Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mercher, 9 Mawrth 2011
Wednesday, 9 March 2011

Cynnwys
Contents

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Peter Black	Democratiaid Rhyddfrydol Cymreig Welsh Liberal Democrats
Jeff Cuthbert	Llafur Labour
Alun Davies	Llafur Labour
Irene James	Llafur Labour
Bethan Jenkins	Plaid Cymru The Party of Wales
Sandy Mewies	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Chair of the Committee)
Nick Ramsay	Ceidwadwyr Cymreig (yn dirprwyo ar ran Jonathan Morgan) Welsh Conservatives (substitute for Jonathan Morgan)

Eraill yn bresennol
Others in attendance

Gillian Body	Partner Rheoli, Swyddfa Archwilio Cymru Managing Partner, Wales Audit Office
Dr Andrew Goodall	Prif Weithredwr, Bwrdd Iechyd Aneurin Bevan Chief Executive, Aneurin Bevan Health Board
Dr Karen Gully	Uwch-swyddog Meddygol Senior Medical Officer
Elwyn Price-Morris	Prif Weithredwr, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Chief Executive, Welsh Ambulance Services NHS Trust
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales
Yr Athro/Professor Roger Walker	Prif Swyddog Fferyllol Chief Pharmaceutical Officer
Paul Williams	Cyfarwyddwr Cyffredinol, y Gyfarwyddiaeth Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cynulliad Cymru Director General, Health and Social Services, Welsh Assembly Government

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

Alun Davidson	Clerc Clerk
Catherine Hunt	Dirprwy Glerc Deputy Clerk
Joanest Jackson	Cynghorydd Cyfreithiol Legal Adviser

Dechreuodd y cyfarfod am 9.32 a.m.
The meeting began at 9.32 a.m.

Ymddiheuriadau a Dirprwyon
Apologies and Substitutions

[1] **Darren Millar:** Good morning, everyone, and welcome to this morning's meeting of the National Assembly's Public Accounts Committee. I remind everyone that the National Assembly for Wales is a bilingual institution, and people should feel free to speak in either English or Welsh, as they please. Headsets are available for translation and amplification, with channel 0 for amplification and channel 1 for translation. I ask everyone in the room and in the public gallery to switch off their mobile phones, BlackBerrys and pagers, because these interfere with the broadcasting and other equipment. If the fire alarm sounds, people should follow the instructions of the ushers, who will guide them to the nearest appropriate exit.

[2] I have received apologies from Janet Ryder and Lorraine Barrett. I have also been notified of a substitution—Nick Ramsay is substituting for Jonathan Morgan this morning. Welcome to the committee, Nick. Are there any further apologies? I see that there are not, so we will move straight to item 2.

9.33 a.m.

Gofal heb ei Drefnu: Tystiolaeth gan y Cyfarwyddwr Cyffredinol dros Iechyd a Gwasanaethau Cymdeithasol a Prif Weithredwr Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Unscheduled Care: Evidence by the Director General for Health and Social Services and the Chief Executive of the Welsh Ambulance Services NHS Trust

[3] **Darren Millar:** The committee has considered this broad subject on a number of occasions over the past few years, drawing on a variety of Wales Audit Office reports that culminated in a report in January 2010 entitled 'Unscheduled care: developing a whole systems approach'. In today's session, we will be considering the extent of progress on implementing the recommendations in that particular report, and in previous reports on NHS Direct in Wales. We will also take some fresh evidence in relation to the general performance of the Welsh Ambulance Services NHS Trust and the issue of patient handovers, in particular at accident and emergency departments. These matters are of course very relevant to the broader topic of unscheduled care but have also featured in their own right in the committee's previous work.

[4] I welcome our witnesses. Paul Williams is the director general of health and social services; I believe that this will be your last appearance before the committee in that capacity, so I will take the opportunity to thank you for the support that you have given in providing evidence over the years. I welcome Elwyn Price-Morris, who was recently confirmed as the permanent chief executive of the Welsh Ambulance Services NHS Trust. I also welcome Dr Andrew Goodall, chief executive of Aneurin Bevan Local Health Board. We will go straight into questions. It has been more than a year since the Wales Audit Office made whole-systems recommendations in its report. How satisfied are you with progress? If the Wales Audit Office were to repeat its review, would there be any difference in what it would find? Paul, do you want to start with that?

[5] **Mr Williams:** Thank you for your kind remarks, Chair. Progress is slow, but I think that we can discern changes. We are talking about whole systems, and that is an incredibly ambitious and complex agenda. Nevertheless, the new NHS reforms that are embedded in the system, which are very much about the integration of health and social care, are absolutely going in the right direction. However, that is against the backdrop of a 12 per cent increase in attendance at major accident and emergency departments over the past five years. It is a challenge and an issue that we need to turn around in terms of whole systems.

[6] There is also the way in which demographics are changing the demand on our service. The number of people aged over 85 admitted to accident and emergency departments has increased by more than 22 per cent. So, we are dealing with people who are much more frail and have much more complex needs.

[7] On the whole-systems side of things, delayed transfers of care have reduced by about 27 per cent. So, we are working to ensure that people have more effective discharge arrangements. Another very important area with regard to whole systems is the chronic disease management agenda. As you know, we have had three pilot schemes, in Carmarthen, Cardiff and Gwynedd. What we are seeing as a result is reduced admissions, particularly for patients with complex needs, who might have more than one chronic disease. We are also seeing shorter lengths of stay. You are probably going to respond, 'It's not happening everywhere, is it?', and the issue for us now is how we can start to roll out this good practice and start to think in terms of whole systems. We have pursued it very strategically. I have set up 12 national boards that are looking at what I think are the big issues across Wales. One of those boards is looking at unscheduled care and another is looking at chronic diseases and primary care. Those two issues are interrelated.

[8] We also need to look at how we can change behaviour, and that is the other big challenge. Patients tend to use the 999 number and tend to look to the accident and emergency department. What we have to do is to turn around the whole system and thinking. We have now launched the Choose Well campaign, and we might want to explore that in terms of how it will change matters. We have also established new communication hubs in three pilot areas, and we will be rolling those out throughout the rest of the year. We will probably want to explore how we shift from an automatic reference to 999 to an alternative and more robust system for those people that do not need a 999 response. That is an issue for us to educate people about, to improve our systems and an issue about how we can change behaviour and the attitude towards the health system. That would be an issue that the Wales Audit Office might need to look at in terms of what more we can learn about how we can change the system and change behaviour.

[9] **Darren Millar:** Thank you for that response, Paul. Andrew, in terms of the changes that you have seen in your local health board area, what is different now from 12 months ago? We have heard about some of the initiatives that the Government has taken, but what is different for people on your patch?

[10] **Dr Goodall:** The starting point with the WAO report is that its recommendations are helpful, given that we had embarked on integrated organisations. It set out for us a local checklist of the areas that we needed to take forward. I will make a few observations on what is different. I think that relationships are different, with a smaller number of organisations. The health boards are working with each other across the different geographical areas that we represent. This is a reflection as much on my own area as elsewhere in Wales, but I think that the relationships with the Welsh Ambulance Services NHS Trust are far more effective, not just at a more senior level, but with our local teams. I also think that the relationships with local government are better. There were a number of concerns that, in creating larger health boards, we might lose the local focus. However, many colleagues have commented that we have really embraced that local relationship and driven a lot of changes. I have seen an emphasis in my own area on grabbing the opportunity for the development of community services, recognising that they are not just about the health services that we put in place but finding programmes, such as our frailty programme in Gwent, focusing on older people, which is being rolled out across the whole of Wales. We have also been able to keep the focus on performance and targets. One of the challenges of the WAO report is that we have to redesign the system, while keeping an ongoing focus on the performance targets that we are expected to meet.

[11] My final comment, Chair, is about some of the challenges that came through the report about the level of data and information used. If you walk into any of the local systems at present, the amount of data that are available, and the visibility of the whole system right through from the ambulance service to the availability of community services, is, from my perspective, much improved. However, there is still further improvement that we can make in that regard.

