Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Archwilio
The Audit Committee

Dydd Iau, 18 Mehefin 2009
Thursday, 18 June 2009

Cynnwys
Contents

Aelodau Cynulliad yn bresennol
Assembly Members in attendance

Lorraine Barrett	Llafur Labour
Janice Gregory	Llafur Labour
Lesley Griffiths	Llafur Labour
Irene James	Llafur Labour
Bethan Jenkins	Plaid Cymru The Party of Wales
Huw Lewis	Llafur Labour
David Lloyd	Plaid Cymru (yn dirprwyo ar ran Janet Ryder) The Party of Wales (substitute for Janet Ryder)
Jonathan Morgan	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Chair of the Committee)
Nick Ramsay	Ceidwadwyr Cymreig Welsh Conservatives

Eraill yn bresennol
Others in attendance

Gillian Body	Swyddfa Archwilio Cymru Wales Audit Office
Jeremy Colman	Archwilydd Cyffredinol Cymru Auditor General for Wales
Simon Dean	Cyfarwyddwr Cyflenwi Gwasanaethau a Rheoli Perfformiad, Llywodraeth Cynulliad Cymru Director of Service Delivery and Performance Management, Welsh Assembly Government
Jon Falcus	Rheolwr Cyffredinol y Gyfarwyddiaeth, Ysbyty Maelor Wrecsam Directorate General Manager, Wrexham Maelor Hospital.
Meredith Gardiner	Rheolwr y Gyfarwyddiaeth, Ysbyty Prifysgol Cymru Directorate Manager, University Hospital of Wales.
Martin Gibson	Swyddfa Archwilio Cymru Wales Audit Office
Alan Murray	Prif Weithredwr, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Chief Executive, Welsh Ambulance Services NHS Trust
Jennie Palmer	Uwch Nyrs sy'n Arwain Tîm, Uned Argyfyngau Ysbyty Prifysgol Cymru Senior Team Leader Nurse, Emergency Unit, University Hospital of Wales
Judith Rees	Dirprwy Reolwr Cyffredinol y Gyfarwyddiaeth, Ysbyty Maelor Wrecsam Deputy Directorate General Manager, Wrexham Maelor Hospital
Paul Williams	Pennaeth Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cynulliad Cymru Head of Health and Social Services, Welsh Assembly

	Government
Tim Woodhead	Cyfarwyddwr Cyllid, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Director of Finance, Welsh Ambulance Services NHS Trust

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

John Grimes	Clerc Clerk
Abigail Phillips	Dirprwy Glerc Deputy Clerk

9.30 a.m.

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

Ymddiheuriadau a Dirprwyon
Apologies and Substitutions

[1] **Jonathan Morgan:** Good morning. I welcome Members to the National Assembly's Audit Committee. We have received apologies from Mike German—there is no substitution. We also have apologies from Janet Ryder. I am delighted to say that Dai Lloyd is substituting for Janet who, I understand, is away for the rest of the week in Guernsey with Mike German—do not read anything into that; they are on a Commonwealth Parliamentary Association visit. [*Laughter.*] They are in the company of a significant number of other Assembly Members.

[2] I remind Members of the usual housekeeping arrangements. The Assembly operates bilingually, so, those people who require it can receive a translation via the headsets. Channel 1 is for the translation from Welsh to English, while channel 0 can be used to amplify the sound if you find the proceedings difficult to hear.

[3] There is no indication of a fire drill this morning, so if the alarm sounds, please follow the advice of the ushers. Those are all of the housekeeping arrangements for this morning.

9.31 a.m.

Gwasanaethau Ambiwlans yng Nghymru
Ambulance Services in Wales

[4] **Jonathan Morgan:** This item relates to our inquiry into ambulance services. Members will recall that the Wales Audit Office published two reports recently. One is entitled, 'Ambulance services in Wales—further update to the National Assembly for Wales' Audit Committee', and the other, and most recent, report, which we have started to deal with, is 'Unscheduled Care—Patient handovers at hospital emergency departments'. The purpose of this first substantive item this morning, which is listed as item 2 on the agenda, is to take evidence from colleagues who work in our hospitals. I am delighted that we have four witnesses here this morning.

[5] For the record, could you just identify yourselves before we move on to our questions?

[6] **Ms Rees:** My name is Judith Rees and I am a deputy general manager for the

directorate of medicine in Wrexham Maelor Hospital. One of my responsibilities is to operationally manage the emergency department.

[7] **Mr Falcus:** I am Jon Falcus and I am the general manager for the medical directorate at Wrexham. My responsibilities cover all the medical wards, the support facilities, and the accident and emergency departments.

[8] **Ms Gardiner:** I am Meredith Gardiner and I am the directorate manager for unscheduled care at the Cardiff and Vale NHS Trust, which includes the emergency unit at the University Hospital of Wales.

[9] **Ms Palmer:** I am Jennie Palmer and I am the clinical nurse leader at the emergency department of Cardiff and Vale NHS Trust. I work closely with the ambulance service in looking at the 15-minute target.

[10] **Jonathan Morgan:** Thank you. Before we proceed to questions, do you have any opening remarks to make, or are you happy for us to proceed to our questions?

[11] **Mr Falcus:** We are happy for you to proceed.

[12] **Jonathan Morgan:** Okay. I will kick things off. Jennie Palmer and Judith Rees, the auditor general's report on handovers highlights the plight of patients who are affected by handover delays at accident and emergency departments. Patients and their families and carers can understandably become anxious, frustrated and somewhat confused by the length of any delay. In your experience, how are patients' expectations managed during times of pressure on your accident and emergency departments? Let us start with Jennie.

[13] **Ms Palmer:** Patients have to be at the centre of every journey. In some respects, the 15-minute target for ambulances has taken away from patient focus. As a trust, we try to make the patients the centre of every interaction that we have with them. We work closely with the ambulance service to ensure some sort of streamlining in the interface between the ambulance service and the trust. We have been complying quite well with hitting the handover times—somewhere in the high 80s to 90 per cent according to the data collection system that we use. The system has changed now; we have gone over to the hospital admissions syndromic surveillance system 100 per cent wholeheartedly, and our reporting has dropped from there. I will hand over to Meredith to say something about the operational aspects.

[14] **Ms Gardiner:** In our contact with patients whose handover has possibly been delayed, we have some general operating instructions in that I am informed, or the nurse in charge of a department is informed. One of us will go to speak to the patients concerned, apologise for any delay, and explain to them some of the reasons for that delay. We make every attempt to move the patient as quickly as possible. We apologise to the ambulance team as well, and also try to explain to them what is happening to move patients through.

[15] **Ms Rees:** I agree with what Meredith said about the patient being at the centre of that process. The staff in the department think about the patient safety element, and how important it is from a patient's safety point of view to move the patients quickly from the ambulance into the area where they are best cared for. We tend not to talk about the targets, but more about the safety issues on the floor and what is best for the patient—the targets will take care of themselves if we do that properly.

[16] On performance, our department's performance against the four-hour target, the eight-hour target and the 15-minute target is good, but there is room for improvement in all of those areas. Jon will talk more later about our whole systems process and how we will improve that,

but we are conscious that while people are outside in an ambulance, it is an anxious, uncomfortable and difficult time for them—they are sick people and sometimes the relatives are with them in the ambulance or are close by—so that anxiety is managed and helped along. We try to make sure that we have good communication with the patient and the relative at that time.

[17] We have done some work with the ambulance service and our colleagues in Ysbyty Glan Clwyd—which is part of our trust—on how we can more safely manage the risks and the care for those patients while they are in the ambulance. No-one would agree that it is the right thing to do because everyone thinks that no-one should ever wait outside a hospital in an ambulance, but that inevitably happens so they must be managed safely when they are there. We are going though a process of putting in a monitoring system based on what the ambulance service needs to do and what information we need to receive from it about the condition of the patient in the ambulance, so that we can manage that as well as the person in the department because the person in the ambulance might be more sick than the person in the department. It is about how we manage all of that appropriately.

[18] **Bethan Jenkins:** Thank you for coming in to give evidence. I am looking at paragraphs 1.6 and 1.7 of the report, which talk about the pressures on nursing staff, especially when excessive delays in handover coincide with the pressures that you previously outlined. Do some nurses feel powerless to prevent delays as outlined in the report, and how does this affect morale in the team? Does this affect their relationship with the paramedics in transferring patients from one area to another?

[19] **Ms Palmer:** Staff do feel powerless. In the Cardiff and Vale NHS Trust we offload every ambulance as soon as they arrive. We then have a horrible picture, which people may have seen in the press, of queues in the corridor. Anyone who has to walk past a patient who is lying on a stretcher in pain, and their relative, feels totally helpless. That is not what people go into nursing for, it is not what nursing is about, and it is certainly not what patients expect.

[20] The flip side of that is where can you put the people on the trolleys that have been offloaded from the ambulance that also face a delay in getting into a hospital bed? Do we leave them in the corridor to prioritise ambulance patients? When pressures are very high and when we are not able to hit even the four-hour target or the 15-minute target, deciding which patient should have the priority of care is a very difficult decision for any nurse to make. It is then difficult to communicate that decision to relatives and the patient. In the back of every nurse's mind is also the fact that there is someone else out there who has called 999, and that we are delaying that ambulance and crew in getting to them. The ambulance crews also feel that—they do not come to work to stand in a corridor for an hour, or sometimes longer; they come to work to help people at the front line. As a service, we are aware that we sometimes prevent that from happening.

[21] **Bethan Jenkins:** Judith, do you have anything to add to that?

[22] **Ms Rees:** I agree that if the staff are not able to deliver the appropriate care at the right pace and in the right way to patients who might be waiting outside in an ambulance, or because the department is generally busy even if ambulances are not waiting outside, it is an anxious and worrying time for staff because they care about what they do. It is the care that they give to patients and what is happening to those patients that is most important to staff.

9.40 a.m.

[23] They are not driven by the target in that sense; they will not see patients according to who has been waiting the longest and therefore might breach a target, but according to who is the sickest. So they focus on that, but there are different pressures. When there are delays in

our patient flow process, staff feel powerless to influence that, but that is my job, the lead nurse's job and Jon's job. The relationship that we have is important in ensuring that we pull through that quickly. I am immersed in what happens in the department throughout the day and we have a good escalation plan, but, even before that is implemented and the department gets quite hot, I will know about it because of my constant monitoring of the situation. However, we have a good escalation plan to instigate improvements in flow, if we need to, quite quickly. There are other pressures that are not about beds. For example, there are seasonal pressures. At this time of year, pressure can be about an increase in the number of attendances in the department, with a different type of patient coming through, with less pressure with regard to beds. Care can often be about those who we call emergency department patients—it about patients who are coming in and out, rather than about beds. So, that is in their control, but there can be too many patients and not enough staff—in an emergency service, you cannot control when someone comes in, as you can with elective treatment, so there is an element of powerlessness. Again, it is then my job to get in there quickly and to work with the lead nurse—she would have been here today, but she is on holiday—to ensure that we make that flow more quickly and support the staff in that. However, there are definite frustrations.

[24] On your point about tensions with ambulance crews, they can arise at times if we are holding ambulances outside, because crews know the importance of getting the ambulance back on the road for the next patient who needs to be brought in. There is equal pressure from our staff, because they also know the impact that not being able to bring the patient into the department quickly enough will have. We do not operate a corridor wait, but hold the ambulances outside. We do that for a number of reasons. The pressures are on both sides, so it causes a little tension at times. However, we have a pretty good working relationship with the ambulance crews and their leading officers, which enables us to work through those issues quite well.

[25] **Mr Falcus:** To pick up that point, the issue that is highlighted in the report is that there was a feeling that a policing role was being played by the emergency departments, but we have got over that. It was a cultural thing, but we have now reached a point at which there is an understanding that it is a shared target between the emergency department and the ambulance trust. We have got over the idea that people are policing. People are taking reminders to use the system as that: reminders, not necessarily policing. Over the past few months, we have got around that and there is a much more positive attitude.

[26] **Bethan Jenkins:** It is also a shared experience now. As you will have read, it was about the location of the data terminals. Do you think that, because of that cultural change, it does not matter where the terminals are located, and that it was more about the ethos of delivering the target together?

[27] **Ms Rees:** It is both. The location of the terminal is important, because its visibility acts a reminder to the crews and staff. If you put a terminal in a location that is not easily accessible, it is easy to walk past it, forget about it and not to use it. So, its location is important. We are going through a structural change in our department. We have put the terminals where best we can in our current configuration, but, as we make our improvements over the coming months, we will change the location of the terminals to make their use easier. There is also a cultural issue. We have seen a big change in people's attitudes and, from my personal observations, I think that the culture has improved quite significantly over a period of months. People used to feel that they were being monitored too closely and followed up too tightly and that ED staff were checking up on ambulance crews, and there were some slight tensions there, but it is hugely different now. It is automatic. We have been doing some very close monitoring in recent weeks to try to improve our compliance with hitting the screen, which is important, and the attitude of the crews is much better. It is very rare now for there to be an attitude that is not quite acceptable or for someone to challenge it or make a comment.

Complaints are few and far between. It is quite automatic for the crews to come in to do the notification and, quite often, to do the handover. There has been some tension over whose responsibility it is to the handover, the department staff or the crew staff. There are still one or two issues there, but generally the attitude has swung round quite considerably.

[28] **Janice Gregory:** Good morning, and thank you for coming to committee this morning. My questions are on the hours lost at emergency departments. My first question is to Jennie. Annex 3 of the report is quite clear about the hours that have been lost in the University Hospital of Wales. In November 2008, a total of 547 ambulance hours beyond the maximum 20 minutes given for turnaround were lost. Has the number of hours lost reduced since then?

[29] **Ms Palmer:** I do not have any specific data to back it up, but it has been reduced and we are looking at processes and trying to streamline the process for patients who come through the front door. We are looking at new ways of working, and we have recently appointed a new clinical director who has come in with many new ideas on how we can improve processes. In that respect, we are trying to process and stream patients into a specific area where we have a medical team waiting for them. In that respect, we can offload the ambulance stretcher and the crews much more quickly and efficiently and improve handover times.

[30] We are also doing some work with the ambulance liaison officers on whether we can double up patients, when we have times of pressure, to be able to release crews to again reduce the number of lost hours for more than one crew. I appreciate that we will still be having lost hours for a crew, but we are looking at ways of working where we can cohort patients—although the term ‘cohort’ is not a very nice term to use—and so release crews to be able to get back on the road to deal with patients who need them more urgently.

