Cynulliad Cenedlaethol Cymru
Y Pwyllgor Archwilio

The National Assembly for Wales
The Audit Committee

Dydd Iau, 14 Rhagfyr 2006
Thursday, 14 December 2006

Cynnwys
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Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau o'r Cynulliad yn bresennol: Janet Davies (Cadeirydd), Leighton Andrews, Lorraine Barrett, Jeff Cuthbert, Jocelyn Davies, Mark Isherwood, Irene James, Denise Idris Jones, Jonathan Morgan, Jenny Randerson, Carl Sargeant.

Swyddogion yn bresennol: Simon Dean, Prif Weithredwr, Comisiwn Iechyd Cymru; Derek Griffin, Cyfarwyddwr Rhanbarthol, Swyddfa Ranbarthol Gogledd Cymru; Ann Lloyd, Pennaeth yr Adran Iechyd a Gwasanaethau Cymdeithasol; Stuart Marples, Cyd Gyfarwyddwr, y Gyfarwyddiaeth Perfformiad a Gweithrediadau; David Powell, Swyddog Cydymffurfiaeth y Cynulliad.

Eraill yn bresennol: Jeremy Colman, Archwilydd Cyffredinol Cymru; Gill Lewis, Swyddfa Archwilio Cymru; Alan Murray, Prif Weithredwr, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru; Rob Powell, Swyddfa Archwilio Cymru; Philip Selwood, Cynghorydd Ambiwlans, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru.

Gwasanaeth Pwyllgor: Dr Kathryn Jenkins, Clerc; Dan Collier, Dirprwy Glerc.

Assembly Members in attendance: Janet Davies (Chair), Leighton Andrews, Lorraine Barrett, Jeff Cuthbert, Jocelyn Davies, Mark Isherwood, Irene James, Denise Idris Jones, Jonathan Morgan, Jenny Randerson, Carl Sargeant.

Officials in attendance: Simon Dean, Chief Executive, Health Commission Wales; Derek Griffin, Regional Director, North Wales Regional Office; Ann Lloyd, Head of Department of Health and Social Services; Stuart Marples, Joint Director, Directorate of Performance and Operations; David Powell, Assembly Compliance Officer.

Others in attendance: Jeremy Colman, Auditor General for Wales; Gill Lewis, Wales Audit Office; Alan Murray, Chief Executive, Welsh Ambulance Services NHS Trust; Rob Powell, Wales Audit Office; Philip Selwood, Ambulance Adviser, Welsh Ambulance Services NHS Trust.

Committee Service: Dr Kathryn Jenkins, Clerk; Dan Collier, Deputy Clerk.

Dechreuodd y cyfarfod am 9.01 a.m.
The meeting began at 9.01 a.m.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introduction, Apologies, Substitutions and Declaration of Interests

[1] **Janet Davies:** Bore da. Croeso i'r cyfarfod i aelodau'r pwyllgor ac i aelodau'r cyhoedd.

Janet Davies: Good morning. I welcome committee members and members of the public to the meeting.

[2] I remind everyone that the committee operates bilingually, and that headsets are available for translation of Welsh into English, and also to amplify the sound.

[3] Atgoffaf bawb i ddiffodd eu ffonau symudol, *pagers*, neu unrhyw ddyfais electronig arall, gan eu bod yn ymyrryd â'r offer cyfieithu a darlledu. Os oes rhaid gadael yr ystafell mewn argyfwng, dylid gadael drwy'r drws agosaf, a dilyn cyfarwyddyd y tywyswyr.

I remind everyone to switch off their mobile telephones, pagers, or any other electronic device, as they interfere with the translation and broadcasting equipment. Should we have to leave the room in an emergency, you should leave via the nearest exit and follow the ushers' instructions.

[4] Yr wyf wedi cael ymddiheuriad gan Alun Cairns, ac mae Jonathan Morgan yn cymryd ei le. Hefyd, mae Leighton Andrews wedi ymddiheuro. Bydd Lorraine Barrett yn cymryd ei le y bore yma, ond bydd Leighton yn bresennol y prynhawn yma. Mae Catherine Thomas yn ymddiheuro hefyd, ac mae Jeff Cuthbert yn cymryd ei lle hi. Mae Mick Bates yn ymddiheuro, ac mae Jenny Randerson yn cymryd ei le. Croeso i chi i gyd.

I have received an apology from Alun Cairns; Jonathan Morgan is substituting on his behalf. I have also received apologies from Leighton Andrews. Lorraine Barrett will substitute for him this morning, but Leighton will be in attendance this afternoon. Catherine Thomas also apologises, and Jeff Cuthbert is substituting on her behalf. Mick Bates has sent apologies, and Jenny Randerson is substituting on his behalf. A warm welcome to you all.

[5] A oes gan Aelodau unrhyw fuddiannau i'w datgan? Gwelaf nad oes.

Do Members have any declarations of interest? I see that you do not.

9.02 a.m.