[12] **Darren Millar:** I saw a grin appear across your face, Elwyn, when the relationship with the Welsh Ambulance Services NHS Trust was mentioned. You obviously have an interest in ensuring that there is a proper whole-systems approach to unscheduled care. What sorts of things have been happening in the Welsh ambulance service to improve the approach to unscheduled care?

[13] **Mr Price-Morris:** I was smiling at the wider point about relationships and joint working, which I think has now become much more embedded in the work of the NHS as a team in Wales, rather than issues being viewed on the ground locally. From my perspective, I see health boards working together on common issues. I certainly see my organisation working with health boards at national and local level to take things forward on a number of different tiers, particularly at the planning level, but also, very importantly, in terms of the interface on the ground between our clinicians, which I believe is now much stronger. There is a far better understanding of the pressures that we respectively face, and a real push and desire to work together to resolve them. There are examples around pathways, direct admission protocols and so forth as part of a progressive clinical model around unscheduled care.

[14] We are also now beginning to get into the issue of demand management and how we utilise the total system, rather than certain points in the system, in handling unscheduled care. Choose Well, for example, is an acorn waiting to take root in terms of having the public help us to help them.

[15] The other thing that I have seen over the past 12 months is NHSDW becoming an integral part of supporting demand management, triage, sound clinical assessment and screening of patients.

[16] **Darren Millar:** What does NHSDW stand for?

[17] **Mr Price-Morris:** NHS Direct Wales. Also, there is our ability at times of very high demand—as Paul said—to maintain a credible performance.

[18] **Darren Millar:** Thank you for those opening remarks. We will now move straight into some supplementary questions before moving on.

[19] **Alun Davies:** Mr Williams, in answering a question earlier, you talked about the need for a change in behaviour among the population in relation to the Choose Well campaign and so forth. I accept that. I think that you are right and that people make much greater use of accident and emergency departments than is absolutely necessary. Do you not agree that at least part of the reason for that is confusion in the provision of services? Take minor injuries, for example. We know that a number of hospitals have minor injuries departments. When I approached the Aneurin Bevan Local Health Board for a definition of minor injuries, I think that it ran to five pages. That level of confusion from the service itself does not enable the public to make good choices.

[20] 9.45 a.m.

[21] Do you not agree that this, at least in part, must be about the service itself being clearer about what can be delivered from which centre? What I find resonates among the electorate is that people are uncertain about these things, and I think that it is the responsibility of the service itself to get some of these things right.

[22] **Mr Williams:** There may be a perception that every hospital is the same in terms of the service that it can provide, but that is not the case. We need very specialised trauma centres, which may cover relatively large and even regional population centres. We need emergency care centres that will provide a lower form of support for the majority of ailments. Again, we need to look at this in a whole-systems context, and the communication hubs that we are developing will form the point of contact, we hope, with the public. If a condition is not a life-threatening one that requires a 999 response, people can call the communication hub, which will be able to access details of where people should go to receive the appropriate form of care. That will also include having health professionals involved to help to triage calls and provide advice. For me, that is the key to what we want to change in relation to behaviour so that, even if a call is wrongly made to the 999 service, it can be automatically streamed across and dealt with at the most appropriate level. I think that the new communication hubs will be central to access and delivery, in addition to the other side of it in the Choose Well education campaign.

[23] **Jeff Cuthbert:** My questions are directed to Andrew and Elwyn, mainly because of my experience with the Aneurin Bevan board—I am speaking on behalf of my constituency only here. When I became an AM in 2003, the biggest single complaint I had concerned ambulance waiting times. That is no longer the case; it is now about council house repairs—it has completely shifted. That is not your responsibility, of course, and perhaps that is just as well. [*Laughter*.] However, with regard to medical issues, until about 18 months ago, the biggest single complaint I had concerned ambulance waiting times. That is not the case now. I still get complaints, but there are nowhere near as many. So, joint working is presumably improving this, and that is crucial, because I want to know about examples of good practice—the public are not interested in whether ambulance services have a different management structure to a hospital or a GP practice; it is just the NHS as far as they are concerned, and if one section lets them down, then the whole service is tarnished. What examples of good practice are now being developed for joint working to improve the matter, as appears to be the case in my experience?

[24] **Dr Goodall:** It is about making people understand that the structures should not get in the way. Part of that is about the organisation itself giving a steer. The structures of WAST and Aneurin Bevan LHB are irrelevant; what is crucial is that we have patients moving through the system who need to receive the right kind of care. We have tried to emphasise that, certainly over the past 12 months, by working with our teams. We liaise daily—we commissioned an ambulance liaison officer to be on site with us in support of the ambulance trust. We do not have a hospital team meeting and then a discussion with the ambulance team at a separate meeting; we are all part of the same team. Every two weeks, we have a debriefing on the previous two weeks. I chair those sessions, and we have ambulance colleagues in the room with us, because they are part of our team. Some of this is about getting it across to everybody that this is about taking a single approach and not allowing the organisational structures to get in the way.

[25] Part of it is also about ensuring that we put in practical changes. We have seen significant improvement in ambulance handover just over the past seven weeks or so. One critical point about our initiative to have ambulance liaison nurses at the front door is that it came from the staff themselves; it was actually the nursing teams who said that they understood absolutely the priority of having ambulance vehicles back on the road, and they were frustrated that some of our previous initiatives had not worked—even if they had made an impact at a certain stage, it had not been sustained—so they came up with a plan

themselves. Part of the relationship is about everybody taking responsibility within the system. When the staff come up with the ideas, that is when things really do become sustainable within the organisation.

[26] **Mr Williams:** Unfortunately, a feature of some parts of the public sector is that they have been very deft at managing the boundary and shifting a problem on. This concept of integration now runs very deep in managing the health service. The fact that I have only 10 chief executives means that I can call them into a room and say that if performance in one place is affecting performance somewhere else, we have to deal with it collectively. I have been particularly exercised on behalf of the Welsh ambulance trust in that handovers are far too long, impacting upon the reputation of the ambulance service and its ability to get back out on the road to deliver for the next patient. Those interface issues are being identified now and we work on them collectively. My officials are part of daily, weekly or monthly meetings to look at how the whole unscheduled care package is operating, and targeting where we need to take particular actions.

[27] **Mr Price-Morris:** I will just add to that in terms of my perspective on some of the important things that my organisation needs to be involved in. Our work with Andrew and his colleagues is a very good example of this. We have to ensure, as a trust, that we convey only those patients who need to get to an accident and emergency department. We cannot be in a situation of overwhelming the accident and emergency department with patients who do not need to be there. That is dependent on other pathways. That leads me to my second point, about having a whole-system understanding of how primary care, community services and community nursing services, all the way through to secondary care, work within a particular area. For me, it is about the ability to ensure that I am taking patients or directing them to the right part of the healthcare system. It is also incumbent upon my crews to turn around quickly at the hospital, so that they are doing their part to get back out there for the next patient. It is not simply about the front door of the accident and emergency department either; I see a very important role for the trust in discharge planning, to ensure that the back door of the organisation and the hospital is also moving to allow a flow for patient care.

[28] **Sandy Mewies:** Good morning. You might consider this a slightly strange question. We have been talking about the whole-system network, and it is good to see NHS Direct Wales working with the ambulance trust and so on, which is the only way that things will work. One problem that individual members of the community face is that they sometimes cannot analyse for themselves where to go. Some people's reaction to a minor injury is that it may overwhelm them, while for others, it is not quite the same. I was wondering—because of a case that I was involved in recently—where community pharmacists fit into this. I know that community pharmacists often advise members of the public. Like many Assembly Members, I do not have a GP in Cardiff, but I was able to consult a community pharmacist on behalf of someone else who gave excellent advice on the out-of-hours service in Cardiff. It worked very well indeed. Elwyn will know that I will write to congratulate people; I did it recently with the ambulance service. Community pharmacists should be congratulated. I know that community pharmacists are prepared to be used quite extensively in the health service, so I wonder where you see them fitting into this.