[31] **Janice Gregory:** So, you are quite confident that you will bring those hours down substantially, are you?

[32] **Ms Palmer:** Yes. I am confident that we are doing that. The processes are proving that.

[33] **Janice Gregory:** That is great. Thank you. My next question is to Judith. According to annex 3 of the report, at Wrexham Maelor Hospital a total of 100 hours were lost for the same month, November 2008. If you look at the previous hours, you will see that there is a discrepancy. Can you explain why 100 hours were lost?

[34] **Ms Rees:** In which figures is there a discrepancy?

[35] **Janice Gregory:** I am looking at the report. Perhaps I am reading it incorrectly. I cannot find it now; I need more fingers to keep in the report. It is the discrepancy—

[36] **Lorraine Barrett:** Is it between Cardiff and Wrexham Maelor?

[37] **Janice Gregory:** Well, I can answer that question. I assumed that the question that I needed to ask you was about the discrepancy between the number of hours that you lost in November and the previous hours that you lost.

[38] **Jonathan Morgan:** For clarification, I think that the question is about the fact that, in November 2008, 547 ambulance hours were lost at the University Hospital of Wales, but in the same month at Wrexham Maelor Hospital, fewer than 100 hours were lost. The issue that we want to try to tease out is what is it that is different between Wrexham Maelor Hospital and the University Hospital of Wales that means that there is more of a difficulty in south Wales, compared with hospitals in north Wales. Obviously, you lost fewer hours, so I am just wondering whether there is a reason for why fewer hours were lost.

[39] **Janice Gregory:** I can answer that question, I think. Forgive me, Chair, but if our witnesses do not want to answer that question, I do not think that that is one of the best questions. It is about the north and the south and different hospitals, and looking the number of people coming through the doors.

9.50 a.m.

[40] **Mr Falcus:** I cannot comment on the situation at the University Hospital of Wales, but I can say why I think that, generally speaking, we do fairly well with ambulance turnaround times. In north-east Wales, we have a very good history of working together, and not just with ambulance staff. We have recognised for a good number of years that this is a whole-systems issue, and although we are today concentrating on ambulance handover time, the real issue is the whole system and the flow of patients through the hospital—the discharge arrangements, and so on. We are not good enough at that, but we have historically had good working relationships with colleagues in local authorities and social services departments, and with the ambulance trust at the front door; we have a long history of working together and trying to solve this problem of patient flow. That is probably what sets us in a fairly good position for ambulance handover times—we have a very good emergency department with very good senior medical staff who work proactively, and that is another of the key issues. As to the difference, we do not work in a major tertiary city-centre hospital, so I cannot comment on why there is a difference.

[41] **Janice Gregory:** In case you are wondering why I was unhappy with that, just as an example—and this is not to take anything away from what you are doing in Wrexham—there is a significant difference in the number of people through the doors, and that needs to be put on record, Chair. I am sure that what you are doing is great, and if it was replicated elsewhere, that would be good, but in UHW there are almost 2,500 people going through the door, and in Wrexham there are nowhere near that many. However, I take your point about the good work that is being done there.

[42] **Jonathan Morgan:** What might help is a quick follow-up question that both UHW and Wrexham Maelor could answer. Looking at the situation in both accident and emergency departments, what is the capacity with regard to the number of staff that are attached to those departments, and what is the capacity of the medical assessment units that patients would be seen in, once they come through the door? The areas that you serve obviously have significantly different populations, and I would be interested to know the capacity of both units. Perhaps we could start with Jon from Wrexham Maelor.

[43] **Mr Falcus:** We serve a population—it varies according to whether you are buying or selling—of about 250,000 in north-east Wales. Our accident and emergency department was originally designed to cope with a capacity of about 45,000 attendances a year, and we are currently getting about 60,000. We are undergoing a redevelopment, as Judith said, which will expand our capacity and add a clinical decision unit, which is one of the keys to managing increases in demand. What we are designing should be able to cope with the foreseeable future.

[44] As for the systems behind that, we have a medical admissions unit and surgical admissions unit with around 40 beds. Over the last few years we have identified that physical capacity is not necessarily the key to this—it is also about the standard, competence and seniority of the decision-makers and staff within your departments. The more senior staff that you have at the front door, the more you are able to turn around the demand that is coming through it. So, it is not just about beds and capacity.

[45] **Ms Gardiner:** It is an interesting question. I will take it in three different sections.

First, on the structural capacity of UHW's emergency unit, we currently have a series of compartmentalised rooms in which we will see a variety of different patients according to their need. The department was built around 10 years ago with the capacity to deal with the patients that we predicted would come in. We are currently undertaking a re-survey to understand the patterns of demand that are coming through and to look at the potential for redesigning the department. Once you get through that initial structural shape of the emergency unit, there are two further assessment units. There are about 26 trolleys in our surgical assessment unit and a further 22 in our medical assessment unit. Similar to our colleagues in the north, we are looking at how we use the assessment unit capacity and at whether a clinical decision unit would be an option for us in the not too distant future. I am pretty certain that, with some tweaks in our capacity, we could manage our flows better, but our problem is around the demand coming through the doors and the fact that there is not a straightforward bell curve; there are big fluctuations 24 hours a day, seven day a week, and across the year, as well. It is about understanding those flows and matching our structural and staffing capacity to the demand.

[46] On staffing capacity, we have excellent medical and nursing staff. We have invested heavily in nursing staff and in improving their skills to develop more emergency nurse practitioners, for example. Where we have a much bigger problem, unfortunately, is with our medical staffing complement, particularly at middle-grade level. You may already be aware of the national staffing shortages that we have, which affect our ability to recruit to all the posts that we would like to see filled in our department. The royal college of emergency physicians has recently created guidelines on the exact numbers of medical staff in the department and, unfortunately, we fall short. So, at a structural, demand and staffing level, there are big implications for us, and that is just within the department. The running of the department is only as good as the capacity that we have in the rest of the hospital to ensure speedy admissions and in the wider community to provide alternatives to admission. So, several issues affect us in Cardiff and we are trying to work through them at the moment.

[47] **Jonathan Morgan:** That is helpful. Are there any further points on that, Janice?

[48] **Janice Gregory:** No.

[49] **Jonathan Morgan:** Dai Lloyd is next.

[50] **David Lloyd:** My question follows on from that. Previously, I was a junior hospital doctor in several south Wales hospitals. I spent half my time in accident and emergency units facing upwards of 40 people at any one time with various bits of their anatomy dropping off, and the other half as a junior medical or surgical houseman dealing with upwards of 20 patients at any time during the 24-hour on-call period expecting me to find them a bed—and this was back in the 1980s when that was the junior houseman's job. This is a Wales Audit Office report and, from an auditor's point of view, not the greatest stress in the world is placed on the demand side, to follow on from the last series of answers. All the questions need to be set in the context of the huge demand placed on the service at any given time. Having given that rolling preamble, my question relates to paragraphs 1.25 to 1.32. The true extent to which patients are delayed during the handover process is unclear, and handover times are not being consistently recorded because of problems with data terminals and human behaviour.

[51] If the auditor general were before me, I would have some questions to put to him on those statements, but he is not here and you are. We are back to data terminal systems again, and I know that you mentioned those briefly in answer to Bethan Jenkins. Given the huge numbers of the public presenting at any given time with all sorts of illness, we are now focusing on whether staff are fully trained to use the data terminal system, particularly to reset it if it malfunctions. What are the barriers to dealing with the data system?

[52] **Jonathan Morgan:** We will start with Meredith, or Jennie. Perhaps Jennie—

[53] **Ms Gardiner:** Jennie has first-hand experience of this, so I will let her answer this.

10.00 a.m.

[54] **Ms Palmer:** The problem stems from the design of the terminals and the design of the data collection. It was not really designed with users in mind—or the service, to some extent. It is not very user-friendly. The data that are collected on it are very crude, so there is no capacity within the system to document those patients who go into the resuscitation area, who need high-priority care, and for whom the ambulance handover screen is not a priority. The breach reasons on it do not necessarily reflect specific units. I appreciate that it is an all-Wales system—and my colleague from Wrexham may be able to back me up on this point—but the breach reasons are all-Wales reasons and not unit-specific, so they do not represent what is happening on the floor.

[55] In some respects, having live feedback is useful for data collection but, from a user's point of view, it is not very useful to have to put in data live because of the patients whom we are dealing with. On the training, we have recently employed an ambulance liaison officer, and he and I are doing some joint training with the ambulance service and staff. We have recently employed some new healthcare support workers, and it will be their role to do the data entry, so that we do not detract qualified staff away from assessing patients. So, we are looking at groups of staff and at how the system can help. In some respects, the data entry system is not user-friendly.

[56] **David Lloyd:** Okay. Does that cover the situation in Wrexham?

[57] **Ms Rees:** To a degree, yes. In the beginning, there was definitely poor compliance, with pressing the buttons on the screen. We had good support and training to start with, which took place jointly with ambulance and nursing staff. There was not a huge amount of discussion prior to putting the terminals in as to how they should look, from a service point of view. As Jennie said, we had what we were faced with. There are issues surrounding the breach reasons, but I know that the task and finish group is looking at them, and is looking to people like us to put forward reasonable reasons for a breach of the 15-minute period.

[58] It is better now, as staff are more comfortable with using the screens. There were technological issues at the beginning, for quite a number of months. There still are glitches, but it is getting better. One issue is the time that it takes staff to reset the screen if they need to. We have support cards under every screen to advise staff what to look for. So, if it is not doing this or that, it gives the answer and tells you how you reset it. We also have a training guide that explains how to reset the screen. As Jennie said, when the nurse's priority is the patients on the trolley, the screen is not such an important thing for them. That is why our manual system shows a different level of performance compared with the screen. That gives a truer reflection of the 15-minute handover, which is the important bit, namely caring for the patient within 15 minutes, not having the time to press the screen. So, we are getting over those glitches quite well now.

[59] **David Lloyd:** That was an excellent answer, thank you.

[60] **Lorraine Barrett:** The first part of my question about the use of the screens or the data terminals has been answered by the responses to the last few questions, but is there any confusion or inconsistency over which members of staff should be inputting the data?

[61] **Ms Rees:** I do not know whether Jennie agrees, but there was definitely some

confusion at the beginning. Once the decision had been made to put the screens in, we worked through the training with our Welsh Ambulance Services NHS Trust colleagues, working on how it would happen and on our implementation programmes, and we reached agreement that notification would be the responsibility of WAST, so the ambulance crews. The initial perception was that the handover was the responsibility of the hospital staff, but we came to an agreement that, because patients are handed over to the nursing staff who immediately start caring for them in almost every case, it was quite reasonable to ask the ambulance crew to input the completed handover onto the screen. In the beginning, there was a definite difference of opinion, as the ambulance crews were of the opinion that the handover was much more for the hospital staff, not them, to do. That is probably why our performance at pressing the screen was quite poor at the beginning, but it is much better now. The crew does not even think about it and does the handover automatically in many cases. I witness that daily. However, there is still the occasional crew member who says that it is not their responsibility, and we are working closely with our WAST colleagues to identify those crew members, who are taken to task if they are not doing what they should be doing.

[62] Things are much better now that the most appropriate person, clinically, does it. As Jennie said, the big weakness—if it is a weakness, as you could argue that it is a strength—is the resuscitation area, because the condition of patients brought to that area means that they will virtually automatically require a 15-minute handover. As soon as that patient arrives, care is provided, so definitely within 15 minutes. The ambulance crew, the nursing staff and the doctors who are there at that time are, rightly, focused on dealing with the urgent and critical care of that patient. The last thing on their minds is the ambulance handover screen. Even when the ambulance crew has finished handing over a patient, given the nature of the illness or condition and the circumstances in which someone has been brought to the resuscitation area, the ambulance crew can often walk away without inputting the data. That is unintentional, and they do so because they are moving on to their next job, and the focus is on the patient.

[63] Again, we are in discussions with WAST on how we can resolve that. When the allocation is made through its computer-aided despatch system, it could identify that the patient is going to resuscitation and so the handover will automatically be concluded within 15 minutes. There will never be a time when there is not a 15-minute handover time for a patient requiring resuscitation.

[64] **Lorraine Barrett:** We have all learned a lot about these data terminals and handovers. Finally I have a clear picture of this. Hypothetically, is it for the ambulance staff to say, ‘My responsibility ends here, so I am logging that that is the end of my hourly responsibility’, or is it for the nursing staff to say, ‘I am taking over responsibility for this patient’? I can see that there is a role for both, is there not? Is there a right or wrong way, for audit purposes?

[65] **Mr Falcus:** We have gone through this cultural change. When the arrival of the ambulance was seen as the absolute target, and that was what was monitored in performance measurement, the staff did not react terribly well to that, it is fair to say. When we explained that, although it was a target, the reason for it was to get ambulances on the road, to focus on patient care issues and so on, they understood. We have overcome that initial hurdle that this was about their performance being measured in some way.

[66] Over the last month or so, we have seen that this is now a part of how they work. It is a shared responsibility in the same way as ambulance crews and emergency department staff work jointly to help each other out. It is not a them-and-us situation; it is about providing joint care for the patient. Working jointly on this is the same as just asking someone to pass you a drip stand or whatever; it is the same type of approach. That is the point that we have moved to. The important point is that we are not talking to staff about the need to hit the 15-minute target but about the reasons why we need to hit it and be as slick as we can. Staff understand

that. We are beginning to consider how we measure that and whether it becomes an unconscious competence; it has just taken us some time to get there.

[67] **Lorraine Barrett:** When Jennie replies on this, could she give us an idea of how long it takes to input those data and how much detail is required? I am not sure that we know how much detail needs to be input.

10.10 a.m.

