymised postal questionnaire, but used validated clinical instruments; it is possible to diagnose mental ill health using forms, rather than a face-to-face interview. I was very concerned because it was a very thick document—as thick as your file—and I thought that no individual would fill in the form and send it back and that we would have a very low return rate. In practice, we had a return rate of 65 per cent, which was astonishing—it suggested that it was a concern that was high on people's agenda. Much to our horror, we discovered that 21 per cent of staff had clinically diagnosable post-traumatic stress disorder. Between 16 per cent and 17 per cent had clinically diagnosable anxiety and depression, so we were absolutely appalled. Paramedics join the ambulance service because they are caring individuals and they want to look after their patients, and it seemed to us that they were not being cared for.

[54] We looked at the determinants of the incidence of mental ill health among these individuals, and we found two standout problems. One would imagine post-traumatic stress disorder to be a result of a specific incident, but we found no evidence of that. It appeared to be cumulative, but the two main predictive factors were negative effect on the part of the individual—that is a rather negative way to describe their effect, but what that means is that they tend to be caring individuals, they are thoughtful, they think about other people, they care for other people and they are dedicated to their jobs, so that is a rather good effect for ambulance personnel to have. However, much more worryingly, the second leading indicator of the risk of mental ill health was management issues. It was clear to us from some of the written responses that were added to these questionnaires that there was a culture of bullying. For example, we had questionnaires returned to us on which the recipient had written, 'I have driven 100 miles across Wales to post this so that you will be unable to track where I am'. They knew that we were not managers in the Welsh ambulance service but, even so, that was their level of concern.

10.10 a.m.

[55] We worked with the Advisory, Conciliation and Arbitration Service professor of bullying, Professor Duncan Lewis at the University of Glamorgan, to develop an outline protocol, and we approached the Welsh ambulance service at that time—it was a long time ago, before the current management was in place—and offered to undertake a review of the management culture, the incidence of bullying, and then to implement systems to reduce that problem. We were told that that would adversely affect the public image of the ambulance service and to come back when they had sorted out the bullying because it would not then be such a problem.

[56] I do not believe that the current management team would adopt that attitude, but I also do not believe that that high level of ill health has gone away. I am absolutely sure that it has worsened. The staff are working under a much greater workload than was the case at that time, working constantly with emergency cases and with cases that access the emergency system that are not emergencies and therefore expectations are not met. It is not a criticism of the patients using the service, but the very negative public perception, which reflects directly on individual paramedics. They are the people who get the brunt of the public's poor perception of the ambulance service, not the middle or senior managers.

[57] I apologise to Lorraine Barrett for not answering this question earlier, but the increase in single working is also likely to increase stress because the most effective way of reducing post-traumatic stress disorder is to be able to defuse with your colleagues. That is happening less and less because after crews get to the ambulance station in the morning, they go out and do not see anyone else until they get back to their station late at the end of their shift. Alternatively, they are on their own in a rapid response vehicle and have no-one to defuse with or to talk to. There is no time to do that with the ambulance crew at the scene.

[58] As my colleague from the Royal College of Nursing has suggested, if you are not provided regular training or if you are not trained for the job that you are asked to do—and remember that paramedics are trained really to deal with 10 per cent of their workload: the truly life-threatening emergencies, not the 80 per cent or 90 per cent of patients who do not have time-critical emergencies but still use the 999 system—there is an issue of not being able to provide the type of care that they would like to, so that affects job satisfaction. There is a very grave problem with the mental health of paramedics in Wales and England, but particularly in Wales.

[59] **Bethan Jenkins:** You say that the new management would take a different stance. Are there any plans to put forward that research or to use that research in any way to show that the problems are still current and exist among the staff?

[60] **Professor Woollard:** I would suspect not because that research is old now. The focus of the management has been on achieving performance. It is very difficult when there is such pressure on achieving response times and financial targets to consider the broader agenda. Again, there is a tension between the mental wellbeing of your staff and hitting performance targets against a background of very high demand and reduced resources due to the need to make financial savings. Again, that is not a criticism of the management team; it is a reflection of the environment that they work in.

[61] **Bethan Jenkins:** To follow on from that, I note that Mr Galligan's paper touches on that, stating that there are tensions between staff and management due to the efficiency savings that have to be made. Is there any way that this could be grasped, and the morale could be improved by the way in which efficiency savings are administered, or is that just not possible?

[62] **Mr Galligan:** Everything is probably possible; it is just a matter of how quickly you want it done. Echoing much of what Malcolm said, there is a significant degree of cynicism and scepticism in the ambulance service. Frankly, staff are sceptical about the support that they get for their role. I also made reference to this on the bullying issue, but it seems that the service is always under the spotlight, and it is always very much under scrutiny. Every mistake is magnified and repeated a thousand times through the media, but no-one mentions the hundreds and the thousands of good examples every day where people are absolutely indebted to the ambulance service. That is the culture that we live in; it is a bad-news world, which has a negative impact on people and their perceptions.

[63] I know of ambulance staff who will not tell people where they work. They change out of their green uniforms before they leave the workplace, because they have been subjected to criticism in the pub or other social environments. Surely that is not right. They should be proud of where they work. There is a drip-drip of criticism, but some of it starts here, which is an awful thing to say. Every time I pick up another Wales Audit Office report, it is all doom and gloom and everything is dreadful. That has an impact over time: people feel less supported politically and less supported by the public. I do not know how you change that perception. As Malcolm says, perhaps we should stop emphasising performance and start concentrating on the good things, bigging up some alternative measures to the simple question of how quickly ambulances can get to their destination.

[64] **Irene James:** I do not know whether this is appropriate, but I just want to thank the ambulance service and the paramedics who attended my house last Friday.

[65] **Mr Galligan:** It will not have been any of us.

[66] **Irene James:** No, it was not, but I just want to thank them wholeheartedly, because a member of my family would probably not be here now had they not attended. I want to place my thanks for that on record. That is nothing to do with my question. Sorry, Chair.

[67] My question is about training, which has already been mentioned, and it is for Professor Woollard and Mr Galligan. The auditor general's follow-up report, 'Ambulance Services in Wales', identified that between 7 and 34 per cent of managers had accessed various required training courses on the management and skills training programme. It was indicated to this committee by Mr Murray that that was due in part to managers having spent time in accident and emergency departments. Has the situation improved since funding for additional staff was secured?

[68] **Professor Woollard:** I am afraid that my answer, again, to that is that I do not know. However, it is disappointing that such a low proportion of managers have undertaken the training. I understand that it is available via e-learning. When you volunteer to join an ambulance service, you are taking on a responsible job, so, as an individual, you have a responsibility to ensure that you can do that job.

[69] I want to place on record the fact that the College of Paramedics has a great deal of confidence in the senior management of the Welsh ambulance service, and in Alan Murray in particular. Many of us have known him for a long time, and, although the Welsh ambulance service is in distress, we believe that he can help to move it forward. However, it has to be recognised that, when organisations change, the group that changes the least is that of middle managers. Unfortunately, some of them can present a considerable barrier to change. You have paramedics pushing for change from the bottom, senior managers pushing for change from the top, and the middle managers—and this is true of any organisation—are more resistant to change. Prioritising their education is of paramount importance. Without a doubt, it is education that changes individuals, and not only their skills, but also their beliefs and attitudes, and that is very important.

[70] **Jonathan Morgan:** I have a quick supplementary on the need for managers to undertake this sort of training. Do you think that it ought to be a requirement of the job?

[71] **Professor Woollard:** Absolutely. Many of my colleagues have been saying for as long as I have worked in pre-hospital care—and I have been a paramedic for 25 years—that it is bizarre that, in the other emergency services, you have to take exams to achieve promotion, but that has never been the case in the ambulance service. It still is not. We do not know in advance whether someone is fit for the job that we are asking them to do. I am sure that the committee will be familiar with the concept of interviews being about as helpful as drawing

names out of a hat in identifying effective individuals. So, yes, I agree entirely that training should be a pre-requisite for management positions.

[72] **Irene James:** I was going to ask whether staff on the ground are receiving the training that they require, and whether, in your experience, enough focus is given to professional development, but you have just answered that question.

10.20 a.m.

[73] **Professor Woollard:** Yes. I must say that we did another study a few years ago when I was here, looking at staff perceptions of the needs for, and barriers to, change to develop a high-performance ambulance service. Fascinatingly, one thing that staff said was that they wanted more managers, but they made it very clear that they meant that they wanted more managers whom they could turn to for clinical advice, expertise and clinical support. At the moment, being a paramedic is a very lonely job. We do not have the systems of clinical supervision that are extant in the nursing and medical professions. I know that there are plans under way and that some progress has been made in introducing clinical team leaders, but those people need to be very specialised and must be carefully selected. They need to be supportive of their staff, they need to be clinical managers, not administrators, and they need to be available to staff 24 hours a day, seven days a week.

[74] **Mr Galligan:** I want to add to the comment about staff having the opportunity to develop. There is a tool for that, namely the knowledge and skills framework, but its take-up has been low, and the take-up among managers who are trained as development reviewers in that context has been low, because everything has been concentrated on performance. There is an issue of making space in the day; there are only so many hours in a day that people can find for this. It really must be prioritised, because staff development is an essential part of taking this workforce forward. Malcolm has mentioned the clinical team leaders' programme. It is an excellent piece of work, but it is like pulling teeth trying to deliver it. It has been well thought out and badly implemented. It is as simple as that.

[75] There was a raft of people on the ground known, for want of a better description, as paramedic supervisors. You would have expected them to be the logical candidates to convert to being clinical team leaders, but the skills base is very different for the very reason that Malcolm gave—people were appointed and promoted over the years to the role of paramedic supervisor simply because they did a good interview and not necessarily because they had the skills that are now required to be a clinical team leader. So, you end up with a group of people who were supervisors, who are no longer supervisors although they are still being paid as supervisors—for obvious contractual reasons—and there are new people coming through as clinical team leaders who are taking over that role. It is a good idea that has been poorly implemented. It has been at least 18 months in the implementation phase. Clinical team leaders are essential for future workforce development. They need space to do their job, to train others to do their job.

[76] **Ms Donnelly:** I wish to make a few comments based on our links with the clinical directorate within the Welsh ambulance services trust. There are some key significant areas in which the ambulance service is not engaged in training at the moment. Nevertheless, before I say what I want to say about that, I also want to put on record our support for Alan Murray and what he is trying to do. There needs to be engagement to recognise that, if you are trying to improve performance in a trust, such as the ambulance service, where you are measured against higher performance targets, the cost is often staff training and development, because staff must be released for those. So, if you are constantly measured against performance to deliver an agenda that gets patients into hospital in a timely fashion, you have to look at a cost improvement programme within a trust to establish where you are going to make those cuts. Currently, those cuts happen to be to statutory and mandatory training. Child protection and

the protection of vulnerable adults are key issues, and staff need to be made aware of what type of things to look for to pick up where patients, such as those who are going into homes, may be at risk. In relation to transporting patients to hospital, that is not an area that is currently high on the agenda of the Welsh ambulance services trust.

[77] In the clinical directorate, stress levels are also increasing among clinical staff in trying to implement that, because the high-performance agenda is making the middle managers almost wonder why they are beating themselves up to get people trained when everything is geared towards performance and the timeliness of getting patients to hospitals. It is the wrong culture in which to engage people to try to improve the management of change. Around that focus, my understanding is that an independent review has recently been carried out, considered by the ambulance service management team this week, which identified that it needs £13.3 million to engage this year and to deliver the performance that is required of it, and yet it had to save £34 million in cost improvements last year.

[78] A large number of our members in the ambulance service also raised the following with me. The service is trying to improve, and, under the knowledge skills framework that Dave spoke about, the paramedics that are training—that is, those that can be released—are trained to a level that will take them into a higher pay band. This all goes back to 'Agenda for Change'. We have people who are on band 5 and who are then trained to a band 6 or 7 skillset, but we are working a cost improvement programme and not getting the funding to deliver on that agenda, given that the 'Agenda for Change' pay scales have not been fully funded, and so the cost has to come from somewhere either to employ a large number of those people or to take in less qualified people or ambulance technicians. That could lead to questions about their not having the clinical acumen of experienced paramedics when dealing with traumatic cases out in the field. We have to look at that and at where we are asking the ambulance services to make those cost improvements. Alan Murray is a very skilled ambulance service manager. I have known him for a long time. I worked with him in Belfast and know the changes that he made in north-west England. He is a very skilled operator, but a price is being paid as a result of the pressures that we are putting senior management under with these key performance indicators on timeliness. This will hit us fairly rapidly if we do not invest in training people. That £13.3 million has been independently evaluated as being needed to deliver the service, and I strongly suggest that the committee asks Alan to look at the independent review that was done recently.

[79] **Irene James:** I seem to be picking on you, Professor Woollard, because my next question is also for you. In your paper, you refer to emergency care practitioners working in England but not in Wales. On 11 March, the chief executive of the Welsh Ambulance Services NHS Trust told this committee that paramedic practitioners will shortly be in place in Gwent and Powys to provide an around-the-clock admission avoidance service for patients who dial 999, working closely with GPs and out-of-hours primary care centres to provide alternative care. Do you welcome that development?

[80] **Professor Woollard:** We do, but we believe strongly that it is important that those individuals be appropriately trained. When one is working under such enormous pressure—and one can see the benefits of having practitioners who can discharge patients in the community—the temptation is to look for shortcuts to training and development. There is a reasonable cadre of paramedics who have been through a BSc honours programme that has provided them with the theoretical underpinnings, but they still need about 400 or 500 hours of clinical placements where they would work with a GP, a nurse practitioner, in emergency departments, and alongside social services before they can be safe, independent practitioners. Even then, they will still need a period of preceptorship, of supervision in practice. The College of Paramedics has very clear standards for this, and we are anxious to ensure that they are followed. There is no evidence that they will not be, but we do not know whether they will be. Provided that these individuals are trained adequately, we welcome it absolutely.

There is good evidence—and this has been true for several years—that approximately half of the patients taken to emergency departments by emergency ambulance are discharged with no significant treatment and no ongoing referral. Clearly, many of those patients did not need to go the emergency department in the first place.

10.30 a.m.

[81] I emphasise again that paramedics are not trained to identify those patients. I do not want to trivialise what paramedics do, but we have to be very clear that, although you have to be highly skilled to deal with patients who have a life-threatening condition, the underpinning knowledge required is relatively simple. You can document the treatment algorithm for the management of a cardiac arrest on one side of a sheet of A4 paper, but, if you are presented with mild to moderate abdominal pain, you would need a book to decide whether that patient was suffering from a severe, moderate or mild condition. The amount of underpinning knowledge and the clinical expertise required to determine whether a patient has a minor or a major problem, even if it appears to be minor, is quite significant. The level of training is very important. Without a doubt, diverting those patients away from emergency departments, and, importantly, away from the need to have an ambulance response at all, will be invaluable. It will be better for the patients, because they will not need to be taken a long distance from home; they can stay with their loved ones and still get appropriate care. It will also be better for the staff, because they will have a much greater sense of job satisfaction. Right now, all that they can do for those patients, which is very frustrating, is be nice to them and take them to hospital, where they know that they will be waiting for hours and hours before they get care. Without a doubt, being able to deal with those patients brings increased job satisfaction, and it will mean that emergency ambulances are not dispatched to those calls.

[82] One concern that I have is that, six or seven years ago, the Assembly Government, very generously, funded a pilot advanced paramedic practitioner programme. The difference between those individuals and paramedic or nurse practitioners, in the context in which that has been described, is that they worked completely autonomously. They did not work within protocols or guidelines; they were autonomous practitioners. They were educated to Master's level—they had one year of full-time education following on from a BSc honours degree. We selected those individuals very carefully. After they had had their training, they staffed one vehicle in one locality—I think that four of them graduated—and, in that area, they responded to about 60 per cent of 999 calls. We sent them to category A, B and C calls, because telephone triage is very sensitive to high-priority calls, but it is not very specific. That means that it will pick up most cardiac arrests, but it will also identify many patients with less serious conditions as having serious conditions. So, we sent them to many calls and, of the calls that they went to, they changed the care pathway for 63 per cent of patients. About 48 per cent of those patients were not taken to hospital: they were either cared for entirely by the advanced paramedic practitioners in the community, or they were referred to general practitioners or specialist asthma nurses, for example. For a small proportion—about 5 per cent—they arranged direct admissions to the surgical on-take team, the medical on-take team, and to orthopaedic, obstetric and paediatric wards. It was a very effective programme.

[83] Those advanced paramedic practitioners are now flying desks. They are not seeing patients clinically other than on an ad hoc basis, and that is unforgivable. It was a very effective service. I have to say that it was very expensive to implement. So, a tiered approach, having people at that level and at the specialist-paramedic level that you have talked about, is appropriate. That expertise needs to be harnessed, and the Assembly Government needs to examine whether there is benefit in expanding that programme.

[84] **Irene James:** I think, Chair, that Professor Woollard has pre-empted the next part of my question.

[85] **Michael German:** I will focus on the very narrow timeframe for the actual handover, when ambulances arrive at accident and emergency departments and when people are transferred. I heard what Tina said earlier about appropriate facilities—oxygen and so forth—but let us deal, first of all, with the person who is managing and releasing the ambulance crews. We have used the words 'manager', 'supervisor', 'clinical team leader': what is the role of the person from the ambulance service who is inside the accident and emergency department? What level of training and skills would that person have? What are the principal tasks undertaken? Allied to all that, can you describe whether there are any clinical risks in the system? We understand that patients have been stacked in corridors and that there have been shortages of oxygen and so on, but are there any clinical risks associated with having someone there to say, 'I will take responsibility for these people while we are waiting for the hospital to take them in'? I do not know who wants to go first.

[86] **Professor Woollard:** Without a doubt, there are clinical risks. I will start with the beginning of your question. The individual who goes to the hospital has, as I understand it, two major functions. The first is to try to work with the hospital staff to try to facilitate a reduction in the queuing time. That is very difficult to do if there is nothing that the hospital staff can do because beds are blocked and they have no space in the emergency department. The other is to take responsibility for groups of patients, so that ambulance crews can be freed up to get back in to their ambulances and respond to the emergency calls that are waiting. That individual, at least potentially, will often be a paramedic, but may sometimes be an emergency medical technician. The difference is quite significant in the care that can be provided to patients. The best way to describe those individuals, regardless of their level of training, is as fish out of water. They are not trained to work in that environment. Even though they may now, on a regular basis, stand in that corridor, it is not their environment and it is not a role that they are trained to deal with. Paramedics are not trained to deal with patients over a period of time. They do not normally get to see how patients' conditions change.

[87] There is a clinical risk because some patients require medical intervention by a doctor or by a specialist nurse practitioner within a very short space of time to prevent their condition from deteriorating. There is a clinical risk because of the lack of available equipment, as you have highlighted, but also from the confusion that will be inevitable in that individual's mind, if a patient does deteriorate suddenly, about whose equipment they should use, whether or not they can use hospital equipment, whether it is quicker to get hospital equipment or go back to the ambulance and use their equipment. If they use their equipment, then when doctors and nurses arrive, they will not be familiar with the ambulance equipment and there will be a doubling up of equipment and people may even be looking at two monitors or the wrong monitor if there are two connected to the patient. The patient may also need drugs that paramedics are unable to administer. Inevitably, there will be patients in pain for much longer than they need to be. Paramedics are limited by law to being able to give patients 20 mg of morphine. Certainly, in a significant sub-group of patients, that is not adequate to provide pain relief. On the other hand, if patients are provided with stronger analgesics by doctors, while the patient is waiting, the paramedics will not be familiar with the side effects of those drugs or how to manage them. So, without a doubt, there is a clinical risk.

[88] I hate to be a traditionalist—and I am not; I am very pro-change—but it is not the job of the ambulance service to work in hospitals. It is the job of the ambulance service to see patients in the community. If they are not doing it, no-one else is. The fire service and the police make a very poor substitute for the ambulance service and for ambulance paramedics. That is happening largely because of queuing in emergency departments of ambulance crews undertaking the role of looking after a patient for a prolonged period of time outside the ambulance, rather than being in their vehicles and being able to respond to those calls. It is just appalling. As a career paramedic, I am appalled and embarrassed that, in any ambulance service, but particularly the Welsh ambulance service—as I live in Wales and I have a Welsh

genetic background—there are reports of patients being taken to hospital in fire engines and police cars. We do not expect paramedics to arrest people if the police are busy, because it is not appropriate and they are not trained for it. We do not expect paramedics to carry small-bore hose-reels to put out fires, because it is not appropriate and they are not trained for it. There is an excellent organisation, in both those cases, to do the job. Paramedics are highly trained. There is no replacement for a paramedic. When you need a paramedic, that is what you should get. We need to sort out this problem of tying them up in hospitals undertaking a role that they are not equipped to do, which is depriving other patients of adequate care.

[89] **Michael German:** I do not know who else wants to comment. A treatise on Welsh genetic make-up might be a PhD subject for someone. [*Laughter*.] Does anyone else want to talk about clinical risk?

[90] **Jonathan Morgan:** The Royal College of Nursing may be able to add something.

[91] **Ms Donnelly:** There are a few issues. I concur with what Malcolm said about the fire and ambulance services. Sometimes, we use research positively and sometimes we use it to make up answers to questions that we want different answers to. Often, the Seattle response, where the fire and ambulance service respond within three minutes is recognised worldwide. Nevertheless, there is a scale of different skillsets and training for people and you do get transported to hospital in an ambulance, not in a fire engine or a police vehicle. So, it is a different type of area.

10.40 a.m.

[92] However, looking at the skillset and handover, we have to look at the front end of the hospital. When you hand over a patient, for all the reasons outlined by Malcolm, that clinician is then responsible for that care. You have to ensure that that handover is precise and concise. If something has been given to the patient, and you miss it, for example, if that patient has been given 20 mg of morphine and is handed over by the paramedic to a nurse, who is unaware of that fact—because the handover was inappropriate—that nurse could give the patient another dose. As a result, that patient could have a respiratory arrest in an area where there is no oxygen, intubation equipment or the necessary resuscitation kit. You should be admitting patients to a safe, clinical environment where that practitioner can carry out a safe, clinical assessment and can reassess and re-triage as necessary. We end up with a system that is clogged up at the front end; we cannot put patients in that situation. The nurse is hesitant because of her professional accountability and the frustration that she feels because, for example, she has to take on yet another patient, having already taken on eight that morning. She will not be sure which she should be looking after. So, there are issues about the skills mix, training and appropriate staffing levels.

[93] To focus on the other end of the hospital, we are looking at the appropriateness of continuing and intermediate care beds and the transfer of patients from hospital, which relates to the ambulance service and a patient transport system. If hospitals are waiting to transfer discharged patients at the other end, and do not have the transport to do so, those patients are using facilities that could be used by patients discharged from the accident and emergency department on to other wards in order to clear that front end.

[94] Trusts have to deal with those frustrations. A high proportion of the patients who are sitting and waiting in accident and emergency—and we have previously given evidence to this committee about violence and aggression—witness all this going on and wonder about the clinical care provided when they see patients, three abreast, in a hospital corridor waiting to be seen. The patients closest to the wall physically have to move the other trolleys just to get a glass of water, because they do not have a locker or a jug or glass of water. The nurse has to be taken away from providing care to a patient in a cubicle to take those patients, who

are waiting in the corridor, to the toilet, to maintain privacy and dignity.

[95] It is not simply a case of someone saying, ‘Right, I’ve got a nurse, so I can hand this patient over’. They work in clinical teams; you have to be clear that that documented handover is sufficient for you to be able to reassess that patient and to diagnose and treat where necessary. Our concern is that, if you miss something, you are clinically accountable and your professional judgment and career are at risk. We are putting nurses in that position and they are reluctant to accept it. A 15 minute handover is not as simple as bringing a patient in and saying, ‘Right, this is the patient, and this is what has happened’. There has to be a receptive area that is clinically geared up should that patient suddenly stop breathing. That is the most appropriate system, but that is not what is happening in Welsh hospitals.

[96] **Jonathan Morgan:** I think that Professor Woollard wants to come back on this.

[97] **Professor Woollard:** I have one simple statement on clinical risk. You have to remember that clinical risk is not only to the patients in the accident and emergency department. There is a substantial clinical risk to the patients who are waiting for their ambulance to arrive. That should not be forgotten.

[98] **Michael German:** Would someone else like to make a point?

[99] **Mr Galligan:** This issue seems to be polarised in a number of particular hospitals. Perhaps those hospitals need to be addressed as a priority. South-east Wales seems to be the focus of this. The University Hospital of Wales and the Royal Gwent Hospital, for example, seem to have the highest figures in this regard. The difficulty is that the ambulance crew, whether paramedics or a paramedic and a technician, is instinctively risk averse. They will not leave their patients in that environment. The patient whom they have yet to see is probably not their problem at that moment; their problem is the patient whom they are trying to discharge to a nurse or clinician at the hospital and because we would expect them to be risk averse in such a situation—it is instinctive—they do not leave that patient. That has to be their priority. We need to manage that interface. Tina is right—no-one seems to take responsibility, but my view is that the responsibility probably lies more with the health trusts than with the ambulance service, but it is only the ambulance service that seems to carry the consequences, and that cannot be right or fair.

[100] **Michael German:** You all made your points very powerfully indeed. There is obviously a great deal of passion about the issue, which is probably shared by most members of the committee. Having experienced the accident and emergency departments at both the University Hospital of Wales and the Royal Gwent Hospital and seen all the problems inside and outside the front door, I share your concerns and your passion.

[101] I want talk now about the very moment of handover. We heard from the auditor general about the machinery that is now in existence that demonstrates when handover takes place. Is that handover machinery or electronic process working well and universally across Wales? Precisely when, in your view, should that handover take place? This is again a general question for everybody.

[102] **Professor Woollard:** Handover should take place immediately, as soon as the ambulance arrives because, until that handover takes place, the paramedics still have a duty of care for the patient. The handover should take place immediately because the patient needs to be triaged by staff to determine which part of the emergency department he or she should be admitted to and, more importantly, how urgent his or her clinical condition is. Until they have been triaged, there is no way that the staff can know the answer to that very important question.

[103] **Michael German:** What about the machinery, the button thing, or whatever it is called?

[104] **Ms Donnelly:** There have been reports of times when nurses have had difficulties in accessing it. I know that the auditor general comments on infection control issues and screen freezes and all that kind of stuff. When you are under pressure and it happens twice or three times, staff lose confidence in it. The issue is about getting the patient in and getting them clinically treated where you can. The issue with regard to triaging is that you urgently want to triage all patients with airway and breathing difficulties and put them into resuscitation, so there is a priority process that allows people to scoot through. I guess that the concerns would be where you have got patients who are not in that acute phase, but who still need clinical care and supervision. If you have a machine that is not clicking in or you have a screen freeze, that certainly does not inspire confidence and you will have nurses bypassing it because they have seen that—the patient comes first and the paperwork comes second.

[105] **Michael German:** For accuracy purposes and for the record, am I right in my understanding that it is at the moment when a member of the hospital staff touches the screen that the handover takes place?

[106] **Ms Donnelly:** That is when it starts; it is completed when the ambulance personnel feel that they have given all the information to the clinician and that the clinician has accepted responsibility and signed off on it.

[107] **Jonathan Morgan:** May I ask for clarification because I think that there is an important point being raised here? If we were to refer to paragraph 1.42 of the auditor general's report, he talks about potential inaccuracy in the target time and the ways in which it is reported and recorded, because you may have a situation where an ambulance crew will hand the patient over to somebody else who works for the ambulance trust. This is not clear in my mind. Although he refers to the person as an 'ambulance officer', I do not know whether that person is a paramedic, a driver or just somebody else who happens to be employed by the trust, but the ambulance crew hand the patient to A.N. Other before he or she is handed to the clinical team in the accident and emergency department. So, on the one hand, the paramedic team has discharged that patient and is back on the road, hopefully dealing with other 999 calls, but patient A seems to be in limbo somewhere between the paramedic team that has gone and the clinical team that, at that point, has not taken care of the patient. I am particularly concerned about that aspect. I did not know that that happened until the auditor general published his report. I am not criticising the process, but I think that most of us understood the policy as being a handover and turnaround time that would ensure that the ambulance crew leaves and that the patient would be in the care of the clinical team that is dealing with his or her particular needs. Have you got a view about how that process works? I see a situation there where a patient is in limbo and, therefore, at that point, is not subject to any target at all because he or she is not in the care of the ambulance paramedic team, although they are technically still within the care of the Welsh Ambulance Services NHS Trust, and they are not yet in the care of the accident and emergency department. So, I think that that is quite a concern. Do you have any views as to how that bit of the process operates because there is that in-between stage?

10.50 a.m.