[29] **Mr Williams:** Andrew can give you a bit more detail, but it comes back to the concept of the communication hub. Local health boards now have integrated services, which include primary care—not just GPs, but also pharmacists and optometrists; I may touch on the primary eye care initiative as another example. Discussions are taking place, but they are co-ordinated through the communication hub, so that the message comes back. We have evidence already in terms of what NHS Direct has been doing, where it has been able to ensure that 20 to 40 per cent of the patients that it has seen self-care and perhaps go to see their pharmacist, going back to that service if necessary. Therefore, we are already shifting those emphases, but we can do it only by ensuring that we have tied all our primary care

colleagues into this network.

[30] I will use the primary eye care initiative as an example. If I get a foreign body in my eye, what do I do? I turn up at the accident and emergency department. However, it is possible to go to your local optician, where someone—probably a trained optometrist—will be able to deal with it. That is another example of how that is working on the ground. That will now be embedded in the communication hub, so that people will be able get that advice and rapid care, possibly close to where they live. That will be part of turning this whole system around. I am sure that Andrew can give you some further examples.

[31] **Dr Goodall:** Regarding pharmacy specifically, we have all had discussions with Community Pharmacy Wales. Indeed, my chair and I are meeting with the chief executive of CPW next week to talk through some of these options. It is about ensuring that the communication works. There are examples across Wales of minor ailment schemes. As Paul said, they not only support minor injuries; they are a way of unlocking some of the capacity that is needed in GP practices.

[32] However, the important thing about the communication hub is that it is not just about how patients access it; it is also about ensuring that professionals, who can sometimes struggle to know what choices exist for patients, can use it to give immediate advice to patients. Whether it is a GP who needs advice or a steer, or a social worker, or a community-based pharmacist, they can access the communication hub to give immediate advice. Therefore, it is an important mechanism. Having more than 700 pharmacy practices across Wales and not using them as a holistic part of our system would be wrong. That is the nature of the discussion that we will be having with CPW.

[33] **Nick Ramsay:** There have been criticisms about delivering emergency care services. Therefore, regarding the new service model that is coming in, are there any definitive timescales for finalising its introduction? Weaknesses have been identified with the old model, including the lack of a full understanding about the demands that would be on unscheduled care at any one point. Are you confident that the new model will have a better understanding of where and when the need will be for unscheduled care?

[34] **Mr Williams:** I will start with the last part of your question, if I understood it correctly. I am not entirely happy that we have the modelling correct in terms of whether accident and emergency departments are correctly calibrated—their physical capacity or the number of staff required to deal with the patients who attend, who need to be properly assessed, and streamed accordingly. There is much work still to do, and I believe that we can improve that system significantly. I have recently written to all the chief executives asking to see plans, because some performance targets have not been achieved and fall far short of my expectations.

[35] There is a lot of work in progress. We have invested more than £70 million in accident and emergency departments, and another £100 million is being spent in the next few years. Prince Charles Hospital is one example, where there will be a complete redesign. However, it is not just about the building. As I say, we need to ensure that the right staff are in the right place, at the right time, at the right grade; there also needs to be good access to diagnostics and so on. We have ambitions for the whole system, which is where the communication hubs and our locality management teams will be vital. We have started this process, and, again, each board has a different timescale. For example, I believe that Abertawe Bro Morgannwg University Local Health Board has identified seven locality teams and locality managers for the establishment of its hub. We have the three hubs; Andrew is piloting one in Gwent, and, by the end of the year, all the hubs will be up and running.

10.00 a.m.

[36] We are on a two or three-year journey, in terms of the transition from the old to the new model. We are seeing significant improvements, so I am confident. However, I am not confident that we have the whole system running. We need good project management to make sure that key elements are delivered along the way.

[37] **Nick Ramsay:** How much progress have the local health boards made individually on developing their own models of unscheduled care? Perhaps Andrew could talk about his experiences at the Aneurin Bevan health board and describe how he feels things are going.

[38] **Dr Goodall:** I will comment for my board, and I will also try to give a couple of examples of experiences elsewhere in Wales. We are not waiting to implement this. We have been implementing it over the past 12 to 18 months, with the new health boards being in place. However, there are stepping stones ahead. For example, we focus on our community service development, and we have been bringing together integrated teams. We have used our structures, to some extent, to demonstrate changes in different areas. For example, the Torfaen director of social services is one of my locality directors, and we have seen delayed transfers of care reduced by 75 per cent. That shows the difference made by having someone in office who has shared responsibilities. We have fully established mental health crisis intervention teams across our entire patch over the past 12 months, because this service was not universal. Elsewhere in Wales, Abertawe Bro Morgannwg University Local Health Board has recently made changes to its out-of-hours services, so that referrals can go directly from accident and emergency departments. That is diverting 20 patients from accident and emergency departments to out-of-hours services on a daily basis. We have used contracts with our GPs over the past 12 months to re-emphasise issues relating to opening times, our expectations for the last appointment times of the day and access points. So, we have taken on board many of the service components described in the Wales Audit Office report, and we have been developing and implementing them. From a local perspective, the frailty model, which we are implementing and going live with from 4 April, is the really significant issue. This is not just about picking off one individual local area. We are putting in a universal service across the whole of the Aneurin Bevan health board area. Given that this is integrated with local government, because it has third-sector involvement and because it has the communication hub perspective, we are expecting a significant step change in the overall experience of patients moving through our system. This is a major change that people have been planning over the past two years.

[39] **Peter Black:** Recommendation 6 of the whole-systems report talked about the need for the Welsh Government to support local bodies in working towards 24/7 working for certain services, where appropriate, to meet local needs. The recommendation also talked about the need for greater continuity, consistency and coherence between in-hours and out-of-hours care. How far will the new service model go in specifying the need for extended hours of working, where required, and for greater continuity between in-hours and out-of-hours unscheduled care?

[40] **Mr Williams:** Ultimately, that is the responsibility of the local health boards. We set a fairly sophisticated suite of policies, and we have also moved away from the process targets, though some of those remain important. We are looking at quality of outcome targets to ensure, for example, that a fractured neck or femur is dealt with in a timely manner, how to get good access to CT scanning for stroke care and so forth. We are now looking at the unscheduled care board and expecting it to come forward on a national basis with a review of those plans, to ensure that those various elements are brought together. We have learned in the past that a national one-size-fits-all plan is inappropriate, because each board has its own particular requirements. At a national level, we need to pick out those key indicators and ensure that they are starting to deliver, whether they are hard-time process targets or whether they are quality outcome targets. That is the way that we are ensuring that the plan moves

forward and determining, where necessary, that it requires either improvement or investment. We are working through this on a monthly basis. Sometimes, where things are particularly acute, we are looking at things on a weekly or daily basis.

[41] **Peter Black:** In light of the financial constraints you face in the public sector, and given the availability of resources, how are you managing to achieve 24/7 working?

[42] **Mr Williams:** I think that resources can be used more effectively and wisely. We touched earlier on chronic disease management, for instance. We have seen that the three demonstrator sites have not only improved access to services but, by reducing the number of admissions and the length of stays, saved around £2.5 million. That is only a small example of how providing appropriate 24/7 services not only improves quality but saves money. That is the approach we are taking. Quality does not necessarily cost more—'quality' means 'fit for purpose'. Some of our services have been confused; they have not been delivering in the right place at the right time.

[43] **Peter Black:** Perhaps Andrew could give us some specific examples of what is happening in Aneurin Bevan Local Health Board.

[44] **Dr Goodall:** I will give some examples in out-of-hour services. Sometimes it is unhelpful for us to distinguish the out-of-hours service from the in-hours service. It is pretty obvious that an emergency can occur at any time of the day or night, but we have compartmentalised some of the services in the past. One area in which we have progressed—and I know that Cardiff and Vale University Local Health Board has done this over recent months as well—is recognising that there are peaks and troughs of demand. For example, it is necessary to ensure that senior decision making is in place for the key 12 to 14-hour periods through the day and late into the evening, seven days a week. I know that Cardiff has put in changes recently to have that cover, and we have also done that in order to ensure that there is 12-hour access to acute-care physicians at the Royal Gwent Hospital site that takes us into the weekend. We have also recognised that there is a different requirement for management support, and so we have on-site management at a senior level, which is available over the weekend, too.

