Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Archwilio
The Audit Committee

Dydd Mercher, 11 Mawrth 2009
Wednesday, 11 March 2009

Cynnwys
Contents

Aelodau Cynulliad yn bresennol
Assembly Members in attendance

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

Eraill yn bresennol
Others in attendance

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

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

John Grimes	Clerc Clerk
Abigail Phillips	Dirprwy Glerc Deputy Clerk

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

Ethol Cadeirydd
Election of Chair

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

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

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

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

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

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

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

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

9.33 a.m.

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

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

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

Social Services.

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

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

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

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

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

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

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

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

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

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

9.40 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.50 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10.00 a.m.

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

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

contribution.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10.10 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10.20 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10.30 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10.40 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10.50 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.00 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

11.07 a.m.

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

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

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

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

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

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

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

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

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

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

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

11.10 a.m.

Cynnig Trefniadol
Procedural Motion

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

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

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

Derbyniwyd y cynnig.
Motion carried.

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