[108] **Ms Donnelly:** I am aware, from feedback from nursing staff, of cases where an ambulance officer has agreed to supervise—that was the word used—a patient who does not need the A and B parts, or even the circulatory C part, of resuscitation, but who nonetheless cannot be left alone because of the potential risks. You therefore have an ambulance officer, who has agreed to free up other ambulance personnel, supervising until a clinician is ready to take over. With the timelines for that, it is not easy to determine how long that patient is being

supervised by an ambulance officer, and that goes back to the point that Malcolm made about whether ambulance personnel are trained to deal with acute emergencies or diagnose detrimental developments or deterioration in a patient's condition compared to his or her original clinical condition. That needs to be addressed by the NHS trust.

[109] **Professor Woollard:** For the sake of clarity, in the ambulance service, 'officer' is a synonym for 'manager', so it will be somebody with some level of seniority. They may or may not be a paramedic. Common sense would suggest that they would try to send paramedic officers, but that may not always be possible.

[110] I agree entirely with your concerns about the patient being in limbo. I do not believe that the right target has been set, because the starting point is wrong; it should be when the ambulance crew walk through the doors of the emergency department, because the delay to handover is clinically significant. The aim of getting patients to hospital is to hand them over to clinical staff who have different and more education and training than ambulance personnel. So, the start point is completely wrong. Also, while I recognise what my colleague said about patients with obvious airway and breathing problems being sent straight through, what about the patients who have hidden problems or problems that are not immediately apparent and are not identified by the ambulance crew. They are not doctors—they are paramedics, and so they can miss things.

[111] **Michael German:** We have this supposed system in which there is a technical moment during which the handover takes place. The question asked whether that is inappropriate. I think that you have answered that. Is there a need now for a different system for measuring what happens when the ambulance crew arrives and goes through the front door to when full care takes over by the hospital's medical staff?

[112] **Professor Woollard:** The only reliable way to gather data, aside from when the clock starts, is to have an automated system. If the system requires human intervention in a high-pressure environment, it will inevitably be inaccurate and it will fail, because paramedics' and nurses' focus will be on the patient, and not on a bit of hardware. It therefore needs to be an automated system, and it is not beyond the bounds of possibility to organise that; it can be done.

[113] **Ms Donnelly:** I agree with that. You could use something like a smartcard for when the ambulance personnel arrive. As opposed to anything that is open to human error, if somebody swipes in on arrival, then it is indisputable that they are on the premises, until they swipe out. That will give you accurate information, and doing that is not rocket science.

[114] **Lesley Griffiths:** Any delay in handover time will have an impact on response times, because ambulances and their crews cannot be in two places at once. Given that rotas are based on predicted demand, and the fact that an ambulance will be on a call for an hour, do you think that the targets that have been set are appropriate, and is enough intelligence coming in to ensure that they are appropriate?

[115] **Mr Galligan:** Are we talking about the eight-minute target or some other target?

[116] **Lesley Griffiths:** Any target. There is a delay in the handover.

[117] **Mr Galligan:** There is a school of thought that says that all our targets seem to be purely quantitative. We need to do some work on this. Some work is being done in England currently, and I believe that some is being done throughout the UK on trying to produce a more qualitative measure, rather than be dictated to by the time. Time is essential, but as Malcolm said, you can be there in eight minutes and somebody dies, and it is still a success, perversely. It could be over eight minutes and someone still survives, but it is still marked as a

failure. We need to have a more objective measure of dealing with emergency patients which, hopefully, will mean that we will not send ambulances everywhere, because if you send for an ambulance you can end up in hospital. That is a fact of life at the moment.

[118] **Lesley Griffiths:** Is there anything that you wish to add, Malcolm?

[119] **Professor Woollard:** The eight-minute standard is not based on any evidence whatsoever. The original ORCON, Operational Research Consultancy, response standards for ambulance services, which were developed in 1974, were based on what ambulance services were achieving at the time, so that ambulances would not fall below those standards. In the 1990s, based on experience from the United States of America, it was suggested that calls could be categorised using commercially available systems so that the priority of the calls could be identified. In the USA, where the system was developed and is widely used, the system was designed to determine who should attend, and not how quickly they should attend, whether or not it was paramedics, emergency medical technicians or the nearest person, no matter who they were. So, from the beginning, the system has been used for something that it was not designed to do.

[120] The categorisation—what types of patients fall into what categories—was developed by a panel of physicians with no direct experience of pre-hospital care whatsoever in the United Kingdom. So, the categorisation is flawed. The system that is used—and this will be true of any telephone triage systems; I am not criticising the one that is used in Wales in particular, because it is also used throughout England—is naturally risk averse. If you cannot see the patient, you have to be cautious. So, there is always a huge over-triage of patients, which means that far more patients are categorised as a higher priority group than is needed, as determined when the paramedics arrive. However, it is not possible to change that. If you do, the system becomes unsafe and you start to miss things like cardiac arrest, and we never want to do that.

[121] So, the performance targets are not based on evidence. When the new ambulance response target was implemented, I was contacted by one of the civil servants in the Department of Health the day before it was launched, who said that he was a bit concerned that the committee had not given him any research papers to support the new target. He was horrified when I told him that there were no such research papers. Eight minutes is not an adequate target for a cardiac arrest—it is completely useless. Most people that receive an ambulance within eight minutes of having a cardiac arrest will die—we know that without a shadow of a doubt. Patients in cardiac arrest need a defibrillator within less than five minutes, and we do not have a target for that. Why not? However, if a patient has a stroke, for example, and is conscious, they need definitive hospital treatment within three hours. So, why are we trying to get to them in eight minutes if that means that we cannot get to a patient in cardiac arrest in five minutes? There are many other such examples.

[122] There must be some constraints. If someone has a non-life-threatening injury, but is in very significant pain, you want to get an ambulance to them quickly, but does it matter if it is within eight or nine minutes? In an ideal world, we want an ambulance to drop out of the sky, but that is not possible or fundable. We want to get to them quickly, but does a minute make a difference? I do not think so. I agree entirely with Dave; we need to look at clinical outcome issues for patients and put much less of an emphasis on performance. The response time category should be targeted at a much narrower proportion of patients, and it is something that you could almost do after the event, rather than necessarily before the event.

[123] I also said in my report that we need to be more imaginative in the way that we use the resources that are available to achieve much shorter response times than eight minutes for the patients that will truly benefit from them. They need simple interventions such as cardiopulmonary resuscitation, which you can teach anyone with adequate time, and an

automated external defibrillator. Most of the fire services in Wales now carry automated external defibrillators, but I have no idea why. Patients who are involved in a road traffic accident do not have the type of cardiac arrest that can be treated with a defibrillator. Patients that die of a cardiac arrest as a result of a fire do not have a cardiac arrest that can be treated with a defibrillator. So, there has been an enormous expense to the public purse to put those automated external defibrillators on fire engines. What should be happening is that the ambulance service should have access to those resources so that they can request the fire service to attend incidents of cardiac arrest, where five minutes is the critical time when they can achieve that target, and the ambulance service cannot. They would save far more lives than would happen in the absence of that system. It needs to be a system that is entirely integrated with the ambulance service. The training and clinical governance needs to be provided by the ambulance service and the ambulance service needs to decide what calls fire resources should respond to make sure that there is maximum patient benefit.

11.00 a.m.

[124] **Lesley Griffiths:** Do you feel that paramedics feel under pressure to meet handover times, or do you think that they think that they have very little impact on them?

[125] **Mr Galligan:** Do you mean the handover times or to meet the targets?

[126] **Lesley Griffiths:** I mean the handover targets.

[127] **Mr Galligan:** I think that everyone in the ambulance service just feels under pressure constantly and continually, no matter what their grade or rank. I think that the whole service always feels very much under pressure and under the microscope. There is no let up. For that reason, it will impact upon every individual's personal application to their job. It is a case of drip-drip all the time. Everyone that I talk to, without exception, says that they are stressed and feel under pressure. This may impact upon their sickness levels. I do not know what the current staff turnover is, but I certainly think that people enjoy their job but do not enjoy the culture around it.

[128] **Lesley Griffiths:** Therefore, do you feel under pressure on all of the targets, not just on the handover targets?

[129] **Mr Galligan:** The key target is the one that they are measured on. It is the only thing that the newspapers pick up, and it is the only thing that the media focuses on. Sometimes, the only thing that we hear coming from Cardiff bay and the Wales Audit Office is the times, the times, the times. As Malcolm just said, if the time is irrelevant, why are we focusing on it?

[130] **Lesley Griffiths:** Do you want to add to that, Malcolm?

[131] **Professor Woollard:** Yes. It is clearly the wrong target on which to manage the performance of individual paramedics; they cannot influence it. They could influence it before we had ambulances queuing because staff could stay and chat with their colleagues at the emergency department, but there is no time for that now. The responsibility for that target lies with the hospital trust. However, I believe in performance management at the individual level, because it is individuals, where they can influence performance, that do influence performance. It is not the managers. Managers should be managing the performance of those individuals. The trust has not yet put in place performance management for response times targets that individual staff can positively influence. However, this has been done in the past. Again, in my previous life as a deputy chief ambulance officer in the south-east Wales area, we identified that our computer-aided dispatch systems could tell us the activation time of individuals. The activation time is the time from when a 999 call comes in to the time that the ambulances will start rolling. At the time, the nationally agreed standard throughout the

United Kingdom was that that should be a three-minute interval 95 per cent of the time. We were managing it within three minutes 93 per cent of the time. That was something that I wanted to fix. Therefore, we published a requirement that ambulance dispatchers, who take the call, process the call, and assign an ambulance, would have a minute and a half of that interval, and we monitored their performance as individuals on achieving that target, and we set a target of 90 per cent—you should never set 100 per cent targets, as there are always exceptions—and we required individuals to achieve a one and a half minute's handover to the crew so that the crew could go mobile within a minute and a half. We then did the same for the ambulance crews. We gave them a minute and a half from the time that they answered the telephone or the radio to become mobile. Again, we requested that they do that 90 per cent of the time. We started to monitor that by individual. Every week, I would meet with the line managers, during which time we would look at the performance by their stations, problem individuals, and high-performing individuals. The managers would then be sent out to discuss with people either their poor or excellent performance, and to agree a plan of action. We explained to people that they would enter the disciplinary procedure if they did not achieve the targets, but we implemented several stages of counselling before that. I am sorry to tell you that no member of staff ever got disciplined, but a member of the management team did get disciplined for not actually implementing the performance management.

[132] We were concerned that there would be some resistance to this from staff, because people do not like to be monitored, but instead, we found that paramedics, not surprisingly, like to do a good job. When we told them that their activation times were too long as individuals, the response that we usually got was, 'But I'm a good paramedic; I want to get out quickly'. We also spoke to the staff about what we could do to help them. We had garage doors that were mechanically operated and would take a minute and a half to open and then had to be closed manually, which took a minute and a half; we had ambulance stations with two sets of doors, but the doors that were the quickest to get out of did not work, therefore they took longer to get out; and we had ambulance stations with electrically operated doors but the motors were clapped out and took a minute to open and a minute to close. We fixed all of that, for a start. We put buttons by telephones in crew rooms, so that they could open the door remotely, and it would already be open when they reached the ambulance. Within about three months, the interval from receiving the call to getting the ambulance mobile was less than two minutes 95 per cent of the time. We saved a minute, and that minute counts towards the response time, and meant that patients got an ambulance a minute quicker 95 per cent of the time. That is absolutely invaluable, so why is it not still being done?

[133] **Lesley Griffiths:** Tina, do you think that staff working in the accident and emergency units feel under pressure to meet handover targets?

[134] **Ms Donnelly:** That is a difficult question. There is a four-hour target for processing a patient through an emergency department, and when we have met with accident and emergency staff and talked about targets, they have said that it gives them evidence to give to management to show that they need more resources in a department to meet the management target. I guess that every individual, whether ambulance personnel, a receptive nurse, or a nurse practitioner in an emergency department, wants to do the best that they can for the patient. I concur with what has been said about measuring outcomes according to time. There is far too much emphasis placed on the negativity around time as opposed to the successes in getting a patient from the point of injury, or whatever, into an emergency department.

[135] There also has to be a greater emphasis on the other effects of the handover time, which is the clogging up of the front end. I go back to the point that I mentioned at the beginning of my evidence about partnership working in the management system. When hospitals are on full escalation right up to red, and you have a green hospital sitting 12 miles down the road, the ambulance personnel cannot transfer a patient because of the target times; the outcome for that patient is that they will be taken to the red hospital and have to sit in a

corridor. That has to be addressed. In that instance, I would say that the handover time is just one part of the eight minutes, or 14 or 21 minutes, involved in getting a patient to a clinical facility. When the handover time is breached, let us start to measure the outcome for the patient, and the effect. That is important.

[136] **Nick Ramsay:** This is a general question on the reorganisation of the NHS. How do the improvements to the ambulance service fit into that, if at all? Clearly, the NHS in Wales will be in a huge state of flux over the coming months. Will that have any effect on what you are trying to achieve in the ambulance service? How do staff feel about the way that changes are progressing? Do they feel that it is happening with less vigour than could have been the case? Bearing in mind the earlier question about staff morale, is there a general sense of hope for the future? Do we think that these problems will be ironed out with the coming changes?

[137] **Professor Woollard:** The first thing to say, coming back to my point about performance management, is that if you manage staff performance in an area that they can influence, they do not find it particularly stressful; they feel that you care about what they do, and you do not need to do it through bullying. However, change in general, in any organisation, is difficult for people, particularly when they feel that they have no influence over it.

[138] The pace of change in Wales, particularly in the ambulance service, has been unrelenting for a number of years. I joined the south-east ambulance trust 10 or 12 years ago, and when I joined we unearthed all sorts of horrible problems that basically had been inherited from the three previous ambulance services that were still extant in people's minds. We had a difficult period, but we sorted those out, and turned ourselves into a good, well-performing ambulance service, which the staff enjoyed working in—whereas a year before they had said that they did not want to work for the trust anymore, and wanted to move to the mid Glamorgan ambulance service, which knew what it was doing. We changed that attitude very quickly, and they were horrified at the thought of being merged into a Welsh ambulance service. Their view was that they had just been through all this pain, had got things right, and were really proud of the organisation they were working for, so why was it being changed? What was the point of that? So, it became a Welsh ambulance service, and it had a relatively rapid succession of chief executives and the management structure was in great flux. People like to know who they are working for, which is very difficult, if not impossible, in a large organisation; I suspect that, even at a regional level, most people do not now know their regional manager, perhaps even by sight or name, and would not feel comfortable talking to them.

11.10 a.m.

[139] There have been changes to the NHS within which they work. A particular change that has had an important impact on the ambulance service, particularly with regard to demand, has been the change in the provision of GP unscheduled care services; there is no question that the ambulance service has taken the brunt of that, and the staff have taken the brunt of it. Now they are seeing yet another reorganisation in the NHS. My view is that the reorganisation that is happening in Wales is much more positive than the reorganisation that has happened in England. I am certainly not a fan of foundation trusts; they are absolutely disastrous and full of perverse incentives, and I and my colleagues in the College of Paramedics are delighted that you are not going down that route. Your focus on patients will be considerably greater than is the case in organisations that are trying to obtain foundation status. However, it will be a difficult time for staff, and change always has an impact on performance. The Department of Health has commissioned a number of studies that have shown that changing the NHS results in either a reduction in performance or stagnation; in the first two years, it does not result in any improvements in performance. So, it is a worrying time.

[140] **Mr Galligan:** The current NHS reform programme is having a minimal effect on the ambulance service, as it is not part of the current reforms itself. The consequences of the NHS reforms however, with the eradication of commissioners and the creation of much larger organisations presents a new challenge to the ambulance service in particular, in respect of engaging with new bodies—new health boards, with quite a number of new appointments, it would appear—and, perhaps, re-establishing the agenda, including some of what we have been talking about today with regard to the problems and finding solutions through fewer but much larger organisations. Whether that is counted as an opportunity, I do not know. However, the NHS reform programme will continue, and, as I said, I think that the effect on the ambulance service will be minimal. There are no proposals for change in the ambulance service, aside from its internal management reorganisation, which is ongoing.

[141] We have dealt with organisational change time after time. It is not rocket science; we have done it before and we will do it again, although it is to be hoped that that will not be within the next couple of years. The real issue for the ambulance service is to work with the new health boards, which will be totally new organisations, to establish an agenda very early on for the issues that we discussed this morning relating to handover challenges, to ensure that the new organisations take their share of responsibility. Let us deal with the new and not worry about the old and what went before. Let us set a new agenda.

[142] **Jonathan Morgan:** I wish to ask the Royal College of Nursing whether the fact that, from October, one organisation will be responsible for running accident and emergency departments and for primary and community care in those areas—the whole thing under one umbrella, so to speak—will have a positive impact on the way in which unscheduled care could be managed.

[143] **Ms Donnelly:** That was the point I was going to raise. The current NHS reforms are a given and are accepted, as is the issue of partnership working, which I mentioned earlier. However, I also think that this will have quite a major impact with regard to primary care issues. Looking at the work that Chris Jones is undertaking, the three hubs that he is talking about on a regional basis and the electronic infrastructure, I think that there will be a considerable effect on the way in which the ambulance service will respond to the primary care elements, and to the community nursing and unscheduled care and intermediate care elements. It is the primary care strategy, which is still under discussion, that the ambulance service needs to be engaged in, and that should not be an afterthought. That is vital, because, from looking at Chris Jones's preliminary work, it seems that there are potential changes for the ambulance service hubs, based on an infrastructure, electronically, that does not exist at present.

[144] **Nick Ramsay:** To go back to the comment that you made earlier, Professor Woollard, about fire service equipment, you touched on the broader issue. We talk here, particularly in times of recession, about the need to prioritise. From what you said, it seems that you believe that there is a whole set of priorities relating to the on-the-ground equipment that is at least partially misguided, if not totally wrong.

[145] **Professor Woollard:** I do not think that those priorities are misguided if the equipment is used. If the ambulance service has access to those resources, they are definitely not misguided and will definitely save lives. If they are carried on the fire truck just in case somebody is found who needs that equipment, they will almost never be used and, when they are, it will almost never be successful. So, the resources are there and, as my colleague said, let the past be the past, but we must ensure that we use those resources for the benefit of the public. Those machines cost about £2,000 each, and the initial and ongoing training of the fire officers to use them will have a significant cost effect, so let us turn that into an improved patient outcome. It is just a way for the fire service to show that it has developed its capacity,

and we want that to make a difference.

[146] **Jonathan Morgan:** I thank our witnesses for being with us this morning. The evidence session has been extremely helpful and has provided us with a considerable amount of information that we will consider later this morning. Thank you for coming in. We appreciate it.

[147] **Mr Galligan:** Could I just make a plea? [*Inaudible.*]—seek some clarity on the financial situation in the Welsh ambulance service. There is disbelief and incredulity among the staff, because they have heard different stories from different people at different times. We understand that the current service change and efficiency plan is to save some £23 million, which is 17 per cent of the trust's budget for this year. That cannot be saved without there being a huge impact on patient services. Whether that is factual or not, the whole financial situation seems to be obfuscated, and we need somebody please to bring some clarity to it. Until we have a credible set of figures, we will not know what the challenges really are.

[148] **Jonathan Morgan:** Paul Williams and Alan Murray are coming to committee in the next few weeks, and I am sure that Members will put that point to them.

[149] **Mr Galligan:** Thank you.

[150] **Jonathan Morgan:** Thank you for coming in.

[151] **Professor Woollard:** Thank you for asking us. If there is anything that the college can do to assist in the future, please do not hesitate to ask.

[152] **Jonathan Morgan:** Thank you.

11.19 a.m.

'Adroddiad Dilynol ar Achosion o Oedi wrth Drosglwyddo Gofal': Adroddiad gan Archwilydd Cyffredinol Cymru
'Delayed Transfers of Care Follow-through': Briefing from the Auditor General for Wales

[153] **Jonathan Morgan:** This report by the Auditor General for Wales on delayed transfers of care was published by the Wales Audit Office on 13 May. I am delighted to welcome the auditor general, along with Rob Powell. I apologise for keeping you waiting. The earlier session overran with the evidence that we were taking. Perhaps the auditor general would like to introduce the report, and then we can have a discussion about the findings and determine how the committee wishes to take the report forward.

11.20 a.m.

[154] **Mr Colman:** I will say a certain amount about the context in which we did this work, and Rob will then go through the findings in a bit more detail. You may recall that we produced a report on delayed transfers of care last year, which was unusual in that, although it was reported to the National Assembly and was, in that sense, a national report, it focused on the problem of delayed transfers of care in three communities: Gwent, Cardiff and the Vale, and Carmarthenshire. You may think that that was a rather odd thing to do, but my view is that it was rather a good idea, because the magnitude of the problem of delayed transfers of care is such that if that problem could be solved in Gwent and Cardiff and the Vale, there would not really be much of a problem in the rest of Wales. So, we focused on the areas

where the problem seemed to be the most severe.

[155] Many people now accept—and I think that this came out of our earlier work—that the problem of delayed transfers of care is not just to do with how hospitals and social services do or do not co-ordinate their activities in relation to a patient who is ready to move on; it is partly that, but the problem has much more to do with the entire system of health and social care. You could say that it is a problem at the back door of a hospital, but some of the solutions involve actions before patients even reach the front door, so it is a good example of a whole-systems issue. One advantage of the powers that I have here, in contrast to the situation in England, for example, is that my office can look at whole-systems problems across organisational boundaries in a straightforward way, although that does not mean that the problems are straightforward to solve.

[156] We published the original report, and there was evidence that reached us quite soon after that that it had had a very big effect on the attitudes of senior people in the NHS and in local government. There were some very encouraging signs of changed approaches and early action leading, it seemed, to greatly improved results. So, rather than waiting two, three or four years before following it up, we thought that it would be a good idea to follow it through. That was not at all with the aim of pestering people to ask what they had done about a report that was published just last week; it was rather to identify whether the actions that were being taken—and there was a lot of activity—were in line with what we had recommended. That is all that I will say by way of context.

[157] One thing that I will refer to is the measurement of the problem of delayed transfers of care. Rob will, no doubt, want to say a bit more about that. The figures that are generally quoted are based on a monthly census, which is a measure of the number of patients affected. It is not the best possible measure that you could imagine, because the census is taken on only one night of the month, and so the figure could have been higher the previous day and higher the following day. So, there is that issue. Secondly, it does not directly measure the length of the delay that such patients suffer.

[158] The length of the delay is rather important, given the average lengths of delays that patients suffer. In Cardiff and the Vale, for example, it is around 80 days on average. Being in hospital for 80 days longer than needed can have devastating effects, especially for those who are already frail and vulnerable. So, it is important to measure the length of the delay as well as the number of people who are delayed. In our earlier report, we did that by looking at the number of bed days taken up by patients suffering a delay. That showed the rather disturbing fact that, although the head count had gone down, the number of days had gone up, which meant that there was a smaller number of people staying in hospital but that they were delayed for far longer. That was not really an improvement in the situation.

[159] Measurement problems continue. Bed days can be measured only over a period that is long enough for them to be counted. Therefore, getting a short-term measure of improvement in bed days is very difficult. With that, I will pass the question over to Rob to give you a bit more detail.

[160] **Mr Powell:** Thank you, Jeremy. I will try to expand a little on Jeremy's comments. It is worth stressing that this piece of work tried to follow up the committee's own report on delayed transfers of care, which talked about the need for more concerted action, and which tried to build on what we discerned to be some quite encouraging early momentum and a real desire to address what is fundamentally an extremely difficult problem to resolve, with no easy answers and without a single answer that would apply everywhere.

[161] We tried to do some very light-touch work to follow up on how things were going in Cardiff and the Vale, and Gwent. We did a lot of work on case studies and examples of what

had worked elsewhere, from which the communities in Cardiff and the Vale and Gwent might learn. That culminated in a shared learning event, at which we had presentations from various organisations in England and Scotland as well as from the communities involved in this project about not only what they had done, but what had worked and what had not worked. That was with a view to informing the final report and producing a range of materials that will help people to address this very difficult cross-cutting problem, which impinges largely on the independence of vulnerable older people who, in the original report, accounted for eight out of 10 delayed transfers of care. So, it is usually very vulnerable, frail, elderly people who are affected by delayed transfers of care.

[162] Our overall conclusion was that there has been some positive progress in dealing with delayed transfers of care but there are still longer term opportunities and challenges that will need to be seized if we are to deliver a genuinely sustainable improvement by promoting independence across the whole system. This goes much wider than simply tackling delayed transfers of care. That is simply a symptom of wider problems with the system of health and social care.

[163] The report is split into two parts. Part 1 talks about what has been done since the original report and the trends in the incidence and impact of delayed transfers of care. Part 2 sets out some of the ongoing, longer term, difficult challenges that face the health and social care bodies, as well as some of the issues that need to be taken into account during a reorganisation of the NHS.

[164] I will turn to part 1. The first section deals with clear evidence that partners have taken the issue more seriously. In a number of areas, there has clearly been a more holistic approach to thinking about how to design and deliver the system rather than individual services, to develop service models and shared resources to address the needs of vulnerable older people. I particularly want to emphasise the work that is going on at a pan-Gwent level, which you will see in case study A. It is called the frail older person's project, to which 11 chief executives have signed up. That happened around the time that our original report was published and was aimed at developing an approach to service provision that starts with the needs of frail elderly people and then works back to the contributions that each organisation can make and then to the service design and delivery. We are trying to work with the partners of that project because we think that it has significant scope, if done well, really to improve the outcomes for frail older people in Gwent. It also has the benefit of having taken a pan-Gwent approach rather than looking at it from the perspective of five localities, which was a clear finding of the original work.

[165] We also found some examples of different thinking about service models, which are set out in box 1, the pooling of resources or the alignment of resources across health and social care, which you can see in box 2, and some progress in sharing human resources, which you can see in box 3.

[166] We also found some operational improvements in the senior engagement and management of individual cases of delayed transfers of care. As well as re-designing the system and delivering the strategic improvements, those people who are facing delays of up to 80 days on average need to have their cases managed very well and very proactively to get them into a more appropriate care setting. There is certainly evidence that senior executives and clinical leaders have been working operationally to improve things there.

11.30 a.m.

[167] The Assembly Government has also taken several positive steps, which we have identified in paragraphs 1.13 to 1.17. It has signalled a strong commitment, set new targets, and has encouraged work from the National Leadership and Innovation Agency for

Healthcare to improve discharge planning and processes. There is also an ongoing review of choice and some internal restructuring in the Assembly Government, which in the medium term, should improve the extent to which the Assembly Government is joined up in the policy and delivery of the health and social care agenda.

[168] The second part of part 1, paragraphs 1.18 to 1.30, presents the data and some of the trends on delayed transfers of care. It is important to stress that delayed transfers of care are a surrogate measure—a proxy indicator of wider systemic issues. However, it is a useful measure of the impact on individuals and in highlighting problems in the system. The census is a snapshot that takes place every month, which shows a significant reduction in bed days lost and in the number of patients over a longer period of time, but particularly since the original piece of work was undertaken. We have tended to take the raw data and identified the number of days and the number of people who experience delays in each financial year. Those show a smaller reduction between 2006-07 and 2007-08, but a reduction nonetheless. There is still quite a significant problem in that the bed costs that we estimated for delayed transfers of care in 2007-08 remained at around £66 million, which is down from around £70 million in the previous year.

[169] Drilling down into the two communities, in Cardiff and Vale NHS Trust, there has been a bigger reduction in the number of bed days lost between 2006-07 and 2007-08; there is a 24 per cent reduction in the bed days, largely driven by reductions in mental health cases. There are some quite encouraging figures on reductions in social care and in delays arising from choice and patient-family-related delays. Having said that, the trust still has by far the highest average duration of delay in transfers of care of any of the Welsh trusts. There are also problems with delays arising from continuing healthcare, for example, patients at various stages of continuing healthcare that are not necessarily picked up by the census.

[170] In Gwent, there was a slight increase in the bed days lost between 2006-07 and 2007-08, set out in figures 5 and 6, largely driven by quite serious problems in Caerphilly and Torfaen. The census data for 2008-09 show a very encouraging trend in Gwent, where the number of people halved between April 2008 and April 2009. However, we do not know how exactly that translated into the number of bed days that were lost, but there has clearly been some progress in those two problem localities from the 2007-08 position.

[171] Part 2 of the report deals with these longer-term issues, where there are not yet consistently effective actions in place to address the longer-term barriers. In itself, that is not a surprise, but there is probably a heightened risk, in the context of the reorganisation, to the effective delivery of those longer-term changes. Those relate to translating the visions that exist for a more holistic approach into concrete action and improvement.