[45] As for the way in which the 24-hour system works, clearly there are pressures on individual services, and so, again, it is important to ensure that we unlock opportunities relating to diagnostic support and therapies working. Although the danger is that we focus only on the front door, a lot of this is about ensuring that seven-day access works for all of our support. It is as important to keep a seven-day focus on our discharge mechanisms, for example, as it is to have seven-day services in place for the front door of the organisation.

[46] **Mr Williams:** One thing I have emphasised to the health boards is that whole-systems working also means working 24/7. It is not a 9 a.m. to 5 p.m., Monday-to-Friday job. If we need managers to be there 24/7 to make sure that the system is working, we will have to ensure that that is what happens. That requires greater flexibility. We have been investing specifically in having more consultant staff at the front door. For me, a lot of unscheduled care is about ensuring that what appears to be unpredictable is predictable; the statistics show you exactly where there is demand, and then you have to ensure that you have the capacity to meet those demands.

[47] **Mr Price-Morris:** To add to that, from the perspective of the trust, it is important to recognise that we are already working in a 24/7 environment, but it is equally important for us to ensure that our response is commensurate throughout the 24-hour, seven-day-a-week period. To that end, we are giving particular attention to the 11 p.m. to 8 p.m. period and, as Andrew said, to working with health boards in relation to peak times. We are extending management presence in the organisation and at the interface of the front door of the

hospitals. We are also supporting GPs when they seek to access urgent care, whether it is for admission purposes—other than 999 cases—or for diagnostic purposes. Supporting GPs to do that, at the right time and in the right way, is an important part of the system.

[48] **Irene James:** I want to go back to the issue of public engagement and access to unscheduled care. 'Unscheduled care: developing a whole systems approach' states that the unscheduled care system is a disjointed network of services—and we touched on that earlier. It says that many people do not have a complete understanding of which services they need to contact. In its second response to the report, the Welsh Government highlights progress in implementing a national communications campaign, which we have already mentioned. If we assume that the new service model for unscheduled care will lead to a new pattern of services, can you explain why the national communications campaign has been rolled out before service changes have been finalised?

[49] **Mr Williams:** It is not an either/or situation. There are many things that we need to address where we know that the services are falling short. We know where we can improve services using the whole-systems support that I described earlier, and we know that we need to shift behaviours. The interesting thing about the national communications strategy is that we piloted it in Betsi Cadwaladr and Cwm Taf and we learned from that. We particularly learned about the difficulty of engaging the public, and we need a range of ways of doing that. It is not a flash in the pan—it has to be done on a continuous basis. We are the first of the UK countries to launch a national campaign on the back of what we learned from the pilots. I do not know whether that is putting the cart before the horse, but we are trying to move on a number of fronts at the same time, and there is a degree of learning in this, because each board has a different set of circumstances, with greater or lesser investment, different resources—either physical or in terms of staff—and each board has a different relationship with its key partners, particularly local government, around what it can contribute. It is through the unscheduled care board that we are trying to bring all of these elements together to ensure that we have a coherent picture. However, I can now see a discernible shift in the quality of care that we are providing and in access times.

[50] **Dr Goodall:** I think that there are some new areas that we need to describe for people, such as the development of community services—it is important to raise awareness of that. For me locally, it is a matter of looking at the reasons why people use certain parts of the system, particularly accident and emergency departments. It is important to point out to people that it is still about using the GP appropriately, and ensuring that they have access to a GP. It is still about using the local pharmacy, if there is one available, and the out-of-hours services. That support needs to be there for people, and that is why the communication hub can give that answer immediately. One of my local GPs has said that what he really requires when he has a patient in front of him is the answer to the question of where they go next. That is required within 10 or 15 minutes in order to be really clear. What they do not want is to be held on the phone for an hour or two while people try to judge what the appropriate service is. They want someone to take responsibility.

[51] **Irene James:** You have mentioned this communication hub, but how will its success be monitored?

[52] **Dr Goodall:** There is quite a crude measure for the communications hub. It will be about measuring demand, which continues to increase year-on-year, for accident and emergency departments, via ambulance vehicles and the out-of-hours services, to see whether that decreases. What we are looking to do through the communications hub is ensure that the front doors of our organisations do not have the same numbers coming through. At the moment, about half of the people who arrive by ambulance do not need admission or any follow-up intervention, so we know that they are choosing to come to accident and emergency departments for particular reasons, but I would expect to be able to describe an increased use

of other areas of the system, such as the community care packages, and an increased workload for the community teams that we are putting in place. That would demonstrate that we have compensated elsewhere for a decrease in the use of accident and emergency departments.

[53] **Irene James:** You raised the issue of using ambulances to go to accident and emergency departments, but we have not yet educated the public that, if someone falls over and cuts a finger, they do not need an ambulance to go to hospital. I have real concerns about how we will educate Joe Public, as well as doctors, that services are not always needed when we assume that they are.

[54] **Mr Williams:** Part of that is more effective triaging. We talked about NHS Direct, and the number of calls has gone up to nearly half a million per year. Effective interventions now mean that fewer people are being referred to hospital and fewer calls are being converted into a requirement for an ambulance. We are starting to track these data. One swallow does not make a summer, but we are seeing progress. I do not have the information with me now, but we have mapped the various ways in which the Welsh nation accesses unscheduled care services.

10.15 a.m.

[55] It is an unbelievably complicated picture, which has grown like Topsy over the years. Our plans will ensure that we can track a logical alignment to ensure that the services will be there at the right time in the right place. So, we can give you those figures. We can show you the figures for category C, which show that we are starting to make a difference. As I say, if we have a growing elderly population, we will inevitably see more people coming to hospital, but we will now be seeing many more people being referred to the most appropriate form of care and support. So, we are seeing some of this coming through, and that is what the unscheduled care board is mapping in order to see whether these various interventions are making a difference and whether we are seeing different trends, and the answer is, 'Yes we are'.

[56] **Irene James:** It would be useful to see that.

[57] **Darren Millar:** It would. It looked a bit like a Jackson Pollock.

[58] **Mr Williams:** Absolutely. I might frame this.

[59] **Darren Millar:** I want to ask you about something that you touched on before, which is a fundamental question about whether the cart is being put before the horse. We know that service reviews of unscheduled care are taking place across the country. They are taking place in my area in north Wales, for example. You seemed to hint in your opening remarks that we might begin to see the shape of unscheduled care services being regional trauma centres, with emergency care centres being almost in a different category. It seems that there would be the introduction of a different category of entry to the healthcare system for unscheduled care. Is it not going to cause more confusion to the public, clinicians and other people in the health marketplace, if you like, to introduce another tier of entry to the system? If you introduce regional trauma centres and emergency care centres, what is an accident and emergency department? Is it both of those? Is it one of those and not the other?

[60] **Mr Williams:** What I think we have to do, Chair, is ensure that the public has a single point of entry to the system. It will be arguable whether that will be just 999 or 08454647 or whether we get rid of that and go to 111. There is a debate going on about that. There should be confidence that you go to either one or one of two numbers and that, whether you go to one or the other, you will be streamed accordingly. The system will then prioritise and ensure that you get the best care at the right place at the right time.

[61] **Alun Davies:** I am looking for reassurance because, as this conversation develops about the communications hub and streamlining access to services, I am still left with a nagging fear. If you think about a pensioner in her seventies who is not feeling well and who cannot contact family members, the certainty that medical support is available is critical. I understand the issues you refer to with regard to 999. However, I feel that we are still not completely clear about the relationship between the services you have discussed and the GP out-of-hours services and access to those. I have discussed before with Dr Goodall bringing services for minor injuries and GP out-of-hours services together to provide a more coherent service.

[62] When I think about different localities across different parts of Wales, I think that what people want is certainty that there is qualified medical support close by that is accessible 24 hours a day. People feel that that is what the national health service is there to provide. Clearly, there are other services—we have discussed opticians and pharmacies and so on—and I understand and accept all of that. However, if someone is feeling seriously unwell late on a Saturday afternoon or Saturday evening, the knowledge that, within a short distance, there is access to medical support is critical, and I do not believe we are yet clear about accessing that; we do not yet have that coherence. Some of the issues we have discussed, Dr Goodall, about bringing together minor injuries services and GP out-of-hours services would provide people with that certainty. Is that fair?