[68] **Ms Palmer:** It may be useful if we go through the three processes that happen on the ambulance screen. When a crew arrives at UHW, or any hospital in Wales, they automatically generate an 'arrive', which comes up on the ambulance screen as a job number and an 'arrive' at the hospital. When they book their patient into the emergency department, they then need to click onto the screen and put in their pin number to say that they have notified the hospital that they have arrived. It is from that notified time that the 15-minute clock starts ticking. The crew, in the Cardiff and Vale NHS Trust, will speak to an assessment nurse and be directed to an area that is most suited to the patient's clinical need. The handover occurs and the definition that we have jointly agreed, between the ambulance service and the trust, is that when the ambulance stretcher is empty, that is when handover, in its crudest sense, has occurred. From there, it is about making a member of staff available, whether that is ambulance service personnel or a member of the trust, who then clicks on the screen to say that handover has happened. It is from the notification, when the crew has booked the patient into the reception area, to the handover resulting in an empty ambulance stretcher that the 15 minutes comes from.

[69] **Ms Gardiner:** The final element is when the ambulance vehicle is ready to depart to pick up its next casualty. So, there are almost four stages to the way in which it is recorded. The actual inputting onto the screen is not that difficult; the issue is more around the data that the screen is displaying, in that there is just a figure that you then have to match up to a piece of paper that is attached to the patient. It is not a very easy thing and it is a bit fiddly. It is not as user-friendly as it could be.

[70] **Lesley Griffiths:** The auditor general's report states that, at times of extreme or particular pressure, ambulance liaison officers are employed—I think, Jennie, that you have referred to them. This enables the paramedics to hand the patients over to an officer, so that they can get back on the road, which is good, but does that mean that the patients are just hanging around the corridors waiting? How often are these officers employed at the hospital? Perhaps you could start, Jennie.

[71] **Ms Palmer:** At the moment, we have one officer—[*Inaudible*.]—we have to cover a range of times. At the moment, he has only been in post for two weeks.

[72] **Ms Gardiner:** It is a pilot scheme.

[73] **Ms Palmer:** Yes, it is a pilot scheme for four months. We are looking at where our peaks in demand are and where some of our compliance, from the ambulance service and the trust, is failing. We are trying to get him to look at those peak times. We do not see his role as one of taking over handover from existing crews. At the moment, pressures are not too bad and crews are able to offload straight into a clinical space. In times of pressure, it is about getting a balance between the liaison officer co-ordinating the ambulance crews as they come in and dealing with handover and taking ownership of patients. We have not been able to bottom out exactly where that line will be. As a trust, I think that we see the role of the liaison officer as being to co-ordinate the service, to keep on top of the service, and to escalate when necessary to the appropriate people, not necessarily of dealing with handover, taking ownership of patients and looking after them in a corridor.

[74] **Lesley Griffiths:** You say that you are doing a pilot scheme. Are you doing any other work alongside that to try to improve things or is this what you think will improve things?

[75] **Ms Palmer:** We are doing other work. We have new staff who are starting. We are doing lots of training. We have put in two new terminal stations that are more visible in the clinical areas. We are looking at how the flow of patients is working, so that is about looking at the system and trying to make it more user friendly, in a more appropriate area, to try to increase compliance as well.

[76] **Ms Gardiner:** It is also about the clinical effectiveness of the handover. We want to develop an agreed protocol with the Welsh Ambulance Services NHS Trust about the content of the handover. I do not think that the 15-minute handover is the main thing—we need a clinical peg to hang on that. If we can improve the clinical process and the nature of the handover, and if the nature of the information that is shared between teams is appropriate, then the 15-minute handover time and the need to press that button will come with it. For us, the ambulance liaison officer is about improving the quality of the handover as well as its timeliness. That is why we are piloting it, because it is as much a training role as anything else.

[77] **Lesley Griffiths:** Do you think that the employment of these officers presents any clinical risk to patients?

[78] **Ms Palmer:** No, I do not, because I do not see the ambulance liaison officer as a role with clinical accountability for the patients who are in the corridor. Currently, I think that it is more a matter of helping the process rather than being clinically responsible. In that respect, no, I do not think that they do.

[79] **Lesley Griffiths:** So, it is just to address the handover and turnaround times.

[80] **Ms Palmer:** Yes.

[81] **Ms Rees:** We have a different approach in Wrexham—[*Inaudible*.]—which were quite effective from a communication and relationship point of view. That stopped quite some time ago—I cannot remember exactly when. If we find ourselves under pressure, with a few ambulances outside, then the ambulance service will send an ambulance liaison officer to work with us to identify the problem and how quickly we can release those ambulances, and to see what we are doing to manage the process to address the cause of the blockage at that stage.

[82] The patients remain outside in the ambulances; we do not bring them in to a corridor. There are a couple of reasons for that. It is partly because we have been going through such a structural change that it would not be safe anyway, because the corridor can be a bit of a building site. Our view is that the clinical risks would be greater for them if we were to bring them in to a corridor; at least in the ambulance the crews have some pieces of kit, so that, should the patient suddenly deteriorate, the crew can react. If they bring their patients in to a corridor, we have no quick access, because all our spaces are full and all our equipment is in use. That is, therefore, not a process that we would follow.

[83] The ambulance liaison officer comes to us and he will work with the crews manning those ambulances outside. Occasionally, if it is safe to do so—and they will make the judgments—they might put two patients in one ambulance, depending on their condition and a number of other factors, and that would release one of the ambulances to go back on the road. Mostly, that officer will work with the crews to assess which are the most serious cases to be admitted next, because it is not always the one who has arrived first. You might have a

sicker patient in the most recent ambulance to arrive, and the crews' judgment might be that that one needs to come in next.

[84] We have ambulances not just from the Welsh Ambulance Services NHS Trust, but from England as well, as we are on the border. There are different targets, different relationships and different ways of working, but they are all equal for us. Regardless of whether the ambulance is from Wales or from the west midlands with a patient from Shropshire, patients are brought in according to clinical priority, and not because they are from a certain county.

[85] **Mr Falcus:** The other thing to add is that, before Christmas, we instituted a rapid escalation policy. We have urgent bleep systems, so if the accident and emergency department reaches a certain point, then it is down tools, from management to senior doctors, senior and lead nurses and so on, and everybody responds immediately to the situation. We look at what the issues are and what we can do to immediately unblock the downstream issues. Our point is that it is not necessarily about creating a bigger reservoir at the front door; it is about how we can safely get the patients who are already there through the system. That has worked pretty well. We have had very good responses from clinical staff and managerial staff across the trust.

[86] **Ms Rees:** As I touched on at the beginning, we acknowledge that there is a clinical risk to patients while they are out in the ambulances, but there is no formal monitoring of that, with reporting back between ambulance staff and the emergency department. It has been more an informal form of monitoring, to keep an eye on the patients while they are out there. We are going through a process now, having had quite a large meeting on the issue, of formalising that arrangement, looking at early warning scores, and looking at how we can apply specific monitoring for patients at different times, because the crew make certain observations when they pick a patient up, but those might not be taken again until the patient is in the department. If they are going to be out there for any great time, we identify the observations that we want the crews to take, so that they can feed that information to the lead nurse or the nurse in charge of the department. Then, there is a joint review of how sick that patient is compared with somebody who may already be in the department. We ask whether that means that we can bypass the emergency department altogether and move them straight through to a ward, by a reorganisation of patients who might be on our wards. So, we are doing quite a large piece of work on that.

10.20 a.m.

[87] Once we have done that monitoring, which should not take much longer, we will pilot that for a while with Ysbyty Glan Clwyd, because we are doing it jointly. If that is successful, the ambulance service is keen to roll it out across Wales; but we will see how it goes. We are confident that it will make it safer for the patients who we have to keep out there.

[88] **Lesley Griffiths:** You have both mentioned the doubling-up of patients in ambulances. I do not know if you can answer this question, but is that practice usual?

[89] **Ms Rees:** It is quite rare from my experience in Wrexham.

[90] **Ms Palmer:** With time and capacity issues, it can happen, so it probably happens in our trust more frequently than it does in Wrexham. We have difficulty at the moment with regard to the data collection from the handover screens. When we double-up patients and assess the clinical risk and patient need within that process, that information is not captured on the data system at the moment. We are doing some work with the all-Wales team to look at how we can capture those data.

[91] **Nick Ramsay:** Paragraphs 2.1 to 2.10 of the auditor general's report are on unscheduled care and the handovers at emergency departments. There was a feeling in some hospitals that meeting the four-hour and eight-hour targets was a higher priority than meeting the handover target. Why might this be the case? In other words, why is the target for handovers not seen to be as important in some hospitals?

[92] **Mr Falcus:** I would not accept that comment, from a Wrexham point of view. The four-hour target has been there for longer and the organisation is more aware of it. On the 15-minute target, we have tried to sell the message about patient flow that will deliver the 15-minute target. As I have said before, staff do not necessarily react well to a target of 15 minutes. They react to creating capacity in the patient flow, thereby delivering more rapid ambulance handover times. That is the message that we have given to staff. They may not report that it is being given a priority, but that is more to do with the way of selling it and wrapping it up. The staff in the hospital are clear about the fact that we need to improve our patient flow, and the four-hour target is very useful in demonstrating or monitoring the pressures within our system. The target of seeing 95 per cent of patients within four hours is a good and useful target. My only slight criticism of a 100 per cent target is that, if you miss it by one patient, you have missed it, whereas with the 95 per cent target you can have clinically appropriate breaches and you do not make inappropriate clinical decisions around the target.

[93] **Ms Gardiner:** I agree with that. At UHW, it is about eliminating corridor waits for patients, which we consider to be completely unacceptable. So, any target that helps as a lever for that is very important, and must be backed as well as we possibly can.

[94] **Nick Ramsay:** Do you think that there is a danger that staff might consider delays to be evidence that they can use to show that they are under-resourced?

[95] **Ms Gardiner:** Yes.

[96] **Mr Falcus:** What we have worked hard to do within our trust is to get a real sense that this is about the patient, and to look at it from the patient's perspective. The staff respond very well to that. Talking to them about targets is not necessarily the best way to get the staff there, but it is a useful management tool to measure that. I do not think that we have that level of gaming, but there is no doubt that staff could use delays in the system to highlight deficits in resource.

[97] **Ms Rees:** I do not think that, at the minute, our staff are purposely adding delays to patient care to enable them to demonstrate resource issues.

[98] **Nick Ramsay:** I was not suggesting that there is any increase in delays, I just wondered whether, because the delay existed, it might be easier—

[99] **Ms Rees:** It is an indicator of the pressure that we are under.

[100] **Mr Falcus:** That is how we use it. We use the handover target and, particularly, the four-hour target, and we have just run an exercise called the perfect fortnight across the whole trust and social services to try to improve and to engage staff in that perfect flow. One of the measures that we use to demonstrate improvement is the four-hour target because, if we get that right, the ambulance handover will not be an issue. So, if we get our patient flow, our delayed transfers of care and so on right, we will not have a problem with ambulance handover times.

[101] **Nick Ramsay:** I suppose that, in my last question, I am trying to return to Bethan Jenkins's earlier question about the culture that grows in the department. We are talking today about how we do not think that these handover delays are acceptable and that the best-case

scenario would be to eliminate them altogether—it might be impossible, but we would like to. Is there a danger that handover delays are becoming part of the culture?

[102] **Ms Gardiner:** There has been a long-standing culture in which there has been an acceptance that patients can wait. That needs to change. Part of the changes with the screens coming in is that people will see that they are being watched and that their performance is being noticed. Perhaps that has not always been the case in the past. There is a big move by all of us to change that culture and to focus on the patient and get them moving to where they need to be seen. In relation to that, that is where the target is a driver.

[103] **Huw Lewis:** I wanted to open up the questions beyond the mechanics of handover per se to look at where emergency admission sits in the whole hospital system. This has been much discussed and debated, but can you give me a snapshot of what problems your hospitals need to overcome and how the whole hospital operation is impacting upon emergency admission? Are we still talking about bed capacity as the primary problem? Are there other issues that are having an impact, such as getting a specialist assessment done promptly and are we still, for instance, looking at hospital discharge as having a major impact on what is coming in through the front door of the hospital? Are things changing? This has been flogged to death in discussion, but how is the situation evolving, and can you provide a snapshot of what is going on today at Wrexham Maelor and UHW?

[104] **Jonathan Morgan:** We will start with UHW.

[105] **Ms Gardiner:** We all know the issues that have been apparent in UHW for a number of years. A relatively new management team has come in to look at unscheduled care in the organisation as a whole. We have skilled staff and we have a lot of enthusiasm at ground level to make the change. With that, there is a lot of hope for the future. The biggest issue for us is getting that flow and getting past that point at which the patient waits or pauses in their flow through the process. There are issues around capacity in the Cardiff and Vale NHS Trust, which have been well-documented, but the key issue is flow—moving the patient forward through the department into the rest of the hospital and back out into the community.

10.30 a.m.

[106] For that, we need to look very carefully at seven-day-a-week working and making sure that we have health and social services that are responsive throughout that seven-day week. If I am honest, it is also about breaking down some of the professional boundaries and expectations about what can and cannot be done and who can do that particular task. That flexibility and the need to work more flexibly have to be pushed at all levels within health and social organisations.

[107] **Huw Lewis:** We have been saying this for years, have we not?

[108] **Ms Gardiner:** I know.

[109] **Huw Lewis:** So, are things changing? Are things better than where we were two or three years ago?

[110] **Ms Gardiner:** I think that there are signs for change. Certainly, there are some key people in key decision-making roles that have changed recently in the Cardiff and Vale NHS Trust at both a managerial and clinical level. If these people have the right support to manage that change, great things can be done.

[111] **Mr Falcus:** From Wrexham Maelor's point of view, I would agree with everything that Meredith has said. As to whether it has improved, the issue is that the situation is always

changing. As we take patients out of the acute system as drugs, diagnostics and so on improve, they are being replaced by an older and more complex group of patients. It is an evolving situation rather than just a fixed situation that we can solve.

[112] As I mentioned earlier, we have just run a two-week exercise in the trust, which again involved senior clinicians, nurses, doctors, therapists and senior management from all across the hospital, from diagnostics to surgical departments and so on to look at the patient flow issues. During that exercise, we had some light-bulb moments. We were asking 'Why are we doing this?', and saying 'We don't know; let's change it', and we had the authority and the empowerment to change those things. We came up with some of the really difficult things that we have to address, such as patient choice with regard to discharge, where I do not think that we have particularly good systems or coverage. It is a very difficult situation for us. Seven-day working is another issue and there are resource implications around that. The increase in elderly patients with mental illness is significant for us in the acute system, which was not there five or 10 years ago. There would not have been a system. This will be an iterative issue that we will have to continue to consider. The change or improvement that I would flag up is the willingness to adopt cross-agency working.