[172] Part 2 also sets out some examples of innovative strategic thinking in areas like West Lothian and Poole in Dorset. We visited West Lothian and the system that has developed through the community health and care partnership there has achieved some significant improvements in service delivery and costs. I visited the home of a lady being cared for by her mother through telecare, which was radical and very powerful because it had changed their quality of life and enabled that lady to live at home and that carer to have some sort of quality of life; it also increased safety in a cheaper way than had she been in a care home or a hospital bed.

[173] The second area is that there are cost pressures that can make it difficult to make the upstream investments in service model change to lock costs into institutional-based services at the higher end of health and social care services. In many ways, delayed transfers of care represent another cost of the kind of failure demand, where the system is not promoting independence and where people become institutionalised and, thereby, less likely to be able to live independently. There is still some way to go to unlock that vicious circle that we

described in the initial report, although plans are clearly emerging to do that. Capacity problems remain, particularly for the elderly mentally infirm. There are also problems with top-up fees and the supply and demand of care home beds despite the fact that we highlight quite large-scale vacancies in the report.

[174] The sharing of financial and human resources is not yet highly developed. There are initiatives in Wales and beyond, but there is undoubtedly scope to more effectively share human and financial resources to align or pool budgets and to set up more flexible workforce arrangements to deliver a more holistic and flexible service to promote independence, either by facilitating a speedy discharge or services that prevent people from being admitted to hospital in the first place. There remain very serious problems around continuing healthcare, given how services are provided, the costs of continuing healthcare and the impact on individual citizens. There is scope for clearer leadership, which may involve clinical, political or executive leaders giving up a degree of power and control to increase their influence on the system. The developments in Gwent represent steps taken along that road, but obviously there is a long way to go to deliver concrete change.

[175] As Jeremy said, there are still weaknesses in the way that delayed transfers are measured. There are different performance indicators in health and social care, which is a perverse incentive to partnership working. Although there is a commitment to abolish local agreements, they still exist, pending wider reorganisation of the census process, at which point the Assembly Government is committed to abolishing the local agreements that can distort the figures somewhat.

[176] Finally, there are some challenges around assessment and discharge processes, which can be risk averse and inflexible. I think that the earlier evidence session on handovers reflected some of those issues very well, but unified assessment is still quite a bureaucratic process with a lack of ICT support and information sharing, and there are still really significant problems around patient choice. The Assembly Government is working on revised guidance on that. On the reorganisation of the NHS, there are some really significant potential opportunities from that, with seven health boards and the scale benefits that may result from that, such as developing better whole-systems approaches, such as that which is emerging in Gwent. However, local engagement will still need to be preserved during a period of change. Obviously, a discontinuity of partnership arrangements locally will need to be managed very carefully and there will be scope for more challenges in aligning resources. So, those are things that the committee might wish to bear in mind for the future.

[177] **Jonathan Morgan:** Thank you. Do Members have questions on particular points on the report?

[178] **Michael German:** I have three questions and I will work from the back of the report. On page 24, there is ‘Figure 6—There has been a large increase in the number of bed days lost due to healthcare reasons in Gwent Healthcare NHS Trust’. However, if you look at it, it is not just healthcare, it also in patient/carer/families and so on. The only area where there has been a fall is in social care. I presume that that has contributed to the earlier comment that they are solving the problem in Gwent and that it is getting better. I just want to try to tease this out, because, quite clearly, if that trend were to be continued—I would like to know when we are going to get the figures for bed days for 2009—it is masking a problem that you identified as getting better.

[179] My second question relates to page 12, recommendation 3c, about the mechanisms for co-operation. You have identified boxes 1, 2, 3 and 4 as good ways of working. Of the four boxes, of all those cases, which would you say has provided the biggest turn for change? Is it the sharing of human resources or other forms of working together? Is it the sort of Julie Evans model that you have in Torfaen?

[180] My third question is very simple. It is really Jeremy's question. He tells us that we should be measuring bed days and then says, 'We cannot measure it because it is too difficult'. Please, can you give us an answer? Is it measurable? Can we measure it and how should we measure it? Tempting us with something that we should do and then saying that we cannot do it is not something that I like very much.

[181] **Mr Powell:** The first question about the position in Gwent is a good question because the report captures a point in time. The position certainly got worse between 2006-07 and 2007-08, as you rightly point out is noted in figure 6. That was driven by Caerphilly and Torfaen, which experienced some really serious problems. However, figure 7 shows the number of people who experienced a delayed transfer of care between April and December 2008 in Gwent and in each locality. You will see the number of patients during that period halved from 120 to 60 a month, and that has been sustained through to the end of April 2009.

11.40 a.m.

[182] **Michael German:** Do you expect that to result in—[*Inaudible.*] That is the measure, so do you expect it to happen?

[183] **Mr Powell:** We have just requested the data to enable us to make the 2008-09 comparison. I cannot guarantee it, because I do not know how long each of those patients has been delayed each month, but my guess is that the figures will be significantly better for 2008-09. The softer intelligence that we have picked up from the field work suggests that there is much more confidence in Gwent that this problem is getting easier.

[184] On the second point about the best example of good practice, it is difficult to pick the best example, because they all have their merits and they all depend on their context. If I am forced to point to one where you could really identify a measurable impact, however, it would be the advanced clinical assessment team in Torfaen. The case study on page 16 talks about the 975 admissions that were avoided between January 2007 and April 2008, which is the vast majority of patients who went through that service. Based on estimates of the average length of stay and the cost of a day in hospital, they think that they saved about £2 million. This project has been widely publicised; it has been evaluated and it has won awards for its innovative approach. It is effectively a peripatetic medical admissions unit. That is the different service model, and it is the vision of how you provide the service that should drive some of the other issues to do with how you align resources, financial or human. I would perhaps point to that, which is one of the better and more advanced ones, but they all have their strengths.

[185] On measurements, the ideal measure is the actual number of bed days occupied and the number of people involved. The cost of maintaining that information every month is potentially high. The Assembly Government, therefore, records the number of patients on a given day and the number of days that that cohort of patients has been delayed. That does not tell you the actual impact, however, which is why we have done some in-depth analysis to strip out delays that span different financial years and to identify the actual duration of individual delays, patient by patient, which is clearly the best way to measure this.

[186] **Michael German:** What about your recommendation of what we should do by way of data collection? Could you describe that?

[187] **Mr Powell:** A feasibility study would be needed to assess the cost of maintaining that sort of information. That would be the best way to do it. However, the census as it is now would be improved by abolishing the local agreements, and that work is in train, because the period between when a clinician declares somebody fit for discharge and when the delayed

transfer is counted varies still between different localities. Even the census figures are less reliable as a result of that. A mix of both approaches may be sufficient to measure progress.

[188] **Mr Colman:** You might think it bad enough to say that the local agreements result in the figures being systematically understated, but it is actually worse than that. It is not even systematic. They are haphazardly understated, because the local agreements do not start the clock until a variable number of days have elapsed—and it could be a very large number of days. From the patients' point of view, the clock starts the moment they are told that they are clinically clear to move on, but the local agreements delay the start of the clock.

[189] **Michael German:** Thank you. That is very helpful.

[190] **Jonathan Morgan:** Are there any more questions to Jeremy or Rob? I have a few points to raise. The table on page 20, at figure 2, shows the reduction in the number of bed days lost due to patient/carer/family reasons, and social care reasons. There is a 26 per cent reduction in one case, and a 36 per cent reduction in the other. Were you able to identify what either the trust or the local authority did to contribute to the reduction in the number of bed days lost in those two examples? I am told by managers who run our hospitals that one of the principal reasons is that the local authorities are not quick enough to identify social workers and to put care packages together so that there is something in the social model that a patient can move into. Likewise, we are told by patients, families and carers that they are not particularly happy with where their loved one may end up if they are discharged from hospitals. Dealing with those two categories seems to be quite significant. Can you identify what contributed to that?

[191] **Mr Powell:** As always with delayed transfers of care, it is a complicated multi-factorial issue. We feel that there has been a real focus in the Cardiff and Vale NHS Trust on trying to address delayed transfers of care. As you heard earlier, the trust has terribly high bed-occupancy and delayed transfers of care are a significant factor in that, which affects the front door of the hospital and contributes to turnaround times and the wider problems. There has been significant management focus on it.

[192] There have also been attempts by the local health board and the local authority to commission additional care home capacity, and also to look at continuing care capacity. However, the majority of the reduction in Cardiff and Vale NHS Trust relates to mental health delays, which partly relates to resolving some long-standing individual cases of delays, where patients have moved into community placements, and so on, which has had an impact. So, there is a range of things that have led to this.

[193] **Jonathan Morgan:** So, in essence, it was resolved because of the long-standing mental health issue around certain patients, but what we cannot see from this is whether or not those improvements will be sustained throughout the year. In a sense, that is a big blip that has been resolved, but there may be other issues that might not lead to a sustained reduction in bed days lost. That was one of the issues that you flagged up in the report about the medium-term sustainability of the reduction in bed days, and it is something that we should take into account.

[194] **Mr Colman:** Rob referred to the fact that we have seen the benefit of the engagement of very senior people within the NHS and local government in these issues, and our original report did something to engage those senior people. That is certainly good, but in the nature of things, senior people's attention wanders, and if improvements have been due to the engagement of local authority chief executives in this regard, that is not sustainable. There are some signs that this is happening, but we hope that the chief executives who are taking a close interest in this issue are not simply focusing on operational issues, but will also be looking to establish systems that deliver sustainable improvement.

[195] **Jonathan Morgan:** The other point that I wanted to raise is that when you look at the graph on page 21, the seven trust areas with more than 50 days lost on average because of delayed transfers of care are all along the south Wales M4 corridor. Clearly, there is an issue, because the north Wales trusts are performing better—historically they have performed better anyway. What is it about the configuration of the national health service in south Wales that makes delayed transfers of care more of a problem in comparison with the configuration of the health service and social care in north Wales? We frequently see the impact of geographical differences—whether it is in delayed transfers of care or the performance of the ambulance service. During your fieldwork, were you able to glean from colleagues that you spoke to what the problem might be?

[196] **Mr Powell:** I probably could not give you a satisfactory answer to the whole of the problems of the NHS, but I can say—and your earlier evidence would back this up—that there is significant system capacity pressure within south-east Wales, particularly within the Gwent and Cardiff and Vale health communities. It manifests itself in a variety of ways. One of them is the problem at the front door of the hospital in handing patients over, and the knock-on consequences for ambulance responses in the community. Another problem is at the back door of the hospital in the timely and effective discharge of patients that have had a delayed transfer of care and those who can go home without a delayed transfer of care. There is also a problem with general occupancy levels. When you look at the system capacity across the piece, it is clear that resources are not necessarily going to the right place at the right time, and this is what Tina Donnelly talked about earlier with regard to the status of one hospital being red and the status of another hospital nearby being green. Perhaps a wider look at capacity across the region would help to smooth out some of the flows.

11.50 a.m.

[197] **Bethan Jenkins:** I have a general question on part 1 and 2. Do you think that part 1, on the Government taking a holistic approach to changing the structures, will balance out the negatives in part 2 to justify, perhaps, the committee taking on more work to look into this further? Is there enough progress to suggest that this will look better for future years?

[198] **Mr Powell:** There is good cause for optimism in many respects. It is good that the issues in part 1 have happened. I am not sure that it is entirely surprising that there are still these intractable whole-systems cross-cutting challenges in part 2. Many of the positive issues that we point to in the boxes and case studies in part 1 are things that will take time to come through. Much of this will turn on whether they work and what impact the reorganisation might have. It is a matter for the committee to determine whether you share that optimism because there are real risks to sustainability in all of this.

[199] **Jonathan Morgan:** Are there any further points to Jeremy or to Rob? I see that there are none. We will now have a departure from a previous practice. Previously, we have considered the report and briefing in private and then considered how to approach the report and decide which of the four options to proceed with. It is my intention that we have that discussion now, in public, with the auditor general and Rob, as this document is already very much in the public domain, and we have had time to read it and to consider the briefing this morning. At this point, I would like us to think about which of the four options that we wish to follow with regards to this report.

[200] The first option available to us is to write to the Government urging it to implement the recommendations. The second option is to write to the accounting officer about all of the report or just part of it. Part 2 is clearly where work needs to be done. The third option is to refer this to a subject committee and the fourth is to undertake a fuller inquiry. Having read the report and having listened to the briefing from the audit office this morning, are there any

particular views one way or another as to how to proceed?

[201] **Lorraine Barrett:** My problem, which I discussed at the last meeting, is at what point does the Audit Committee's responsibility or remit for a report end and a subject committee starts? We must not become a health committee in this instance as it is a health matter in question. Therefore, my first question is how much of this can we pursue as an audit committee, rather than if we were the health committee? I would like to have some more information from those responsible, whether it is from the Government side or the partners, on how some of the work on delivering the outcomes is progressing. From my personal perspective, it might be useful to know how that is working, to bring the partners in, and consider whether we look at the Gwent example and pursue that a little further. Those are my initial thoughts.

[202] **Jonathan Morgan:** Are there any more views as to how you would wish to proceed with the report?

[203] **Michael German:** There are some longer term issues. We have already discussed the measurement issue, which is an action that needs to be pursued. We have heard the word 'haphazard' used today, but there is no uniform approach to how this is working. I do not know whether we have developed best practice enough. It seems that there is more investigation to do to pull this out. Whether that should most probably be done by committee—and this committee—is a matter of timing and resource, who has the most time available to do it, and whether the health committee is prepared to take on this matter. I do not know the answer to that question. If it is willing and thinks that it is important for it do that work, I suggest that that is how we proceed, and that we look at its report when completed to see whether any further questions arise. At this stage, I think that there is work to be done, but I cannot necessarily put my finger on it.

[204] **Jonathan Morgan:** Before I ask for Nick's view, and in response to both Lorraine and Mike, we have to be careful in that we are the Audit Committee; we are not here to pass judgment on whether a policy is the right one. We are here to examine that policy and see how it works in relation to performance and practice. The Health, Wellbeing and Local Government Committee can look at policy and pass judgment on whether the Government is pursuing the right policy. Our indication from the clerk of that committee is that this would not fit into their current schedule of work, so that is probably a subtle way of saying that it would not be helpful at this stage.

[205] One solution to this—and I would appreciate your view on this before I bring in Nick—is that, bearing in mind that there are issues around part 2 of the report, we could certainly write to the accounting officer pointing to part 2. We have to recognise that the Wales Audit Office report shows that there has been progress, but we can look at those particular issues around part 2, raise them with the accounting officer, and ask for further detail about how the Government responds specifically to that part of the report. Then we can examine that response when we get it. That might be the best way of approaching this at this stage.

[206] **Michael German:** So, it would not be a full inquiry.

[207] **Jonathan Morgan:** It would not be a full inquiry, but one of the options is to write to the accounting officer.

[208] **Nick Ramsay:** You have pre-empted the point that I was going to make—we could write to the accounting officer, but also to the Government. I would not think that it is appropriate to have a review at the moment. Let us be careful about stepping on the toes of other committees. However, the report says at page 43, paragraph 2.82, near the end of part 2,

that:

[209] ‘This provides an opportunity for the Assembly Government to provide a more coherent approach to policy across the whole system’.

[210] There is an opportunity for the Government to do this, but peppered throughout the report are examples of how it has not happened. I think that it is our role as an Audit Committee to look at why it has not happened, and at what will happen in the future. There is another line somewhere—I cannot remember the page—about the Government saying that one size does not fit all. It strikes me that that is fine, but I detect a vacuum here. It is fine to leave this to local authorities, and yes, there is good practice in some areas, but it is not being followed through into other areas, and it should be: there should be some sort of impetus from above to say that this is happening, it is working in some areas—albeit with imperfections—and it should be carried through elsewhere.

[211] Before you ask other Members their views, I would say that a report is not appropriate at this stage, and we should not tread on the toes of the health committee, but we should ask the Government what it is doing to solve this, and also the accounting officer, and see if we can at least get some sort of remit on how to go ahead.

[212] **Jonathan Morgan:** At this stage, my recommendation would be that we write, in the first instance, to the accounting officer because of the strategic aspect of part 2, the leadership within the NHS, the partnership working, and the issue of financial resources. We can ask for a response, and when we have it, we can take a view as to whether it needs further work. Does the audit office have a view?

[213] **Mr Colman:** I certainly would not dissent from that proposal, Chair. It occurs to me that there are two issues on which the committee might consider that there is a need for further assurance. The first is the one that you have described: what is the Government doing about the issues to which we draw attention in part 2? The second might be the sustainability of some of the local initiatives. I would not for a minute suggest that looking at that should precede writing to the accounting officer, but when you get a reply, if the committee considers taking evidence, I think that it would be a good idea, picking up Lorraine’s point, to examine a range of witnesses from Gwent in particular, asking what they have done that has worked, and what they will do to ensure that it goes on working. This is a complex issue that requires very strong collaboration locally within a framework set by the Assembly Government. You need to cover both.

[214] **Jonathan Morgan:** That is a sensible way to proceed. Are we all happy with that?

12.00 p.m.

[215] **Irene James:** Following on from what Jeremy said, and Lorraine, because all too often, we question organisations that come here but we do not push them on what they are going to do to change things. I wonder whether that is something that we can look at and develop. I am thinking along the lines of a school inspection. There is always an action plan, following the inspection, for how the school will put things right. Would it be helpful to us as a committee to see what was going to be done to change the things we are talking about?

[216] **Jonathan Morgan:** What is very useful in this report is that you point to examples that have improved the situation. The question for us then is: how does the Assembly Government or the NHS, at a strategic level, hold those examples up as best practice and try to encourage others to mirror some of that good work? There is some very innovative work being undertaken, and we need to see how that can be taken forward at a strategic level.

[217] **Nick Ramsay:** The auditor general has made a valid point that it is not just about using that good practice, but checking on the sustainability of it. It might look great today, but we need to ask what it will be like in a year or two years' time and whether it is actually transferable. Getting witnesses in from those organisations is a good idea.

[218] **Jonathan Morgan:** Okay. We will write to the accounting officer, and following the reply we will examine how to take that forward. That will be a very useful way to proceed.

12.01 p.m.

Trafod Ymateb Llywodraeth Cymru i Adroddiad y Pwyllgor Archwilio, 'Rheoli Cyflyrau Cronig yn y GIG yng Nghymru'
Consideration of the Welsh Assembly Government's Response to the Audit Committee Report, 'The Management of Chronic Conditions by NHS Wales'

[219] **Jonathan Morgan:** I ask the auditor general to introduce his assessment of the Government's response to the committee's report. The Government has accepted all the recommendations in full.

[220] **Mr Colman:** That is obviously good news; better than that, it has brought forward a workshop to this month, which was supposed to happen next year. I can therefore be reasonably positive about the Government's response. There is of course a big 'if' in the response, which is that this depends on the effective operation of the new health boards. It is certainly true that the new structure of the NHS is supposed to be better than the previous structure at dealing with many problems, one of which is chronic conditions. However, there must be an element of 'wait and see'. I generally end these letters by undertaking to draw the committee's attention to issues arising from ongoing work in this area, and I can assure the committee that there will be ongoing work in this area and that it is highly likely that we will be following up this particular subject to see how it fares in the new NHS structures.

[221] **Jonathan Morgan:** Do Members have any views to express, bearing in mind that we have had the Assembly Government's response? Perhaps this is something that we will just wish to keep an eye on.

12.03 p.m.

Trafod Ymateb Llywodraeth Cymru i Adroddiad y Pwyllgor Archwilio, 'Gweithrediadau'r Comisiwn Coedwigaeth yng Nghymru'
Consideration of the Welsh Assembly Government's Response to the Audit Committee Report, 'Operations of the Forestry Commission Wales'

[222] **Jonathan Morgan:** Again, I ask the auditor general to provide his assessment of the Government's response to the committee report.

[223] **Mr Colman:** This, too, is a positive response. I referred favourably to the action of holding a workshop earlier; in this case, I can refer even more favourably to the fact that the Assembly Government has acted upon one of the committee's recommendations regarding the funding of Forestry Commission Wales to enable it to keep a measure of financial reserves. It is very welcome that the Assembly Government has responded quickly to a specific recommendations; it is good news. The rest of the response also seems to be satisfactory. Committee members will recall that the committee had quite an extensive debate about the terms of its report. I think that that reflected the fact that not all Members were completely happy with the way in which the forestry commission has conducted itself. Therefore, in this response too, there is an element of 'wait and see'. Therefore, as before, this

is one that we will follow up and report back on as necessary.

[224] **Michael German:** The one concern that Jeremy might want to comment on, and about which we may want to write to the Government again, is reflected in paragraph 1 of Jeremy's response. It states, to paraphrase it, that public bodies should not rely on internal and external audit to promote improvement and to provide assurance about the impact of changes, and that internal evaluation is also vital. This is a systemic issue; it is an operational matter. Perhaps we ought to write to the Minister or the accounting officer and say that, having reflected on the Government's response and having seen a response letter from the auditor general, we think that the Minister might need to reflect on the methods used in order to take a longer-term and more practical approach to managing resources. I do not know whether Jeremy thinks that would make the point strongly enough. You have made a point about an internal, operational matter, Jeremy. You are saying that if you follow the route outlined in paragraph 1, you are more likely to get a better and more proactive use of your resources in the longer term.

[225] **Mr Colman:** There is a case for two letters, or a letter copied to two people, because there is the very specific issue of what Forestry Commission Wales and its accounting officer will do in relation to these matters, but you have quite rightly raised this as a generic issue, so it seems to me that the committee could write to the forestry commission with a copy to the accounting officer for the Assembly Government.

[226] **Jonathan Morgan:** That is sound advice, and we will certainly pursue it. Are there any additional points on that from Members? I see that there are none.

12.07 p.m.

Trafodaeth ar Ymateb Archwilydd Cyffredinol Cymru i Adroddiad y Pwyllgor Archwilio, 'Y Fenter Twyll Genedlaethol'
Consideration of the Auditor General for Wales's Response to the Audit Committee Report, 'The National Fraud Initiative'

[227] **Jonathan Morgan:** I thank the auditor general for his response. Do Members have any comments to make on this?

[228] **Michael German:** It is very good to see—[*Inaudible.*]

[229] **Jonathan Morgan:** Absolutely. Is there anything that the auditor general would wish to say in response?

[230] **Mr Colman:** No, I have nothing to add to my rather brief letter. One of the disadvantages of working in collaboration—and the disadvantage is completely overwhelmed by the benefits of working in collaboration—is that my ability to accept a recommendation applying to other people is limited. [*Laughter*.]

[231] **Jonathan Morgan:** I appreciate that.

12.08 p.m.

Cynnig Trefniadol
Procedural Motion

[232] **Jonathan Morgan:** I propose that

The committee resolves to exclude the public from the remained of the meeting in accordance with Standing Order No. 10.37(vi).

[233] I see that the committee is in agreement.

Derbyniwyd y cynnig.
Motion carried.

Daeth rhan gyhoeddus y cyfarfod i ben am 12.08 p.m.
The public part of the meeting ended at 12.08 p.m.

Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Archwilio
The Audit Committee

Dydd Iau, 18 Mehefin 2009
Thursday, 18 June 2009

Cynnwys
Contents

Aelodau Cynulliad yn bresennol
Assembly Members in attendance

Lorraine Barrett	Llafur Labour
Janice Gregory	Llafur Labour
Lesley Griffiths	Llafur Labour
Irene James	Llafur Labour
Bethan Jenkins	Plaid Cymru The Party of Wales
Huw Lewis	Llafur Labour
David Lloyd	Plaid Cymru (yn dirprwyo ar ran Janet Ryder) The Party of Wales (substitute for Janet Ryder)
Jonathan Morgan	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Chair of the Committee)
Nick Ramsay	Ceidwadwyr Cymreig Welsh Conservatives

Eraill yn bresennol
Others in attendance

Gillian Body	Swyddfa Archwilio Cymru Wales Audit Office
Jeremy Colman	Archwilydd Cyffredinol Cymru Auditor General for Wales
Simon Dean	Cyfarwyddwr Cyflenwi Gwasanaethau a Rheoli Perfformiad, Llywodraeth Cynulliad Cymru Director of Service Delivery and Performance Management, Welsh Assembly Government
Jon Falcus	Rheolwr Cyffredinol y Gyfarwyddiaeth, Ysbyty Maelor Wrecsam Directorate General Manager, Wrexham Maelor Hospital.
Meredith Gardiner	Rheolwr y Gyfarwyddiaeth, Ysbyty Prifysgol Cymru Directorate Manager, University Hospital of Wales.
Martin Gibson	Swyddfa Archwilio Cymru Wales Audit Office
Alan Murray	Prif Weithredwr, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Chief Executive, Welsh Ambulance Services NHS Trust
Jennie Palmer	Uwch Nyrs sy'n Arwain Tîm, Uned Argyfyngau Ysbyty Prifysgol Cymru Senior Team Leader Nurse, Emergency Unit, University Hospital of Wales
Judith Rees	Dirprwy Reolwr Cyffredinol y Gyfarwyddiaeth, Ysbyty Maelor Wrecsam Deputy Directorate General Manager, Wrexham Maelor Hospital
Paul Williams	Pennaeth Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cynulliad Cymru Head of Health and Social Services, Welsh Assembly

	Government
Tim Woodhead	Cyfarwyddwr Cyllid, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Director of Finance, Welsh Ambulance Services NHS Trust

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

John Grimes	Clerc Clerk
Abigail Phillips	Dirprwy Glerc Deputy Clerk

9.30 a.m.

Dechreuodd y cyfarfod am 9.30 a.m.
The meeting began at 9.30 a.m.

Ymddiheuriadau a Dirprwyon
Apologies and Substitutions

[1] **Jonathan Morgan:** Good morning. I welcome Members to the National Assembly's Audit Committee. We have received apologies from Mike German—there is no substitution. We also have apologies from Janet Ryder. I am delighted to say that Dai Lloyd is substituting for Janet who, I understand, is away for the rest of the week in Guernsey with Mike German—do not read anything into that; they are on a Commonwealth Parliamentary Association visit. [*Laughter.*] They are in the company of a significant number of other Assembly Members.

[2] I remind Members of the usual housekeeping arrangements. The Assembly operates bilingually, so, those people who require it can receive a translation via the headsets. Channel 1 is for the translation from Welsh to English, while channel 0 can be used to amplify the sound if you find the proceedings difficult to hear.

[3] There is no indication of a fire drill this morning, so if the alarm sounds, please follow the advice of the ushers. Those are all of the housekeeping arrangements for this morning.

9.31 a.m.

Gwasanaethau Ambiwlans yng Nghymru
Ambulance Services in Wales

[4] **Jonathan Morgan:** This item relates to our inquiry into ambulance services. Members will recall that the Wales Audit Office published two reports recently. One is entitled, 'Ambulance services in Wales—further update to the National Assembly for Wales' Audit Committee', and the other, and most recent, report, which we have started to deal with, is 'Unscheduled Care—Patient handovers at hospital emergency departments'. The purpose of this first substantive item this morning, which is listed as item 2 on the agenda, is to take evidence from colleagues who work in our hospitals. I am delighted that we have four witnesses here this morning.

[5] For the record, could you just identify yourselves before we move on to our questions?

[6] **Ms Rees:** My name is Judith Rees and I am a deputy general manager for the

directorate of medicine in Wrexham Maelor Hospital. One of my responsibilities is to operationally manage the emergency department.

[7] **Mr Falcus:** I am Jon Falcus and I am the general manager for the medical directorate at Wrexham. My responsibilities cover all the medical wards, the support facilities, and the accident and emergency departments.

[8] **Ms Gardiner:** I am Meredith Gardiner and I am the directorate manager for unscheduled care at the Cardiff and Vale NHS Trust, which includes the emergency unit at the University Hospital of Wales.

[9] **Ms Palmer:** I am Jennie Palmer and I am the clinical nurse leader at the emergency department of Cardiff and Vale NHS Trust. I work closely with the ambulance service in looking at the 15-minute target.

[10] **Jonathan Morgan:** Thank you. Before we proceed to questions, do you have any opening remarks to make, or are you happy for us to proceed to our questions?

[11] **Mr Falcus:** We are happy for you to proceed.

[12] **Jonathan Morgan:** Okay. I will kick things off. Jennie Palmer and Judith Rees, the auditor general's report on handovers highlights the plight of patients who are affected by handover delays at accident and emergency departments. Patients and their families and carers can understandably become anxious, frustrated and somewhat confused by the length of any delay. In your experience, how are patients' expectations managed during times of pressure on your accident and emergency departments? Let us start with Jennie.