[63] **Mr Williams:** I think that it is, and I would perhaps want to go a step further and be even more ambitious. We cannot have a situation where, for the lack of support or identification, Mrs Jones falls in the middle of the night, fractures her hip and turns up in the accident and emergency department because we have not identified that there was a potential problem of her falling. So, I would go back even further to say that we want to establish locality teams that have active care programmes for all at-risk people so that we try to avoid the breakdown and the emergency situation. Those will always happen. Part of our ambition is to develop locality teams—integrated health and social care teams. We hope that GPs will have a significant role to play in these teams, and, because primary care is so important, we are also talking about the other primary care practitioners. When there is an emergency, the appropriate service will be accessed through the hub. That might mean sending a paramedic out to the scene or an ambulance, and, when the patient arrives at the appropriate facility, it might mean making available a fully trained trauma surgeon, a general physician or a general practitioner. That is where we have to work through these graduated forms of care. However, we must get away from this lottery, whereby people are searching around trying to find the appropriate way into the system. We must have that one point of access, but I want to get even further upstream of that in terms of how we can manage at-risk groups proactively.

[64] **Alun Davies:** Thank you for that answer; it was very useful. In terms of that access—

[65] **Darren Millar:** Are you going to be brief, Alun, because we need to move on?

[66] **Alun Davies:** Yes. My view, and perhaps you can confirm whether I am right in this, is that the communications hub would be accessed via, say, a 111 number, which would go through to a local call centre, and which would then almost replace the GP out-of-hours number. So, you would have 999 for absolute emergencies and 111, for argument's sake, which would take you through—in Dr Goodall's area, for example, the call would go through to Abergavenny, Ebbw Vale, Cwmbran and so on. That person would then be able to be provided with access to their GP or other qualified medical assistance as necessary.

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

[68] **Darren Millar:** I will let you respond to that as we go on. Sandy has an important

question.

[69] **Sandy Mewies:** We have talked quite a bit about GPs, primary care practitioners and the other primary care practitioners who need to be involved in this. However, paragraphs 1.4 to 1.19 of the report illustrate that some people face delays in accessing urgent primary care appointments and, when that happens, that is when they default to more acute services, which they may or may not need. The Welsh Government's second response to the report has set out a number of initiatives designed to improve access in this regard, which we have already discussed. What actual improvements have there been to ensure that everyone in every area of Wales can access urgent primary care appointments consistently? It is the Welsh national health service, is it not? That is the point.

[70] Perhaps you would also like to comment on the fact that the first and second responses both look at the work of the national unscheduled care programme board, but also highlight key work in relation to the primary care national programme board. How do you ensure that those are sufficiently connected and are working together and separately to add value and to drive improvement in unscheduled care?

[71] **Darren Millar:** I ask you to be as brief as possible in your response, please.

[72] **Mr Williams:** There is still more to be done in terms of access to primary care but, at present, the surveys show that 83 per cent of people questioned could have an appointment on the same day or on the following day. That is the truth of the matter. There is a satisfaction rate of around 92 per cent. However, there is more to be done. Around 47 practices have now extended their opening hours. Some very good work has been taking place in Neath Port Talbot and Newport—Andrew might want to mention what is happening in Newport. I have been having a conversation with the British Medical Association and negotiations about ways in which we can further increase access to GPs across Wales. It is not as gloomy as some might suggest. Is there more to be done? There certainly is, and we are in conversation with the British Medical Association about this and are looking at the general medical services contract.

[73] The unscheduled care board and the primary care board interrelate. They have members in common. Again, we discuss these issues, as chief executives, to ensure that they interrelate.

[74] **Sandy Mewies:** You just talked about contracts. Can you direct or guide those contracts?

[75] **Mr Williams:** I know that you are in a hurry, Chair, but I have two points on that, if I may. We now have a national primary care report, which looks at the use of primary care, and we have asked every health board to produce its own primary care report. That is where I expect the key interaction to take place between general practitioners and the local health board with regard to where there may be variations or where we feel that the opening hours are not as extensive as they should be. So, that is where the work should be.

[76] It is not a question of direction, but of negotiation through contracts. However, there is still plenty of scope within existing contracts before we start talking about new changes.

[77] **Darren Millar:** One area of questioning that we will not be able to cover today is around walk-in centres, on which commitments have been made in the past by the Welsh Government.

[78] **Mr Williams:** Yes. We have examples that we are trialling in Cardiff Royal Infirmary and Merthyr health park. They are being built as we speak.

[79] **Darren Millar:** Perhaps you could drop us a note to update us on the situation with walk-in centres. I am keen to move on and there are some questions on the Welsh Ambulance Services NHS Trust that are important for us to cover. The next question is from Bethan, and then we will move on to the section on the Welsh Ambulance Services NHS Trust if we can.

[80] **Bethan Jenkins:** Mae fy nghwestiwn ar drywyddau sydd wedi'u rhag-gynllunio er mwyn cynorthwyo cleifion. Yn eich ateb ar ran y Llywodraeth, rhowch fanylion ynghylch ymdrechion i gryfhau ac ehangu'r llwybrau. Pa wybodaeth sydd ar gael am y manteision go iawn i bobl pan ddefnyddiant y llwybrau hyn a sut maent wedi newid ers ichi newid y system yn y sector iechyd?

Bethan Jenkins: My question is on the pathways that have been pre-designed to help patients. In your response on behalf of the Government, you give details about efforts to strengthen and expand those pathways. What information is available about the true advantages for people when they use these pathways and how they have changed since you changed the system in the health sector?

[81] **Mr Price-Morris:** I think that it comes down to the clinical response model that, as a trust, we want to put in place. It is something that we have started to work on in earnest over this past year. What it is important for us is to ensure is that, when patients come into contact with our service at the front end of unscheduled care—whether it is to do with cardiac, mental health, alcohol or sepsis issues—we are clear about ensuring that there is the appropriate response in the right place at the right time by the right clinician and that we hand over patients to the NHS partner at the right point of contact. What is critical in that regard is that we ensure that we have the right pathways in place to allow us to take that forward. As a trust, we are developing around seven clinical pathways at the front end of unscheduled care, and I have just given some examples of what they look like.

[82] Strong clinical assessment is crucial in pathway development. Our clinicians, paramedics and nurses need to be empowered to ensure that they are assessing patients in a robust way, so that what we experience as patients is the very best clinical outcome, because the Welsh Ambulance Services NHS Trust is making a clinical difference at the front of that pathway. However, ultimately, it must be a pathway throughout the entire unscheduled care event for that patient. Being able to work those through with partners locally and health boards is the right way forward. We have seen very good examples already of how that is moving forward around strokes and falls in particular, but there is so much more to go for in this regard.

[83] **Dr Goodall:** I just want to comment on stroke and respiratory services. Stroke services across Wales have been transformed over the past 12 months. We have taken evidence based on interventions, and we have really driven them through the system, and we have had local clinicians taking on that responsibility. As a result, there is a different experience with stroke care. To give you a single example, there have been real improvements in quality on my stroke ward in the Royal Gwent Hospital, and even lengths of stay have reduced by 50 per cent. Our colleagues in Cardiff, following the changes that they have put in place around respiratory services, have seen a reduction of 35 per cent in the number of people admitted with respiratory conditions. So, getting the pathways right has a direct impact on how the system works.

[84] **Bethan Jenkins:** Yn yr adroddiad gan Swyddfa Archwilio Cymru, y broblem oedd rhannu gwybodaeth rhwng ardaloedd gwahanol. Ym mharagraff 1.41 o'r adroddiad, mae sôn am y diffyg rhannu gwybodaeth rhwng ardaloedd a'r diffyg cyfathrebu tu allan i oriau gwaith. A yw

Bethan Jenkins: In the Wales Audit Office's report, the problem was sharing information between different areas. In paragraph 1.41 of the report, the lack of sharing of information between areas and of communication outside office hours are mentioned. Has that improved as a result of the new pathways that

hynny wedi gwella oherwydd y llwybrau newydd yr ydych wedi enwi yng nghyd-destun strôc a chwympo? A yw hynny wedi newid?

you have named in relation to stroke and falls? Has that changed?