[113] **Huw Lewis:** There is a lot of resonance in the experience of both hospitals. They have things in common that just stay with us year after year as issues that need to be tackled. However, I will move on to a specific point as a follow-up question. The auditor general tells us that the performance reports that are e-mailed to managers every day are being largely ignored because they are distrusted, which is slightly disturbing. Is that the case, and are people right to distrust them?

[114] **Ms Palmer:** I think that they are distrusted, from my experience. Some of the data that have been reported are not accurate. From my own experience from a shift that I worked two weeks ago, there was a 26 per cent error, which I feel is unacceptable.

[115] **Huw Lewis:** It is as useful as a chocolate fireguard, is it not?

[116] **Ms Palmer:** In that respect, perhaps that is why there is an error. We have been working with the ambulance service with regard to that error—

[117] **Jonathan Morgan:** I am sorry to interrupt. I am very interested in what you say about the number of errors. What types of errors were encountered?

[118] **Ms Palmer:** My ambulance liaison officer colleague calls them 'ghost jobs'. On one shift that he worked there was a patient at the Royal Glamorgan Hospital who was shown on our screen as having arrived at UHW. I believe that the error is with the control room and the data that are being entered. There is a global positioning system, which should have shown that the ambulance was at the Royal Glamorgan rather than UHW, but those are the kinds of data that are being reported on a daily basis, and that is where some of the distrust is coming from. Some of the expected patients who are not included in the 15-minute handover target data are coming up as accident and emergency patients, and again, the notification of handover is not being recorded, and therefore they are giving us a false reading. There are some ghost jobs among the 26 per cent error that I found on my shift.

[119] **Ms Gardiner:** You might have more than one vehicle reporting to the same job, and only one patient involved in the incident, so only one could report completion. Also, if the ambulance has not clicked that it has arrived, we can click our button to say that we have handed over as often as we want, but it will still be recorded as a negative error on the report. There are a number of issues in the way that we validate that data, and we need to take that forward. It is something that we are currently working on with the ambulances.

[120] **Irene James:** When you talk about numbers of vehicles, are you talking about ambulances or paramedics' vehicles and ambulances?

[121] **Ms Gardiner:** Potentially, both.

[122] **Jonathan Morgan:** Huw, do you want to pursue this?

[123] **Huw Lewis:** Yes, this is worrying stuff. What occurs to me, among all this button-clicking, patient flows and professional boundaries and so on is that, as a non-professional looking in from the outside, throughout the patient experience of being picked up by the ambulance, taken to the point of care, assessed, and all the rest of it, there does not seem to be anyone in charge of that patient's experience. There are a series of stages to go through, and there are gatekeepers at each stage, and the patient is pushed from one to the next in an efficient, or perhaps not so efficient, way. The parallel that strikes me—and I know that this might sound silly—is with the television series *M*A*S*H*. I do not know whether you remember it, but it seems to me that every hospital needs someone like the character called Radar. Our patients do not ever seem to see a Radar—someone who is in charge of ensuring that the doctors, patients and staff have everything that they need to perform. Who is in charge of that?

[124] **Mr Falcus:** I do not accept that analysis. What we are concentrating on in Wrexham is the small percentage of patients that get delayed. As for the general flow and handover, that system, by and large, works well. Yes, we have capacity issues periodically, and we are putting in escalation procedures, and I have explained that they are working well now. So, as difficulties arise, we are addressing them, but I think that people are clear about who is responsible at each stage of the patient journey.

[125] **Huw Lewis:** So why do we still have problems with seven-day working not happening and the professional boundaries that were mentioned, with people not quite knowing who is responsible for what, and no-one taking responsibility in the end? That is still part of our system, and there is no-one battering through all of that on behalf of the patient.

[126] **Mr Falcus:** Seven-day working is a complex issue about resources and staff availability. On the issue of care co-ordination for the patient, we already have that in the hospital—there are people responsible for the patient at each stage.

[127] **Huw Lewis:** I could go on, Chair, but I am aware that time is against us.

[128] **Jonathan Morgan:** Thank you. Irene James has the final question—last, but by no means least.

[129] **Irene James:** The auditor general's report highlights examples of best practice in handing over patients, and I must say that, over the past few months, I have spent far more time in ambulances and accident and emergency departments with members of my family than I would have liked, and it varies from day to day. Do hospitals share best practice with other hospitals? Would a standard procedure help to reduce handover times, or do you think it is a local issue? I will push my luck and also ask whether you are revising the handover of patients in light of the auditor general's report.

10.40 a.m.

[130] **Mr Falcus:** There were a number of questions there. Yes, we try to share best practice. The emergency services collaborative, which is no longer operating, was a very good way of sharing practice. The process is perhaps more ad hoc now than it used to be. The emergency services collaborative was very good. Are we trying to improve ambulance handover? Yes we

are. Is that because of the report? I would say that we were trying to do it anyway. The emphasis that has been placed on it over the past few months has brought about a significant improvement in the way in which we are approaching this and in the feedback and joint working with the ambulance trust.

[131] In fairness, to pick up on the previous point, I think that the ambulance trust had a point that we perhaps were not feeding back the discrepancies and errors as well as we could have done. It is really only as we are starting to get into using the system in anger that we are starting to give the trust good feedback on some of the errors and problems we have with it. In fairness to it, it is responding to that. Our response would therefore be that, yes, we are trying to improve the situation—and with some signs of effect as well—but we probably can do more to try to share best practice. Perhaps something needs to be done to help facilitate our doing that.

[132] **Ms Gardiner:** I would agree with that. It is interesting that you have been talking about the perfect fortnight, which was an idea implemented in my previous trust, Bro Morgannwg. I was the project manager for that, so it is nice to hear it mentioned. The team that was there is now working in Cardiff and Vale NHS Trust, so there is an inherent sharing of good ideas and practice. However, I would echo what you have said in that there is value in having national programmes for sharing practice with colleagues across Wales. That was particularly useful.

[133] The audit office report is very useful in ensuring that we take forward some of this stuff, but for me and for Jennie, it is about the quality of patient care that we are giving to people at the front door, and this is something we are really striving for at the moment.

[134] **Ms Rees:** I would like to comment on the practical issues because we have identified over a period of time that the clinical handover—a pass from paramedic to nurse—is different according to who is doing it, and there are different standards and different ways in which it is done. As a hospital, we have been looking to improve our clinical handovers by the use of a system called SBAR—the SBAR communication method. It is a formal mechanism for handing over patients. The ‘S’ stands for ‘situation’; ‘B’ stands for ‘background’; ‘A’ stands for ‘assessment’; and ‘R’ for ‘recommendations’. We have carried out a brief pilot scheme with the ambulance trust to see how using the SBAR format to hand over all care to nurses would work, and it worked very well. The ambulance crews liked it; they liked the standardisation. It means that the type of communication is standard and equal so you always get the right information. We are trying to move this on now, looking at implementing it further and at their taking it forward through their clinical governance structures to do it on a wider basis. So, that improves the whole clinical handover—the information that is passed on—which is really important for patient safety.

[135] **Irene James:** That also gets the ambulance crew back out on the road more quickly to save the next life.

[136] **Ms Rees:** That is it. It means that they are not saying the wrong things, which people do not want or need to know; it is quite clear. For each type of handover—doctor to doctor, nurse to nurse, nurse to doctor and so on—we will add certain frames. There are specific things that will be covered; the same SBAR format will be used, but different information headings will be used within that. So, with regard to handovers from ambulance crews to nurses, we have sat down with them to ask what we need to know as a department and what they want and need to give us. Those will form the headings, and we hope that that will be successful and will improve the clinical handover.

[137] **Jonathan Morgan:** We have run over by about 15 minutes, so we will need to wind matters up there. The evidence received this morning has been extremely useful. Members

were obviously very interested in what you had to tell us. I thank all four of you for coming in; it has been a very useful session. We will provide a transcript of the session within a couple of days and we will send that to you.

[138] I apologise to our next set of witnesses for starting this session slightly late. As you have seen, we have our own issues with turnaround and handover times. The evidence that we took earlier was extremely useful and Members wished to probe the witnesses somewhat further. We now continue taking evidence for the committee inquiry into the ambulance service in Wales. I ask the witnesses to identify themselves for the record.

[139] **Mr Dean:** I am Simon Dean, director of operations from the Department for Health and Social Services.

[140] **Mr Williams:** I am Paul Williams, director general of the Department for Health and Social Services.

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

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

[143] **Mr Gibson:** I am Martin Gibson from the Wales Audit Office.

[144] **Jonathan Morgan:** It is nice to see you this morning. Good morning, auditor general.

[145] My first question is to Alan Murray. The auditor general's update report to this committee stated that there had been a downward trend in category A performance during 2008-09. Do the latest figures show an improvement in this area?

[146] **Mr Murray:** Yes, they do. We have consistently achieved the sixty-fifth percentile for our eight-minute response to life-threatening emergencies since March. We are on an improving trend in terms of headline performance and equity measured by the number of local health board areas in which we are compliant with the sixtieth percentile standard.

[147] **Jonathan Morgan:** During evidence to this committee on 4 June, Professor Woollard of the British Paramedic Association told the committee that the use of rapid response vehicles to attend category A calls had enabled the trust to meet its target. However, he stated his opinion that, following the initial response, the sometimes lengthy wait for an ambulance to transport patients to hospital can result in clinical risks to patients, psychological risks to paramedics driving RRVs and an increase in the resource allocated to the call. What is your response to that view?

[148] **Mr Murray:** On the first part about delays and ambulance follow-up, Professor Woollard is correct to say that delays in the response of an ambulance where the patient needs to be taken to hospital quickly will be detrimental to that patient. We have been working on that area, and our performance in getting ambulances to patients as measured by our ninety-fifth percentile standard for responses to category A incidents within 14, 18, 21 minutes is also on an improving trend, and at the moment it is sitting at 92 per cent. There were two other parts to the question, I believe, Chair.

10.50 a.m.

[149] **Jonathan Morgan:** The first part was about the use of rapid response vehicles, but he also said that there was sometimes a lengthy wait for an ambulance to arrive after the RRV

had got there.

[150] **Mr Murray:** That is the part that I responded to.

[151] **Jonathan Morgan:** He said that, as a result, there was a risk to patients and also a psychological risk to the paramedics.

[152] **Mr Murray:** I agree with both of those statements. That is why, as I say, we are putting equal emphasis on getting follow-up ambulances to the scene within the 14, 18 and 21-minute standards that apply to urban, rural and sparsely populated areas respectively.

[153] **David Lloyd:** I will turn to the consideration of the financial implications of handover times in the Wales Audit Office report, which is mentioned in paragraphs 1.8 to 1.17. My first question is to Paul Williams. The estimated cost to the Welsh Ambulance Services NHS Trust of time lost during lengthy handover times in 2008 was £2.4 million. What plans, as a consequence—or perhaps anyway—do you have to manage capacity in a more effective way, in order to make more effective use of that resource? Perhaps capacity is managed as effectively as it can be now, in which case, what else can be done to address handover times?

[154] **Mr Williams:** There is a whole raft of issues for us with regard to turnaround times, because, as you pointed out, significant resources will be tied up and opportunity costs lost. One thing that I did when I took over this job was to place greater emphasis on improving both the turnaround and handover times. We have made some progress; we have decreased the hours lost from around 4,600 to 2,500, so we have made gains there. That needs to go back into the efficiency savings, because we are still testing the ability of the ambulance service to release more savings, in order to close the gap in respect of its budgetary responsibilities. There is still a way to go. I am encouraged by the task group that I have set up, which has been working on some of the technical issues in relation to the handover screens, and you might want to go into that in a bit more detail. We had to go back to first principles to build on how we address the issue of what is the most effective way in which we provide patient care. At the end of the day, it is about patient care and getting the patient into the hands of clinicians in hospitals as swiftly as possible.

[155] **David Lloyd:** Excellent. On the same issue of handover times, I turn to Alan Murray. At a previous meeting of the Audit Committee, we heard evidence from the Royal College of Nursing that when overstretched hospitals have accident and emergency departments that are at or near capacity, sometimes a neighbouring hospital might be better placed to accept emergency patients—although I do have to say that, from my experience, quite often there is precious little capacity along the M4 corridor in any of the accident and energy departments, and there are also issues with beds. That is as may be. The question here as regards managing handover times better is whether there is scope within the Welsh Ambulance Services NHS Trust for better capacity management in relation to which accident and emergency departments your ambulances take people. Is there scope for being versatile in redirecting ambulances to where there is spare capacity, rare as that situation may be?

[156] **Mr Murray:** Your experience was certainly the case a year and a half to two years ago, when hospitals were generally reaching capacity at the same time in different parts of the M4 corridor. However, the work that has been done since then has resulted in capacity being used much more effectively. The best that I can say is that the idea that you and the RCN have put forward is worth exploring. I could not put it any more firmly than that at the moment, because there is some finding out to do as to whether that capacity is different in one part of the M4 corridor, or indeed in one part of the A55 corridor, than it is in another at any given time.

[157] Services have been set up in other parts of the UK. Surrey, for example, set up a

capacity management system that managed the capacity of hospital beds, accident and emergency departments and alternative beds reasonably successfully. However, Surrey is a much more densely populated area than Wales. So, I could not say any more than that it is an idea that is worth exploring.

[158] **Irene James:** Following on from the points raised by Dai Lloyd about paragraphs 1.8 to 1.17, I want to discuss staffing levels. My question is for Alan Murray. Staffing levels in the south east in particular have been a problem. On 16 March, you told this committee that using non-recurrent funding, you were able to fill posts that had previously been left vacant. Are staffing levels now as they should be in the south east?

[159] **Mr Murray:** They have certainly improved. An emergency medical technician group of 12 people and a slightly larger paramedic group graduated recently. I should emphasise that having new paramedics does not put more feet on the ground. Existing emergency medical technicians are trained to be paramedics, but while they are in training, their capacity is lost, so bringing them back into the service brings that capacity back online. We are planning, this year, to train 28 paramedics, 60 emergency medical technicians, and around 50 new high-dependency staff. There will be another technician course coming on-stream at the end of September.

[160] **Mr Woodhead:** The 12 technicians who have just been mentioned will be operational next week, so very shortly. Another 24 will be operational at the beginning of September. They are already in training.