[13] **Ms Palmer:** Patients have to be at the centre of every journey. In some respects, the 15-minute target for ambulances has taken away from patient focus. As a trust, we try to make the patients the centre of every interaction that we have with them. We work closely with the ambulance service to ensure some sort of streamlining in the interface between the ambulance service and the trust. We have been complying quite well with hitting the handover times—somewhere in the high 80s to 90 per cent according to the data collection system that we use. The system has changed now; we have gone over to the hospital admissions syndromic surveillance system 100 per cent wholeheartedly, and our reporting has dropped from there. I will hand over to Meredith to say something about the operational aspects.

[14] **Ms Gardiner:** In our contact with patients whose handover has possibly been delayed, we have some general operating instructions in that I am informed, or the nurse in charge of a department is informed. One of us will go to speak to the patients concerned, apologise for any delay, and explain to them some of the reasons for that delay. We make every attempt to move the patient as quickly as possible. We apologise to the ambulance team as well, and also try to explain to them what is happening to move patients through.

[15] **Ms Rees:** I agree with what Meredith said about the patient being at the centre of that process. The staff in the department think about the patient safety element, and how important it is from a patient's safety point of view to move the patients quickly from the ambulance into the area where they are best cared for. We tend not to talk about the targets, but more about the safety issues on the floor and what is best for the patient—the targets will take care of themselves if we do that properly.

[16] On performance, our department's performance against the four-hour target, the eight-hour target and the 15-minute target is good, but there is room for improvement in all of those areas. Jon will talk more later about our whole systems process and how we will improve that,

but we are conscious that while people are outside in an ambulance, it is an anxious, uncomfortable and difficult time for them—they are sick people and sometimes the relatives are with them in the ambulance or are close by—so that anxiety is managed and helped along. We try to make sure that we have good communication with the patient and the relative at that time.

[17] We have done some work with the ambulance service and our colleagues in Ysbyty Glan Clwyd—which is part of our trust—on how we can more safely manage the risks and the care for those patients while they are in the ambulance. No-one would agree that it is the right thing to do because everyone thinks that no-one should ever wait outside a hospital in an ambulance, but that inevitably happens so they must be managed safely when they are there. We are going though a process of putting in a monitoring system based on what the ambulance service needs to do and what information we need to receive from it about the condition of the patient in the ambulance, so that we can manage that as well as the person in the department because the person in the ambulance might be more sick than the person in the department. It is about how we manage all of that appropriately.

[18] **Bethan Jenkins:** Thank you for coming in to give evidence. I am looking at paragraphs 1.6 and 1.7 of the report, which talk about the pressures on nursing staff, especially when excessive delays in handover coincide with the pressures that you previously outlined. Do some nurses feel powerless to prevent delays as outlined in the report, and how does this affect morale in the team? Does this affect their relationship with the paramedics in transferring patients from one area to another?

[19] **Ms Palmer:** Staff do feel powerless. In the Cardiff and Vale NHS Trust we offload every ambulance as soon as they arrive. We then have a horrible picture, which people may have seen in the press, of queues in the corridor. Anyone who has to walk past a patient who is lying on a stretcher in pain, and their relative, feels totally helpless. That is not what people go into nursing for, it is not what nursing is about, and it is certainly not what patients expect.

[20] The flip side of that is where can you put the people on the trolleys that have been offloaded from the ambulance that also face a delay in getting into a hospital bed? Do we leave them in the corridor to prioritise ambulance patients? When pressures are very high and when we are not able to hit even the four-hour target or the 15-minute target, deciding which patient should have the priority of care is a very difficult decision for any nurse to make. It is then difficult to communicate that decision to relatives and the patient. In the back of every nurse's mind is also the fact that there is someone else out there who has called 999, and that we are delaying that ambulance and crew in getting to them. The ambulance crews also feel that—they do not come to work to stand in a corridor for an hour, or sometimes longer; they come to work to help people at the front line. As a service, we are aware that we sometimes prevent that from happening.

[21] **Bethan Jenkins:** Judith, do you have anything to add to that?

[22] **Ms Rees:** I agree that if the staff are not able to deliver the appropriate care at the right pace and in the right way to patients who might be waiting outside in an ambulance, or because the department is generally busy even if ambulances are not waiting outside, it is an anxious and worrying time for staff because they care about what they do. It is the care that they give to patients and what is happening to those patients that is most important to staff.

9.40 a.m.

[23] They are not driven by the target in that sense; they will not see patients according to who has been waiting the longest and therefore might breach a target, but according to who is the sickest. So they focus on that, but there are different pressures. When there are delays in

our patient flow process, staff feel powerless to influence that, but that is my job, the lead nurse's job and Jon's job. The relationship that we have is important in ensuring that we pull through that quickly. I am immersed in what happens in the department throughout the day and we have a good escalation plan, but, even before that is implemented and the department gets quite hot, I will know about it because of my constant monitoring of the situation. However, we have a good escalation plan to instigate improvements in flow, if we need to, quite quickly. There are other pressures that are not about beds. For example, there are seasonal pressures. At this time of year, pressure can be about an increase in the number of attendances in the department, with a different type of patient coming through, with less pressure with regard to beds. Care can often be about those who we call emergency department patients—it about patients who are coming in and out, rather than about beds. So, that is in their control, but there can be too many patients and not enough staff—in an emergency service, you cannot control when someone comes in, as you can with elective treatment, so there is an element of powerlessness. Again, it is then my job to get in there quickly and to work with the lead nurse—she would have been here today, but she is on holiday—to ensure that we make that flow more quickly and support the staff in that. However, there are definite frustrations.

[24] On your point about tensions with ambulance crews, they can arise at times if we are holding ambulances outside, because crews know the importance of getting the ambulance back on the road for the next patient who needs to be brought in. There is equal pressure from our staff, because they also know the impact that not being able to bring the patient into the department quickly enough will have. We do not operate a corridor wait, but hold the ambulances outside. We do that for a number of reasons. The pressures are on both sides, so it causes a little tension at times. However, we have a pretty good working relationship with the ambulance crews and their leading officers, which enables us to work through those issues quite well.

[25] **Mr Falcus:** To pick up that point, the issue that is highlighted in the report is that there was a feeling that a policing role was being played by the emergency departments, but we have got over that. It was a cultural thing, but we have now reached a point at which there is an understanding that it is a shared target between the emergency department and the ambulance trust. We have got over the idea that people are policing. People are taking reminders to use the system as that: reminders, not necessarily policing. Over the past few months, we have got around that and there is a much more positive attitude.

[26] **Bethan Jenkins:** It is also a shared experience now. As you will have read, it was about the location of the data terminals. Do you think that, because of that cultural change, it does not matter where the terminals are located, and that it was more about the ethos of delivering the target together?

[27] **Ms Rees:** It is both. The location of the terminal is important, because its visibility acts a reminder to the crews and staff. If you put a terminal in a location that is not easily accessible, it is easy to walk past it, forget about it and not to use it. So, its location is important. We are going through a structural change in our department. We have put the terminals where best we can in our current configuration, but, as we make our improvements over the coming months, we will change the location of the terminals to make their use easier. There is also a cultural issue. We have seen a big change in people's attitudes and, from my personal observations, I think that the culture has improved quite significantly over a period of months. People used to feel that they were being monitored too closely and followed up too tightly and that ED staff were checking up on ambulance crews, and there were some slight tensions there, but it is hugely different now. It is automatic. We have been doing some very close monitoring in recent weeks to try to improve our compliance with hitting the screen, which is important, and the attitude of the crews is much better. It is very rare now for there to be an attitude that is not quite acceptable or for someone to challenge it or make a comment.

Complaints are few and far between. It is quite automatic for the crews to come in to do the notification and, quite often, to do the handover. There has been some tension over whose responsibility it is to the handover, the department staff or the crew staff. There are still one or two issues there, but generally the attitude has swung round quite considerably.

[28] **Janice Gregory:** Good morning, and thank you for coming to committee this morning. My questions are on the hours lost at emergency departments. My first question is to Jennie. Annex 3 of the report is quite clear about the hours that have been lost in the University Hospital of Wales. In November 2008, a total of 547 ambulance hours beyond the maximum 20 minutes given for turnaround were lost. Has the number of hours lost reduced since then?

[29] **Ms Palmer:** I do not have any specific data to back it up, but it has been reduced and we are looking at processes and trying to streamline the process for patients who come through the front door. We are looking at new ways of working, and we have recently appointed a new clinical director who has come in with many new ideas on how we can improve processes. In that respect, we are trying to process and stream patients into a specific area where we have a medical team waiting for them. In that respect, we can offload the ambulance stretcher and the crews much more quickly and efficiently and improve handover times.

[30] We are also doing some work with the ambulance liaison officers on whether we can double up patients, when we have times of pressure, to be able to release crews to again reduce the number of lost hours for more than one crew. I appreciate that we will still be having lost hours for a crew, but we are looking at ways of working where we can cohort patients—although the term ‘cohort’ is not a very nice term to use—and so release crews to be able to get back on the road to deal with patients who need them more urgently.

[31] **Janice Gregory:** So, you are quite confident that you will bring those hours down substantially, are you?

[32] **Ms Palmer:** Yes. I am confident that we are doing that. The processes are proving that.

[33] **Janice Gregory:** That is great. Thank you. My next question is to Judith. According to annex 3 of the report, at Wrexham Maelor Hospital a total of 100 hours were lost for the same month, November 2008. If you look at the previous hours, you will see that there is a discrepancy. Can you explain why 100 hours were lost?

[34] **Ms Rees:** In which figures is there a discrepancy?

[35] **Janice Gregory:** I am looking at the report. Perhaps I am reading it incorrectly. I cannot find it now; I need more fingers to keep in the report. It is the discrepancy—

[36] **Lorraine Barrett:** Is it between Cardiff and Wrexham Maelor?

[37] **Janice Gregory:** Well, I can answer that question. I assumed that the question that I needed to ask you was about the discrepancy between the number of hours that you lost in November and the previous hours that you lost.

[38] **Jonathan Morgan:** For clarification, I think that the question is about the fact that, in November 2008, 547 ambulance hours were lost at the University Hospital of Wales, but in the same month at Wrexham Maelor Hospital, fewer than 100 hours were lost. The issue that we want to try to tease out is what is it that is different between Wrexham Maelor Hospital and the University Hospital of Wales that means that there is more of a difficulty in south Wales, compared with hospitals in north Wales. Obviously, you lost fewer hours, so I am just wondering whether there is a reason for why fewer hours were lost.

[39] **Janice Gregory:** I can answer that question, I think. Forgive me, Chair, but if our witnesses do not want to answer that question, I do not think that that is one of the best questions. It is about the north and the south and different hospitals, and looking the number of people coming through the doors.

9.50 a.m.

[40] **Mr Falcus:** I cannot comment on the situation at the University Hospital of Wales, but I can say why I think that, generally speaking, we do fairly well with ambulance turnaround times. In north-east Wales, we have a very good history of working together, and not just with ambulance staff. We have recognised for a good number of years that this is a whole-systems issue, and although we are today concentrating on ambulance handover time, the real issue is the whole system and the flow of patients through the hospital—the discharge arrangements, and so on. We are not good enough at that, but we have historically had good working relationships with colleagues in local authorities and social services departments, and with the ambulance trust at the front door; we have a long history of working together and trying to solve this problem of patient flow. That is probably what sets us in a fairly good position for ambulance handover times—we have a very good emergency department with very good senior medical staff who work proactively, and that is another of the key issues. As to the difference, we do not work in a major tertiary city-centre hospital, so I cannot comment on why there is a difference.

[41] **Janice Gregory:** In case you are wondering why I was unhappy with that, just as an example—and this is not to take anything away from what you are doing in Wrexham—there is a significant difference in the number of people through the doors, and that needs to be put on record, Chair. I am sure that what you are doing is great, and if it was replicated elsewhere, that would be good, but in UHW there are almost 2,500 people going through the door, and in Wrexham there are nowhere near that many. However, I take your point about the good work that is being done there.

[42] **Jonathan Morgan:** What might help is a quick follow-up question that both UHW and Wrexham Maelor could answer. Looking at the situation in both accident and emergency departments, what is the capacity with regard to the number of staff that are attached to those departments, and what is the capacity of the medical assessment units that patients would be seen in, once they come through the door? The areas that you serve obviously have significantly different populations, and I would be interested to know the capacity of both units. Perhaps we could start with Jon from Wrexham Maelor.

[43] **Mr Falcus:** We serve a population—it varies according to whether you are buying or selling—of about 250,000 in north-east Wales. Our accident and emergency department was originally designed to cope with a capacity of about 45,000 attendances a year, and we are currently getting about 60,000. We are undergoing a redevelopment, as Judith said, which will expand our capacity and add a clinical decision unit, which is one of the keys to managing increases in demand. What we are designing should be able to cope with the foreseeable future.

[44] As for the systems behind that, we have a medical admissions unit and surgical admissions unit with around 40 beds. Over the last few years we have identified that physical capacity is not necessarily the key to this—it is also about the standard, competence and seniority of the decision-makers and staff within your departments. The more senior staff that you have at the front door, the more you are able to turn around the demand that is coming through it. So, it is not just about beds and capacity.

[45] **Ms Gardiner:** It is an interesting question. I will take it in three different sections.

First, on the structural capacity of UHW's emergency unit, we currently have a series of compartmentalised rooms in which we will see a variety of different patients according to their need. The department was built around 10 years ago with the capacity to deal with the patients that we predicted would come in. We are currently undertaking a re-survey to understand the patterns of demand that are coming through and to look at the potential for redesigning the department. Once you get through that initial structural shape of the emergency unit, there are two further assessment units. There are about 26 trolleys in our surgical assessment unit and a further 22 in our medical assessment unit. Similar to our colleagues in the north, we are looking at how we use the assessment unit capacity and at whether a clinical decision unit would be an option for us in the not too distant future. I am pretty certain that, with some tweaks in our capacity, we could manage our flows better, but our problem is around the demand coming through the doors and the fact that there is not a straightforward bell curve; there are big fluctuations 24 hours a day, seven day a week, and across the year, as well. It is about understanding those flows and matching our structural and staffing capacity to the demand.

[46] On staffing capacity, we have excellent medical and nursing staff. We have invested heavily in nursing staff and in improving their skills to develop more emergency nurse practitioners, for example. Where we have a much bigger problem, unfortunately, is with our medical staffing complement, particularly at middle-grade level. You may already be aware of the national staffing shortages that we have, which affect our ability to recruit to all the posts that we would like to see filled in our department. The royal college of emergency physicians has recently created guidelines on the exact numbers of medical staff in the department and, unfortunately, we fall short. So, at a structural, demand and staffing level, there are big implications for us, and that is just within the department. The running of the department is only as good as the capacity that we have in the rest of the hospital to ensure speedy admissions and in the wider community to provide alternatives to admission. So, several issues affect us in Cardiff and we are trying to work through them at the moment.

[47] **Jonathan Morgan:** That is helpful. Are there any further points on that, Janice?

[48] **Janice Gregory:** No.

[49] **Jonathan Morgan:** Dai Lloyd is next.

[50] **David Lloyd:** My question follows on from that. Previously, I was a junior hospital doctor in several south Wales hospitals. I spent half my time in accident and emergency units facing upwards of 40 people at any one time with various bits of their anatomy dropping off, and the other half as a junior medical or surgical houseman dealing with upwards of 20 patients at any time during the 24-hour on-call period expecting me to find them a bed—and this was back in the 1980s when that was the junior houseman's job. This is a Wales Audit Office report and, from an auditor's point of view, not the greatest stress in the world is placed on the demand side, to follow on from the last series of answers. All the questions need to be set in the context of the huge demand placed on the service at any given time. Having given that rolling preamble, my question relates to paragraphs 1.25 to 1.32. The true extent to which patients are delayed during the handover process is unclear, and handover times are not being consistently recorded because of problems with data terminals and human behaviour.

[51] If the auditor general were before me, I would have some questions to put to him on those statements, but he is not here and you are. We are back to data terminal systems again, and I know that you mentioned those briefly in answer to Bethan Jenkins. Given the huge numbers of the public presenting at any given time with all sorts of illness, we are now focusing on whether staff are fully trained to use the data terminal system, particularly to reset it if it malfunctions. What are the barriers to dealing with the data system?

[52] **Jonathan Morgan:** We will start with Meredith, or Jennie. Perhaps Jennie—

[53] **Ms Gardiner:** Jennie has first-hand experience of this, so I will let her answer this.

10.00 a.m.

[54] **Ms Palmer:** The problem stems from the design of the terminals and the design of the data collection. It was not really designed with users in mind—or the service, to some extent. It is not very user-friendly. The data that are collected on it are very crude, so there is no capacity within the system to document those patients who go into the resuscitation area, who need high-priority care, and for whom the ambulance handover screen is not a priority. The breach reasons on it do not necessarily reflect specific units. I appreciate that it is an all-Wales system—and my colleague from Wrexham may be able to back me up on this point—but the breach reasons are all-Wales reasons and not unit-specific, so they do not represent what is happening on the floor.

[55] In some respects, having live feedback is useful for data collection but, from a user's point of view, it is not very useful to have to put in data live because of the patients whom we are dealing with. On the training, we have recently employed an ambulance liaison officer, and he and I are doing some joint training with the ambulance service and staff. We have recently employed some new healthcare support workers, and it will be their role to do the data entry, so that we do not detract qualified staff away from assessing patients. So, we are looking at groups of staff and at how the system can help. In some respects, the data entry system is not user-friendly.

[56] **David Lloyd:** Okay. Does that cover the situation in Wrexham?

[57] **Ms Rees:** To a degree, yes. In the beginning, there was definitely poor compliance, with pressing the buttons on the screen. We had good support and training to start with, which took place jointly with ambulance and nursing staff. There was not a huge amount of discussion prior to putting the terminals in as to how they should look, from a service point of view. As Jennie said, we had what we were faced with. There are issues surrounding the breach reasons, but I know that the task and finish group is looking at them, and is looking to people like us to put forward reasonable reasons for a breach of the 15-minute period.

[58] It is better now, as staff are more comfortable with using the screens. There were technological issues at the beginning, for quite a number of months. There still are glitches, but it is getting better. One issue is the time that it takes staff to reset the screen if they need to. We have support cards under every screen to advise staff what to look for. So, if it is not doing this or that, it gives the answer and tells you how you reset it. We also have a training guide that explains how to reset the screen. As Jennie said, when the nurse's priority is the patients on the trolley, the screen is not such an important thing for them. That is why our manual system shows a different level of performance compared with the screen. That gives a truer reflection of the 15-minute handover, which is the important bit, namely caring for the patient within 15 minutes, not having the time to press the screen. So, we are getting over those glitches quite well now.

[59] **David Lloyd:** That was an excellent answer, thank you.

[60] **Lorraine Barrett:** The first part of my question about the use of the screens or the data terminals has been answered by the responses to the last few questions, but is there any confusion or inconsistency over which members of staff should be inputting the data?

[61] **Ms Rees:** I do not know whether Jennie agrees, but there was definitely some

confusion at the beginning. Once the decision had been made to put the screens in, we worked through the training with our Welsh Ambulance Services NHS Trust colleagues, working on how it would happen and on our implementation programmes, and we reached agreement that notification would be the responsibility of WAST, so the ambulance crews. The initial perception was that the handover was the responsibility of the hospital staff, but we came to an agreement that, because patients are handed over to the nursing staff who immediately start caring for them in almost every case, it was quite reasonable to ask the ambulance crew to input the completed handover onto the screen. In the beginning, there was a definite difference of opinion, as the ambulance crews were of the opinion that the handover was much more for the hospital staff, not them, to do. That is probably why our performance at pressing the screen was quite poor at the beginning, but it is much better now. The crew does not even think about it and does the handover automatically in many cases. I witness that daily. However, there is still the occasional crew member who says that it is not their responsibility, and we are working closely with our WAST colleagues to identify those crew members, who are taken to task if they are not doing what they should be doing.

[62] Things are much better now that the most appropriate person, clinically, does it. As Jennie said, the big weakness—if it is a weakness, as you could argue that it is a strength—is the resuscitation area, because the condition of patients brought to that area means that they will virtually automatically require a 15-minute handover. As soon as that patient arrives, care is provided, so definitely within 15 minutes. The ambulance crew, the nursing staff and the doctors who are there at that time are, rightly, focused on dealing with the urgent and critical care of that patient. The last thing on their minds is the ambulance handover screen. Even when the ambulance crew has finished handing over a patient, given the nature of the illness or condition and the circumstances in which someone has been brought to the resuscitation area, the ambulance crew can often walk away without inputting the data. That is unintentional, and they do so because they are moving on to their next job, and the focus is on the patient.

[63] Again, we are in discussions with WAST on how we can resolve that. When the allocation is made through its computer-aided despatch system, it could identify that the patient is going to resuscitation and so the handover will automatically be concluded within 15 minutes. There will never be a time when there is not a 15-minute handover time for a patient requiring resuscitation.

[64] **Lorraine Barrett:** We have all learned a lot about these data terminals and handovers. Finally I have a clear picture of this. Hypothetically, is it for the ambulance staff to say, ‘My responsibility ends here, so I am logging that that is the end of my hourly responsibility’, or is it for the nursing staff to say, ‘I am taking over responsibility for this patient’? I can see that there is a role for both, is there not? Is there a right or wrong way, for audit purposes?

[65] **Mr Falcus:** We have gone through this cultural change. When the arrival of the ambulance was seen as the absolute target, and that was what was monitored in performance measurement, the staff did not react terribly well to that, it is fair to say. When we explained that, although it was a target, the reason for it was to get ambulances on the road, to focus on patient care issues and so on, they understood. We have overcome that initial hurdle that this was about their performance being measured in some way.

[66] Over the last month or so, we have seen that this is now a part of how they work. It is a shared responsibility in the same way as ambulance crews and emergency department staff work jointly to help each other out. It is not a them-and-us situation; it is about providing joint care for the patient. Working jointly on this is the same as just asking someone to pass you a drip stand or whatever; it is the same type of approach. That is the point that we have moved to. The important point is that we are not talking to staff about the need to hit the 15-minute target but about the reasons why we need to hit it and be as slick as we can. Staff understand

that. We are beginning to consider how we measure that and whether it becomes an unconscious competence; it has just taken us some time to get there.

[67] **Lorraine Barrett:** When Jennie replies on this, could she give us an idea of how long it takes to input those data and how much detail is required? I am not sure that we know how much detail needs to be input.

10.10 a.m.

[68] **Ms Palmer:** It may be useful if we go through the three processes that happen on the ambulance screen. When a crew arrives at UHW, or any hospital in Wales, they automatically generate an 'arrive', which comes up on the ambulance screen as a job number and an 'arrive' at the hospital. When they book their patient into the emergency department, they then need to click onto the screen and put in their pin number to say that they have notified the hospital that they have arrived. It is from that notified time that the 15-minute clock starts ticking. The crew, in the Cardiff and Vale NHS Trust, will speak to an assessment nurse and be directed to an area that is most suited to the patient's clinical need. The handover occurs and the definition that we have jointly agreed, between the ambulance service and the trust, is that when the ambulance stretcher is empty, that is when handover, in its crudest sense, has occurred. From there, it is about making a member of staff available, whether that is ambulance service personnel or a member of the trust, who then clicks on the screen to say that handover has happened. It is from the notification, when the crew has booked the patient into the reception area, to the handover resulting in an empty ambulance stretcher that the 15 minutes comes from.

[69] **Ms Gardiner:** The final element is when the ambulance vehicle is ready to depart to pick up its next casualty. So, there are almost four stages to the way in which it is recorded. The actual inputting onto the screen is not that difficult; the issue is more around the data that the screen is displaying, in that there is just a figure that you then have to match up to a piece of paper that is attached to the patient. It is not a very easy thing and it is a bit fiddly. It is not as user-friendly as it could be.

[70] **Lesley Griffiths:** The auditor general's report states that, at times of extreme or particular pressure, ambulance liaison officers are employed—I think, Jennie, that you have referred to them. This enables the paramedics to hand the patients over to an officer, so that they can get back on the road, which is good, but does that mean that the patients are just hanging around the corridors waiting? How often are these officers employed at the hospital? Perhaps you could start, Jennie.

[71] **Ms Palmer:** At the moment, we have one officer—[*Inaudible*.]—we have to cover a range of times. At the moment, he has only been in post for two weeks.

[72] **Ms Gardiner:** It is a pilot scheme.

[73] **Ms Palmer:** Yes, it is a pilot scheme for four months. We are looking at where our peaks in demand are and where some of our compliance, from the ambulance service and the trust, is failing. We are trying to get him to look at those peak times. We do not see his role as one of taking over handover from existing crews. At the moment, pressures are not too bad and crews are able to offload straight into a clinical space. In times of pressure, it is about getting a balance between the liaison officer co-ordinating the ambulance crews as they come in and dealing with handover and taking ownership of patients. We have not been able to bottom out exactly where that line will be. As a trust, I think that we see the role of the liaison officer as being to co-ordinate the service, to keep on top of the service, and to escalate when necessary to the appropriate people, not necessarily of dealing with handover, taking ownership of patients and looking after them in a corridor.

[74] **Lesley Griffiths:** You say that you are doing a pilot scheme. Are you doing any other work alongside that to try to improve things or is this what you think will improve things?

[75] **Ms Palmer:** We are doing other work. We have new staff who are starting. We are doing lots of training. We have put in two new terminal stations that are more visible in the clinical areas. We are looking at how the flow of patients is working, so that is about looking at the system and trying to make it more user friendly, in a more appropriate area, to try to increase compliance as well.

[76] **Ms Gardiner:** It is also about the clinical effectiveness of the handover. We want to develop an agreed protocol with the Welsh Ambulance Services NHS Trust about the content of the handover. I do not think that the 15-minute handover is the main thing—we need a clinical peg to hang on that. If we can improve the clinical process and the nature of the handover, and if the nature of the information that is shared between teams is appropriate, then the 15-minute handover time and the need to press that button will come with it. For us, the ambulance liaison officer is about improving the quality of the handover as well as its timeliness. That is why we are piloting it, because it is as much a training role as anything else.

[77] **Lesley Griffiths:** Do you think that the employment of these officers presents any clinical risk to patients?

[78] **Ms Palmer:** No, I do not, because I do not see the ambulance liaison officer as a role with clinical accountability for the patients who are in the corridor. Currently, I think that it is more a matter of helping the process rather than being clinically responsible. In that respect, no, I do not think that they do.

[79] **Lesley Griffiths:** So, it is just to address the handover and turnaround times.

[80] **Ms Palmer:** Yes.

[81] **Ms Rees:** We have a different approach in Wrexham—[*Inaudible*.]—which were quite effective from a communication and relationship point of view. That stopped quite some time ago—I cannot remember exactly when. If we find ourselves under pressure, with a few ambulances outside, then the ambulance service will send an ambulance liaison officer to work with us to identify the problem and how quickly we can release those ambulances, and to see what we are doing to manage the process to address the cause of the blockage at that stage.

[82] The patients remain outside in the ambulances; we do not bring them in to a corridor. There are a couple of reasons for that. It is partly because we have been going through such a structural change that it would not be safe anyway, because the corridor can be a bit of a building site. Our view is that the clinical risks would be greater for them if we were to bring them in to a corridor; at least in the ambulance the crews have some pieces of kit, so that, should the patient suddenly deteriorate, the crew can react. If they bring their patients in to a corridor, we have no quick access, because all our spaces are full and all our equipment is in use. That is, therefore, not a process that we would follow.

[83] The ambulance liaison officer comes to us and he will work with the crews manning those ambulances outside. Occasionally, if it is safe to do so—and they will make the judgments—they might put two patients in one ambulance, depending on their condition and a number of other factors, and that would release one of the ambulances to go back on the road. Mostly, that officer will work with the crews to assess which are the most serious cases to be admitted next, because it is not always the one who has arrived first. You might have a

sicker patient in the most recent ambulance to arrive, and the crews' judgment might be that that one needs to come in next.

[84] We have ambulances not just from the Welsh Ambulance Services NHS Trust, but from England as well, as we are on the border. There are different targets, different relationships and different ways of working, but they are all equal for us. Regardless of whether the ambulance is from Wales or from the west midlands with a patient from Shropshire, patients are brought in according to clinical priority, and not because they are from a certain county.

[85] **Mr Falcus:** The other thing to add is that, before Christmas, we instituted a rapid escalation policy. We have urgent bleep systems, so if the accident and emergency department reaches a certain point, then it is down tools, from management to senior doctors, senior and lead nurses and so on, and everybody responds immediately to the situation. We look at what the issues are and what we can do to immediately unblock the downstream issues. Our point is that it is not necessarily about creating a bigger reservoir at the front door; it is about how we can safely get the patients who are already there through the system. That has worked pretty well. We have had very good responses from clinical staff and managerial staff across the trust.