10.30 a.m.

[85] **Dr Goodall:** 'Yes' is the answer. The key to our changing our respiratory services in Aneurin Bevan LHB was ensuring that it was not necessarily just an in-hospital pathway, but that GPs, in particular, along with their specialist colleagues on the hospital side, were working together to produce it. We have tried to develop a lot of pathways on a national basis, but you still need to have local ownership. So, the feedback that I have had on respiratory services is that that change has worked for that reason. The focus on programmes that we have in place in Wales, which have tried to develop a series of different pathways, has again used the evidence base, but it is also about how we monitor them in practical terms on the ground. To use the stroke example again, we have used data through the whole system to demonstrate that the pathways are having an impact. At any one time, we are probably chasing 40 areas on a day-to-day basis to ensure that the pathways are significantly put in place.

[86] **Mr Williams:** This is a difficult issue, but I have learned that you cannot impose pathways on clinicians. They need the evidence and to understand how it will work, and, when they do, you can accelerate the pace. Dr Anne Freeman has been leading this work for us in stroke care. We also have the use of what we call intelligent targets, whereby clinicians design what they think is the most important target, which may be quick access to CT scanning, for example. Whereas previously Wales was lagging behind in stroke care, we are now the fastest improving country of any of the UK countries in terms of our direction on stroke care.

[87] **Darren Millar:** That is absolutely clear. Before we draw to a close in a few minutes' time, we will move on to look at ambulance services and, in particular, patient handovers, because there are some interesting questions here. Irene, will you ask those questions for us, please?

[88] **Irene James:** On 3 March 2010, the committee received a progress report from the Welsh Government on the response-time performance of the Welsh Ambulance Services NHS Trust. The report suggested encouraging signs of improvement, although the Wales Audit Office concluded that the progress report was not enough to provide robust evidence of sustained improvement. Can you update the committee on trends in the trust's response-time performance over the past 12 months? How satisfied are you that the trust is now on the path to sustained improvement in its performance?

[89] **Mr Williams:** When I first took over this job, I was dismayed by the performance and spent a lot of time and effort on this area. The performance target has been exceeded in nine of the past 12 months. Regrettably, we did not hit the target in November, December and January, because of the inclement weather. We had the first snowfall in November, and then we had the coldest winter for 100 years. It was not just about the snow on the ground; there was an issue about vehicles not being able to travel at safe speeds in order to hit the targets. We had around a 22 per cent increase in life-threatening calls during December and the first couple of weeks of January. We are still dealing with the numbers of patients in hospitals, because we also had the flu epidemic. In fact, despite the evidence of the previous pandemic, it affected the health service more profoundly. Nearly half of our intensive care beds were taken up by patients with flu-related symptoms. So, the whole system coped remarkably well under huge stress. I was hoping to be able to report that we had had 12 months of hitting the target, but, unfortunately, we did not hit it in November, December and January. My

management information tells me that, in February, we bounced back and are exceeding the target again.

[90] **Darren Millar:** The weather is a bit of a poor excuse, is it not? We get cold weather and snow every year. People get the flu during the flu season, when we have cold winter weather. This seems to be a particular problem each and every year, however. Is it simply that you are not focusing resources properly in order to tackle the issue?

[91] **Mr Williams:** I think that part of what keeps us eternally optimistic is that we forget all of the bad things that have happened in the past. For example, you just could not get around Cardiff. In my area, I had to walk to work for four days because public transport could not run. How do you expect an ambulance to gain access? We were really worried. These are practical issues. With regard to the flu, this was a particularly virulent strain that affected young people and meant that they required intensive care. The fact is that we had the coldest winter for 100 years, and there is good evidence to show that when we get a really cold snap, we have a sharper increase in the number of strokes and respiratory diseases, and that leads, within a couple of days, to a huge demand on the health service. So, this is not just some excuse like snow on a railway line; we had some particular issues to deal with during this period.

[92] Elwyn, do you want to say something about this?

[93] **Darren Millar:** Before that, I know that Alun wants to throw a comment in. Perhaps you can respond to both points, Elwyn.

[94] **Alun Davies:** I understand the points that you are making, and the purpose of management is to plan your way through these difficulties and you have structural learning—[*Interruption.*] I will just make my point. You have structural institutional learning within that. I understand that, if the roads are not passable, there are issues for you, but we need to ensure that we have institutional learning within the organisation to enable us to capture those experiences and learn from them.

[95] The substantive point that I want to make concerns something that came up during questions to the Minister for Health and Social Services in the Chamber about a month ago. The Minister responded that one of the key issues facing the ambulance service was that of inconsistencies of time and place, in that the ambulance service does meet its targets, but it does not do so everywhere and all of the time. That inconsistency is a key issue. While we understand what happened in December, why are those inconsistencies still there for the rest of the year? Also, why are those inconsistencies—I am trying to avoid using the word ‘inconsistent’ but, in some places, you hit targets sometimes, but in other places, you miss targets, and there does not seem to be a pattern to it.

[96] **Mr Williams:** I think that there is a pattern, frankly. I think that you are right to pursue this issue because, if there is a pattern, one must ask why we are not tackling it. There are two areas that caused me particular problems, one of which is the Rhondda. The Rhondda Fawr is 17 miles from top to bottom and there is virtually only one road. It does not take much to disrupt the traffic on that road, and if an ambulance is in the wrong place at the wrong time, it can be very difficult. However, there are issues there about having much more of what we call ‘dynamic planning’ to get the vehicles around, and we are using more rapid response vehicles so that we can get paramedics to patients quickly where we might not be able to get a full ambulance in time. Torfaen is another challenging area. In the past, the situation in Torfaen was exacerbated by poor handover times at the Royal Gwent Hospital, so we had to go back to this issue of whole-system healthcare and say that if we cannot sort out handover times at the Royal Gwent, then we cannot release our vehicles. So, I would agree that we need to be consistent across the board, as that will help us to meet our targets

consistently. Perhaps Elwyn would like to come in on this point.

[97] **Mr Price-Morris:** My answer is true in relation to both sets of questions. We are now at a point where we have to plan service delivery on the basis that we are going to see difficulties caused by spikes in demand and peaks of real activity throughout the year. Yes, we will get those particular winter pressures, but they are, in my view, in addition to the underlying demand level in the population. We have to be responsive to that, at the planned care level and the unscheduled care level, because I think that there is a strong connection between the two.

[98] From a trust perspective, I recognise that there is variability with regard to response times, and we are certainly not complacent about that. I charge my regional directors to do the very thing that Paul has described—to understand why the Rhondda Cynon Taf area is a particular challenge to us. We pay particular attention to developing plans and programmes, again in partnership with the wider healthcare system, to ensure that we see continuous improvement, not just at a health board level, but a local level as well. In terms of taking that forward, it comes back to what the trust is now seeking to do through its five-year plan, which is to move much more towards a clinical model. It is about having a clinical level of understanding and assessment and deployment control, but it is also about making sure that we have the right capacity out there, that we are efficient, that we are productive, and that we work with our staff and the public to change behaviour and mindsets, as we said in our discussion earlier.

[99] It is about understanding and reflecting on times of particular difficulty. For example, a year ago, when we had that particular snow outbreak, we looked to change some of our fleet in terms of bringing more four-by-four vehicles in and fitting snow tyres to the fleet. We learn, and we amend and adapt our resources accordingly. However, ultimately, in order for us to be able to provide true sustainability, it has to be about a clinical model for doing things differently, and about putting our capacity in the right place at the right time.

[100] **Darren Millar:** Could I ask you a very practical question? What does the ambulance service do when heavy snow is forecast? Do you get the snow chains out and stick them on the tyres? What do you do if a really cold snap is forecast and you know that the flu is circulating, and there will be an increase in the number of people with respiratory problems, and so on? What did you do this year, and what did you not do this year that you will do next year, when such questions arise?