[161] **Mr Murray:** The answer is that we are continuing to work on creating that capacity. It takes time and we are training an unusually high number of people at the moment, both on EMT and paramedic courses. They are currently going to schedule, and we are replacing staff as quickly as we can.

[162] **Irene James:** Have the funds necessary to maintain that staffing level been accessed?

[163] **Mr Murray:** We have accessed funding to recruit and train the staff, yes.

[164] **Irene James:** Following on from that, at the same meeting on 16 March, you mentioned that the rota in Cardiff needed significant reworking to better match supply and demand. What progress have you made on agreeing a revised rota with Cardiff?

[165] **Mr Murray:** We had a rota review workshop in November before we met at the March hearing. Another review was due to take place in March, but, at around that time, we agreed jointly with Health Commission Wales to commission an efficiency review, which will have a bearing on the rota numbers in all rotas throughout Wales. So, we agreed that it probably would not be prudent to have two reviews following so swiftly on the heels of each other. We are awaiting the outcome of the efficiency review before we make a final decision on the rotas.

[166] **Jonathan Morgan:** I have a quick follow-up question to that, as it is an important point. When will the review that is taking place be completed? That evidence that we took from you was three months ago. The issue of rota reworking was clearly causing concern, so at what point will that review conclude, and when can we expect to see some improvement?

[167] **Mr Murray:** We are expecting to see the conclusions of that review at the end of this month.

[168] **Janice Gregory:** Good morning to you all. I want to move on to the business cases and strategic plans, mentioned in paragraphs 1.19 to 1.30. My question is for both Alan and Paul.

We heard about the business case for the replacement of vehicles back in March, and we heard that it was presented to the Welsh Assembly Government in February 2008. Given that there are potential savings of £400,000 to be made on leasing costs alone, was that business case made a priority between you and the Welsh Assembly Government, and has it now been agreed?

11.00 a.m.

[169] **Mr Williams:** It has not been agreed yet. The trust submitted its revised fleet strategy on 28 April. We reviewed that with the Welsh Assembly Government. We fed our comments back and the strategy was submitted on 25 May for further consideration. We sent those comments back on 15 June and are now awaiting the final comments. One difficulty for the Welsh Assembly Government is that we do not see the overarching strategic direction for the organisation. It is difficult for the trust to complete everything that is required, but I believe that we will make significant progress, as I am anxious to put the case before the Minister as soon as possible.

[170] **Mr Murray:** We have submitted that overarching strategic direction and are waiting for comments on that.

[171] **Janice Gregory:** Alan, do you think that you have had an appropriate level of support from the Welsh Assembly Government to produce a strategic plan? Have you been given an appropriate level of support through all this?

[172] **Mr Murray:** Absolutely. We have been working closely with Simon Dean on this, and Elwyn Price-Morris from the north Wales regional office has also been helpful by undertaking initial reviews of that plan. We have had to make some revisions to it to accommodate some new strategic content, such as the draft rural health strategy and Dr Chris Jones's vision for primary and community care, both of which have a strong bearing on what we do. However, we have been given strong support by the Welsh Assembly Government.

[173] **Mr Williams:** To add my observations, I think that the Welsh Assembly Government previously took a more distant view because, with the more traditional commissioner/provider role, it was very much left to commissioners and providers to determine strategy. We have now removed that and have become more involved. We need to consider the whole interaction. Alan Murray is right: we now need to think about how this will fit into the rural health plan and the primary community plan. So, this is a new way of working. I am clear that I will not be holding up business plans, because we are anxious to get maximum improvements to patients as quickly as we can.

[174] **Janice Gregory:** I hear that you are working together, but, on the strategic plan, the auditor general makes a comment in paragraph 1.39 about the funding uncertainties for the ambulance service. How realistic is it for it to present quite defined strategic plans given such funding uncertainties?

[175] **Mr Murray:** Is that a question for me?

[176] **Janice Gregory:** For both of you, as I am sure that you could both comment on that.

[177] **Mr Williams:** It is not an issue of uncertainties; funding is always challenging. We have a high degree of certainty about the capital programme and, over the next couple of years, we know that that will probably reduce, but that is when we will need to look at priorities and at the most effective use of those resources. On the relationship between Health Commission Wales, as the commissioner, and the ambulance trust, there is certainty about that funding. However, I think that the issue is—and we have explored this before—the level

of efficiency savings that will still be necessary, and, if there is still a funding gap following the efficiencies that are reasonably expected to be made, how that gap will be funded. Nonetheless, there is a high degree of certainty about the resources available at the moment.

[178] **Mr Murray:** That is what the efficiency review aims to establish.

[179] **Janice Gregory:** So, it is not unreasonable to think that you could produce quite robust strategic plans, given the level of certainty about the funding.

[180] **Mr Murray:** Following the actions that we have taken on training, including the efficiency review, we will soon have a much clearer picture of where we stand, financially.

[181] **Huw Lewis:** I want to continue looking at the financial aspects of your work. The auditor general's update document to us, which I think was dated March, rather euphemistically refers to a lack of a shared view on the financial future of the ambulance services trust and Health Commission Wales. I suppose that that is another way of saying that, at that time, there was a stalemate or a lack of agreement on the financial future of the trust. Where are we now on that? I suppose that that is a question for Alan, although I am sure that Paul will have comments to make as well. Does the trust now have financial clarity, at least for 2009-10? Do you know where you are going? Are you content that the funding is sufficient?

[182] **Mr Murray:** The relationship between HCW and us is not adversarial. We have agreed to commission the efficiency review jointly and to be bound by its recommendations. I guess that that is our way of resolving the issue: getting an independent expert view on what efficiencies we can achieve and what level of resources we require. We now have to wait for the outcome of the efficiency review to give us clarity on where we are financially.

[183] **Huw Lewis:** So, we do not yet know where we are.

[184] **Mr Murray:** No, but we are close to knowing where we are. By the end of this month, we should know.

[185] **Mr Williams:** The important point is that, in the meantime, we have been pressing for improved efficiency in the figures that we are seeing, and have hit the 65 per cent target two months in a row. There are a number of strands here. There is an awful lot of operational efficiency that we can pursue while the strategic issues are being looked at. I am delighted that HCW and the Welsh ambulance trust agreed to this independent review, as it demonstrates that theirs is not an adversarial relationship. We are agnostic at the moment on what the review will tell us. We will also have a view on that, and we might need to revisit matters following its results. However, we are anxious for things to move along so that we can bring a further dimension of strategic vision to this and press hard on the day-to-day operational efficiencies.

[186] **Huw Lewis:** Okay, so we have non-adversarial agnostics. This is all getting rather colourful, as metaphors go. [*Laughter.*] My next question is primarily for Alan, as I just want to explore the impact of reorganisation a little further. What do you think will hit the service post reorganisation? In the meantime, in the run-up to it, are you content that you will have an effective service and effective financial planning?

[187] **Mr Murray:** I am very pleased that you asked that question because we believe that the reorganisation will be wholly positive for the Welsh Ambulance Services NHS Trust. The reorganisation makes eminent sense to us. For us, the most important thing is that it gives us a smaller number of partners with whom we have to engage to deliver our broader unscheduled care agenda. We have already hit the ground running with that relationship because we have

contributed to, and substantially influenced, the local delivery plans of all seven organisations already. I am currently in a round of meetings with the new chief executives. I have been in contact with two of them so far, and, obviously, given that at least one has not come into Wales yet, that will take a little longer. I am meeting a couple more next month to discuss issues of joint concern, such as creating new care pathways other than admission to accident and emergency departments. I am very interested in the work that Chris Jones has been doing on primary and community care, particularly communications hubs and the importance of having 999, NHS Direct, out-of-hours services, social care—if we can influence in that direction—community nursing and mental health services all together, from a single communication point of view. With 22 local health boards and, I think, nine trusts, that would have been a logistical nightmare for us. Having just seven health communities with which to engage is a huge step forward.

11.10 a.m.

[188] **Huw Lewis:** You do not see that the journey from here to there might throw up glitches in forward planning? It is quite a change.

[189] **Mr Murray:** Yes, it is quite a change. We are in the process of reviewing our own management structures, to strengthen, among other things, our strategic planning capacity. In thinking about our strategic planning capacity, we have been looking at how we deal with local delivery plans. We are strongly of the view that it is much more important that we contribute to the seven community plans than we have some separate annex plan of our own. Our business plans, thereafter, should be operational plans that are aimed at delivering our components of the health community LDPs.

[190] **Mr Williams:** This was mentioned during an earlier session. I was absolutely clear with regard to the reorganisation that we would maintain and improve performance and service continuity. When I set the seven transition directors in place in December, one of their key tasks was to start working immediately on unscheduled care and not to leave it until the new organisations come into being in October. We are already seeing some of the fruits of that partnership working and thinking about how the whole system can operate in such a way as to relieve the tendency to use hospitals as the default position.

[191] **Mr Murray:** They are practical plans, Chair.

[192] **Nick Ramsay:** My question follows on from Huw Lewis's question on finance and the short-term efficiency savings. It is a question specifically to Paul Williams, but Alan Murray might want to comment as well.

[193] You have required the ambulance service to make the £17 million savings in 2008-09, and you want this to happen without affecting front-line services. When you account for all the other costs that have built up for the trust, such as the increase in fuel costs, the additional lease costs from the delay in the purchase of new ambulances, the lack of funding for the £0.23 million pay award, and the reduction in the funding for the air ambulance, while we all like to see efficiency wherever possible, do you not think that that saving was unrealistic?

[194] **Mr Williams:** That was the position taken by the commissioner on this service efficiency plan. I have to step back to see whether that is deliverable, because management is the art of the possible, and impossible targets are unhelpful. As I said earlier, we still have a number of areas in which we think significant savings are to be made. We talked about turnaround times, and we are starting to see the benefits there, and not just in terms of direct improvements to patient care and cash savings for the Welsh ambulance trust.

[195] We talked earlier about sickness absences, and there is still some way to go on that

issue. We have talked previously about reductions in overtime—although still significant—and that comes back to some degree to the issue of rotas. There is work to be done there, for instance. We have also talked about how to improve triaging and how to bring ambulances to the scene of a call in the most appropriate way. The question is posed as to how far those assumptions are still capable of delivering, and I think that there is still a way to go. What this efficiency review is designed to do is to give an independent view of whether those assumptions were valid. Clearly, I want to see that report as quickly as possible, to test the original assumptions made by HCW. If the assumptions were too radical, there will be a resource issue that will probably end up on my desk in terms of other priorities.

[196] Simon has been dealing with this for a lot longer than I have, and he might be able to add something.

[197] **Mr Dean:** Paul has touched on the main areas on which we are working, with the commissioners and the trust. It is about ensuring that we get operational efficiencies, which all parties would acknowledge are there to be achieved. It is a complex jigsaw because things clearly link with one another. On the rota review and getting the deployment plans right to make sure that we are looking at the right balance between service provided through overtime and other forms of additional working compared with substantive staff, we heard earlier from the trust about the numbers of additional paramedic and technician staff who will come into the system imminently. So, good progress is being made but there is further to go. It is a process that we are continually testing in terms of the commissioner and the provider. As Paul said, we keep a close and careful eye on the position. It is primarily for the trust and Health Commission Wales to resolve the issue, but we are keen to ensure that there is a satisfactory outcome.

[198] **Nick Ramsay:** To come back to the core of my original question, from your answers it sounds as though you have left the door open on those savings being unrealistic.

[199] **Mr Williams:** When this work is done, if there happens to be a resource gap, we must acknowledge it, but there will then be issues about how that is prioritised against other priorities. This is not an exact science—this is the type of work that we are doing in every part of healthcare as to how we can make that money work as hard as possible for us, but we have to do it through people. We must be continually chasing the very best practice, and the debate is how quickly, through using people, we can achieve best performance and best value for money.

[200] **David Lloyd:** On your point about triage, Paul, coming from the patient-demand side of the equation, and the somewhat inappropriate use occasionally of the ambulance service, what procedures are you looking at to address—and opinions vary about this—inappropriate calls on the ambulance services, whether it is in an emergency situation or a non-emergency situation? What are you doing in the wider scheme of things to address that type of thing, so that you can address some of the efficiency savings in that way?

[201] **Mr Murray:** To put that into a context, which you would understand from your professional background, Dai, we are not talking about vexatious issues of the service, which I have mentioned in previous hearings. We are talking about people who are dialling 999 because they do not know what they need and where to get it; they dial 999 to find out. When we started this process, one of our major problems, in terms of delivering patient services and staff morale, was that we were throwing eight-minute response targets at far too many emergencies—over 50 per cent of emergencies during some periods. Last month, because of improvements that we have made in our categorisation process—I will not call it the triage process, which I will come back to in a second—we reduced the figure regarding A categorisations in our 999 caseload to 32 per cent from 52 per cent. That is towards the bottom end of the mainstream for the UK.

[202] We have also put senior and experienced NHS Direct nurses into our control centres. When a call is categorised as category C, which is neither life-threatening nor serious, the caller is passed on—with some exceptions, such as being in a public place—to the nurse. The nurse then has a consultation with the caller. In a 10-month survey, only a third of those callers were passed back to a 999 ambulance—the other two-thirds were managed into other pathways. The numbers are relatively small, because we are doing this at the moment based on what we can afford to fund, and we cannot put the nurses on all of the time. However, we are doing pretty well on that, and the numbers are going up.

[203] We are taking some action at the point of the receipt of the call to triage people into other care pathways that are more appropriate to their needs. We have two major plans at the moment, one of which is to move to a system called NHS pathways, away from advanced medical priority despatch, the rather basic and probably entirely ambulance-orientated categorisation process that we currently use.

11.20 a.m.

[204] NHS pathways is a proper triage system that allows lay call-takers to do a certain amount of clinical triage. It will work for NHS Direct, out-of-hours and 999 ambulance services. At the moment, in Vantage Point House in Cwmbran, those three services are under the same roof, so it will help us to connect them together. We are currently running a pilot scheme with the Gwent out-of-hours service, looking at how we can deploy the out-of-hours GPs and the out-of-hours service into our front-end triage process.