[86] **Ms Rees:** As I touched on at the beginning, we acknowledge that there is a clinical risk to patients while they are out in the ambulances, but there is no formal monitoring of that, with reporting back between ambulance staff and the emergency department. It has been more an informal form of monitoring, to keep an eye on the patients while they are out there. We are going through a process now, having had quite a large meeting on the issue, of formalising that arrangement, looking at early warning scores, and looking at how we can apply specific monitoring for patients at different times, because the crew make certain observations when they pick a patient up, but those might not be taken again until the patient is in the department. If they are going to be out there for any great time, we identify the observations that we want the crews to take, so that they can feed that information to the lead nurse or the nurse in charge of the department. Then, there is a joint review of how sick that patient is compared with somebody who may already be in the department. We ask whether that means that we can bypass the emergency department altogether and move them straight through to a ward, by a reorganisation of patients who might be on our wards. So, we are doing quite a large piece of work on that.

10.20 a.m.

[87] Once we have done that monitoring, which should not take much longer, we will pilot that for a while with Ysbyty Glan Clwyd, because we are doing it jointly. If that is successful, the ambulance service is keen to roll it out across Wales; but we will see how it goes. We are confident that it will make it safer for the patients who we have to keep out there.

[88] **Lesley Griffiths:** You have both mentioned the doubling-up of patients in ambulances. I do not know if you can answer this question, but is that practice usual?

[89] **Ms Rees:** It is quite rare from my experience in Wrexham.

[90] **Ms Palmer:** With time and capacity issues, it can happen, so it probably happens in our trust more frequently than it does in Wrexham. We have difficulty at the moment with regard to the data collection from the handover screens. When we double-up patients and assess the clinical risk and patient need within that process, that information is not captured on the data system at the moment. We are doing some work with the all-Wales team to look at how we can capture those data.

[91] **Nick Ramsay:** Paragraphs 2.1 to 2.10 of the auditor general's report are on unscheduled care and the handovers at emergency departments. There was a feeling in some hospitals that meeting the four-hour and eight-hour targets was a higher priority than meeting the handover target. Why might this be the case? In other words, why is the target for handovers not seen to be as important in some hospitals?

[92] **Mr Falcus:** I would not accept that comment, from a Wrexham point of view. The four-hour target has been there for longer and the organisation is more aware of it. On the 15-minute target, we have tried to sell the message about patient flow that will deliver the 15-minute target. As I have said before, staff do not necessarily react well to a target of 15 minutes. They react to creating capacity in the patient flow, thereby delivering more rapid ambulance handover times. That is the message that we have given to staff. They may not report that it is being given a priority, but that is more to do with the way of selling it and wrapping it up. The staff in the hospital are clear about the fact that we need to improve our patient flow, and the four-hour target is very useful in demonstrating or monitoring the pressures within our system. The target of seeing 95 per cent of patients within four hours is a good and useful target. My only slight criticism of a 100 per cent target is that, if you miss it by one patient, you have missed it, whereas with the 95 per cent target you can have clinically appropriate breaches and you do not make inappropriate clinical decisions around the target.

[93] **Ms Gardiner:** I agree with that. At UHW, it is about eliminating corridor waits for patients, which we consider to be completely unacceptable. So, any target that helps as a lever for that is very important, and must be backed as well as we possibly can.

[94] **Nick Ramsay:** Do you think that there is a danger that staff might consider delays to be evidence that they can use to show that they are under-resourced?

[95] **Ms Gardiner:** Yes.

[96] **Mr Falcus:** What we have worked hard to do within our trust is to get a real sense that this is about the patient, and to look at it from the patient's perspective. The staff respond very well to that. Talking to them about targets is not necessarily the best way to get the staff there, but it is a useful management tool to measure that. I do not think that we have that level of gaming, but there is no doubt that staff could use delays in the system to highlight deficits in resource.

[97] **Ms Rees:** I do not think that, at the minute, our staff are purposely adding delays to patient care to enable them to demonstrate resource issues.

[98] **Nick Ramsay:** I was not suggesting that there is any increase in delays, I just wondered whether, because the delay existed, it might be easier—

[99] **Ms Rees:** It is an indicator of the pressure that we are under.

[100] **Mr Falcus:** That is how we use it. We use the handover target and, particularly, the four-hour target, and we have just run an exercise called the perfect fortnight across the whole trust and social services to try to improve and to engage staff in that perfect flow. One of the measures that we use to demonstrate improvement is the four-hour target because, if we get that right, the ambulance handover will not be an issue. So, if we get our patient flow, our delayed transfers of care and so on right, we will not have a problem with ambulance handover times.

[101] **Nick Ramsay:** I suppose that, in my last question, I am trying to return to Bethan Jenkins's earlier question about the culture that grows in the department. We are talking today about how we do not think that these handover delays are acceptable and that the best-case

scenario would be to eliminate them altogether—it might be impossible, but we would like to. Is there a danger that handover delays are becoming part of the culture?

[102] **Ms Gardiner:** There has been a long-standing culture in which there has been an acceptance that patients can wait. That needs to change. Part of the changes with the screens coming in is that people will see that they are being watched and that their performance is being noticed. Perhaps that has not always been the case in the past. There is a big move by all of us to change that culture and to focus on the patient and get them moving to where they need to be seen. In relation to that, that is where the target is a driver.

[103] **Huw Lewis:** I wanted to open up the questions beyond the mechanics of handover per se to look at where emergency admission sits in the whole hospital system. This has been much discussed and debated, but can you give me a snapshot of what problems your hospitals need to overcome and how the whole hospital operation is impacting upon emergency admission? Are we still talking about bed capacity as the primary problem? Are there other issues that are having an impact, such as getting a specialist assessment done promptly and are we still, for instance, looking at hospital discharge as having a major impact on what is coming in through the front door of the hospital? Are things changing? This has been flogged to death in discussion, but how is the situation evolving, and can you provide a snapshot of what is going on today at Wrexham Maelor and UHW?

[104] **Jonathan Morgan:** We will start with UHW.

[105] **Ms Gardiner:** We all know the issues that have been apparent in UHW for a number of years. A relatively new management team has come in to look at unscheduled care in the organisation as a whole. We have skilled staff and we have a lot of enthusiasm at ground level to make the change. With that, there is a lot of hope for the future. The biggest issue for us is getting that flow and getting past that point at which the patient waits or pauses in their flow through the process. There are issues around capacity in the Cardiff and Vale NHS Trust, which have been well-documented, but the key issue is flow—moving the patient forward through the department into the rest of the hospital and back out into the community.

10.30 a.m.

[106] For that, we need to look very carefully at seven-day-a-week working and making sure that we have health and social services that are responsive throughout that seven-day week. If I am honest, it is also about breaking down some of the professional boundaries and expectations about what can and cannot be done and who can do that particular task. That flexibility and the need to work more flexibly have to be pushed at all levels within health and social organisations.

[107] **Huw Lewis:** We have been saying this for years, have we not?

[108] **Ms Gardiner:** I know.

[109] **Huw Lewis:** So, are things changing? Are things better than where we were two or three years ago?

[110] **Ms Gardiner:** I think that there are signs for change. Certainly, there are some key people in key decision-making roles that have changed recently in the Cardiff and Vale NHS Trust at both a managerial and clinical level. If these people have the right support to manage that change, great things can be done.

[111] **Mr Falcus:** From Wrexham Maelor's point of view, I would agree with everything that Meredith has said. As to whether it has improved, the issue is that the situation is always

changing. As we take patients out of the acute system as drugs, diagnostics and so on improve, they are being replaced by an older and more complex group of patients. It is an evolving situation rather than just a fixed situation that we can solve.

[112] As I mentioned earlier, we have just run a two-week exercise in the trust, which again involved senior clinicians, nurses, doctors, therapists and senior management from all across the hospital, from diagnostics to surgical departments and so on to look at the patient flow issues. During that exercise, we had some light-bulb moments. We were asking 'Why are we doing this?', and saying 'We don't know; let's change it', and we had the authority and the empowerment to change those things. We came up with some of the really difficult things that we have to address, such as patient choice with regard to discharge, where I do not think that we have particularly good systems or coverage. It is a very difficult situation for us. Seven-day working is another issue and there are resource implications around that. The increase in elderly patients with mental illness is significant for us in the acute system, which was not there five or 10 years ago. There would not have been a system. This will be an iterative issue that we will have to continue to consider. The change or improvement that I would flag up is the willingness to adopt cross-agency working.

[113] **Huw Lewis:** There is a lot of resonance in the experience of both hospitals. They have things in common that just stay with us year after year as issues that need to be tackled. However, I will move on to a specific point as a follow-up question. The auditor general tells us that the performance reports that are e-mailed to managers every day are being largely ignored because they are distrusted, which is slightly disturbing. Is that the case, and are people right to distrust them?

[114] **Ms Palmer:** I think that they are distrusted, from my experience. Some of the data that have been reported are not accurate. From my own experience from a shift that I worked two weeks ago, there was a 26 per cent error, which I feel is unacceptable.

[115] **Huw Lewis:** It is as useful as a chocolate fireguard, is it not?

[116] **Ms Palmer:** In that respect, perhaps that is why there is an error. We have been working with the ambulance service with regard to that error—

[117] **Jonathan Morgan:** I am sorry to interrupt. I am very interested in what you say about the number of errors. What types of errors were encountered?

[118] **Ms Palmer:** My ambulance liaison officer colleague calls them 'ghost jobs'. On one shift that he worked there was a patient at the Royal Glamorgan Hospital who was shown on our screen as having arrived at UHW. I believe that the error is with the control room and the data that are being entered. There is a global positioning system, which should have shown that the ambulance was at the Royal Glamorgan rather than UHW, but those are the kinds of data that are being reported on a daily basis, and that is where some of the distrust is coming from. Some of the expected patients who are not included in the 15-minute handover target data are coming up as accident and emergency patients, and again, the notification of handover is not being recorded, and therefore they are giving us a false reading. There are some ghost jobs among the 26 per cent error that I found on my shift.

[119] **Ms Gardiner:** You might have more than one vehicle reporting to the same job, and only one patient involved in the incident, so only one could report completion. Also, if the ambulance has not clicked that it has arrived, we can click our button to say that we have handed over as often as we want, but it will still be recorded as a negative error on the report. There are a number of issues in the way that we validate that data, and we need to take that forward. It is something that we are currently working on with the ambulances.

[120] **Irene James:** When you talk about numbers of vehicles, are you talking about ambulances or paramedics' vehicles and ambulances?

[121] **Ms Gardiner:** Potentially, both.

[122] **Jonathan Morgan:** Huw, do you want to pursue this?

[123] **Huw Lewis:** Yes, this is worrying stuff. What occurs to me, among all this button-clicking, patient flows and professional boundaries and so on is that, as a non-professional looking in from the outside, throughout the patient experience of being picked up by the ambulance, taken to the point of care, assessed, and all the rest of it, there does not seem to be anyone in charge of that patient's experience. There are a series of stages to go through, and there are gatekeepers at each stage, and the patient is pushed from one to the next in an efficient, or perhaps not so efficient, way. The parallel that strikes me—and I know that this might sound silly—is with the television series *M*A*S*H*. I do not know whether you remember it, but it seems to me that every hospital needs someone like the character called Radar. Our patients do not ever seem to see a Radar—someone who is in charge of ensuring that the doctors, patients and staff have everything that they need to perform. Who is in charge of that?

[124] **Mr Falcus:** I do not accept that analysis. What we are concentrating on in Wrexham is the small percentage of patients that get delayed. As for the general flow and handover, that system, by and large, works well. Yes, we have capacity issues periodically, and we are putting in escalation procedures, and I have explained that they are working well now. So, as difficulties arise, we are addressing them, but I think that people are clear about who is responsible at each stage of the patient journey.

[125] **Huw Lewis:** So why do we still have problems with seven-day working not happening and the professional boundaries that were mentioned, with people not quite knowing who is responsible for what, and no-one taking responsibility in the end? That is still part of our system, and there is no-one battering through all of that on behalf of the patient.

[126] **Mr Falcus:** Seven-day working is a complex issue about resources and staff availability. On the issue of care co-ordination for the patient, we already have that in the hospital—there are people responsible for the patient at each stage.

[127] **Huw Lewis:** I could go on, Chair, but I am aware that time is against us.

[128] **Jonathan Morgan:** Thank you. Irene James has the final question—last, but by no means least.

[129] **Irene James:** The auditor general's report highlights examples of best practice in handing over patients, and I must say that, over the past few months, I have spent far more time in ambulances and accident and emergency departments with members of my family than I would have liked, and it varies from day to day. Do hospitals share best practice with other hospitals? Would a standard procedure help to reduce handover times, or do you think it is a local issue? I will push my luck and also ask whether you are revising the handover of patients in light of the auditor general's report.

10.40 a.m.

[130] **Mr Falcus:** There were a number of questions there. Yes, we try to share best practice. The emergency services collaborative, which is no longer operating, was a very good way of sharing practice. The process is perhaps more ad hoc now than it used to be. The emergency services collaborative was very good. Are we trying to improve ambulance handover? Yes we

are. Is that because of the report? I would say that we were trying to do it anyway. The emphasis that has been placed on it over the past few months has brought about a significant improvement in the way in which we are approaching this and in the feedback and joint working with the ambulance trust.

[131] In fairness, to pick up on the previous point, I think that the ambulance trust had a point that we perhaps were not feeding back the discrepancies and errors as well as we could have done. It is really only as we are starting to get into using the system in anger that we are starting to give the trust good feedback on some of the errors and problems we have with it. In fairness to it, it is responding to that. Our response would therefore be that, yes, we are trying to improve the situation—and with some signs of effect as well—but we probably can do more to try to share best practice. Perhaps something needs to be done to help facilitate our doing that.

[132] **Ms Gardiner:** I would agree with that. It is interesting that you have been talking about the perfect fortnight, which was an idea implemented in my previous trust, Bro Morgannwg. I was the project manager for that, so it is nice to hear it mentioned. The team that was there is now working in Cardiff and Vale NHS Trust, so there is an inherent sharing of good ideas and practice. However, I would echo what you have said in that there is value in having national programmes for sharing practice with colleagues across Wales. That was particularly useful.

[133] The audit office report is very useful in ensuring that we take forward some of this stuff, but for me and for Jennie, it is about the quality of patient care that we are giving to people at the front door, and this is something we are really striving for at the moment.

[134] **Ms Rees:** I would like to comment on the practical issues because we have identified over a period of time that the clinical handover—a pass from paramedic to nurse—is different according to who is doing it, and there are different standards and different ways in which it is done. As a hospital, we have been looking to improve our clinical handovers by the use of a system called SBAR—the SBAR communication method. It is a formal mechanism for handing over patients. The ‘S’ stands for ‘situation’; ‘B’ stands for ‘background’; ‘A’ stands for ‘assessment’; and ‘R’ for ‘recommendations’. We have carried out a brief pilot scheme with the ambulance trust to see how using the SBAR format to hand over all care to nurses would work, and it worked very well. The ambulance crews liked it; they liked the standardisation. It means that the type of communication is standard and equal so you always get the right information. We are trying to move this on now, looking at implementing it further and at their taking it forward through their clinical governance structures to do it on a wider basis. So, that improves the whole clinical handover—the information that is passed on—which is really important for patient safety.

[135] **Irene James:** That also gets the ambulance crew back out on the road more quickly to save the next life.

[136] **Ms Rees:** That is it. It means that they are not saying the wrong things, which people do not want or need to know; it is quite clear. For each type of handover—doctor to doctor, nurse to nurse, nurse to doctor and so on—we will add certain frames. There are specific things that will be covered; the same SBAR format will be used, but different information headings will be used within that. So, with regard to handovers from ambulance crews to nurses, we have sat down with them to ask what we need to know as a department and what they want and need to give us. Those will form the headings, and we hope that that will be successful and will improve the clinical handover.

[137] **Jonathan Morgan:** We have run over by about 15 minutes, so we will need to wind matters up there. The evidence received this morning has been extremely useful. Members

were obviously very interested in what you had to tell us. I thank all four of you for coming in; it has been a very useful session. We will provide a transcript of the session within a couple of days and we will send that to you.

[138] I apologise to our next set of witnesses for starting this session slightly late. As you have seen, we have our own issues with turnaround and handover times. The evidence that we took earlier was extremely useful and Members wished to probe the witnesses somewhat further. We now continue taking evidence for the committee inquiry into the ambulance service in Wales. I ask the witnesses to identify themselves for the record.

[139] **Mr Dean:** I am Simon Dean, director of operations from the Department for Health and Social Services.

[140] **Mr Williams:** I am Paul Williams, director general of the Department for Health and Social Services.

[141] **Mr Murray:** I am Alan Murray, chief executive of the Welsh Ambulance Services NHS Trust.

[142] **Mr Woodhead:** I am Tim Woodhead, director of finance for the Welsh Ambulance Services NHS Trust.

[143] **Mr Gibson:** I am Martin Gibson from the Wales Audit Office.

[144] **Jonathan Morgan:** It is nice to see you this morning. Good morning, auditor general.

[145] My first question is to Alan Murray. The auditor general's update report to this committee stated that there had been a downward trend in category A performance during 2008-09. Do the latest figures show an improvement in this area?

[146] **Mr Murray:** Yes, they do. We have consistently achieved the sixty-fifth percentile for our eight-minute response to life-threatening emergencies since March. We are on an improving trend in terms of headline performance and equity measured by the number of local health board areas in which we are compliant with the sixtieth percentile standard.

[147] **Jonathan Morgan:** During evidence to this committee on 4 June, Professor Woollard of the British Paramedic Association told the committee that the use of rapid response vehicles to attend category A calls had enabled the trust to meet its target. However, he stated his opinion that, following the initial response, the sometimes lengthy wait for an ambulance to transport patients to hospital can result in clinical risks to patients, psychological risks to paramedics driving RRVs and an increase in the resource allocated to the call. What is your response to that view?

[148] **Mr Murray:** On the first part about delays and ambulance follow-up, Professor Woollard is correct to say that delays in the response of an ambulance where the patient needs to be taken to hospital quickly will be detrimental to that patient. We have been working on that area, and our performance in getting ambulances to patients as measured by our ninety-fifth percentile standard for responses to category A incidents within 14, 18, 21 minutes is also on an improving trend, and at the moment it is sitting at 92 per cent. There were two other parts to the question, I believe, Chair.

10.50 a.m.

[149] **Jonathan Morgan:** The first part was about the use of rapid response vehicles, but he also said that there was sometimes a lengthy wait for an ambulance to arrive after the RRV

had got there.

[150] **Mr Murray:** That is the part that I responded to.

[151] **Jonathan Morgan:** He said that, as a result, there was a risk to patients and also a psychological risk to the paramedics.

[152] **Mr Murray:** I agree with both of those statements. That is why, as I say, we are putting equal emphasis on getting follow-up ambulances to the scene within the 14, 18 and 21-minute standards that apply to urban, rural and sparsely populated areas respectively.

[153] **David Lloyd:** I will turn to the consideration of the financial implications of handover times in the Wales Audit Office report, which is mentioned in paragraphs 1.8 to 1.17. My first question is to Paul Williams. The estimated cost to the Welsh Ambulance Services NHS Trust of time lost during lengthy handover times in 2008 was £2.4 million. What plans, as a consequence—or perhaps anyway—do you have to manage capacity in a more effective way, in order to make more effective use of that resource? Perhaps capacity is managed as effectively as it can be now, in which case, what else can be done to address handover times?

[154] **Mr Williams:** There is a whole raft of issues for us with regard to turnaround times, because, as you pointed out, significant resources will be tied up and opportunity costs lost. One thing that I did when I took over this job was to place greater emphasis on improving both the turnaround and handover times. We have made some progress; we have decreased the hours lost from around 4,600 to 2,500, so we have made gains there. That needs to go back into the efficiency savings, because we are still testing the ability of the ambulance service to release more savings, in order to close the gap in respect of its budgetary responsibilities. There is still a way to go. I am encouraged by the task group that I have set up, which has been working on some of the technical issues in relation to the handover screens, and you might want to go into that in a bit more detail. We had to go back to first principles to build on how we address the issue of what is the most effective way in which we provide patient care. At the end of the day, it is about patient care and getting the patient into the hands of clinicians in hospitals as swiftly as possible.

[155] **David Lloyd:** Excellent. On the same issue of handover times, I turn to Alan Murray. At a previous meeting of the Audit Committee, we heard evidence from the Royal College of Nursing that when overstretched hospitals have accident and emergency departments that are at or near capacity, sometimes a neighbouring hospital might be better placed to accept emergency patients—although I do have to say that, from my experience, quite often there is precious little capacity along the M4 corridor in any of the accident and energy departments, and there are also issues with beds. That is as may be. The question here as regards managing handover times better is whether there is scope within the Welsh Ambulance Services NHS Trust for better capacity management in relation to which accident and emergency departments your ambulances take people. Is there scope for being versatile in redirecting ambulances to where there is spare capacity, rare as that situation may be?

[156] **Mr Murray:** Your experience was certainly the case a year and a half to two years ago, when hospitals were generally reaching capacity at the same time in different parts of the M4 corridor. However, the work that has been done since then has resulted in capacity being used much more effectively. The best that I can say is that the idea that you and the RCN have put forward is worth exploring. I could not put it any more firmly than that at the moment, because there is some finding out to do as to whether that capacity is different in one part of the M4 corridor, or indeed in one part of the A55 corridor, than it is in another at any given time.

[157] Services have been set up in other parts of the UK. Surrey, for example, set up a

capacity management system that managed the capacity of hospital beds, accident and emergency departments and alternative beds reasonably successfully. However, Surrey is a much more densely populated area than Wales. So, I could not say any more than that it is an idea that is worth exploring.

[158] **Irene James:** Following on from the points raised by Dai Lloyd about paragraphs 1.8 to 1.17, I want to discuss staffing levels. My question is for Alan Murray. Staffing levels in the south east in particular have been a problem. On 16 March, you told this committee that using non-recurrent funding, you were able to fill posts that had previously been left vacant. Are staffing levels now as they should be in the south east?

[159] **Mr Murray:** They have certainly improved. An emergency medical technician group of 12 people and a slightly larger paramedic group graduated recently. I should emphasise that having new paramedics does not put more feet on the ground. Existing emergency medical technicians are trained to be paramedics, but while they are in training, their capacity is lost, so bringing them back into the service brings that capacity back online. We are planning, this year, to train 28 paramedics, 60 emergency medical technicians, and around 50 new high-dependency staff. There will be another technician course coming on-stream at the end of September.

[160] **Mr Woodhead:** The 12 technicians who have just been mentioned will be operational next week, so very shortly. Another 24 will be operational at the beginning of September. They are already in training.

[161] **Mr Murray:** The answer is that we are continuing to work on creating that capacity. It takes time and we are training an unusually high number of people at the moment, both on EMT and paramedic courses. They are currently going to schedule, and we are replacing staff as quickly as we can.

[162] **Irene James:** Have the funds necessary to maintain that staffing level been accessed?

[163] **Mr Murray:** We have accessed funding to recruit and train the staff, yes.

[164] **Irene James:** Following on from that, at the same meeting on 16 March, you mentioned that the rota in Cardiff needed significant reworking to better match supply and demand. What progress have you made on agreeing a revised rota with Cardiff?

[165] **Mr Murray:** We had a rota review workshop in November before we met at the March hearing. Another review was due to take place in March, but, at around that time, we agreed jointly with Health Commission Wales to commission an efficiency review, which will have a bearing on the rota numbers in all rotas throughout Wales. So, we agreed that it probably would not be prudent to have two reviews following so swiftly on the heels of each other. We are awaiting the outcome of the efficiency review before we make a final decision on the rotas.

[166] **Jonathan Morgan:** I have a quick follow-up question to that, as it is an important point. When will the review that is taking place be completed? That evidence that we took from you was three months ago. The issue of rota reworking was clearly causing concern, so at what point will that review conclude, and when can we expect to see some improvement?

[167] **Mr Murray:** We are expecting to see the conclusions of that review at the end of this month.

[168] **Janice Gregory:** Good morning to you all. I want to move on to the business cases and strategic plans, mentioned in paragraphs 1.19 to 1.30. My question is for both Alan and Paul.

We heard about the business case for the replacement of vehicles back in March, and we heard that it was presented to the Welsh Assembly Government in February 2008. Given that there are potential savings of £400,000 to be made on leasing costs alone, was that business case made a priority between you and the Welsh Assembly Government, and has it now been agreed?

11.00 a.m.

[169] **Mr Williams:** It has not been agreed yet. The trust submitted its revised fleet strategy on 28 April. We reviewed that with the Welsh Assembly Government. We fed our comments back and the strategy was submitted on 25 May for further consideration. We sent those comments back on 15 June and are now awaiting the final comments. One difficulty for the Welsh Assembly Government is that we do not see the overarching strategic direction for the organisation. It is difficult for the trust to complete everything that is required, but I believe that we will make significant progress, as I am anxious to put the case before the Minister as soon as possible.

[170] **Mr Murray:** We have submitted that overarching strategic direction and are waiting for comments on that.

[171] **Janice Gregory:** Alan, do you think that you have had an appropriate level of support from the Welsh Assembly Government to produce a strategic plan? Have you been given an appropriate level of support through all this?

[172] **Mr Murray:** Absolutely. We have been working closely with Simon Dean on this, and Elwyn Price-Morris from the north Wales regional office has also been helpful by undertaking initial reviews of that plan. We have had to make some revisions to it to accommodate some new strategic content, such as the draft rural health strategy and Dr Chris Jones's vision for primary and community care, both of which have a strong bearing on what we do. However, we have been given strong support by the Welsh Assembly Government.

[173] **Mr Williams:** To add my observations, I think that the Welsh Assembly Government previously took a more distant view because, with the more traditional commissioner/provider role, it was very much left to commissioners and providers to determine strategy. We have now removed that and have become more involved. We need to consider the whole interaction. Alan Murray is right: we now need to think about how this will fit into the rural health plan and the primary community plan. So, this is a new way of working. I am clear that I will not be holding up business plans, because we are anxious to get maximum improvements to patients as quickly as we can.

[174] **Janice Gregory:** I hear that you are working together, but, on the strategic plan, the auditor general makes a comment in paragraph 1.39 about the funding uncertainties for the ambulance service. How realistic is it for it to present quite defined strategic plans given such funding uncertainties?

[175] **Mr Murray:** Is that a question for me?

[176] **Janice Gregory:** For both of you, as I am sure that you could both comment on that.

[177] **Mr Williams:** It is not an issue of uncertainties; funding is always challenging. We have a high degree of certainty about the capital programme and, over the next couple of years, we know that that will probably reduce, but that is when we will need to look at priorities and at the most effective use of those resources. On the relationship between Health Commission Wales, as the commissioner, and the ambulance trust, there is certainty about that funding. However, I think that the issue is—and we have explored this before—the level

of efficiency savings that will still be necessary, and, if there is still a funding gap following the efficiencies that are reasonably expected to be made, how that gap will be funded. Nonetheless, there is a high degree of certainty about the resources available at the moment.

[178] **Mr Murray:** That is what the efficiency review aims to establish.

[179] **Janice Gregory:** So, it is not unreasonable to think that you could produce quite robust strategic plans, given the level of certainty about the funding.

[180] **Mr Murray:** Following the actions that we have taken on training, including the efficiency review, we will soon have a much clearer picture of where we stand, financially.

[181] **Huw Lewis:** I want to continue looking at the financial aspects of your work. The auditor general's update document to us, which I think was dated March, rather euphemistically refers to a lack of a shared view on the financial future of the ambulance services trust and Health Commission Wales. I suppose that that is another way of saying that, at that time, there was a stalemate or a lack of agreement on the financial future of the trust. Where are we now on that? I suppose that that is a question for Alan, although I am sure that Paul will have comments to make as well. Does the trust now have financial clarity, at least for 2009-10? Do you know where you are going? Are you content that the funding is sufficient?

[182] **Mr Murray:** The relationship between HCW and us is not adversarial. We have agreed to commission the efficiency review jointly and to be bound by its recommendations. I guess that that is our way of resolving the issue: getting an independent expert view on what efficiencies we can achieve and what level of resources we require. We now have to wait for the outcome of the efficiency review to give us clarity on where we are financially.

[183] **Huw Lewis:** So, we do not yet know where we are.

[184] **Mr Murray:** No, but we are close to knowing where we are. By the end of this month, we should know.

[185] **Mr Williams:** The important point is that, in the meantime, we have been pressing for improved efficiency in the figures that we are seeing, and have hit the 65 per cent target two months in a row. There are a number of strands here. There is an awful lot of operational efficiency that we can pursue while the strategic issues are being looked at. I am delighted that HCW and the Welsh ambulance trust agreed to this independent review, as it demonstrates that theirs is not an adversarial relationship. We are agnostic at the moment on what the review will tell us. We will also have a view on that, and we might need to revisit matters following its results. However, we are anxious for things to move along so that we can bring a further dimension of strategic vision to this and press hard on the day-to-day operational efficiencies.