[101] **Mr Price-Morris:** The first thing is that we have an escalation plan within the organisation that builds on the normal and routine management that we have in place. Immediately, when we get an alert that a long period of severe weather has been forecast, we increase our management approach, we look at our deployment arrangements to ensure that, first, we will be putting our crews safely on the road, and secondly, that we are working with the health boards and with local government and others to ensure that we can access patients. There are practical things that we have to do about simply getting our staff in, so that we can join a staff crew with an ambulance to move them forward.

[102] In terms of what we will be learning from this particular period, I think that much more work needs to be done to understand the degree to which the healthcare system was affected, particularly during December. If we are to see sustained periods of severe weather lasting three or four weeks, then I think that, at a very wide level—and the Wales resilience forum picked this up recently—a higher level of escalation planning arrangements will have to be out in place. One of the key things that we did this time, and which we have not done previously, was to utilise our planned patient care services to support unscheduled care. So, this time, the Welsh ambulance service responded by deploying its entire resources on keeping the unscheduled care service going while protecting key areas such as renal and

cancer patients in terms of planned care.

[103] **Mr Williams:** The important point for me on this in terms of learning—and I am grateful for this conversation—is that we coped with a 20 per cent increase in the number of people who were very seriously ill and we got them all to hospital. Targets are all well and good, but in extreme situations like this, we need to consider whether to suspend the eight-minute target. Why would we expect vehicles to dice with death in terms of snow and ice just to hit an eight-minute target if they get the patient to hospital safely? There are important issues there, Chair, in terms of getting behind the targets.

10.45 a.m.

[104] **Darren Millar:** I understand that, but when a category A call comes in and someone needs an urgent response and there are problems—which there have been this winter, even with category A responses—those minutes are vital, so I think that it is important that we have this conversation. Peter, you wanted to come in on this.

[105] **Peter Black:** I think that Elwyn touched on this to an extent, but is it not the case that one of the problems—putting aside the weather and other issues—is that, for most of the year, particularly in secondary care, the system is working to near capacity? When there are unexpected events or events that add to demand, it causes problems in terms of how you respond with regard to how ambulances offload patients and how quickly you are able to discharge patients at the other end.

[106] **Mr Williams:** I made that point earlier, but there is still a great deal to be done on capacity planning in terms of physical and staff capacity. We have a winter plan, and, in fairness to my colleagues, during not just early December but throughout the Christmas period, they were on a conference call daily to update their position.

[107] **Darren Millar:** That draws the first item on our agenda to a close. Thank you, Andrew, Paul and Elwyn for participating. Paul, I believe that you are going to stay for the next item.

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

[109] **Darren Millar:** We had a number of other questions to ask, which we will write to Paul Williams on to seek a response, if that is all right with committee members. I see that it is.

10.47 a.m.

Gwasanaethau Therapi Ocsigen yn y Cartref: Tystiolaeth gan y Cyfarwyddwr Cyffredinol dros Iechyd a Gwasanaethau Cymdeithasol
Home Oxygen Therapy Services: Evidence from the Director General, Health and Social Services

[110] **Darren Millar:** As with the work on unscheduled care, the committee has taken an ongoing interest in this topic over the past two or three years. The director general is staying with us, but we are also joined by some new witnesses. We have Professor Roger Walker, the chief pharmaceutical officer. Welcome, Roger. We also have Dr Karen Gully, the senior medical officer for primary care. Welcome, Karen. I am going to go straight to questions, if I may. The new home oxygen therapy contract has been in place for around five years. During that time, this committee and others have repeatedly expressed concern about how effective it is and, in particular, about the clinical assessment services and their development. I

understand from your recent response to our recommendations that you are awaiting progress reports from each of the health boards against their action plans for developing clinical assessment services. However, your response also indicates that health boards submitted some interim reports in November last year. What did those tell you about the progress that has been made across Wales? We know that there are examples of good practice. How are those being shared across the country?

[111] **Mr Williams:** If I may, I will start with this one, Chairman. With regard to the patient assessment service, before we started, we were peaking at around 8,000 patients. Since the assessment service has started to develop, we are seeing around 7,200, dropping to just above 7,000 people. So, we are seeing fewer people. As to what are we doing to improve things, we have improved the clinical pathways. We talked about the pathways earlier. All of this ties in with changing life strategies and behaviour. Local health boards have been developing training programmes with GPs to raise awareness of patient assessment and when there is a need for specialist referrals. We have improved patient information and we are developing a patient leaflet. Also, we now have a protocol for dealing with those patients who decline to be assessed or feel that they do not require oxygen therapy, or where we feel that it is appropriate that it is removed. These are just some of the issues. Dr Gully and Professor Walker will probably provide some more detail, because they have more expertise than I have in this area.

[112] **Dr Gully:** Very high levels of satisfaction have been reported by patients. The feedback from clinicians shows that the services are very welcome in terms of the improvements that have been achieved. In considering the interim reports and the conversations that we have had with colleagues, we see that there is more consistency in the approach. There are a couple of areas around education that boards are picking up, and they are being dealt with through educational programmes. Also, it is particularly helpful to have a much more consistent use of information. Therefore, patients are being assessed and we have a measure of concordance around what the patient should be receiving. Being able to share that through a national group and promote that practice through leads in each organisation gives us some sense that we have consistency.

[113] **Darren Millar:** Where is it working best in Wales at present? You have had these interim reports, which have given you some idea. Everyone seems to be levelling up to a more consistent approach, but who is really striking ahead here?

[114] **Dr Gully:** Having looked at the Cardiff report, we see that we need to discuss this within the group. There is a degree of peer review, which is very helpful in that discussion. We have not had an opportunity to do that. It is about taking the oxygen issues through a consistent reporting process in the organisation, with some real scrutiny of what is happening. In west Wales, there was an issue in the Hywel Dda Local Health Board where the assessments had taken place but GPs were, perhaps, re-issuing oxygen to patients. The new systems are able to pick up on that inconsistency, giving clinical colleagues detailed information to be able to ask why that is happening. They may have justifiable reasons, but to have that level of scrutiny and information enables us to have those conversations in a much more productive way.

[115] **Darren Millar:** Did you want to add anything, Professor Walker?

[116] **Professor Walker:** From the patient satisfaction perspective, in addition to the survey that we conducted within the service, the provide also did a survey. It surveyed 700 of its users in December. Patient satisfaction was very high; it exceeded 90 per cent across the board. That was supportive of the information that we had also obtained within the service.

[117] The question of how we are monitoring the quality and delivery of the service is a

very complex area, where there are probably seven options with regard to the oxygen to which patients have access. When that is prescribed, the supplier has a mechanism to monitor how closely patients adhere to what has been prescribed for them. If they have been prescribed long-term oxygen for 15 hours a day, the supplier can measure whether the patients have been using it for 15 hours a day. That helps us to identify outliers, and to address and support patients who may be using too much or too little.

[118] **Bethan Jenkins:** Yr ydym yn deall eich bod wedi rhoi £1.6 miliwn o gyllid ychwanegol i fyrddau iechyd yn 2010-11 ar gyfer datblygu gwasanaethau asesu clinigol arbenigol. A ddyrannwyd yr arian hwn ar sail pro rata fesul claf, ynteu a oedd yn ddibynnol, mewn rhyw ffordd, ar asesu lefelau'r cynnydd a wnaed gan fyrddau iechyd unigol? Hefyd, a allwch ddweud a fydd y cyllid hwn yn cael ei roi yn gylchol yn y dyfodol, ynteu ai £1.6 miliwn ar gyfer y cyfnod hwn yn unig ydyw?

Bethan Jenkins: We understand that you have given additional funding of £1.6 million to health boards in 2010-11 for the development of specialist clinical assessment services. Was this money allocated on a pro rata basis per patient, or was it dependent in some way on an assessment of the level of progress being made by individual health boards? Also, can you tell us whether this will be cyclical funding in the future, or is the £1.6 million a one-off payment for this period only?