[205] The second opportunity is face to face with the patient. We now have a workforce plan that has received a pretty positive response from the National Leadership and Innovation Agency for Healthcare. That workforce plan, among other things, envisages the development of 33 specialist practitioners each year for the next five years. We will put specialist practitioners into four localities, in the first instance: Cardiff, Newport, Powys and Monmouthshire. Those people will not be extra feet, they will be ‘Agenda for Change’ band-5 paramedics who are being developed to become band-6 specialist practitioners. We are currently finalising our views about the initial extension of their scope of practice. We focused continuing professional development for our paramedics on home resolution, among other things, with a particular focus on, as I think I said at the last hearing, hypoglycaemia and epileptic convulsions. These extended-scope practitioners will be able to deal with a much wider range of individuals and will be able to consult with their GP and get a much more sanguine view of the balance of risks. Those are some of the developments that the trust is pursuing at the moment.

[206] **Lorraine Barrett:** This question is for Paul Williams. The auditor general’s report highlights the realisation of longer-term efficiencies that need to focus on developing more efficient patient pathways and improving the efficiency and effectiveness of patient handovers at emergency units. As well as focusing on short-term efficiencies, should the Welsh Assembly Government focus more strongly on modernisation of the unscheduled care system? Is the Welsh Assembly Government putting sufficient pressure on those hospitals that are failing to achieve reasonable handover times in order to secure long-term, sustainable efficiency gains?

[207] **Mr Williams:** I have made this a priority since I took over. As I said, I started work on this through the transitional directors and we are now starting to see some benefits coming through. The task group on turnaround times has met regularly over the past few months and is now starting to demonstrate high conformance, which we are hoping to get up to 100 per cent by July. We are in communication with the chief executives on a monthly basis to remind them of the importance of this and to point out where they are not making significant

progress. We have reviewed the plans in relation to unscheduled care across each of those communities, and we are now starting to see the whole system improving. Some areas where performance was not particularly good—I am thinking of Cardiff—have started to come through strongly. For the first time, I am seeing plans coming through that not only identify the need for investment in hospitals, but are thinking fundamentally about the whole unscheduled care package and how that feeds into general practice and community care. By making this a priority and ensuring that I am engaging on a monthly basis to see where we are seeing continuous improvement and where we are not, which we revisit—Simon Dean is going out and talking to colleagues—there is no doubt in my mind that we are serious that this particular part of our responsibility must be discharged in a way that leads to good patient experiences throughout Wales.

[208] There is still a long way to go, and there is uncertainty, because you cannot always legislate for peaks and troughs in demand. Nevertheless, we have a much more professional approach, and much more of a partnership approach than we have had before. It will be of no surprise to you that we are getting into areas of behaviour. This whole business about the screens, for instance, is a classic exercise in not thinking about human behaviour and just thinking about implementing technology. I have always felt that technology is fine, but you need to look at how humans will react to technology being foisted on them. We have to go back to basics here and say, 'Let's start all over again', and 'How will we build this up?'. We are relentless now in looking at all of these issues and making sure that they are all dealt with effectively so that we have a much more effective outcome than we have had in the past.

[209] **Lorraine Barrett:** This question is directed at Alan. I remember previously discussing the number of managers who have accessed various development training modules. During the committee meeting in March, you said that you did not know how many of them had accessed the various training modules because the recording systems were not up to date. Could you give us an update on that now?

[210] **Mr Murray:** It is much clearer now. I can provide the committee with a full update, but perhaps I could just give a highlight. Over 70 per cent of managers have now accessed the personal development review module and the absence management module. The PDR module is extremely important because it gives us the infrastructure that we previously lacked for delivering personal development reviews and plans to our staff. It has not been without difficulty because managers have been very busy over the last few months on issues of performance, as have the staff, but we are now making progress and we are measuring that progress.

[211] **Lorraine Barrett:** This question is to both Paul and Alan. We heard from Professor Woollard that in other emergency services, staff are required to take examinations in order to achieve promotion. Would making training a prerequisite for management positions go some way to ensuring that ongoing training is at least prioritised by staff?

[212] **Mr Murray:** I agree with that. This is a historical issue; it has not historically been the case in ambulance services. We are now working with the National Leadership and Innovation Agency for Healthcare and I commend the support that we have been given by NLIAH through this process to design and develop a supervisory level management training programme for people like our locality managers and our control managers. That is, really, the start of that process.

[213] **Mr Williams:** Managers have to be as professional as other professionals, which means that they should be fit and competent for practice. This is where we have been using NLIAH, as Alan said, to develop a much more professional approach within management to ensure that they are recognised by their peers and particularly by clinical staff as having an effective leadership role, rather than be discredited because they are not actually practising

management at the highest levels. It is a fundamental point and I am glad that you raised it. Thank you.

[214] **Jonathan Morgan:** Before we move on, in relation to training, I would like to refer to the evidence that was given to the committee by Professor Woollard. He referred to a pilot scheme that was funded by the Assembly Government some six or seven years ago. It was an advanced paramedic practitioner pilot scheme. He referred to that pilot and said that, with regard to the outcome, the advanced paramedics were able to reduce the number of patients who were having to attend accident and emergency departments because they were able to be diverted to a more appropriate part of the NHS that they could make use of, and that there were category A, B and C calls. Effectively, the triage system that those advance paramedics were able to put in place changed the care pathway for 63 per cent of the patients that they encountered. I know that you have already mentioned the specialist paramedic system, but that sounds different to the pilot scheme for advanced paramedics.

11.30 a.m.

[215] I wonder, from the perspective of the Assembly Government—and I do not know if you have the information, Paul—what did the pilot scheme cost, what was the outcome, how was that reviewed, and why was it never implemented? If you do not have the data now, a written note might be useful, because that evidence was interesting, and in effect was drawing comparisons with other parts of the UK where, perhaps, this has been rolled out more productively and proactively. I accept that specialist paramedics are different, but this was something that caught our eye, as you might appreciate.

[216] **Mr Murray:** The specialist paramedics are not entirely different from the advanced paramedic practitioners. The APPs went to band 7 on the current 'Agenda for Change' scale, and the specialist practitioners will be band 6, but that does not rule out the potential development of people at higher bands. We have to roll this out carefully, and we cannot just create an annex to the unscheduled care system. This has to be something on which we work with our partners. When I was at Mersey Regional Ambulance Service NHS Trust, which covered Merseyside and Cheshire, we had a fairly high number of emergency care practitioners, and they were at the time—and this is no longer the case—given an off-the-shelf training package, which did not really fit the need, either from the perspective of the individuals or the primary care trust, the GPs, or the other clinical staff that they were working with. We are now creating a new cadre of specialist practitioners. We are not calling them specialist paramedics because, although I know that some of our early literature refers to them in that way, we have nurses working for us as well, and they can contribute to the development of this workforce. They are being developed on the basis of the College of Paramedics development programme, and Professor Woollard has been involved in that, so we are following national practice. One of my senior clinical colleagues, Tim Jones, put it to me—and he is one of the original advanced paramedic practitioners—that the biggest mistake we could make would be to consider these people to be a finished product. We build a core of knowledge and skills, and then we look at what is needed locally, and we add to those knowledge and skills, and that will determine where we go.

[217] **Jonathan Morgan:** Before I move on to Bethan's question, it might be useful to have a note on how the pilot scheme operated, what you discovered from it, and what was learned. The data that we were provided with were quite interesting.

[218] **Bethan Jenkins:** I want to look at morale and the culture of the trust. I will direct my questions at Alan Murray. The data collection systems changed in February 2009 to report against five key indicators: bullying, harassment, grievances, and performance appraisal and development plans. This was due to be presented to the management board, I believe, in March 2009. Do those performance indicators show an improvement in those areas?

[219] **Mr Murray:** I have said previously that I am always cautious about chief executives pronouncing on the morale of their workforce, but I am encouraged that Dave Galligan from Unison said in evidence to the committee that he felt that morale and relationships with managers had improved. If I can look at those five areas and deal first with appraisals and personal development plans. Over 20 per cent of our staff have now had appraisals, and I believe that it was about 1 per cent when we last spoke. We have a programme for getting 100 per cent of our staff through personal development reviews with personal development plans by the end of the financial year. There are a number of factors that are giving impetus to that, but also a number that are slowing it down, and we need to acknowledge that. Pursuit of performance clearly has implications for our ability to release staff and give them protected time, and that also applies to managers, so it is something that we have had to keep a careful eye on. We are also releasing a larger number of people than we normally would for paramedic training, and some of our technicians also come from within our workforce, from our patient care and high dependency services. Those people are on release, with protected time, to upgrade their qualifications, which means that they cannot have personal development reviews, and they will not have personal development plans until later in the year when they have finished that training.

[220] As I have said already, more than 70 per cent of our managers now have personal development review training. We now require people applying for development posts, such as the specialist practitioner posts, to bring their personal development plans with them. That has started to produce a culture change from, 'When are you giving me my personal development review?' to 'Can I now please have my personal development review?'. I understand that more than 1,000 people have now accessed the e-KSF system, and we are receiving 20 requests for access a day from people who do not currently have access. We now have a number of people actively seeking personal development reviews.

[221] We have some information on bullying. We have a range of measures already under way and under development, with the support of the NHS Centre for Equality and Human Rights, which, as you know, has been involved with us in this process from the start. We established an equality and human rights steering group earlier this year, which has now had two meetings. We have put out some information to staff about the development of a staff charter, which will make it clear what the relationship between staff and managers should be and what staff's rights and responsibilities are. We have asked staff whether they wish to be involved in the development of that. We have had hundreds of responses from staff who wish to be engaged in the process, and we are now coping with success I suppose, working out with the equality and human rights steering group how we use that staff interest and engagement to develop the charter in a way that will be helpful.

[222] On grievances, there were 49 outstanding grievances from 2007 to March 2009. We have now fully resolved 23 of those. Several of the remaining grievances relate to 'Agenda for Change' issues, so we are using our formal staff consultation mechanisms to deal with those in a much more corporate way. We are bringing together individual grievances that have common factors and dealing with them as collective grievances. We have also received a total of six collective grievances. We have resolved three of those, and they were on fairly meaty and difficult issues, such as meal breaks, the knowledge and skills framework and the way in which we deal with annual leave. We have dealt with the annual leave process, among other things, through the development of a jointly agreed process for our resource centres for the filling of shifts, the issuing of leave and so on. So, we are making measurable and fairly significant progress on grievances. Those were the major issues.

[223] **Mr Williams:** As far as the Assembly Government is concerned, apart from the support that we provide through the NHS Centre for Equality and Human Rights and NLIAH, we are actively engaging with the trust to carry out another staff survey this year, so that will

provide some more objective evidence behind all the actions.

[224] **Mr Murray:** That will be done during September and October this year. I understand that we will be the only NHS organisation undertaking a staff survey this year.

[225] **Bethan Jenkins:** I note the progress there, and I would like to see more information on the charter and the role of the NHS Centre for Equality and Human Rights. This seems to be quite a novel way of working. In light of the new research published this week by the Equality and Human Rights Commission about service delivery enshrined in the human rights agenda, I think that that is really important. However, regardless of that progress, to put a negative spin on this for a moment, Professor Woollard said that research that he had seen indicated that staff in the ambulance service still had a lot of mental health issues.

11.40 a.m.

[226] We had evidence that many people had said that they had posted their surveys from a different area because they did not want to be identified. What do you think of these noble schemes that have been brought in to address the fact that there are still a lot of problems out there among staff who obviously feel quite isolated on occasion?

[227] **Mr Murray:** Let me put that into context. I was chief ambulance officer in Belfast in 1987, when the Troubles were at their height. On taking over, I knew that there was absolutely no staff support available. We set up a confidential staff support service using a talented team of individuals who worked for another healthcare trust in Belfast. When I came to Wales, I discovered that a similar service was already in existence through NOS, and it is a very well-used service. I may be wrong but I believe that those services are of fairly recent provenance. I would doubt that there was staff support of that kind when Professor Woollard did his study. I will stand corrected if I am proven wrong on that, and I will certainly discuss it with Malcolm Woollard, but I believe that those services have been introduced since Malcolm's study was done.

[228] On isolation, we have staff working on rapid response vehicles, but when they get to the scene, they are followed up—and we discussed the fact that there are sometimes delays in the follow-up—by an ambulance crew. They generally work as a team of three. It is difficult to work on a cardiac arrest, for example, if there are only two people; it is easier if there are three people. We do not keep people on standby points for extended periods; we bring them back to their stations periodically, where they associate with other staff. The ambulance crews are in and out of accident and emergency departments—that is less true of rapid response paramedics—where they interact with their colleagues from the green-suit side of the service and with their nursing colleagues. So, I would not paint too bleak a picture of the isolation of the job. I have done the job myself—it may be quite a long time ago now, but I still remember quite vividly the camaraderie that exists in the job.

[229] **Bethan Jenkins:** On the research, you said that you are going to do a staff survey. Will there be a recap question to follow up that research about staff morale and mental health issues? If that is out of date, we need to know what the current situation is.

[230] **Mr Murray:** Yes.

[231] **Mr Williams:** Yes, we do. Our understanding of post-traumatic stress disorder and the appropriate counselling is getting more sophisticated.

[232] **Irene James:** I will move on to lengthy handover times, and my question is to both Paul and Alan Murray. Paramedics and nursing staff feel frustrated by lengthy handover delays. The auditor general's report also highlighted that issue and the fact that they feel

powerless in the face of such delays. In the time since the auditor general's report was published, what has been done to reduce handover times?

[233] **Mr Murray:** We now have very close partnerships with all of the major hospitals. We have escalation plans that are put into place very rapidly if there is an influx of patients into a hospital. I had such an experience last week in Glan Clwyd Hospital. Five ambulances came into the accident and emergency department simultaneously. I knew about it because I was at the liaison officer's desk at the time, and he was paged. He and I went to the accident and emergency department to see what was happening. He became involved with ambulance control and establishing what else was coming in and whether it could be diverted. The senior nurse on duty rapidly assessed the patients and called in her clinical director—I am not familiar with the officer concerned, but I believe that she is an assistant director of nursing. They both got to the department within a matter of minutes. They established that four of the five patients were medical patients and they paged physicians from the medical ward to come down in order to assess them and get them off the stretchers. As soon as they had done that, the senior nurse went back into action again and said to the nurses and the paramedics, 'Go and put your pin numbers into the screens'.