[186] **Huw Lewis:** Okay, so we have non-adversarial agnostics. This is all getting rather colourful, as metaphors go. [*Laughter.*] My next question is primarily for Alan, as I just want to explore the impact of reorganisation a little further. What do you think will hit the service post reorganisation? In the meantime, in the run-up to it, are you content that you will have an effective service and effective financial planning?

[187] **Mr Murray:** I am very pleased that you asked that question because we believe that the reorganisation will be wholly positive for the Welsh Ambulance Services NHS Trust. The reorganisation makes eminent sense to us. For us, the most important thing is that it gives us a smaller number of partners with whom we have to engage to deliver our broader unscheduled care agenda. We have already hit the ground running with that relationship because we have

contributed to, and substantially influenced, the local delivery plans of all seven organisations already. I am currently in a round of meetings with the new chief executives. I have been in contact with two of them so far, and, obviously, given that at least one has not come into Wales yet, that will take a little longer. I am meeting a couple more next month to discuss issues of joint concern, such as creating new care pathways other than admission to accident and emergency departments. I am very interested in the work that Chris Jones has been doing on primary and community care, particularly communications hubs and the importance of having 999, NHS Direct, out-of-hours services, social care—if we can influence in that direction—community nursing and mental health services all together, from a single communication point of view. With 22 local health boards and, I think, nine trusts, that would have been a logistical nightmare for us. Having just seven health communities with which to engage is a huge step forward.

11.10 a.m.

[188] **Huw Lewis:** You do not see that the journey from here to there might throw up glitches in forward planning? It is quite a change.

[189] **Mr Murray:** Yes, it is quite a change. We are in the process of reviewing our own management structures, to strengthen, among other things, our strategic planning capacity. In thinking about our strategic planning capacity, we have been looking at how we deal with local delivery plans. We are strongly of the view that it is much more important that we contribute to the seven community plans than we have some separate annex plan of our own. Our business plans, thereafter, should be operational plans that are aimed at delivering our components of the health community LDPs.

[190] **Mr Williams:** This was mentioned during an earlier session. I was absolutely clear with regard to the reorganisation that we would maintain and improve performance and service continuity. When I set the seven transition directors in place in December, one of their key tasks was to start working immediately on unscheduled care and not to leave it until the new organisations come into being in October. We are already seeing some of the fruits of that partnership working and thinking about how the whole system can operate in such a way as to relieve the tendency to use hospitals as the default position.

[191] **Mr Murray:** They are practical plans, Chair.

[192] **Nick Ramsay:** My question follows on from Huw Lewis's question on finance and the short-term efficiency savings. It is a question specifically to Paul Williams, but Alan Murray might want to comment as well.

[193] You have required the ambulance service to make the £17 million savings in 2008-09, and you want this to happen without affecting front-line services. When you account for all the other costs that have built up for the trust, such as the increase in fuel costs, the additional lease costs from the delay in the purchase of new ambulances, the lack of funding for the £0.23 million pay award, and the reduction in the funding for the air ambulance, while we all like to see efficiency wherever possible, do you not think that that saving was unrealistic?

[194] **Mr Williams:** That was the position taken by the commissioner on this service efficiency plan. I have to step back to see whether that is deliverable, because management is the art of the possible, and impossible targets are unhelpful. As I said earlier, we still have a number of areas in which we think significant savings are to be made. We talked about turnaround times, and we are starting to see the benefits there, and not just in terms of direct improvements to patient care and cash savings for the Welsh ambulance trust.

[195] We talked earlier about sickness absences, and there is still some way to go on that

issue. We have talked previously about reductions in overtime—although still significant—and that comes back to some degree to the issue of rotas. There is work to be done there, for instance. We have also talked about how to improve triaging and how to bring ambulances to the scene of a call in the most appropriate way. The question is posed as to how far those assumptions are still capable of delivering, and I think that there is still a way to go. What this efficiency review is designed to do is to give an independent view of whether those assumptions were valid. Clearly, I want to see that report as quickly as possible, to test the original assumptions made by HCW. If the assumptions were too radical, there will be a resource issue that will probably end up on my desk in terms of other priorities.

[196] Simon has been dealing with this for a lot longer than I have, and he might be able to add something.

[197] **Mr Dean:** Paul has touched on the main areas on which we are working, with the commissioners and the trust. It is about ensuring that we get operational efficiencies, which all parties would acknowledge are there to be achieved. It is a complex jigsaw because things clearly link with one another. On the rota review and getting the deployment plans right to make sure that we are looking at the right balance between service provided through overtime and other forms of additional working compared with substantive staff, we heard earlier from the trust about the numbers of additional paramedic and technician staff who will come into the system imminently. So, good progress is being made but there is further to go. It is a process that we are continually testing in terms of the commissioner and the provider. As Paul said, we keep a close and careful eye on the position. It is primarily for the trust and Health Commission Wales to resolve the issue, but we are keen to ensure that there is a satisfactory outcome.

[198] **Nick Ramsay:** To come back to the core of my original question, from your answers it sounds as though you have left the door open on those savings being unrealistic.

[199] **Mr Williams:** When this work is done, if there happens to be a resource gap, we must acknowledge it, but there will then be issues about how that is prioritised against other priorities. This is not an exact science—this is the type of work that we are doing in every part of healthcare as to how we can make that money work as hard as possible for us, but we have to do it through people. We must be continually chasing the very best practice, and the debate is how quickly, through using people, we can achieve best performance and best value for money.

[200] **David Lloyd:** On your point about triage, Paul, coming from the patient-demand side of the equation, and the somewhat inappropriate use occasionally of the ambulance service, what procedures are you looking at to address—and opinions vary about this—inappropriate calls on the ambulance services, whether it is in an emergency situation or a non-emergency situation? What are you doing in the wider scheme of things to address that type of thing, so that you can address some of the efficiency savings in that way?

[201] **Mr Murray:** To put that into a context, which you would understand from your professional background, Dai, we are not talking about vexatious issues of the service, which I have mentioned in previous hearings. We are talking about people who are dialling 999 because they do not know what they need and where to get it; they dial 999 to find out. When we started this process, one of our major problems, in terms of delivering patient services and staff morale, was that we were throwing eight-minute response targets at far too many emergencies—over 50 per cent of emergencies during some periods. Last month, because of improvements that we have made in our categorisation process—I will not call it the triage process, which I will come back to in a second—we reduced the figure regarding A categorisations in our 999 caseload to 32 per cent from 52 per cent. That is towards the bottom end of the mainstream for the UK.

[202] We have also put senior and experienced NHS Direct nurses into our control centres. When a call is categorised as category C, which is neither life-threatening nor serious, the caller is passed on—with some exceptions, such as being in a public place—to the nurse. The nurse then has a consultation with the caller. In a 10-month survey, only a third of those callers were passed back to a 999 ambulance—the other two-thirds were managed into other pathways. The numbers are relatively small, because we are doing this at the moment based on what we can afford to fund, and we cannot put the nurses on all of the time. However, we are doing pretty well on that, and the numbers are going up.

[203] We are taking some action at the point of the receipt of the call to triage people into other care pathways that are more appropriate to their needs. We have two major plans at the moment, one of which is to move to a system called NHS pathways, away from advanced medical priority despatch, the rather basic and probably entirely ambulance-orientated categorisation process that we currently use.

11.20 a.m.

[204] NHS pathways is a proper triage system that allows lay call-takers to do a certain amount of clinical triage. It will work for NHS Direct, out-of-hours and 999 ambulance services. At the moment, in Vantage Point House in Cwmbran, those three services are under the same roof, so it will help us to connect them together. We are currently running a pilot scheme with the Gwent out-of-hours service, looking at how we can deploy the out-of-hours GPs and the out-of-hours service into our front-end triage process.

[205] The second opportunity is face to face with the patient. We now have a workforce plan that has received a pretty positive response from the National Leadership and Innovation Agency for Healthcare. That workforce plan, among other things, envisages the development of 33 specialist practitioners each year for the next five years. We will put specialist practitioners into four localities, in the first instance: Cardiff, Newport, Powys and Monmouthshire. Those people will not be extra feet, they will be ‘Agenda for Change’ band-5 paramedics who are being developed to become band-6 specialist practitioners. We are currently finalising our views about the initial extension of their scope of practice. We focused continuing professional development for our paramedics on home resolution, among other things, with a particular focus on, as I think I said at the last hearing, hypoglycaemia and epileptic convulsions. These extended-scope practitioners will be able to deal with a much wider range of individuals and will be able to consult with their GP and get a much more sanguine view of the balance of risks. Those are some of the developments that the trust is pursuing at the moment.

[206] **Lorraine Barrett:** This question is for Paul Williams. The auditor general’s report highlights the realisation of longer-term efficiencies that need to focus on developing more efficient patient pathways and improving the efficiency and effectiveness of patient handovers at emergency units. As well as focusing on short-term efficiencies, should the Welsh Assembly Government focus more strongly on modernisation of the unscheduled care system? Is the Welsh Assembly Government putting sufficient pressure on those hospitals that are failing to achieve reasonable handover times in order to secure long-term, sustainable efficiency gains?

[207] **Mr Williams:** I have made this a priority since I took over. As I said, I started work on this through the transitional directors and we are now starting to see some benefits coming through. The task group on turnaround times has met regularly over the past few months and is now starting to demonstrate high conformance, which we are hoping to get up to 100 per cent by July. We are in communication with the chief executives on a monthly basis to remind them of the importance of this and to point out where they are not making significant

progress. We have reviewed the plans in relation to unscheduled care across each of those communities, and we are now starting to see the whole system improving. Some areas where performance was not particularly good—I am thinking of Cardiff—have started to come through strongly. For the first time, I am seeing plans coming through that not only identify the need for investment in hospitals, but are thinking fundamentally about the whole unscheduled care package and how that feeds into general practice and community care. By making this a priority and ensuring that I am engaging on a monthly basis to see where we are seeing continuous improvement and where we are not, which we revisit—Simon Dean is going out and talking to colleagues—there is no doubt in my mind that we are serious that this particular part of our responsibility must be discharged in a way that leads to good patient experiences throughout Wales.

[208] There is still a long way to go, and there is uncertainty, because you cannot always legislate for peaks and troughs in demand. Nevertheless, we have a much more professional approach, and much more of a partnership approach than we have had before. It will be of no surprise to you that we are getting into areas of behaviour. This whole business about the screens, for instance, is a classic exercise in not thinking about human behaviour and just thinking about implementing technology. I have always felt that technology is fine, but you need to look at how humans will react to technology being foisted on them. We have to go back to basics here and say, 'Let's start all over again', and 'How will we build this up?'. We are relentless now in looking at all of these issues and making sure that they are all dealt with effectively so that we have a much more effective outcome than we have had in the past.

[209] **Lorraine Barrett:** This question is directed at Alan. I remember previously discussing the number of managers who have accessed various development training modules. During the committee meeting in March, you said that you did not know how many of them had accessed the various training modules because the recording systems were not up to date. Could you give us an update on that now?

[210] **Mr Murray:** It is much clearer now. I can provide the committee with a full update, but perhaps I could just give a highlight. Over 70 per cent of managers have now accessed the personal development review module and the absence management module. The PDR module is extremely important because it gives us the infrastructure that we previously lacked for delivering personal development reviews and plans to our staff. It has not been without difficulty because managers have been very busy over the last few months on issues of performance, as have the staff, but we are now making progress and we are measuring that progress.

[211] **Lorraine Barrett:** This question is to both Paul and Alan. We heard from Professor Woollard that in other emergency services, staff are required to take examinations in order to achieve promotion. Would making training a prerequisite for management positions go some way to ensuring that ongoing training is at least prioritised by staff?

[212] **Mr Murray:** I agree with that. This is a historical issue; it has not historically been the case in ambulance services. We are now working with the National Leadership and Innovation Agency for Healthcare and I commend the support that we have been given by NLIAH through this process to design and develop a supervisory level management training programme for people like our locality managers and our control managers. That is, really, the start of that process.

[213] **Mr Williams:** Managers have to be as professional as other professionals, which means that they should be fit and competent for practice. This is where we have been using NLIAH, as Alan said, to develop a much more professional approach within management to ensure that they are recognised by their peers and particularly by clinical staff as having an effective leadership role, rather than be discredited because they are not actually practising

management at the highest levels. It is a fundamental point and I am glad that you raised it. Thank you.

[214] **Jonathan Morgan:** Before we move on, in relation to training, I would like to refer to the evidence that was given to the committee by Professor Woollard. He referred to a pilot scheme that was funded by the Assembly Government some six or seven years ago. It was an advanced paramedic practitioner pilot scheme. He referred to that pilot and said that, with regard to the outcome, the advanced paramedics were able to reduce the number of patients who were having to attend accident and emergency departments because they were able to be diverted to a more appropriate part of the NHS that they could make use of, and that there were category A, B and C calls. Effectively, the triage system that those advance paramedics were able to put in place changed the care pathway for 63 per cent of the patients that they encountered. I know that you have already mentioned the specialist paramedic system, but that sounds different to the pilot scheme for advanced paramedics.

11.30 a.m.

[215] I wonder, from the perspective of the Assembly Government—and I do not know if you have the information, Paul—what did the pilot scheme cost, what was the outcome, how was that reviewed, and why was it never implemented? If you do not have the data now, a written note might be useful, because that evidence was interesting, and in effect was drawing comparisons with other parts of the UK where, perhaps, this has been rolled out more productively and proactively. I accept that specialist paramedics are different, but this was something that caught our eye, as you might appreciate.

[216] **Mr Murray:** The specialist paramedics are not entirely different from the advanced paramedic practitioners. The APPs went to band 7 on the current 'Agenda for Change' scale, and the specialist practitioners will be band 6, but that does not rule out the potential development of people at higher bands. We have to roll this out carefully, and we cannot just create an annex to the unscheduled care system. This has to be something on which we work with our partners. When I was at Mersey Regional Ambulance Service NHS Trust, which covered Merseyside and Cheshire, we had a fairly high number of emergency care practitioners, and they were at the time—and this is no longer the case—given an off-the-shelf training package, which did not really fit the need, either from the perspective of the individuals or the primary care trust, the GPs, or the other clinical staff that they were working with. We are now creating a new cadre of specialist practitioners. We are not calling them specialist paramedics because, although I know that some of our early literature refers to them in that way, we have nurses working for us as well, and they can contribute to the development of this workforce. They are being developed on the basis of the College of Paramedics development programme, and Professor Woollard has been involved in that, so we are following national practice. One of my senior clinical colleagues, Tim Jones, put it to me—and he is one of the original advanced paramedic practitioners—that the biggest mistake we could make would be to consider these people to be a finished product. We build a core of knowledge and skills, and then we look at what is needed locally, and we add to those knowledge and skills, and that will determine where we go.

[217] **Jonathan Morgan:** Before I move on to Bethan's question, it might be useful to have a note on how the pilot scheme operated, what you discovered from it, and what was learned. The data that we were provided with were quite interesting.

[218] **Bethan Jenkins:** I want to look at morale and the culture of the trust. I will direct my questions at Alan Murray. The data collection systems changed in February 2009 to report against five key indicators: bullying, harassment, grievances, and performance appraisal and development plans. This was due to be presented to the management board, I believe, in March 2009. Do those performance indicators show an improvement in those areas?

[219] **Mr Murray:** I have said previously that I am always cautious about chief executives pronouncing on the morale of their workforce, but I am encouraged that Dave Galligan from Unison said in evidence to the committee that he felt that morale and relationships with managers had improved. If I can look at those five areas and deal first with appraisals and personal development plans. Over 20 per cent of our staff have now had appraisals, and I believe that it was about 1 per cent when we last spoke. We have a programme for getting 100 per cent of our staff through personal development reviews with personal development plans by the end of the financial year. There are a number of factors that are giving impetus to that, but also a number that are slowing it down, and we need to acknowledge that. Pursuit of performance clearly has implications for our ability to release staff and give them protected time, and that also applies to managers, so it is something that we have had to keep a careful eye on. We are also releasing a larger number of people than we normally would for paramedic training, and some of our technicians also come from within our workforce, from our patient care and high dependency services. Those people are on release, with protected time, to upgrade their qualifications, which means that they cannot have personal development reviews, and they will not have personal development plans until later in the year when they have finished that training.

[220] As I have said already, more than 70 per cent of our managers now have personal development review training. We now require people applying for development posts, such as the specialist practitioner posts, to bring their personal development plans with them. That has started to produce a culture change from, 'When are you giving me my personal development review?' to 'Can I now please have my personal development review?'. I understand that more than 1,000 people have now accessed the e-KSF system, and we are receiving 20 requests for access a day from people who do not currently have access. We now have a number of people actively seeking personal development reviews.

[221] We have some information on bullying. We have a range of measures already under way and under development, with the support of the NHS Centre for Equality and Human Rights, which, as you know, has been involved with us in this process from the start. We established an equality and human rights steering group earlier this year, which has now had two meetings. We have put out some information to staff about the development of a staff charter, which will make it clear what the relationship between staff and managers should be and what staff's rights and responsibilities are. We have asked staff whether they wish to be involved in the development of that. We have had hundreds of responses from staff who wish to be engaged in the process, and we are now coping with success I suppose, working out with the equality and human rights steering group how we use that staff interest and engagement to develop the charter in a way that will be helpful.

[222] On grievances, there were 49 outstanding grievances from 2007 to March 2009. We have now fully resolved 23 of those. Several of the remaining grievances relate to 'Agenda for Change' issues, so we are using our formal staff consultation mechanisms to deal with those in a much more corporate way. We are bringing together individual grievances that have common factors and dealing with them as collective grievances. We have also received a total of six collective grievances. We have resolved three of those, and they were on fairly meaty and difficult issues, such as meal breaks, the knowledge and skills framework and the way in which we deal with annual leave. We have dealt with the annual leave process, among other things, through the development of a jointly agreed process for our resource centres for the filling of shifts, the issuing of leave and so on. So, we are making measurable and fairly significant progress on grievances. Those were the major issues.

[223] **Mr Williams:** As far as the Assembly Government is concerned, apart from the support that we provide through the NHS Centre for Equality and Human Rights and NLIAH, we are actively engaging with the trust to carry out another staff survey this year, so that will

provide some more objective evidence behind all the actions.

[224] **Mr Murray:** That will be done during September and October this year. I understand that we will be the only NHS organisation undertaking a staff survey this year.

[225] **Bethan Jenkins:** I note the progress there, and I would like to see more information on the charter and the role of the NHS Centre for Equality and Human Rights. This seems to be quite a novel way of working. In light of the new research published this week by the Equality and Human Rights Commission about service delivery enshrined in the human rights agenda, I think that that is really important. However, regardless of that progress, to put a negative spin on this for a moment, Professor Woollard said that research that he had seen indicated that staff in the ambulance service still had a lot of mental health issues.

11.40 a.m.

[226] We had evidence that many people had said that they had posted their surveys from a different area because they did not want to be identified. What do you think of these noble schemes that have been brought in to address the fact that there are still a lot of problems out there among staff who obviously feel quite isolated on occasion?

[227] **Mr Murray:** Let me put that into context. I was chief ambulance officer in Belfast in 1987, when the Troubles were at their height. On taking over, I knew that there was absolutely no staff support available. We set up a confidential staff support service using a talented team of individuals who worked for another healthcare trust in Belfast. When I came to Wales, I discovered that a similar service was already in existence through NOS, and it is a very well-used service. I may be wrong but I believe that those services are of fairly recent provenance. I would doubt that there was staff support of that kind when Professor Woollard did his study. I will stand corrected if I am proven wrong on that, and I will certainly discuss it with Malcolm Woollard, but I believe that those services have been introduced since Malcolm's study was done.

[228] On isolation, we have staff working on rapid response vehicles, but when they get to the scene, they are followed up—and we discussed the fact that there are sometimes delays in the follow-up—by an ambulance crew. They generally work as a team of three. It is difficult to work on a cardiac arrest, for example, if there are only two people; it is easier if there are three people. We do not keep people on standby points for extended periods; we bring them back to their stations periodically, where they associate with other staff. The ambulance crews are in and out of accident and emergency departments—that is less true of rapid response paramedics—where they interact with their colleagues from the green-suit side of the service and with their nursing colleagues. So, I would not paint too bleak a picture of the isolation of the job. I have done the job myself—it may be quite a long time ago now, but I still remember quite vividly the camaraderie that exists in the job.

[229] **Bethan Jenkins:** On the research, you said that you are going to do a staff survey. Will there be a recap question to follow up that research about staff morale and mental health issues? If that is out of date, we need to know what the current situation is.

[230] **Mr Murray:** Yes.

[231] **Mr Williams:** Yes, we do. Our understanding of post-traumatic stress disorder and the appropriate counselling is getting more sophisticated.

[232] **Irene James:** I will move on to lengthy handover times, and my question is to both Paul and Alan Murray. Paramedics and nursing staff feel frustrated by lengthy handover delays. The auditor general's report also highlighted that issue and the fact that they feel

powerless in the face of such delays. In the time since the auditor general's report was published, what has been done to reduce handover times?

[233] **Mr Murray:** We now have very close partnerships with all of the major hospitals. We have escalation plans that are put into place very rapidly if there is an influx of patients into a hospital. I had such an experience last week in Glan Clwyd Hospital. Five ambulances came into the accident and emergency department simultaneously. I knew about it because I was at the liaison officer's desk at the time, and he was paged. He and I went to the accident and emergency department to see what was happening. He became involved with ambulance control and establishing what else was coming in and whether it could be diverted. The senior nurse on duty rapidly assessed the patients and called in her clinical director—I am not familiar with the officer concerned, but I believe that she is an assistant director of nursing. They both got to the department within a matter of minutes. They established that four of the five patients were medical patients and they paged physicians from the medical ward to come down in order to assess them and get them off the stretchers. As soon as they had done that, the senior nurse went back into action again and said to the nurses and the paramedics, 'Go and put your pin numbers into the screens'.

[234] That is the kind of joint planning and joint action that we have been taking with the accident and emergency departments. We have also been working very closely with the accident and emergency departments to ensure that the screens are in the right position, that people understand how to use them and that they do use them. Our own staff are currently hitting a level of compliance of around 85 per cent. There was a technical issue in a hospital in west Wales, which reduced our compliance somewhat. The compliance rate would be higher than that had it not been for that issue, which I believe has now been resolved. That is the kind of partnership working that we have been doing with hospitals. It has been working. At the University Hospital of Wales we are now experiencing around 50 per cent of the delays that we were experiencing a few months ago. Between January and April we saw a 50 per cent reduction. It will be less than that again since April, because the performance trend is going pretty steeply downwards in the number of lost ambulance hours.

[235] **Irene James:** Was that 15 per cent or 50 per cent? I did not quite hear.

[236] **Mr Murray:** It was 50 per cent.

[237] **Irene James:** That is wonderful, thank you.

[238] **Mr Murray:** It is, and it has been done by and large without significant friction between the paramedics and nurses.

[239] **Mr Woodhead:** Although the percentages are not as high, those kinds of reductions are being seen across the rest of Wales as well, including in Swansea and Wrexham.

[240] **Mr Williams:** That goes back to my earlier remarks about the internal market, which created all sorts of perverse behaviours. If you had a trust that wanted to improve its accident and emergency department, and it put forward business cases to the commissioner and the commissioner did not see that as being a priority, or it had to deal with four or five commissioners, things slowed down and in some areas managers gave up, frankly. So, the departments were not fit for purpose. We have had behaviour that has meant that teams within hospitals were not working as effectively as they should have been. The internal market and perverse behaviours meant that people were sometimes saying, 'It is not the hospital's problem; we can leave it to the ambulance service.' That is not acceptable.

[241] We have been quite relentless over the past few months in saying that this is a major cultural change; we are going to be serious about working, we are going to attack the

efficiency issues where they need to be attacked, and address situations where we have accident and emergency departments that are still not properly designed. It cannot be right that if we have over a certain number of patients, they have to be cared for in corridors, and it may simply be that insufficient attention has been given to the fact that the design of the accident and emergency department needs to be radically overhauled. We are seeing a lot of that happening now, for example at Nevill Hall Hospital, Royal Gwent Hospital, and I have just given some early indications that I want to do something at the University Hospital of Wales. The University Hospital of Wales has sent me a very significant plan about how it is tackling the 15-minute handover, and it has now had its best month of performance ever, reaching a level of compliance of 95 per cent. These are still early days, but we are now being quite relentless in saying that we are going to deal with this issue together, in partnership. That is starting to bear fruit. There is still much to do, but the early signs are encouraging.

[242] **Janice Gregory:** Sticking with 'Unscheduled care: patient handovers at hospital emergency departments', and paragraphs 1.21 to 1.24, paragraph 1.22 is quite specific on the clinical risk to patients and, indeed, the personal and professional risks for the police or the fire services when they have to transport patients to hospital if an ambulance is not available. One part of this paragraph struck me, namely where it says that the police have identified that if a patient dies in their care when they are transporting that patient to hospital, it goes a stage further because that patient is deemed to have died in police care—or rather, as it states in the report, it is classified as a death in police contact. It would then be subject to an inquiry by the Independent Police Complaints Commission with all that that involves in terms of resources and the reputation of the service. The report also states that the joint emergency services group raised this as a concern with the Welsh Assembly Government and was working to achieve a sustainable solution to the problems. Can you tell us what progress the Welsh Assembly Government has made? The question is to Paul primarily, but I am sure that Alan will have a comment to make on that.

11.50 a.m.

[243] **Mr Williams:** First and foremost, it is not appropriate for the other emergency services to be stepping in on a regular basis to substitute for the ambulance service. That is the first principle. However, there is also the principle of the first responder. At times, it would be a reasonable thing to do. When it was raised with the Minister and me in January, the joint emergency service group identified that there were 59 events during January and 65 in February, which is far more than we would expect. Our instructions were that a taskforce should be established immediately to start to deal with these issues.

[244] In mitigation, the ambulance service was in the difficult winter period, when the whole system is under huge pressure because there was a prolonged cold snap. The figures improved in March to 13 and 14. We have made significant progress. I think that the figures have crept up a little since then, which is cause for concern. However, we are clear that this needs to be dealt with. We do not expect the emergency services to undertake inappropriate work.

[245] **Mr Murray:** I can provide an update on that. There have been only four reports so far this month. However, I would also like to emphasise that the numbers that Paul Williams has just given you are not all transports to hospital by the fire service or the police; they are exceptions and include things such as ambulance control taking too long to answer the phone. So, some are more serious than others. As I said, four exceptions have been reported this month in total. I have been working with my colleagues in the joint emergency services group.

[246] The real solution to this is in issues that we have already discussed: getting more of our shifts filled, which we have been doing—we have been getting substantially more of our shifts filled—and dealing with turnaround times at hospitals, which we have been doing and,

as a result, the turnaround times are now much shorter than they were. Those things, along with the improvements that we have made in our deployment planning and our control room processes, in the categorisation of our A, B and C calls and triage by nurses, have really been the solution to the problem. We also have to deal with our relationship with our fire and police colleagues in practical terms. I am not just talking about how well we co-exist with them, but about resolving practical issues.

[247] The trust has now taken responsibility for the operation and management of a web-based reporting tool, which each service will use to report exceptions with other services. So, for example, if we have a delayed police response, we will put that on the web-based system. If the police have a delayed ambulance response, they will put it on. We collate that information and report it, but we are now taking the next step, which is about performance managing it. We have now agreed to set up both a formal and an informal process for managing performance. This is in south-east Wales, where most of the problems arose. The informal process involves all four control managers from the four services—the two police services, the fire and rescue service and WAST—meeting on a weekly basis over coffee and working on some set agenda items, but also identifying any issues that are arising and nipping them in the bud at an early stage.

[248] The formal process will involve the assistant chief fire officer, the two assistant chief constables responsible for operations, and our regional director for south-east Wales getting together on a monthly basis for a formal review of the most prevalent problems that have been identified by one of the services about the others. They will go through a process of deciding what they are going to do about it jointly, and they then leave the room and get on with implementing it. At the next meeting, they consider how they did with the measures that were identified the previous month and what the issues are for the next month. We agreed that, initially, those meetings should be monthly, but we will review their frequency, as they may not need to be held every month if the number of incidences is reducing. I just want to put on record my thanks to our police and fire service colleagues for the support that they have given us during a very difficult period.