[119] **Professor Walker:** With regard to how the money is allocated, it was historically allocated equally to each of the local health boards. When they went from 22 boards down to seven boards, it reflected the distribution of moneys. With regard to how that matches across to the funding of patients, in five of the seven health boards there is a relationship between how much is invested and the lower use of oxygen. Our interpretation of why that is the case is that it has probably been better assessed in those boards. For example, the funding for Betsi Cadwaladr University Local Health Board is £329,000. The percentage of its population on home oxygen is 0.21 per cent, compared with Abertawe Bro Morgannwg University Local Health Board, where the funding is £156,000 and the population on home oxygen is 0.28 per cent. So, there is quite a narrow band across Wales for the majority with regard to funding per patient on oxygen—it is between 0.21 per cent and 0.28 per cent of the population.

[120] **Dr Gully:** Some of the costs relate to real new services for patients that were not consistently available before this approach was developed. Other aspects such as education are a one-off for that whole area. Now that we have seven local health boards, we are pulling together those educational opportunities and other opportunities so that there is consistency across the new board areas. That is much more equitable between the LHBs.

[121] **Peter Black:** The Minister indicated that there was a reduction in the cost of the home oxygen contract of nearly £800,000 in 2009-10. How has this reduction been achieved, and do you know to what extent the use of specialist clinical assessments has contributed to it?

[122] **Dr Gully:** The specialist assessment is the key part. We had a lot of patients who were receiving oxygen for quite prolonged periods, and the assessment has introduced review and planning for patient education and clinician education. So, that plays a significant role. The other aspect, as I mentioned previously, is the detailed information that we have and the ability to monitor concordance moving forward, which allows us to check that people are receiving the intended service. Some patients have difficulties withdrawing from something that gives them a lot of reassurance, even if there is no strong clinical evidence base. We are working with the national group to see how we can overcome those concerns, because that can be a real difficulty for the clinician and patient.

[123] **Peter Black:** Is the reduction in costs evenly spread across health boards, or are some doing better than others?

[124] **Dr Gully:** There is some variability; I think that Roger has the details.

[125] **Professor Walker:** The reduction is generally consistent. There has been a slight increase in expenditure in two health boards, because of increased patient numbers. We must bear in mind that it is estimated by the British Lung Foundation that there are about 3.7 million people with chronic obstructive pulmonary disease across the UK, of whom only 900,000 have been diagnosed. A lot of people who have not been diagnosed may require oxygen. As part of this programme, we have ensured that those who need oxygen get the best oxygen package. While we have been able to do that and manage a general downward trend in five of the seven health boards, we must be aware that new patients will, unfortunately, arrive on the scene with COPD who will need oxygen and future management.

[126] **Peter Black:** I think that you indicated that the extra £1.6 million was driving savings as well. What reduction in cost do you expect in the current financial year?

[127] **Professor Walker:** In terms of the existing contract, before we get on to the new contract, we anticipate savings in the order of £660,000 in the interim period before we apply the new contract. Where we have invested in additional consultant sessions, this has resulted in a downward trend in the costs of the oxygen being prescribed.

11.00 a.m.

[128] Putting simple housekeeping measures in place for the review of invoices is saving us in the region of £15,000. I also mention the issue of pathways that are ensuring a saving of around £13,000. We are making good progress, and we have further ambitions for the new contract; we will be starting with rights on the call-off contract in October 2011, and it will be implemented by June 2012.

[129] **Dr Gully:** One of the more difficult things to capture is the impact on costs of emergency admissions and the use of hospital services. Lung disease is one of the biggest causes of emergency admission, so we are trying to move care upstream; the oxygen assessment plays a key part in that, and we are also doing work further upstream again in primary care to try to improve identification and early management. It is difficult to capture that work and measure it against the cost of the service, but it would be relevant.

[130] **Darren Millar:** As a matter of interest, in which two areas have the costs increased?

[131] **Professor Walker:** There have been slight increases in Abertawe Bro Morgannwg University Local Health Board and Hywel Dda Local Health Board. We had a meeting with the supplier at the beginning of this month to look at how the Welsh contract was performing in comparison with the five other contracts that it holds in England. The Welsh contract is performing best and has produced the greatest savings. Four of the other contracts have increased expenditure; one other region has shown a reduction, but the reduction in expenditure in Wales is greater.

[132] **Darren Millar:** That is an interesting point.

[133] **Alun Davies:** In terms of where we are today, the response that we have received from the Government is that lessons are being learnt from the 2006 contract, and that you are currently undertaking analysis of your current work. Could you outline the main risks that you have identified from this exercise, and what action is being planned to ameliorate those risks?

[134] **Professor Walker:** Regarding the risk register, we have identified 34 items from looking back at the issues that have arisen in the past. We have logged eight issues with

communications; we have identified issues around contract management, engagement, operations, regional governance, regional procurement and six points around transition. We have logged those issues and will be focusing on them initially; there will be more to add to the register, but that is part of the programme that we have developed to date to take the matter forward.

[135] **Alun Davies:** What lessons have been learnt?

[136] **Professor Walker:** All of these points have been accumulated from the lesson-learning agenda. None of us were in post when the initial process took place in 2006, but from trawling through the Wales Audit Office's records and discussing the matter with colleagues who were in the office at the time, we have been able to identify the points that I mentioned. I can go through them if you want; as I say, there are 34 of them.

[137] **Alun Davies:** I do not think that that is necessary; you have answered my question.

[138] **Bethan Jenkins:** I do not know whether you will be dealing with this issue in the new contracts, but the Breathe Easy groups in my area talk about the fact that many of the oxygen canisters that they get from the NHS are too large and heavy for them to use. Many users have had to invest in their own canisters so that they can travel with them on buses, for example; they worry about that, because they feel that they should not have to do that. Are you addressing that issue, or are you looking to do so in future?

[139] **Dr Gully:** As part of the new contract, we have discussed giving much more control to the clinician over the equipment that is provided. The clinician, in discussion with the patient, will know what the issues are, so there is more of an opportunity for the patient to influence the sort of equipment that is available to them. If they are travelling over any distance, the supplier will deliver to a holiday setting or another place. In the current contract, it is the supplier who determines what equipment is provided. That may be what has caused some concerns.

[140] **Darren Millar:** In your recent response to the committee's recommendations, you suggest that the invitations to tender for the new contract will be issued around October, and that your new contract needs to be in place by June of next year. What will the transitional arrangements be in respect of that handover period? That was the biggest challenge with the introduction of the existing contract.

[141] **Mr Williams:** It goes back to the risk assessment, and it is critical that there is a proper transition and a requirement for the existing supplier and the new supplier to work closely together to ensure the smoothest of transitions. That has been built into the specification.

[142] **Darren Millar:** That is the six-month period when there will be a gradual handover of services.

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

[144] **Professor Walker:** We have already had a meeting with the current supplier to address this issue. So, the supplier is fully aware of the need for that transitional arrangement.

[145] **Darren Millar:** That is assuming that there will be a new supplier. It may be that the existing supplier continues to receive the contract. With regard to potential sanctions if something goes wrong, will you build something into the contract so that the public purse does not lose out, as it were, if the supplier fails to deliver to the contractual standards?

[146] **Mr Williams:** I do not have the details of the sanctions, but any contract must contain appropriate sanctions. One interesting thing is that the contract will have a fixed price for three years, but we need to look at the quality side as well as the price.

[147] **Darren Millar:** That is an interesting point. Are there are any further questions from Members?

[148] **Peter Black:** When you say 'fixed price', are you talking about a fixed price per unit or a fixed price per patient? I was just wondering how you drive savings out of a fixed-price contract.

[149] **Professor Walker:** There are seven bands in the pricing system. So, the price for the provision of oxygen is set across those seven bands.

[150] **Darren Millar:** Are there are any further questions from Members? I see that there are not. So, we will bring this part of the meeting to a close. Thank you, Professor Walker, Paul and Karen.

11.07 a.m.

Cynnig Trefniadol
Procedural Motion

[151] **Darren Millar:** I move that

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

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

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11.07 p.m.
The public part of the meeting ended at 11.07 p.m.