[234] That is the kind of joint planning and joint action that we have been taking with the accident and emergency departments. We have also been working very closely with the accident and emergency departments to ensure that the screens are in the right position, that people understand how to use them and that they do use them. Our own staff are currently hitting a level of compliance of around 85 per cent. There was a technical issue in a hospital in west Wales, which reduced our compliance somewhat. The compliance rate would be higher than that had it not been for that issue, which I believe has now been resolved. That is the kind of partnership working that we have been doing with hospitals. It has been working. At the University Hospital of Wales we are now experiencing around 50 per cent of the delays that we were experiencing a few months ago. Between January and April we saw a 50 per cent reduction. It will be less than that again since April, because the performance trend is going pretty steeply downwards in the number of lost ambulance hours.

[235] **Irene James:** Was that 15 per cent or 50 per cent? I did not quite hear.

[236] **Mr Murray:** It was 50 per cent.

[237] **Irene James:** That is wonderful, thank you.

[238] **Mr Murray:** It is, and it has been done by and large without significant friction between the paramedics and nurses.

[239] **Mr Woodhead:** Although the percentages are not as high, those kinds of reductions are being seen across the rest of Wales as well, including in Swansea and Wrexham.

[240] **Mr Williams:** That goes back to my earlier remarks about the internal market, which created all sorts of perverse behaviours. If you had a trust that wanted to improve its accident and emergency department, and it put forward business cases to the commissioner and the commissioner did not see that as being a priority, or it had to deal with four or five commissioners, things slowed down and in some areas managers gave up, frankly. So, the departments were not fit for purpose. We have had behaviour that has meant that teams within hospitals were not working as effectively as they should have been. The internal market and perverse behaviours meant that people were sometimes saying, 'It is not the hospital's problem; we can leave it to the ambulance service.' That is not acceptable.

[241] We have been quite relentless over the past few months in saying that this is a major cultural change; we are going to be serious about working, we are going to attack the

efficiency issues where they need to be attacked, and address situations where we have accident and emergency departments that are still not properly designed. It cannot be right that if we have over a certain number of patients, they have to be cared for in corridors, and it may simply be that insufficient attention has been given to the fact that the design of the accident and emergency department needs to be radically overhauled. We are seeing a lot of that happening now, for example at Nevill Hall Hospital, Royal Gwent Hospital, and I have just given some early indications that I want to do something at the University Hospital of Wales. The University Hospital of Wales has sent me a very significant plan about how it is tackling the 15-minute handover, and it has now had its best month of performance ever, reaching a level of compliance of 95 per cent. These are still early days, but we are now being quite relentless in saying that we are going to deal with this issue together, in partnership. That is starting to bear fruit. There is still much to do, but the early signs are encouraging.

[242] **Janice Gregory:** Sticking with 'Unscheduled care: patient handovers at hospital emergency departments', and paragraphs 1.21 to 1.24, paragraph 1.22 is quite specific on the clinical risk to patients and, indeed, the personal and professional risks for the police or the fire services when they have to transport patients to hospital if an ambulance is not available. One part of this paragraph struck me, namely where it says that the police have identified that if a patient dies in their care when they are transporting that patient to hospital, it goes a stage further because that patient is deemed to have died in police care—or rather, as it states in the report, it is classified as a death in police contact. It would then be subject to an inquiry by the Independent Police Complaints Commission with all that that involves in terms of resources and the reputation of the service. The report also states that the joint emergency services group raised this as a concern with the Welsh Assembly Government and was working to achieve a sustainable solution to the problems. Can you tell us what progress the Welsh Assembly Government has made? The question is to Paul primarily, but I am sure that Alan will have a comment to make on that.

11.50 a.m.

[243] **Mr Williams:** First and foremost, it is not appropriate for the other emergency services to be stepping in on a regular basis to substitute for the ambulance service. That is the first principle. However, there is also the principle of the first responder. At times, it would be a reasonable thing to do. When it was raised with the Minister and me in January, the joint emergency service group identified that there were 59 events during January and 65 in February, which is far more than we would expect. Our instructions were that a taskforce should be established immediately to start to deal with these issues.

[244] In mitigation, the ambulance service was in the difficult winter period, when the whole system is under huge pressure because there was a prolonged cold snap. The figures improved in March to 13 and 14. We have made significant progress. I think that the figures have crept up a little since then, which is cause for concern. However, we are clear that this needs to be dealt with. We do not expect the emergency services to undertake inappropriate work.

[245] **Mr Murray:** I can provide an update on that. There have been only four reports so far this month. However, I would also like to emphasise that the numbers that Paul Williams has just given you are not all transports to hospital by the fire service or the police; they are exceptions and include things such as ambulance control taking too long to answer the phone. So, some are more serious than others. As I said, four exceptions have been reported this month in total. I have been working with my colleagues in the joint emergency services group.

[246] The real solution to this is in issues that we have already discussed: getting more of our shifts filled, which we have been doing—we have been getting substantially more of our shifts filled—and dealing with turnaround times at hospitals, which we have been doing and,

as a result, the turnaround times are now much shorter than they were. Those things, along with the improvements that we have made in our deployment planning and our control room processes, in the categorisation of our A, B and C calls and triage by nurses, have really been the solution to the problem. We also have to deal with our relationship with our fire and police colleagues in practical terms. I am not just talking about how well we co-exist with them, but about resolving practical issues.

[247] The trust has now taken responsibility for the operation and management of a web-based reporting tool, which each service will use to report exceptions with other services. So, for example, if we have a delayed police response, we will put that on the web-based system. If the police have a delayed ambulance response, they will put it on. We collate that information and report it, but we are now taking the next step, which is about performance managing it. We have now agreed to set up both a formal and an informal process for managing performance. This is in south-east Wales, where most of the problems arose. The informal process involves all four control managers from the four services—the two police services, the fire and rescue service and WAST—meeting on a weekly basis over coffee and working on some set agenda items, but also identifying any issues that are arising and nipping them in the bud at an early stage.

[248] The formal process will involve the assistant chief fire officer, the two assistant chief constables responsible for operations, and our regional director for south-east Wales getting together on a monthly basis for a formal review of the most prevalent problems that have been identified by one of the services about the others. They will go through a process of deciding what they are going to do about it jointly, and they then leave the room and get on with implementing it. At the next meeting, they consider how they did with the measures that were identified the previous month and what the issues are for the next month. We agreed that, initially, those meetings should be monthly, but we will review their frequency, as they may not need to be held every month if the number of incidences is reducing. I just want to put on record my thanks to our police and fire service colleagues for the support that they have given us during a very difficult period.

[249] **Janice Gregory:** It is good to hear that there is joint working. I am sure that everyone would applaud that. To take it a little further, this question is to you, Paul, as well as to Alan. When Professor Woollard came to committee—and, unfortunately, I was not here, but I have read the Record of Proceedings of that meeting—he was quite keen to talk about the fire service, which carries defibrillators on its vehicles. He was quite keen to talk about the first responder service in mid and west Wales, which is well developed. I understand what you say, Paul, about it not being appropriate for people to be transported to hospital in a fire engine, but I think that the general public accepts the first responder service. I certainly have a good new one in my constituency. The service uses volunteers and they are very well accepted, as is the idea behind them. I do not think that anybody would be particularly against the idea of the fire service intervening in a cardiac arrest case, for example. Will that scheme be extended? To what extent has the joint emergency services groups had a good look at it? I do not think that you will tell me that it is being discounted altogether, but what priority has been given to it?

[250] **Mr Murray:** The joint emergency services group has done some work on co-responding. We have developed a memorandum of understanding, which was presented at the last meeting, and that is now being reviewed. It is not just the Mid and West Wales Fire and Rescue Service that co-responds for us; we have quite a number of co-responders in the North Wales Police as well, who carry defibrillators in their patrol cars. We are very open to that. It is kind of a mixed economy because, as you have said, we have some very good community first responder schemes and we certainly do not want to tread on those people's toes, but, in the areas where co-responders are of most interest to us, the fire service is most likely to be made up of retained staff, and so those people would have to come from home. So, we have to

bear that in mind when planning and look at whether there would be any particular advantage to having firefighters coming from home, as opposed to community first responders.

[251] **Mr Williams:** We need to keep an open mind and think much more flexibly for the future. We referred to the rural health plan, for instance, and, in Powys, we have some very difficult challenges so we may need to look at different policies that are more appropriate. There is more work to be done and that will form a part of the strategic review.

12.00 p.m.

[252] **Janice Gregory:** Moving onto my final question, which relates to paragraphs 1.25 to 1.47, we heard evidence earlier about the issues surrounding the data terminals. This question is to both of you. One thing that would have struck all the committee in the evidence that we heard this morning was the error rate of 26 per cent during one shift because of the data terminal. In fact, there was one particular point that struck me, and probably everyone else, which was when the information suggested that there was an ambulance at UHW, when it was in fact at the Royal Glamorgan Hospital, I think, but it may have been the Royal Gwent Hospital. We also heard about ghost jobs. We all understand that frequently malfunctioning data terminals will be a major barrier to acquiring consistent and accurate data. What steps has the Welsh Assembly Government taken to ensure that all the data terminals are suitable for purpose? Alan, I understand that the trust was to conduct an all-Wales audit of the data terminals in April 2009. Can you tell us what the findings of that audit were? I heard what you said about being in that hospital, making sure that people logged on to the data terminals and recorded the data accurately, but we need accurate data.

[253] **Mr Murray:** I will take the first part of your question and ask Tim to come in on the audit point, because he has a copy of the audit report with him. We heard the evidence that was given by our colleagues from Wrexham Maelor Hospital and the University Hospital of Wales, and our colleague from Wrexham dealt partly with that question when he said that, because we are now reaching high levels of compliance in entering the data, we are beginning to find some anomalies. He also said that they were addressing those anomalies with us, the Welsh ambulance services trust, and that we were dealing with those and responding to them seriously. So, we are aware of some of the issues, but we have only recently been made aware of them.

[254] For example, on the patient turning up at the Royal Glamorgan Hospital when they were supposed to be at the University Hospital of Wales, that is an issue with the quality of our control processes. If the system suggests that the patient is going to UHW and if the dispatcher who is managing that call does not change it, in control, to the Royal Glamorgan Hospital, the screen will continue to say that that patient is going to UHW. We are actively addressing that issue with our staff in control.

[255] The screens had to be designed in such a way as to interface properly with our computer-aided despatch system, so there was not a lot of choice about how they were designed, and there were constraints. We tried to keep them as simple as possible and we worked very closely with the Welsh Assembly Government, which also worked very closely with the hospitals, to ensure that we designed them as best as we could. However, we were working with some restrictions on how they could be designed. Our estimate is that, in most cases, they can be updated within 20 seconds, and the malfunctions are no longer frequent. I do not know whether you want to say anything about the audit, Tim.

[256] **Mr Woodhead:** The audit has been concluded and has come up with a couple of key recommendations, and our auditor colleagues will be delighted to know that we have acted on them fairly swiftly. There is one serious recommendation and one relatively minor recommendation. The relatively minor recommendation is about how screens are set up and

how long they continue to show a particular window. Some adjustments were made following discussions with nursing staff and paramedics to try to get that right, and they were relatively easy and minor issues that improved the system slightly.

[257] The much more important issue was about embedding the practice and culture with ambulance and nursing staff, to drive that at grass-roots level with nurses and the managers of the ambulance service and accident and emergency departments. The figures that we now see show that patient flow has improved: we can see that the performance against that has improved dramatically up to the 80 per cent mark. So, that audit is one of the many catalysts for the actions and improvements that we have seen.

[258] **Mr Murray:** I also noted Meredith Gardner's remark about the difficulty of correlating what was on the screen with what was in the paperwork. We will address that, but there is an issue of patient confidentiality with the screens, given that they can be read by passers-by. There is a distinct limit to what we can put on the screen, as it might identify a patient.

[259] **Mr Williams:** From the Welsh Assembly Government's point of view, in February/March, when we started looking at the raft of issues that needed to be addressed to improve performance, we discovered that the issue with screens and handover was patchy to say the least. We had assumed that it was a fairly easy thing to do and had left it to the service. We then set up a task and finish group, which has met on several occasions. First and foremost, that was to get Welsh ambulance staff and hospital trust staff to gain a clear understanding of why it was being done. That needed a lot of communication and training work to ensure that the technology was operating correctly and that the screens were in the right place. All that work has now come together, and we are pretty certain that the technology is working. Screens that were in inappropriate places have been relocated. We continue to monitor it monthly, and we have now moved the compliance rate up from 22 per cent in December to 78 per cent, and we are pushing to get it up to 100 per cent. The Welsh Assembly Government will continue to monitor that regularly, and, if we think that performance is not improving, we will have individual meetings with the organisations involved.

[260] **Mr Murray:** The human issues are beginning to be resolved. It was entirely understandable for paramedics to ask why they should have to do this when, as far as they could see, it would not make a difference. Nothing ever seemed to make a difference. However, now that they can see that it makes a difference, they have an incentive to comply. I recently spoke with a couple of paramedics from Newport who told me that they just do not get the queues at the Royal Gwent that they used to, so things have improved.

[261] **Bethan Jenkins:** I have a question on handover to the ambulance officers. We received evidence from the Royal College of Nursing, Unison and the College of Paramedics stating that they were concerned that, during periods of severe delays in turnaround times, patients were passed to ambulance officers, and that there were risks involved in that. This morning, Jennie Palmer from the University Hospital of Wales said that, because there was no clinical accountability involved, the risks might not be as relevant in that regard. Do you believe that the handover target and the policy objectives behind this can be met if patients are passed to ambulance officers, or is that not the issue? Is it a wider issue of resource?

[262] **Mr Murray:** That would be our vision of a ghost job: a ghost handover. That is not occurring to anything like the extent that it was previously. That was a feature of the period of absolute crisis, if you want to call it that, when it was not unusual for patients to be handed over from one ambulance person to another. I will qualify that by saying that, in the hospitals where we were experiencing the biggest problems, in south-east Wales, nursing staff were exceptionally good at triaging patients. If I entered the Royal Gwent accident and emergency department, as I frequently did, I would invariably find the higher acuity patients in the

department and the lower acuity patients being managed by ambulance staff in the corridors. In fact, there was some question in my mind as to whether there would have been much of a risk in leaving those patients unsupervised but, of course, there are professional accountability issues that make that extremely difficult to achieve. So, I do not want the committee to go away with the impression that this was completely unmanaged; the triage process inside the hospitals was exceptionally good, the people being managed by ambulance officers were not the sickest patients, and it is now far less of a problem than it was.