[249] **Janice Gregory:** It is good to hear that there is joint working. I am sure that everyone would applaud that. To take it a little further, this question is to you, Paul, as well as to Alan. When Professor Woollard came to committee—and, unfortunately, I was not here, but I have read the Record of Proceedings of that meeting—he was quite keen to talk about the fire service, which carries defibrillators on its vehicles. He was quite keen to talk about the first responder service in mid and west Wales, which is well developed. I understand what you say, Paul, about it not being appropriate for people to be transported to hospital in a fire engine, but I think that the general public accepts the first responder service. I certainly have a good new one in my constituency. The service uses volunteers and they are very well accepted, as is the idea behind them. I do not think that anybody would be particularly against the idea of the fire service intervening in a cardiac arrest case, for example. Will that scheme be extended? To what extent has the joint emergency services groups had a good look at it? I do not think that you will tell me that it is being discounted altogether, but what priority has been given to it?

[250] **Mr Murray:** The joint emergency services group has done some work on co-responding. We have developed a memorandum of understanding, which was presented at the last meeting, and that is now being reviewed. It is not just the Mid and West Wales Fire and Rescue Service that co-responds for us; we have quite a number of co-responders in the North Wales Police as well, who carry defibrillators in their patrol cars. We are very open to that. It is kind of a mixed economy because, as you have said, we have some very good community first responder schemes and we certainly do not want to tread on those people's toes, but, in the areas where co-responders are of most interest to us, the fire service is most likely to be made up of retained staff, and so those people would have to come from home. So, we have to

bear that in mind when planning and look at whether there would be any particular advantage to having firefighters coming from home, as opposed to community first responders.

[251] **Mr Williams:** We need to keep an open mind and think much more flexibly for the future. We referred to the rural health plan, for instance, and, in Powys, we have some very difficult challenges so we may need to look at different policies that are more appropriate. There is more work to be done and that will form a part of the strategic review.

12.00 p.m.

[252] **Janice Gregory:** Moving onto my final question, which relates to paragraphs 1.25 to 1.47, we heard evidence earlier about the issues surrounding the data terminals. This question is to both of you. One thing that would have struck all the committee in the evidence that we heard this morning was the error rate of 26 per cent during one shift because of the data terminal. In fact, there was one particular point that struck me, and probably everyone else, which was when the information suggested that there was an ambulance at UHW, when it was in fact at the Royal Glamorgan Hospital, I think, but it may have been the Royal Gwent Hospital. We also heard about ghost jobs. We all understand that frequently malfunctioning data terminals will be a major barrier to acquiring consistent and accurate data. What steps has the Welsh Assembly Government taken to ensure that all the data terminals are suitable for purpose? Alan, I understand that the trust was to conduct an all-Wales audit of the data terminals in April 2009. Can you tell us what the findings of that audit were? I heard what you said about being in that hospital, making sure that people logged on to the data terminals and recorded the data accurately, but we need accurate data.

[253] **Mr Murray:** I will take the first part of your question and ask Tim to come in on the audit point, because he has a copy of the audit report with him. We heard the evidence that was given by our colleagues from Wrexham Maelor Hospital and the University Hospital of Wales, and our colleague from Wrexham dealt partly with that question when he said that, because we are now reaching high levels of compliance in entering the data, we are beginning to find some anomalies. He also said that they were addressing those anomalies with us, the Welsh ambulance services trust, and that we were dealing with those and responding to them seriously. So, we are aware of some of the issues, but we have only recently been made aware of them.

[254] For example, on the patient turning up at the Royal Glamorgan Hospital when they were supposed to be at the University Hospital of Wales, that is an issue with the quality of our control processes. If the system suggests that the patient is going to UHW and if the dispatcher who is managing that call does not change it, in control, to the Royal Glamorgan Hospital, the screen will continue to say that that patient is going to UHW. We are actively addressing that issue with our staff in control.

[255] The screens had to be designed in such a way as to interface properly with our computer-aided despatch system, so there was not a lot of choice about how they were designed, and there were constraints. We tried to keep them as simple as possible and we worked very closely with the Welsh Assembly Government, which also worked very closely with the hospitals, to ensure that we designed them as best as we could. However, we were working with some restrictions on how they could be designed. Our estimate is that, in most cases, they can be updated within 20 seconds, and the malfunctions are no longer frequent. I do not know whether you want to say anything about the audit, Tim.

[256] **Mr Woodhead:** The audit has been concluded and has come up with a couple of key recommendations, and our auditor colleagues will be delighted to know that we have acted on them fairly swiftly. There is one serious recommendation and one relatively minor recommendation. The relatively minor recommendation is about how screens are set up and

how long they continue to show a particular window. Some adjustments were made following discussions with nursing staff and paramedics to try to get that right, and they were relatively easy and minor issues that improved the system slightly.

[257] The much more important issue was about embedding the practice and culture with ambulance and nursing staff, to drive that at grass-roots level with nurses and the managers of the ambulance service and accident and emergency departments. The figures that we now see show that patient flow has improved: we can see that the performance against that has improved dramatically up to the 80 per cent mark. So, that audit is one of the many catalysts for the actions and improvements that we have seen.

[258] **Mr Murray:** I also noted Meredith Gardner's remark about the difficulty of correlating what was on the screen with what was in the paperwork. We will address that, but there is an issue of patient confidentiality with the screens, given that they can be read by passers-by. There is a distinct limit to what we can put on the screen, as it might identify a patient.

[259] **Mr Williams:** From the Welsh Assembly Government's point of view, in February/March, when we started looking at the raft of issues that needed to be addressed to improve performance, we discovered that the issue with screens and handover was patchy to say the least. We had assumed that it was a fairly easy thing to do and had left it to the service. We then set up a task and finish group, which has met on several occasions. First and foremost, that was to get Welsh ambulance staff and hospital trust staff to gain a clear understanding of why it was being done. That needed a lot of communication and training work to ensure that the technology was operating correctly and that the screens were in the right place. All that work has now come together, and we are pretty certain that the technology is working. Screens that were in inappropriate places have been relocated. We continue to monitor it monthly, and we have now moved the compliance rate up from 22 per cent in December to 78 per cent, and we are pushing to get it up to 100 per cent. The Welsh Assembly Government will continue to monitor that regularly, and, if we think that performance is not improving, we will have individual meetings with the organisations involved.

[260] **Mr Murray:** The human issues are beginning to be resolved. It was entirely understandable for paramedics to ask why they should have to do this when, as far as they could see, it would not make a difference. Nothing ever seemed to make a difference. However, now that they can see that it makes a difference, they have an incentive to comply. I recently spoke with a couple of paramedics from Newport who told me that they just do not get the queues at the Royal Gwent that they used to, so things have improved.

[261] **Bethan Jenkins:** I have a question on handover to the ambulance officers. We received evidence from the Royal College of Nursing, Unison and the College of Paramedics stating that they were concerned that, during periods of severe delays in turnaround times, patients were passed to ambulance officers, and that there were risks involved in that. This morning, Jennie Palmer from the University Hospital of Wales said that, because there was no clinical accountability involved, the risks might not be as relevant in that regard. Do you believe that the handover target and the policy objectives behind this can be met if patients are passed to ambulance officers, or is that not the issue? Is it a wider issue of resource?

[262] **Mr Murray:** That would be our vision of a ghost job: a ghost handover. That is not occurring to anything like the extent that it was previously. That was a feature of the period of absolute crisis, if you want to call it that, when it was not unusual for patients to be handed over from one ambulance person to another. I will qualify that by saying that, in the hospitals where we were experiencing the biggest problems, in south-east Wales, nursing staff were exceptionally good at triaging patients. If I entered the Royal Gwent accident and emergency department, as I frequently did, I would invariably find the higher acuity patients in the

department and the lower acuity patients being managed by ambulance staff in the corridors. In fact, there was some question in my mind as to whether there would have been much of a risk in leaving those patients unsupervised but, of course, there are professional accountability issues that make that extremely difficult to achieve. So, I do not want the committee to go away with the impression that this was completely unmanaged; the triage process inside the hospitals was exceptionally good, the people being managed by ambulance officers were not the sickest patients, and it is now far less of a problem than it was.

[263] **Bethan Jenkins:** I note what you have said, but the Minister has also said that it is unacceptable for patients to be held in ambulances, and we have heard evidence this morning that Wrexham is still doing that, mainly because of work on the hospital building. This question is to Alun Murray. Given that that comes from the top level of Government, with the Minister herself saying that it is unacceptable, and yet it is still continuing, does that need to be looked at much more rigorously?

12.10 p.m.

[264] **Mr Williams:** I think that it does. To their credit, I think that the ambulance staff would ensure that the person was not unattended. The issue for me is whether the commissioners and the providers are ensuring that there is sufficient capacity and expertise within the accident and emergency departments to ensure swift handovers. What we have done in setting the target is to say that this is an acceptable target. If it has not been achieved, we have to revisit the issues of resourcing. It may not just be a cash issue; it may be an issue of whether you have enough trained staff, or it could be a recruitment issue.

[265] However, the principle is correct, and what we need to avoid now is any shift of the responsibility back to the ambulance service. It cannot be a case of saying, ‘We cannot find the resources, so, by default, the ambulance service will still pick up the responsibility for tending these patients’. That is unacceptable. I would not suggest it for one minute, but in parts of England, trusts that do that will have the money taken away from them. The approach is that the trust wasted an ambulance so it would be charged for that. I am not suggesting that that would be appropriate in Wales, but we need to rebalance the system. It is wholly appropriate, once they cross the threshold of a hospital, for the patient to be received into the hands of the hospital staff as quickly as possible.

[266] This is a significant change in approach, and emphasis has been placed on this. As I said, it has been confused by the prioritisation of commissioners and providers seeing things in different ways. We have more clarity on these issues now; we just need to keep moving. I received a report only three days ago from the transition director in the Cardiff and Vale NHS Trust on how it is going to submit a much more robust plan than it had before. So, there is a great deal more to do, but we are focusing on this, and this is where the target is helpful. It would be difficult to defend why you should have people waiting in ambulances or in corridors, or why we should be expecting people to wait longer than 15 minutes. It is not without its difficulties, but I think that it is the right thing to do.

[267] **Bethan Jenkins:** Do you have anything to add to that, Mr Murray?

[268] **Mr Murray:** I agree with what Paul said.

[269] **Jonathan Morgan:** I wish to push you on a particular point. Paul, listening to the answer that you gave to Bethan, it was certainly clear in my mind—correct me if I am wrong—that the policy objective of the Assembly Government in using the handover target is to ensure that patient A goes from the care of the paramedics to the care of the nursing and clinical staff within the accident and emergency department. Is it, therefore, the case that, where a patient goes from the paramedics, but to another member of the ambulance staff, that

is certainly not within the spirit of the policy objective as the Government sees it?

[270] **Mr Williams:** It is to the credit of the ambulance staff that they were tending to those patients, but that is not acceptable. It should be a smooth, safe and quick transition.

[271] **Jonathan Morgan:** So, the objective is not just about getting a patient handed over within 15 minutes and the ambulance crew back out within 20 minutes, but about ensuring that the patient is in the care of a member of the appropriate clinical team?

[272] **Mr Williams:** That is correct.

[273] **Lorraine Barrett:** I have a question for Paul about the comments in the report about NHS organisations needing to show leadership and vision to find joint solutions. The Royal College of Nursing said that there needs to be a culture of management within accident and emergency departments that recognises that this is a team approach. What barriers exist across the NHS in Wales that prevent such a culture of joint working developing? The report also suggests that hospitals are failing to share best practice with regard to handover times. There is a picture here of joint working, sharing best practice and an attitude of, 'Let's all get together'. Do barriers to that exist, or are barriers being broken down now?

[274] **Mr Williams:** We are starting to break them down. We are talking about a major cultural change, and that will take time. We have made progress, but we need to accept that the bridge provider arrangement caused some difficulties in terms of perverse incentives and gaming, which are totally unacceptable. I am preaching every day to the leaders of these organisations that they not only have to change their attitudes and behaviour, but that they need to engage with clinical staff and that clinical staff feel that they have the support of the management. Within the clinical teams themselves, they need to ensure good partnership and flexible working. There is a great deal more to do here, but I think that we are starting to set up the right environment to make the difference.

[275] **Jonathan Morgan:** Are there any further supplementary questions that Members wish to ask? I see that there are none. I thank the witnesses; we are very grateful to you for coming in. We will provide a transcript of the session for your consideration.

12.15 p.m.

Ystyried Blaenraglen Waith Swyddfa Archwilio Cymru
Consideration of the Wales Audit Office Forward Work Programme

[276] **Jonathan Morgan:** I am delighted that the Auditor General for Wales is here, along with Gillian Body; it is a pleasure to see you both. Thank you for the forward work programme, which has been circulated to Members. Jeremy, do you want to say anything at this point before Members ask one or two questions about the nature of the work and outline where they are showing a certain interest in aspects of the work that is being undertaken? I know that some Members want to raise some issues that are of concern to them, which you might want to take away and think about.

[277] **Mr Colman:** I am very pleased to receive any such comments. I hope that members of the committee will not feel constrained by the agenda of the committee and that they must only raise what is on the agenda. I am happy to hear from Members at any time with suggestions about things that we should do or directions of inquiry that we might follow with regard to any of the things that are on the list.

[278] If you look at the table that is attached to my letter, it is clear that the reports at the top end of that list are very well advanced indeed. Then, as you proceed downwards, you get to

reports where the work is yet to begin. So, they are at various stages of development. The scope for altering anything in the reports at the top of the list is very limited, whereas the scope for change lower down is very great. I draw your attention to the bullet points. They do look a little like footnotes, but they are actually quite important. There are things in there that will, I suspect, be reports of considerable interest to the committee. They have equal status, but the issue is that, in many cases, we are not quite sure what the timing will be, and it will be ad hoc. For example, waiting-list spot checks will, I strongly suspect, be of high interest, but the timing is still uncertain.

[279] **Jonathan Morgan:** Are there any observations on the list of subject areas that the auditor general and the Wales Audit Office are going to be examining? Are there any other points that members of the committee wish to put to the Wales Audit Office on any other areas where they think that there may be work that could be of use?

[280] **Lesley Griffiths:** This is something that I have raised with Jeremy before. I would like to see an inquiry into Welsh local authority reserves. I substituted at a Finance Committee meeting back in October, and an issue discussed at that meeting still concerns me greatly. At that meeting, Andrew Davies, the Minister for Finance and Public Service Delivery, stated that the 22 local authorities in Wales hold £581 million in reserves. I appreciate that a lot of that is made up of allocated reserves, but there is still a huge sum of money, probably about £145 million—although I would imagine that that is higher now—that is unallocated. I wrote to Jeremy and he sent me a very detailed response. One issue that did concern me was that, following the Finance Committee meeting, there was quite a bit of media interest and Jeremy stated, as he did in the letter, that it is a matter for individual authorities to determine their own level of reserves, while the Welsh Local Government Association said that it was told by the Wales Audit Office to hold up to 5 per cent of revenue in reserves. That is a blatant contradiction; they cannot both be right. In the current economic climate, it is a matter of public interest that there is this huge sum of money sitting around in local authority reserves. The Welsh Assembly Government uses its reserves; I think that it holds 1 per cent of its annual budget in reserves. This is a matter of public interest.

[281] **Jonathan Morgan:** Do you want to respond to each point now?

12.20 p.m.

[282] **Mr Colman:** I will respond to that one, if I may. As Lesley said, we looked into this carefully. I am happy to report the facts on local authority reserves in total, although it is not a function of the Assembly to hold any individual local authority to account. I am very happy to report our policy in speaking to local authorities about levels of reserves. The issue that is difficult for me is that, if a local authority goes through the proper process and decides to hold what Lesley or anyone else might regard as a high level of reserves, that is a matter of policy that I cannot question, provided that they go through the proper process for doing it. They are required to examine the level of their reserves every year. So, if you have an authority that just allows reserves to accumulate without really thinking about it and shows no evidence of having thought about it, then that would be subject to criticism and action from the appointed auditors. However, if it does it deliberately as a matter of policy and goes through the proper process then, as auditors, we cannot question that. We can and do question the opposite problem, which I think is one that Lesley is not concerned about at all, which is that reserves might be too low. However, there is no rule that says what the level of reserves should be—there are rules of thumb rather than rules, if I may make that distinction.

[283] **Jonathan Morgan:** Are there any further points from Members?

[284] **Bethan Jenkins:** I have two suggestions relating to local government: conducting and promoting value for money studies in the local government sector and inspecting for

compliance with best value requirements under the Wales programme for improvement. This is an idea that was passed on to me and I thought that it was worth asking if you wanted to discuss it further.

[285] I also wanted to ask what happened to the suggestions that we gave you previously. I remember asking whether the auditor general could carry out some research into higher education and the effect of the policy on student finance—the way in which it was implemented and its effect on students in Wales. I know that there is a move to change that now, and it might be outdated and it may not be possible to consider it, but that was something on which I wanted you to give some guidance.

[286] **Mr Colman:** On the first point, perhaps we can talk afterwards about exactly what it was, but, as you said it, it appeared to me either to be something that we do already or, alternatively and more likely, something that will be a responsibility under the Local Government (Wales) Measure. I am excited about the changes to the Wales programme for improvement that that Measure will bring. They will enable us, for the first time, to report on a consistent basis across all Welsh local authorities about the extent to which they have delivered improvements in the previous year and to which they are likely to deliver improvements in the coming year. That will greatly enhance democratic accountability for local government in Wales and it is warmly to be welcomed. However, it is not a report that will come to this committee. Twenty-two reports will be published by individual authorities.

[287] On the second point about higher education, you will see towards the end of my list the, perhaps, rather telegraphic language of 'AGW portfolio of vfm work'. In the autumn, I will bring a much longer paper—I am sorry to threaten you with a longer paper—that will list in detail potential topics. I am very happy to include that on that list.

[288] **Huw Lewis:** It is very easy to come up with our own personal wish list here. One thing that strikes me is the absence of a look at what the First Minister has said is the Welsh Assembly Government's No.1 priority, namely child poverty. He has said it repeatedly, but we have never really looked into how the Welsh Assembly Government is tackling the issue. There are many aspects to this and it touches on almost everything that the Assembly Government does, but my personal bid would be for a look at Cymorth and the way in which that is working and changing. I know that it is something that confuses a number of people, particularly the end users of Cymorth and how that operates.

[289] **Jonathan Morgan:** Do you want to respond directly to that?

[290] **Mr Colman:** I am grateful for that suggestion. We have been getting at child poverty indirectly because many of the issues affecting it are outside the Assembly Government's control as they are not devolved functions. So, for example, there is a study on nutrition in schools, which has some bearing on it, and potentially the same is true of the education of looked-after children. However, I am happy to take on that suggestion on Cymorth. That is a good idea.

[291] **Jonathan Morgan:** Janice, did you want to raise a point?

[292] **Janice Gregory:** No. I am okay with the list, but it is all health, health and more health.

[293] **Mr Colman:** If I may say so, that is why I am particularly grateful to have non-health related suggestions.

[294] **Jonathan Morgan:** Although, I have to say that I had a big health issue in my mind, but I will not raise that now. [*Laughter.*]

[295] **Janice Gregory:** I would like to go back to Lesley's point on this. The reality is that the general public does not understand that local authorities hold reserves. If you were to ask someone on the street about this, they would have no idea that the local authority had any money tucked away for any reason. I am not sure about Jeremy's answer and I have not read his letter to Lesley, but if you are suggesting a level of 5 per cent for them—

[296] **Mr Colman:** I am not.

[297] **Janice Gregory:** I must have misunderstood.

[298] **Mr Colman:** Steve Thomas was quoted as saying that we do, but we do not.

[299] **Janice Gregory:** We need to clarify that the auditor general is not suggesting that because I guarantee that out there, local authority members think that he suggested a level of 5 per cent. Can we clarify that before we go any further?

[300] **Jonathan Morgan:** To help, as a result of this discussion and clarification from the auditor general, I could write to the Chair of the Finance Committee and say that, as a result of a brief discussion on a forward work programme, the auditor general clarified the exact position. Perhaps it would then be up to the Finance Committee to pursue that matter further, having had that clarification. I am more than happy to do that.

[301] **Mr Colman:** Since there is interest in this topic, my letter to Lesley was lengthy and perhaps it would be simplest to circulate that letter as a committee document so that everyone could see it, possibly before you write to the Finance Committee because further points may arise from that.

[302] **Jonathan Morgan:** We will circulate that.

[303] **Janice Gregory:** We still need clarification.

[304] **Jonathan Morgan:** Indeed, but as the evidence was given to the Finance Committee, it would be appropriate to write to the Chair to indicate what has happened here so that the Finance Committee is aware that that discrepancy has been addressed by the National Audit Office.

[305] **Janice Gregory:** We should then revisit it to get clarification.

[306] **Jonathan Morgan:** I am more than happy to do that.

[307] **Nick Ramsay:** Going back to Janice's point, it has been my understanding that a specific amount, such as 5 per cent, has never been given to local authorities on reserves. I say that from my background in local government. I go along with what the auditor general says about that. It is up to local authorities to decide what they feel is an appropriate level of reserve and it would be totally inappropriate for any statutory figure from above to determine that.

[308] **Jonathan Morgan:** Are there any further points? I see that there are not. Thank you very much.

12.28 a.m.

Cynnig Trefniadol
Procedural Motion

[309] **Jonathan Morgan:** Cynigiaf fod

y pwyllgor yn penderfynu gwahardd y cyhoedd o'r drafodaeth ar eitem 4 yn unol â Rheol Sefydlog Rhif 10.37(vi).

[311] Gwelaf fod y pwyllgor yn gytûn.

Derbyniwyd y cynnig.
Motion agreed.

[310] **Jonathan Morgan:** I move that

the committee resolves to exclude the public from the discussion on item 4 in accordance with Standing Order No. 10.37(vi).

[312] I see that the committee is in agreement.

Daeth rhan gyhoeddus y cyfarfod i ben am 12.29 p.m.
The public part of the meeting ended at 12.29 p.m.

Audit Committee

AC(3)-08-09 (p1) Unison: Ambulance Services in Wales

Date: Thursday 4 June 2009
Time: 9.30 – 12.30
Venue: Committee Room 3

UNISON welcomes the opportunity to give evidence to the Audit Committee on progress following earlier Wales Audit Office Reports into the Welsh Ambulance Service. UNISON represents over 1400 members of WAST staff across all grades and disciplines including NHS Direct. The majority of those members are involved in front line service delivery in both EMS and PCS.

The last WAO update to the Audit Committee in March 2009 is our start point of this response. That update identified a number of areas of concern which we address below.

PERFORMANCE

We understand that since the poor, but explainable December 2008 figures the performance times have improved month on month in 2009. We believe that positive steps particularly with handover times have contributed to that improvement together with recognition that the staffing shortages in the South East Region have in part been addressed. We believe that it was however avoidable. The staffing disparity was caused by there being some 45 vacant posts deliberately unfilled in the South East Region allegedly to contribute to the Trust's financial efficiency needs (SCEP). Such a position was unsustainable when coupled with the refusal to use overtime to cover those vacancies. Regrettably the poor performance figures were an inevitable consequence of that action.

We have always recognised that matching supply and demand is the absolute ideal; however that has to be balanced with safe staffing levels and an acceptance that rotas have to be seen as sufficiently flexible to meet work/life balance and safe systems of work. It is in our view far more productive to have agreed and/or minimum staffing establishments rather than rely on voluntary overtime to fill gaps. Much progress has been made and continues to be made in addressing rota requirements.

Hospital handover delays have been addressed but primarily at a significant and unfunded financial cost to WAST for providing on-site operational supervisors at Hospitals with the highest/longest delays. Clearly this should be viewed as a

systemic failure and not one which WAST have to assume both the cost and responsibility of correcting.

FINANCE

Again we believe that there is huge degree of scepticism by our members about all matters financial affecting WAST. Indeed it is apparent even within the WAO March 2009 Report that there are references to “negotiation” between WAST, HCW and WAG on Finances, SCEP targets, Cost Efficiency Savings etc. none of which leave any of those bodies with much credibility. We believe there is no transparency about the factual WAST financial situation and how other partners such as HCW may contribute or be the cause of financial challenges any and all of which could actually contribute to the performance of the Trust.

The future financial footing for the Trust 2009-10 and beyond needs to be clarified urgently and with transparency. The WAO quote in March 2009 of it being “uncertain” is far from helpful, it may be accurate but it is surely not acceptable and not a professional way to run such an essential service… The propped SCEP for the Trust of £23m in 2009-10 is frankly viewed as totally unachievable and is in part going to further create a culture of mistrust between the staff and their employer. To achieve savings/efficiencies on that scale would only be at a cost of massive service disruption and potentially run the risk of having a significant detrimental impact upon industrial relations. We do not accept that the suggestions put forward by WAO at Para 1.41 of the March 2009 Report will deliver anything like the level of savings needed in the time frames envisaged.

HR AGENDA

We believe that since the appointment of a permanent HRD in late 2008 there has been a significant improvement in the industrial relations atmosphere. However the earlier HR failings will not be corrected simply with one appointment and we believe that the Trust needs to resource effectively support for the HRD to build on the improvements already made. The modernisation agenda and future workforce development can only be delivered through constructive, progressive partnership arrangements between both sides. That must be resourced effectively at Senior HR level.

However just the one note of caution in that we do not believe that earlier concerns about a bullying culture have been completely resolved. Complaints continue to be raised and their management has to be seen as effective, we do not believe that there is much evidence of effective resolution to date. In saying that however we would add that the constant and often public or media driven criticism of WAST will inevitably mean that many Senior Managers within WAST may also feel bullied by that very process.

