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 incidence. 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.

[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?

[107] **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.

[108] **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?

[109] **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.

[110] **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.

[111] **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.

[112] **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.

[113] **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.

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

[115] **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.

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

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

[118] **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?

[119] **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.

[120] 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.

[121] 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.

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

[123] **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.

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

10.40 a.m.

[125] **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?

[126] **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.

[127] **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?

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

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

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

[131] **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?

[132] **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.

[133] 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.

[134] **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.

[135] **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.

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

[137] **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.

[138] **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?

[139] **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.

[140] **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?

[141] **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.

[142] **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.

[143] **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?

[144] **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.

[145] **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.

[146] **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

[147] **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.

[148] **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.

[149] 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.

[150] 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.

[151] 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.

[152] **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.

[153] 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.

[154] 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.

[155] 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.

[156] 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.

[157] 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.

[158] 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.

[159] 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.

[160] 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.

[161] 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.

[162] 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.

[163] 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.

[164] 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.

[165] 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.

[166] 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.

[167] 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.

[168] 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.

[169] 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.

[170] 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.

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

[172] **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?

[173] 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.

[174] **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.

[175] 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.

[176] **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?

[177] **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.

[178] **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?

[179] **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.

[180] **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.

[181] 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.

[182] I wanted to raise two particular points —

[183] **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?

[184] **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.

[185] **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

[186] ‘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’.

[187] Did the joint emergency services group outline what possible solutions it was considering?

[188] **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.

[189] **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

[190] ‘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’.

[191] 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?

[192] **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.

[193] **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?

[194] **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.

[195] **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.*]

[196] **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?

[197] **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.

[198] **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'

[199] **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.

[200] **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.

[201] 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.

[202] 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.

[203] **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'

[204] **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.

[205] **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.

[206] **Jonathan Morgan:** I think that that concludes that item. Thank you.

11.24 a.m.

Cynnig Trefniadol
Procedural Motion

[207] **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).

[208] 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.