[263] **Bethan Jenkins:** I note what you have said, but the Minister has also said that it is unacceptable for patients to be held in ambulances, and we have heard evidence this morning that Wrexham is still doing that, mainly because of work on the hospital building. This question is to Alun Murray. Given that that comes from the top level of Government, with the Minister herself saying that it is unacceptable, and yet it is still continuing, does that need to be looked at much more rigorously?

12.10 p.m.

[264] **Mr Williams:** I think that it does. To their credit, I think that the ambulance staff would ensure that the person was not unattended. The issue for me is whether the commissioners and the providers are ensuring that there is sufficient capacity and expertise within the accident and emergency departments to ensure swift handovers. What we have done in setting the target is to say that this is an acceptable target. If it has not been achieved, we have to revisit the issues of resourcing. It may not just be a cash issue; it may be an issue of whether you have enough trained staff, or it could be a recruitment issue.

[265] However, the principle is correct, and what we need to avoid now is any shift of the responsibility back to the ambulance service. It cannot be a case of saying, ‘We cannot find the resources, so, by default, the ambulance service will still pick up the responsibility for tending these patients’. That is unacceptable. I would not suggest it for one minute, but in parts of England, trusts that do that will have the money taken away from them. The approach is that the trust wasted an ambulance so it would be charged for that. I am not suggesting that that would be appropriate in Wales, but we need to rebalance the system. It is wholly appropriate, once they cross the threshold of a hospital, for the patient to be received into the hands of the hospital staff as quickly as possible.

[266] This is a significant change in approach, and emphasis has been placed on this. As I said, it has been confused by the prioritisation of commissioners and providers seeing things in different ways. We have more clarity on these issues now; we just need to keep moving. I received a report only three days ago from the transition director in the Cardiff and Vale NHS Trust on how it is going to submit a much more robust plan than it had before. So, there is a great deal more to do, but we are focusing on this, and this is where the target is helpful. It would be difficult to defend why you should have people waiting in ambulances or in corridors, or why we should be expecting people to wait longer than 15 minutes. It is not without its difficulties, but I think that it is the right thing to do.

[267] **Bethan Jenkins:** Do you have anything to add to that, Mr Murray?

[268] **Mr Murray:** I agree with what Paul said.

[269] **Jonathan Morgan:** I wish to push you on a particular point. Paul, listening to the answer that you gave to Bethan, it was certainly clear in my mind—correct me if I am wrong—that the policy objective of the Assembly Government in using the handover target is to ensure that patient A goes from the care of the paramedics to the care of the nursing and clinical staff within the accident and emergency department. Is it, therefore, the case that, where a patient goes from the paramedics, but to another member of the ambulance staff, that

is certainly not within the spirit of the policy objective as the Government sees it?

[270] **Mr Williams:** It is to the credit of the ambulance staff that they were tending to those patients, but that is not acceptable. It should be a smooth, safe and quick transition.

[271] **Jonathan Morgan:** So, the objective is not just about getting a patient handed over within 15 minutes and the ambulance crew back out within 20 minutes, but about ensuring that the patient is in the care of a member of the appropriate clinical team?

[272] **Mr Williams:** That is correct.

[273] **Lorraine Barrett:** I have a question for Paul about the comments in the report about NHS organisations needing to show leadership and vision to find joint solutions. The Royal College of Nursing said that there needs to be a culture of management within accident and emergency departments that recognises that this is a team approach. What barriers exist across the NHS in Wales that prevent such a culture of joint working developing? The report also suggests that hospitals are failing to share best practice with regard to handover times. There is a picture here of joint working, sharing best practice and an attitude of, 'Let's all get together'. Do barriers to that exist, or are barriers being broken down now?

[274] **Mr Williams:** We are starting to break them down. We are talking about a major cultural change, and that will take time. We have made progress, but we need to accept that the bridge provider arrangement caused some difficulties in terms of perverse incentives and gaming, which are totally unacceptable. I am preaching every day to the leaders of these organisations that they not only have to change their attitudes and behaviour, but that they need to engage with clinical staff and that clinical staff feel that they have the support of the management. Within the clinical teams themselves, they need to ensure good partnership and flexible working. There is a great deal more to do here, but I think that we are starting to set up the right environment to make the difference.

[275] **Jonathan Morgan:** Are there any further supplementary questions that Members wish to ask? I see that there are none. I thank the witnesses; we are very grateful to you for coming in. We will provide a transcript of the session for your consideration.

12.15 p.m.

Ystyried Blaenraglen Waith Swyddfa Archwilio Cymru
Consideration of the Wales Audit Office Forward Work Programme

[276] **Jonathan Morgan:** I am delighted that the Auditor General for Wales is here, along with Gillian Body; it is a pleasure to see you both. Thank you for the forward work programme, which has been circulated to Members. Jeremy, do you want to say anything at this point before Members ask one or two questions about the nature of the work and outline where they are showing a certain interest in aspects of the work that is being undertaken? I know that some Members want to raise some issues that are of concern to them, which you might want to take away and think about.

[277] **Mr Colman:** I am very pleased to receive any such comments. I hope that members of the committee will not feel constrained by the agenda of the committee and that they must only raise what is on the agenda. I am happy to hear from Members at any time with suggestions about things that we should do or directions of inquiry that we might follow with regard to any of the things that are on the list.

[278] If you look at the table that is attached to my letter, it is clear that the reports at the top end of that list are very well advanced indeed. Then, as you proceed downwards, you get to

reports where the work is yet to begin. So, they are at various stages of development. The scope for altering anything in the reports at the top of the list is very limited, whereas the scope for change lower down is very great. I draw your attention to the bullet points. They do look a little like footnotes, but they are actually quite important. There are things in there that will, I suspect, be reports of considerable interest to the committee. They have equal status, but the issue is that, in many cases, we are not quite sure what the timing will be, and it will be ad hoc. For example, waiting-list spot checks will, I strongly suspect, be of high interest, but the timing is still uncertain.

[279] **Jonathan Morgan:** Are there any observations on the list of subject areas that the auditor general and the Wales Audit Office are going to be examining? Are there any other points that members of the committee wish to put to the Wales Audit Office on any other areas where they think that there may be work that could be of use?

[280] **Lesley Griffiths:** This is something that I have raised with Jeremy before. I would like to see an inquiry into Welsh local authority reserves. I substituted at a Finance Committee meeting back in October, and an issue discussed at that meeting still concerns me greatly. At that meeting, Andrew Davies, the Minister for Finance and Public Service Delivery, stated that the 22 local authorities in Wales hold £581 million in reserves. I appreciate that a lot of that is made up of allocated reserves, but there is still a huge sum of money, probably about £145 million—although I would imagine that that is higher now—that is unallocated. I wrote to Jeremy and he sent me a very detailed response. One issue that did concern me was that, following the Finance Committee meeting, there was quite a bit of media interest and Jeremy stated, as he did in the letter, that it is a matter for individual authorities to determine their own level of reserves, while the Welsh Local Government Association said that it was told by the Wales Audit Office to hold up to 5 per cent of revenue in reserves. That is a blatant contradiction; they cannot both be right. In the current economic climate, it is a matter of public interest that there is this huge sum of money sitting around in local authority reserves. The Welsh Assembly Government uses its reserves; I think that it holds 1 per cent of its annual budget in reserves. This is a matter of public interest.

[281] **Jonathan Morgan:** Do you want to respond to each point now?

12.20 p.m.

[282] **Mr Colman:** I will respond to that one, if I may. As Lesley said, we looked into this carefully. I am happy to report the facts on local authority reserves in total, although it is not a function of the Assembly to hold any individual local authority to account. I am very happy to report our policy in speaking to local authorities about levels of reserves. The issue that is difficult for me is that, if a local authority goes through the proper process and decides to hold what Lesley or anyone else might regard as a high level of reserves, that is a matter of policy that I cannot question, provided that they go through the proper process for doing it. They are required to examine the level of their reserves every year. So, if you have an authority that just allows reserves to accumulate without really thinking about it and shows no evidence of having thought about it, then that would be subject to criticism and action from the appointed auditors. However, if it does it deliberately as a matter of policy and goes through the proper process then, as auditors, we cannot question that. We can and do question the opposite problem, which I think is one that Lesley is not concerned about at all, which is that reserves might be too low. However, there is no rule that says what the level of reserves should be—there are rules of thumb rather than rules, if I may make that distinction.

[283] **Jonathan Morgan:** Are there any further points from Members?

[284] **Bethan Jenkins:** I have two suggestions relating to local government: conducting and promoting value for money studies in the local government sector and inspecting for

compliance with best value requirements under the Wales programme for improvement. This is an idea that was passed on to me and I thought that it was worth asking if you wanted to discuss it further.

[285] I also wanted to ask what happened to the suggestions that we gave you previously. I remember asking whether the auditor general could carry out some research into higher education and the effect of the policy on student finance—the way in which it was implemented and its effect on students in Wales. I know that there is a move to change that now, and it might be outdated and it may not be possible to consider it, but that was something on which I wanted you to give some guidance.

[286] **Mr Colman:** On the first point, perhaps we can talk afterwards about exactly what it was, but, as you said it, it appeared to me either to be something that we do already or, alternatively and more likely, something that will be a responsibility under the Local Government (Wales) Measure. I am excited about the changes to the Wales programme for improvement that that Measure will bring. They will enable us, for the first time, to report on a consistent basis across all Welsh local authorities about the extent to which they have delivered improvements in the previous year and to which they are likely to deliver improvements in the coming year. That will greatly enhance democratic accountability for local government in Wales and it is warmly to be welcomed. However, it is not a report that will come to this committee. Twenty-two reports will be published by individual authorities.

[287] On the second point about higher education, you will see towards the end of my list the, perhaps, rather telegraphic language of 'AGW portfolio of vfm work'. In the autumn, I will bring a much longer paper—I am sorry to threaten you with a longer paper—that will list in detail potential topics. I am very happy to include that on that list.

[288] **Huw Lewis:** It is very easy to come up with our own personal wish list here. One thing that strikes me is the absence of a look at what the First Minister has said is the Welsh Assembly Government's No.1 priority, namely child poverty. He has said it repeatedly, but we have never really looked into how the Welsh Assembly Government is tackling the issue. There are many aspects to this and it touches on almost everything that the Assembly Government does, but my personal bid would be for a look at Cymorth and the way in which that is working and changing. I know that it is something that confuses a number of people, particularly the end users of Cymorth and how that operates.

[289] **Jonathan Morgan:** Do you want to respond directly to that?

[290] **Mr Colman:** I am grateful for that suggestion. We have been getting at child poverty indirectly because many of the issues affecting it are outside the Assembly Government's control as they are not devolved functions. So, for example, there is a study on nutrition in schools, which has some bearing on it, and potentially the same is true of the education of looked-after children. However, I am happy to take on that suggestion on Cymorth. That is a good idea.

[291] **Jonathan Morgan:** Janice, did you want to raise a point?

[292] **Janice Gregory:** No. I am okay with the list, but it is all health, health and more health.

[293] **Mr Colman:** If I may say so, that is why I am particularly grateful to have non-health related suggestions.

[294] **Jonathan Morgan:** Although, I have to say that I had a big health issue in my mind, but I will not raise that now. [*Laughter.*]

[295] **Janice Gregory:** I would like to go back to Lesley's point on this. The reality is that the general public does not understand that local authorities hold reserves. If you were to ask someone on the street about this, they would have no idea that the local authority had any money tucked away for any reason. I am not sure about Jeremy's answer and I have not read his letter to Lesley, but if you are suggesting a level of 5 per cent for them—

[296] **Mr Colman:** I am not.

[297] **Janice Gregory:** I must have misunderstood.

[298] **Mr Colman:** Steve Thomas was quoted as saying that we do, but we do not.

[299] **Janice Gregory:** We need to clarify that the auditor general is not suggesting that because I guarantee that out there, local authority members think that he suggested a level of 5 per cent. Can we clarify that before we go any further?

[300] **Jonathan Morgan:** To help, as a result of this discussion and clarification from the auditor general, I could write to the Chair of the Finance Committee and say that, as a result of a brief discussion on a forward work programme, the auditor general clarified the exact position. Perhaps it would then be up to the Finance Committee to pursue that matter further, having had that clarification. I am more than happy to do that.

[301] **Mr Colman:** Since there is interest in this topic, my letter to Lesley was lengthy and perhaps it would be simplest to circulate that letter as a committee document so that everyone could see it, possibly before you write to the Finance Committee because further points may arise from that.

[302] **Jonathan Morgan:** We will circulate that.

[303] **Janice Gregory:** We still need clarification.

[304] **Jonathan Morgan:** Indeed, but as the evidence was given to the Finance Committee, it would be appropriate to write to the Chair to indicate what has happened here so that the Finance Committee is aware that that discrepancy has been addressed by the National Audit Office.

[305] **Janice Gregory:** We should then revisit it to get clarification.

[306] **Jonathan Morgan:** I am more than happy to do that.

[307] **Nick Ramsay:** Going back to Janice's point, it has been my understanding that a specific amount, such as 5 per cent, has never been given to local authorities on reserves. I say that from my background in local government. I go along with what the auditor general says about that. It is up to local authorities to decide what they feel is an appropriate level of reserve and it would be totally inappropriate for any statutory figure from above to determine that.

[308] **Jonathan Morgan:** Are there any further points? I see that there are not. Thank you very much.

12.28 a.m.

Cynnig Trefniadol
Procedural Motion

[309] **Jonathan Morgan:** Cynigiaf fod

y pwyllgor yn penderfynu gwahardd y cyhoedd o'r drafodaeth ar eitem 4 yn unol â Rheol Sefydlog Rhif 10.37(vi).

[311] Gwelaf fod y pwyllgor yn gytûn.

Derbyniwyd y cynnig.
Motion agreed.

[310] **Jonathan Morgan:** I move that

the committee resolves to exclude the public from the discussion on item 4 in accordance with Standing Order No. 10.37(vi).

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

Daeth rhan gyhoeddus y cyfarfod i ben am 12.29 p.m.
The public part of the meeting ended at 12.29 p.m.