Dave Galligan - Head of Health UNISON Cymru/Wales May 2009

Audit Committee

AC(3)-08-09 (p2) College of Paramedics: Ambulance Services in Wales

Date: Thursday 4 June 2009
Time: 9.30 – 12.30
Venue: Committee Room 3

Executive Summary

The College of Paramedics wishes to offer the following key observations and recommendations:

1. *The requirement to make cost savings has resulted in a number of shift vacancies not being filled and consequently has led to a reduction in the number of staffed ambulances on duty and performance failures.*
2. *Paramedics are managing a far higher number of patients who call 999 with primary care type needs. Historically, this case mix would have been managed by other primary care providers – there is evidence of a shift from use of locally provided GP on-call services to dialling 999 as a consequence of the change in GP contracts and the subsequent introduction of other arrangement for unscheduled primary care.*
3. *There is evidence to suggest a significant proportion of 999 cases transported to hospital by emergency ambulance are discharged without significant treatment or referral*[1]*. This indicates that transporting all 999 patients to hospital is likely to be placing unnecessary demands on both ambulance transportation capability and emergency department capacity.*
4. *Failure to ensure safe and appropriate resources at alternative points of unscheduled care are likely to result in inappropriate referrals, increased secondary transfer of ambulance patients and protraction of the ambulance job cycle.*
5. *Non transportation guidelines for use by paramedics without significant extended training are only relevant for a small sub-set of the clinical conditions presenting within the ambulance 999 case mix.*
6. *The auditor general previously acknowledge how developing paramedic's clinical education and implementing extended skilled paramedics in Wales can avoid up to 68% of all categories of 999 ambulance calls being unnecessarily referred to emergency departments*[2]*. Specialist paramedic programmes ('emergency care practitioners') have been widely adopted in England but there is little evidence of progress in this area in Wales.*
7. *There has already been considerable investment in Wales in the post registration higher education of paramedics including subjects related to managing 999 patients with primary care needs in the out-of-hospital setting. However, the opportunity to capture this expertise has not been taken up. The graduates of the BSc course have been provided with the requisite knowledge but have* **not** *been offered the required 400 to 500 hours of supervised clinical hospital and primary care placements necessary to develop the ability to apply this in practice.*
8. *Some years ago the Welsh Assembly Government funded a unique and revolutionary pilot programme to educate five graduate paramedics with the aim of developing*

autonomous practitioners capable of treating patients with a very wide range of clinical conditions in the out-of-hospital setting and either treating and discharging them, monitoring them in their homes, referring them to a diversity of primary care services, or arranging direct admissions to specialist hospital units and wards to bypass emergency departments. The advanced paramedic practitioners working in this scheme changed the care pathways of 63% of the patients they attended. Importantly the absolute number of patients with altered care pathways was highest for category A patients, followed by category B patients, and so the impact of this team on category A performance was significant as it preserved ambulances for 'true' category A calls.[3] *The College is very disappointed to learn that this programme was never implemented beyond the pilot stage and that none of these advanced paramedic practitioners now work in a clinical role, and so a very significant opportunity to impact on clinical and operational performance has been squandered.*

9. *Short courses with the aim of teaching paramedics to care for patients in the community are* **not** *fit for purpose and expose patients and practitioners to unnecessary risk. To put this into context, by asking paramedics to treat or treat and refer patients in the out-of-hospital setting we are expecting them to make complex decisions which in the past would only have been made by a general practitioner.*
10. *There is little doubt that protracted hospital turnaround times very substantially reduce the number of emergency ambulances resources available for allocation to 999 calls at any given time. Clearly this adversely affects the ambulance system to perform against given targets, particularly for the life threatening category 'A' calls. For example, in South Glamorgan reducing the average hospital turnaround time to 15 minutes would free up more than eight hours of ambulance capacity each day.*
11. *The College is most concerned about the clinical risks to Patients requiring emergency transportation arising from prolonged management on scene by single-staffed Rapid Response Vehicles (RRVs), and also the attendant pressure and psychological risk to RRV paramedics when ambulance transportation is delayed.*
12. *Not only are hospital handover delays adversely affecting the ability of the ambulance service to respond promptly to and care for its 999 patients, but hospitals are abdicating their responsibility to care for patients immediately on arrival at emergency departments by delegating this responsibility to ambulance paramedics. The College feels this situation is wholly unacceptable to and represents a serious risk to patients and paramedics.*
13. *The College is appalled to learn that this situation has led to a small number of patients being transported to hospital in fire engines and police vehicles. Cleary this is unsafe and completely unacceptable to patients, their carers, the paramedic profession and the police and fire service personnel.*
14. *In a developed country with an allegedly competent national health service the transportation of seriously ill or injured patients in a vehicle other than a fully equipped ambulance staffed by highly trained paramedics should never be considered as a fall-back option other than in the event of an uncompensated major disaster.*
15. *Police and Fire service personnel cannot provide care equitable to that of the statutory emergency ambulance service or realistically be trained as registered paramedics (the emerging standard for which is a two-year full-time foundation degree) without significant disruption to their usual and accepted functions.*
16. *Hundreds of thousands of pounds have been invested to enable many fire appliances across Wales to carry automated defibrillators and to teach fire-fighters first aid and basic life support. The opportunity to utilise this expensive equipment and training as part of a*

*fire-fighters traditional role are close to zero – patients in fires and road traffic accidents do not die of conditions treatable with a defibrillator. However, utilising these resources and skills as part of a formal national tiered first response system led by and integrated with the ambulance service has a significant potential to improve clinical outcomes in those patients who are immediately life threatened – particularly those in or at immediate risk of cardiac arrest as a result of a medical condition, where the ideal response time for a defibrillator is less than five minutes (***not** *the eight minute standard for category A calls).*

17. *The College believes that (in common with many English ambulance trusts) the Welsh ambulance service has placed an over-reliance on the use of single-staffed rapid response cars (RRVs). Few, if any, staff of RRVs have extended training that permits them to identify and manage non-emergency cases in the out-of-hospital setting. This means that two vehicles (the RRV and the ambulance) and three ambulance personnel (the RRV paramedic and the two ambulance crew) will attend many patients, rather than the one vehicle (a transport-capable ambulance) and two staff that would have attended under a traditional system. In the short-term the College recommends that the number of RRVs utilised be significantly reduced and that instead these staff are re-deployed to ambulances capable of transporting patients to hospital. In the longer-term the Trust should implement a robust programme for training Specialist Paramedics with the requisite skills and knowledge necessary to enable them to identify, manage, and safely change the care pathway of non-emergency 999 patients. At this time the re-introduction of RRVs, staffed by these Specialists, can appropriately be considered as they will be able to facilitate non-transportation of significant numbers of patients.*

18. *Prior to the amalgamation of ambulance trusts in Wales into a principality-wide service, the South East Wales Ambulance Service Trust implemented a basic form of 'system-status management' (SSM). This uses historical 999 call data to pre-position ambulances so that they can reach the largest number of 999 calls within eight minutes across the largest possible geographical area. Although this was implemented at its most simple level, its impact was impressive. Before its introduction the Trust was reaching 42% of* **all** *999 calls (not just category A) within a seven minute target in South Glamorgan, and 52% and 45% of* **all** *999 calls within an eight minute target in Gwent and Powys respectively. After the introduction of SSM the proportion of calls reached within these targets increased immediately to 85%, 80% and 55% for South Glamorgan, Gwent, and Powys respectively. There is anecdotal evidence that whilst the Welsh ambulance service implements the principles of SSM in part this is not given robust attention and it is not at all uncommon for more than ambulance vehicle to be on standby in the same ambulance station. This represents a lost opportunity for very significant performance improvements.*

19. *The South East Wales Ambulance Service Trust also implemented performance management at the level of individual ambulance personnel. The target for the activation time – the interval from the point at which a 999 callers chief medical complaint was determined to the time the ambulances wheels started turning to respond to the call – was three minutes for 95% of calls. The Trust was achieving this target for 93% of calls. Subsequently it divided the activation time into two portions – 1.5 minutes for dispatch staff to pass the call to an ambulance crew and 1.5 minutes for the ambulance crew to become 'mobile'. Local managers were tasked with counselling those personnel who failed to achieve these targets for more than 5% of their calls, and congratulated those who exceeded it. Within two months the activation time for the Trust had changed from 93% in three minutes to 95% in* two *minutes*. The impact of this was that response times were also reduced by one minutes, as the activation time forms part of this statistic*. To the best of the Colleges knowledge this system of individual performance management is*

no longer practiced anywhere in Wales. Importantly, at the same time as it was managing the activities of staff the management also asked them what they could do to help them meet this target. As a consequence many ambulance station garage doors were fitted with new remote opening systems and electric motors to rapidly open and close them. Unfortunately the first new ambulance station built by the amalgamated Welsh Ambulance Service had a manually operated door which took at least a minute to open, after which a paramedic had to go back into the ambulance station to manually close it again and then exit via side door which needed to be locked with a key…

20. *The lead author of this report is the Chair of the College of Paramedics and lives in a rural area of Wales, and although I am currently employed as a Professor of Pre-hospital Care at Coventry University I have maintained both my paramedic and nursing registrations and indeed respond to serious 999 calls on behalf of the West Midlands Ambulance Service as one of only four Consultant Paramedics in the UK. I was previously a senior employee of the Welsh Ambulance Service. As I have been provided by West Midlands Ambulance Service with a fully equipped vehicle which is parked outside my house I volunteered my services on an unpaid basis to the Welsh Ambulance Service as a paramedic responder approximately one year ago. Since this time I have been informed that* 'whilst the Trust would like to take me up on my offer they would not be able to do so in the near future as they had no process of providing me with an honorary contract, couldn't provide adequate clinical governance, and could not devote the resources to resolving either issue as 'they were too busy addressing response time problems'*. They also advised me that they* 'had a number of paramedics also volunteering their services to which they had given the same response'*. The College recommends that the Welsh Ambulance Service must review its procedures so that barriers are not placed to prevent simple interventions being implemented that can impact positively on clinical care and operational performance.*

1. Background

1:1 The College notes that since 2006, the Welsh Audit Office (WAO) has published a number of reports on ambulance services in Wales. More recently in its follow up review[4], we note the committee states that the Welsh Ambulance services NHS Trust has made some progress in addressing many of the problems it faced. However, the WAO noted there were a number of significant challenges and serious problems remaining that still required resolution.

1:2 The College further acknowledges the evidence presented by the WAO in its follow up review report to the National Assembly Audit Committee in which it made ten recommendations for action. All of these actions were accepted by the Welsh Assemble Government (WAG) in December 2008[5].

1:3 As a result of slow progress, the College notes that the auditor general produced a further update report on behalf of the National Assembly of Wales (NAfW) Audit Committee in March 2009[6]. We note that the NAfW audit committee called for witness evidence across five thematic areas, with a particular reference to the significant fall in ambulance performance and the protraction of patient handovers at some accident and emergency departments across Wales.

1:4 The College notes that as part of its study into unscheduled care in Wales, the WAO has published a further report on patient handovers at hospital emergency departments (EDs)[7]. We further note that the auditor general has previously associated the severe protractions in patient handover and ambulance turnaround times at EDs throughout Wales as contributory to poor ambulance service performance.

1:5 The College of Paramedics (CoP) has accepted the offer made by the National Assembly of Wales Audit Committee to provide its views on the wider issues affecting ambulance performance in Wales. Subsequently, the College has been invited to give evidence on the 4th June 2009.

2. Introduction

2:1 The College of Paramedics (previously known the British Paramedic Association) is the established professional body for Paramedics throughout the United Kingdom. It represents the professional views of over 3,500 paramedics and associate members from across the United Kingdom. The views contained in this paper have been agreed by its National Council.

2:2 The College of Paramedics (CoP) are pleased to have been invited to provide its views on the broader aspects affecting ambulance service performance in Wales. The College looks forward to working with the Welsh Assembly Government in order to assist in improving the clinical quality and performance of ambulance service delivery to the public of Wales.

3. College of Paramedics Views

3:1 <u>Ambulance performance</u>

a) The College notes there is a considerable tension between the requirement that the Welsh Ambulance Service NHS Trust should achieve a £17 million saving in addition to improving it performance. This situation presents a

significant challenge to the Trust and presents a risk to the quality of care offered to the public. It also begs the question if such an objective can realistically achieved, balanced against the Trusts current financial position and poor performance. *The requirement to make cost savings has resulted in a number of shift vacancies not being filled and consequently has led to a reduction in the number of staffed ambulances on duty and performance failures.*

b) The ambulance 999 case load has significantly changed over the past ten years. *Paramedics are managing a far higher number of patients who call 999 with primary care type needs. Historically, this case mix would have been managed by other primary care providers – there is evidence of a shift from use of locally provided GP on-call services to dialling 999 as a consequence of the change in GP contracts and the subsequent introduction of other arrangement for unscheduled primary care.*

c) There is evidence to suggest a significant proportion of 999 cases transported to hospital by emergency ambulance are discharged without significant treatment or referral[8]. This indicates that transporting all 999 patients to hospital is likely to be placing unnecessary demands on both ambulance transportation capability and emergency department capacity.

d) The College notes there are opportunities for the ambulance service in Wales to work with key stakeholders as part of the Delivering Emergency Care Services (DECs) strategy. *However, the College understands that many of the pathways and services discussed within this strategy are not available 24 hours a day and seven days a week.*

e) Additionally, the college feels that it is essential that the implementation of alternative care pathways for non serious 999 ambulance patients must only be undertaken if paramedic, nursing and medical staff have the appropriate level of knowledge, skills, competence to manage such cases. *Failure to ensure safe and appropriate resources at alternative points of care are likely to result in inappropriate referrals, increased secondary transfer of ambulance patients and protraction of the ambulance job cycle.* In summary this may reduce patient satisfaction and contribute further to poor ambulance performance.

f) The College notes that the ambulance profession throughout the UK has made considerable progress in developing their clinical education and clinical procedural skills. However, the non serious primary care type case mix presents many new challenges to the underpinning knowledge and skills of the registered paramedic profession.

g) The College notes there is some evidence to suggest the use of focused clinical guidelines may assist paramedics with minimal additional training in their clinical decision making for non transportation of a small sub-set of 999 patients[9], care must be taken that such guidelines are not used to legitimise poor clinical judgement and practice.

h) *Non transportation guidelines are only relevant for a small sub-set of the clinical conditions presenting within the ambulance 999 case mix.* The College notes that the ambulance service in Wales has made progress in the

alternative referral of 999 patients with specific resolved conditions which have been treated by paramedics following an initial 999 call.

i) The College feels it is in inadequate to concentrate purely on attempting to alter the 999 patient flow by simple non transportation guidelines in the absence of additional training for paramedics. A wider approach to developing the underpinning knowledge and procedural skills of paramedics in Wales needs to be adopted to increase case closure at patients' homes or in the out-of-hospital and primary care settings.

j) The auditor general previously acknowledge how developing paramedic's clinical education and implementing extended skilled paramedics in Wales can avoid up to 68% of all categories of 999 ambulance calls being unnecessarily referred to emergency departments[10]. More recently this approach has been shown to be cost effective when comparing paramedic practitioners with the current management of 999 ambulance patients[11]. *Specialist paramedic programmes ('emergency care practitioners') have been widely adopted in England but there is little evidence of progress in this area in Wales.*

k) Utilising extended skilled paramedics to manage 999 cases at home has a number of positive benefits. It improves patient satisfaction, facilitates timelier release of emergency ambulance resources, and significantly reduces the unnecessary referral of 999 patients to EDs. *Adopting this approach can have a positive impact on ED capacity and also contribute to reducing the incidence of protracted patient handovers and associated ambulance delays at hospitals.*

l) There has already been considerable investment in Wales in the post registration higher education of paramedics, developed to both graduate and post graduate levels, and these programmes have included subjects related to managing 999 patients with primary care needs in the out-of-hospital setting. However, the opportunity to capture this expertise has not been taken up. *The graduates of the BSc course have been provided with the requisite knowledge but have* **not** *been offered the required 400 to 500 hours of supervised clinical hospital and primary care placements necessary to develop the ability to apply this in practice.* Such clinically-based training is essential to promote safe and effective practice and its absence means that these graduate paramedics are unable to manage non-urgent 999 callers in anyway that is different from their non-graduate peers.

m) Some years ago the Welsh Assembly Government funded a unique and revolutionary pilot programme to educate five graduate paramedics to Masters degree level in parallel with a rigorous one-year clinical education programme, with the aim of developing autonomous practitioners capable of treating patients with a very wide range of clinical conditions in the out-of-hospital setting and either treating and discharging them, monitoring them in their homes, referring them to a diversity of primary care services, or arranging direct admissions to specialist hospital units and wards to bypass emergency departments. The advanced paramedic practitioners working in this scheme changed the care pathways of 63% of the patients they attended. Importantly the absolute number of patients with altered care pathways was highest for category A patients, followed by category B patients, and so the impact of this team on category A performance was significant as it preserved ambulances for 'true' category A calls.[12] *The College is very disappointed to learn that this*

programme was never implemented beyond the pilot stage and that none of these advanced paramedic practitioners now work in a clinical role, and so a very significant opportunity to impact on clinical and operational performance has been squandered.

n) The College proposes that it is important to mobilise the investment the NHS in Wales has already made in post registration paramedic higher education. *This will contribute to increasing the rate of case closure at point of care, ensure safe and effective referrals to other stakeholders and further utilise the opportunities arising from developing the 24/7 paramedic clinical workforce.*

o) The College feels it is vitally important for the ambulance service in Wales to adopt its clinical career framework for paramedics[13]. This framework and guidance includes the specialist and advanced scopes of practice for registrant paramedics. Adopting this guidance will ensure that the standards of education and clinical practice are developed within a recognised construct with the appropriate level of clinical support and mentorship. *Short courses with the aim of teaching paramedics to care for patients in the community are not fit for purpose and expose patients and practitioners to unnecessary risk. To put this into context, by asking paramedics to treat or treat and refer patients in the out-of-hospital setting we are expecting them to make complex decisions which in the past would only have been made by a general practitioner.*

3:2 <u>Ambulance delays at Emergency Departments</u>

a) The College is aware that protracted ambulance turnaround times at some hospital emergency departments in Wales are contributing to significant delays in mobilising emergency ambulance resources to 999 calls. There is little doubt that this situation very substantially reduces the number of emergency ambulances resources available for allocation to 999 calls at any given time. *Clearly this adversely affects the ambulance system to perform against given targets, particularly for the life threatening category 'A' calls. For example, in South Glamorgan reducing the average hospital turnaround time to 15 minutes would free up more than eight hours of ambulance capacity each day.*

b) Protracted ambulance turnarounds at emergency departments in Wales are reducing the ambulance services ability to allocate ambulances to 999 calls when they have already been attended by paramedics staffing single-responder rapid response vehicles (RRVs). These vehicles are cars without the capability of transporting significantly ill patients. This situation unnecessarily delays RRVs at the scene of incidents and prevents them responding to further immediately life threatening calls. This is compounding the problem of poor ambulance performance and public dissatisfaction.

c) Whilst many of the patients attended by RRV paramedics are not seriously ill or injured, and will not therefore require immediate ambulance transportation, a smaller number of patients *will* have an urgent need for immediate ambulance transport to hospital for definitive treatment. *The College is most concerned about the clinical risks to this smaller group of true emergency patients, and also the attendant pressure and psychological risk to RRV paramedics when ambulance transportation is delayed.*

d) During severe hospital handover delays, and in order to release emergency ambulance crews, there is evidence that paramedics are being utilised to manage large numbers of 999 ambulance patients in hospital corridors as they arrive by ambulance. It is unsafe and inappropriate for a single paramedic to be asked to provide care and take responsibility for detecting deterioration for such a large group of undifferentiated patients, and indeed is a role for which they are untrained and unprepared. *Essentially, not only are hospital handover delays adversely affecting the ability of the ambulance service to respond promptly to and care for its 999 patients, but hospitals are abdicating their responsibility to care for patients immediately on arrival at emergency departments by delegating this responsibility to ambulance paramedics. The College feels this situation is wholly unacceptable to and represents a serious risk to patients and paramedics.*

e) The College proposes that the medical clerking of single 999 patients on ambulance trolleys and then expecting paramedics to continue care and observations after medical treatment has been provided until a bed becomes available is also wholly unacceptable. There is considerable clinical risk and ethical and legal issues associated with this practice in relation to who has the duty of care for individual patients at any one time, and of the training and competence of that practitioner. Hospitals emergency department in Wales must give a higher priority to alerting the ambulance service regarding their real-time capacity to accept patient referrals. *The College recommends that, until the emergency department bed capacity crisis has been resolved, a formal system to divert 999 ambulance patients to other emergency departments with current capacity is implemented.*

f) The foundation of practice for paramedics is that they handover their duty of care at the ambulance hospital interface. This is a two part process consisting of providing primary information and therapies undertaken, and then delivering more in depth information by physical handover of a written ambulance patient clinical record. This process is not robustly documented and therefore the expectancy of all stakeholders involved in the patients current and ongoing care at the ambulance/hospital interface is unclear. The college acknowledges that the clinical patient handover between ambulance staff and hospital emergency department staff is a complex interactional process.

g) Evidence does how show however that ambulance staff value active listening by the receiving clinicians as an important part of the handover process[14]. This avoids unnecessary repetition of primary and secondary information at handovers and reduces frustration in the ambulance clinical workforce of having to repeat information.

h) The College recommends the development of a national guidance and a framework to support the safe and effective patient handover at the ambulance/hospital interface. This should include the prima facie clinical elements of the patient handover and also the operational processes specific to individual departments such as updating ambulance arrival information.

3.3 <u>Use of fire service and police vehicles to transport patients</u>

a) The College believes that protracted ambulance turnaround times at hospitals are the major contributing factor to the delay in dispatching emergency ambulance

resources to incidents where other emergency service providers are already in attendance before ambulance service arrival. *The College is appalled to learn that this situation has led to a small number of patients being transported to hospital in fire engines and police vehicles. Cleary this is unsafe and completely unacceptable to patients, their carers, the paramedic profession and the police and fire service personnel.*

b) The College is cornered that utilising fire and police services to transport patient's who have neither been triaged, clinically assessed or treated by a registered paramedic represents a completely inadequate approach to pre-hospital care and carries a significant clinical risk to patients. *In a developed country with an allegedly competent national health service the transportation of seriously ill or injured patients in a vehicle other than a fully equipped ambulance staffed by highly trained paramedics should never be considered as a fall-back option other than in the event of an uncompensated major disaster.*

c) The College of Paramedics does not support the use of either fire or police service resources for patient assessment, treatment and or transportation outside that of the emergency first responder role. *Police and Fire service personnel cannot provide care equitable to that of the statutory emergency ambulance service or realistically be trained as registered paramedics (the emerging standard for which is a two-year full-time foundation degree) without significant disruption to their usual and accepted functions.*

d) The College notes the considerable contribution that fire prevention programs throughout the UK have had in reducing 999 calls to the fire service. The College recognises there are significant opportunities embedded within this success to utilise fire service resource in Wales as emergency first responders. *Hundreds of thousands of pounds have been invested to enable many fire appliances across Wales to carry automated defibrillators and to teach fire-fighters first aid and basic life support. The opportunity to utilise this expensive equipment and training as part of a fire fighters traditional role are close to zero – patients in fires and road traffic accidents do not die of conditions treatable with a defibrillator. However, utilising these resources and skills as part of a formal national tiered first response system led by and integrated with the ambulance service has a significant potential to improve clinical outcomes in those patients who are immediately life threatened – particularly those in or at immediate risk of cardiac arrest as a result of a medical condition, where the ideal response time for a defibrillator is less than five minutes (not the eight minute standard for category A calls).* The rapid attendance of fire service first responders with simple defibrillation and cardio-pulmonary resuscitation training in those areas where ambulance resources are not immediately available (rural areas and high activity urban areas) backed up by ambulance paramedics within eight to ten minutes has repeatedly been shown to increase survival form out-of-hospital medical cardiac arrests. *Although such a role for fire services was recommended in the Home Office's 'New Dimensions' strategy it has not been widely implemented, sadly as a result of resistance by the Fire Brigades Union.*

3.4 <u>Performance management</u>

a) *The College believes that (in common with many English ambulance trusts) the Welsh ambulance service has placed an over-reliance on the use of single-staffed rapid response cars (RRVs).* It is incorrectly believed that these provide a cheaper means of providing a rapid response to a larger area than would be possible with

traditional ambulances. There are a number of flaws with this strategy, however. If these RRVs are not entirely staffed by Specialist Paramedics with extensive additional training in the identification and out-of-hospital management of 999 patients with non-serious conditions, then the substantial majority of patients that they attend will still require admission to an Emergency Department. *This means that two vehicles (the RRV and the ambulance) and three ambulance personnel (the RRV paramedic and the two ambulance crew) will have attended the patient, rather than the one vehicle (an ambulance) and two staff that would have attended under a traditional system.* Clearly this is an ineffective use of resources, and this is evidenced by the very low work load of many RRV units – often only 2 or 3 calls per 12-hour shift, and the protracted length of time they spend on scene with the patients they do attend waiting for an ambulance to transport their patient to hospital.

b) There are two solutions to this problem*. In the short-term the College recommends that the number of RRVs utilised be significantly reduced and that instead these staff are re-deployed to ambulances capable of transporting patients to hospital. This should not be utilised as a cost saving opportunity, as the consequence would be continued poor performance. In the longer-term the Trust should implement a robust programme for training Specialist Paramedics with the requisite skills and knowledge necessary to enable them to identify, manage, and safely change the care pathway of non-emergency 999 patients. At this time the re-introduction of RRVs, staffed by these Specialists, can appropriately be considered as they will be able to facilitate non-transportation of significant numbers of patients.*

c) Prior to the amalgamation of ambulance Trusts in Wales into a principality-wide service, the South East Wales Ambulance Service Trust implemented a basic form of 'system-status management' (SSM). This uses historical 999 call data to pre-position ambulances so that they can reach the largest number of 999 calls within eight minutes across the largest possible geographical area. Although this was implemented at its most simple level, its impact was impressive. Before its introduction the Trust was reaching 42% of *all* 999 calls (not just category A) within a seven minute target in South Glamorgan, and 52% and 45% of *all* 999 calls within an eight minute target in Gwent and Powys respectively. *After the introduction of SSM the proportion of calls reached within these targets increased immediately to 85%, 80% and 55% for South Glamorgan, Gwent, and Powys respectively.* The fundamental principle of SSM is that one should never position two or more ambulances on standby for the next emergency call in the same location – clearly it is most unlikely that two emergency cases will occur at the same time outside an ambulance station's front door. *There is anecdotal evidence that whilst the Welsh ambulance service implements the principles of SSM in part this is not given robust attention and it is not at all uncommon for more than ambulance vehicle to be on standby in the same ambulance station. This represents a lost opportunity for very significant performance improvements.*

d) The South East Wales Ambulance Service Trust also implemented performance management at the level of individual ambulance personnel. This is because attempting to manage performance at a national, regional, or PCT level is meaningless and bound to fail: it is the behaviour of individuals that has by far the greatest impact. The target for the activation time – the interval from the point at which a 999 callers chief medical complaint was determined to the time the ambulances wheels started turning to respond to the call – was three minutes for

95% of calls. The Trust was achieving this target for 93% of calls. Subsequently it divided the activation time into two portions – 1.5 minutes for dispatch staff to pass the call to an ambulance crew and 1.5 minutes for the ambulance crew to become 'mobile'. It then recorded the proportion of calls for which individual dispatchers and ambulance staff met this target, and local managers were tasked with counselling those personnel who failed to do so for more than 5% of their calls, and congratulated those who exceeded it. *Within two months the activation time for the Trust had changed from 93% in three minutes to 95% in two minutes. The impact of this was that response times were also reduced by one minutes, as the activation time forms part of this statistic. To the best of the College's knowledge this system of individual performance management is no longer practiced anywhere in Wales.* Importantly, at the same time as it was managing the activities of staff the management also asked them what they could do to help them meet this target. As a consequence many ambulance station garage doors were fitted with new remote opening systems and electric motors to rapidly open and close them. *Unfortunately the first new ambulance station built by the amalgamated Welsh Ambulance Service had a manually operated door which took at least a minute to open, after which a paramedic had to go back into the ambulance station to manually close it again and then exit via side door which needed to be locked with a key…*

e) The lead author of this report is the Chair of the College of Paramedics and lives in a rural area of Wales, and although I am currently employed as a Professor of Pre-hospital Care at Coventry University I have maintained both my paramedic and nursing registrations and indeed respond to serious 999 calls on behalf of the West Midlands Ambulance Service as one of only four Consultant Paramedics in the UK. I was previously a senior employee of the Welsh Ambulance Service. As I have been provided by West Midlands Ambulance Service with a fully equipped vehicle which is parked outside my house I volunteered my services on an unpaid basis to the Welsh Ambulance Service as a paramedic responder approximately one year ago. Since this time I have been informed that *'whilst the Trust would like to take me up on my offer they would not be able to do so in the near future as they had no process of providing me with an honorary contract, couldn't provide adequate clinical governance, and could not devote the resources to resolving either issue as 'they were too busy addressing response time problems'*. They also advised me that they *'had a number of paramedics also volunteering their services to which they had given the same response'*. During the winter my village was cut off from the nearest ambulance station by flooding, consequently suggesting a minimal ambulance response time of 30 minutes. I contacted a senior ambulance manager for the area and offered to respond on a temporary basis, but the manager told me that it was 'more than his job was worth' to permit me to do so. At the current time my offer to respond has not been taken up, although I understand that after a 12 month hiatus steps are being put in place to facilitate this on a 'trial basis'. *The College recommends that the Welsh Ambulance Service must review its procedures so that barriers are not placed to prevent simple interventions being implemented that can impact positively on clinical care and operational performance.*

Professor Malcolm Woollard, **PA02584, MPH, MBA, MA(Ed), Dip IMC (RCSEd), PGCE, RN, SRPara, NFESC, FASI, FHEA, FACAP**
Chair, College of Paramedics
On behalf of the National Council of the College of Paramedics **May 29th 2009**

References

[1]Volans, A.P (1998) Use and Abuse of the Ambulance Service, *Pre hosp Immed Care; 2:190-192*

[2] Auditor General,(2006) Ambulance Services In Wales, Section 2, case study 'E' pp47 Wales Audit Office.

3 Woollard M. The role of the paramedic practitioner in the UK. *JEPHC*, 2006;4(1):990156 [online]. Available at: < http://www.jephc.com/full_article.cfm?content_id=337 >

[4] National Assembly for Wales Audit Committee (2008) Follow up Review – Ambulance Services in Wales, downloaded on 14th May 2009 @ http://www.assemblywales.org.

[5] Available at http://www.assembly.wales.org/gen-Id73008-e-pdf

[6] Auditor General (2009) Ambulance Services in Wales – further upate to the national assemsbly of Wales Audit Committee; Cardiff Wales Audit Office.

[7] Auditor General (2009) Unscheduled Care - patient handovers at hospital emergency departments, Cardiff: Welsh Audit Office.

[8]Volans, A.P (1998) Use and Abuse of the Ambulance Service, *Pre hosp Immed Care; 2:190-192*

[9] Gray J.T., Wardrope J. (2007) Introduction of non-transportation guidelines into an ambulance service: a retrospective review, Emerg Med J 24:727 – 729.

[10] Auditor General,(2006) Ambulance Services In Wales, Section 2, case study 'E' pp47 Wales Audit Office.

[11] Dixson S, Mason, S, Knowles E, et al (2009) Is it cost effective to introduce paramedic parctitioners for older people to the ambulance service? Results of a cluster randomised controlled trial, *Emerg Med J*, 26:446-451.

12 Woollard M. The role of the paramedic practitioner in the UK. *JEPHC*, 2006;4(1):990156 [online]. Available at: < http://www.jephc.com/full_article.cfm?content_id=337 >

[13] College of Paramedics (2008) Paramedic Curriculum Guidance and Competence Framework, 2nd edition, Derbyshire: ISBN 978-0-9558429-0-0

[14] Jenkin A, Abelson-Mitchell N, Cooper S. Patient handover: time for a change? *Accid*

Emerg Nurs 2007; 15:141–7.