Cyflwyniad gan yr Archwilydd Cyffredinol ar ei Adroddiad, 'Gwasanaethau Ambiwlans yng Nghymru'
Presentation by the Auditor General on his Report, 'Ambulance Services in Wales'

[6] **Janet Davies:** Oherwydd bod yr adroddiad hwn yn un hir a chymhleth, yr ydym wedi gwahodd yr archwilydd cyffredinol i gyflwyno'i adroddiad i ni. Yn dilyn y cyflwyniad, bydd cyfle i'r Aelodau holi Jeremy ar ei gyflwyniad, ac ar natur yr ymchwiliad a'i gasgliadau. Bydd hyn o gymorth i ni wrth holi'r prif dystion yn nes ymlaen.

Janet Davies: Given that this report is lengthy and complex, we have invited the auditor general to present his report to us. Following the presentation, there will be an opportunity for Members to ask questions of Jeremy on his presentation, and on the nature of the inquiry and its conclusions. This will assist us in questioning our main witnesses later on.

[7] **Mr Colman:** Diolch, Gadeirydd. Hoffwn gyflwyno fy adroddiad am y gwasanaethau ambiwlans yng Nghymru.

Mr Colman: Thank you, Chair. I wish to present my report on ambulance services in Wales.

[8] As committee members will know, the origin of this report was rather unconventional, in that the Assembly voted to invite me to carry out the work. It was also unusual in that we have completed what, by any standards, is a major piece of work in as little as four months. That said, however, it is a conventional audit report; it deals with the implementation of Government policy for the ambulance services in Wales.

[9] Given that it was completed to an unusual timetable, I will say a little about how we went about the work. For the first time in my experience as part of this kind of work, we held public hearings at eight locations throughout Wales. That was an interesting attempt to engage the public in our work; a rather small number of members of the public came to the hearings. I learned a lot from those hearings, as points were made that may not have come out so clearly otherwise. We asked the public at large to make written submissions, and we had a large number of those—there were over 87 contacts from that source. We, of course, went through the normal processes of document review; we conducted a large number of semi-structured interviews—175 of them. I am told that the notes of those interviews amount to 214,000 words. We held focus groups with the staff of the ambulance services all over Wales. A number of us, myself included, spent shifts with emergency ambulances and patient

transport services. We paid regional visits and carried out a survey of 860 of the Welsh Ambulance Services NHS Trust's staff. I say all this to make the point that, although the work has been done quickly, it has certainly not lacked thoroughness.

[10] Turning to the findings, may I direct your attention to pages 5 and 6 of the report, to the table of contents? As is our usual practice, the table of contents acts as a kind of summary of the report, and it is the easiest way for me to explain what we found. Part 1 of the report, which is headed, 'There are longstanding problems with the performance of the ambulance service', is the part of the report that analyses the actual performance of the ambulance service. It seemed to be an important part of this inquiry to establish the truth about its performance, and I am sorry to say that the truth is extremely disappointing. The trust has failed to meet important performance targets for many years, and the position has not been getting better over time. There are regional variations—the trust has been more successful in meeting its targets in north Wales than in south-east Wales, for example—but the performance is, to put it mildly, disappointing. I say 'to put it mildly' because the targets that I am talking about here have a clinical foundation. It is important to get to patients within eight minutes—actually, a rather shorter period would be better—and failure to do so could certainly put patients in danger. So, part 1 is about the performance, and asks what the truth is about the performance.

[11] Turning over the page, part 2 is our analysis of the reasons for performance being as it is. Our analysis was conducted in a systematic manner. We looked at all aspects of what you would expect to find in a well managed organisation, and the second half of part 2, in which I say that the trust has been let down by failures in a number of key areas, that could actually be strengthened. We found significant failures in all areas of business management. You would expect to find certain things done well in a well managed organisation, and the trust was either not doing those things at all or doing them badly. I am talking about strategic direction, governance, leadership, processes, systems, and organisational culture. So, those are serious shortcomings in management and direction that, in our view, are the explanation for the poor performance that we see.

[12] Those very serious failures let down what we found to be very considerable strengths within the trust. Unlike on a number of occasions in the past, all over the United Kingdom, the ambulance trust in Wales currently operates within a new strategic framework, set up by the Government. I make no comment on the merit of the strategic framework, but the fact that there is one, applying to the whole of the NHS, within which the trust operates, is undoubtedly a strength. We found that there are things that are done well in the trust; it is not all bad. There are some particularly good examples of innovation and good practice, which, although quite limited, local initiatives that have not been identified and spread, they do exist. As you will all know, there is also considerable public goodwill towards the ambulance service, and that is reflected in the public attitude towards the staff. Without exception, we found that people had nothing but praise for the front-line staff. I will come on in a moment to other strengths that we found in the staff.

9.10 a.m.

[13] The fact that the trust is a single national trust for Wales is a strength, whether or not you agree that it is a good idea to have a single trust in Wales. It is a strength because it means that the trust is not going through a merger; it is not going through organisational change, unlike almost every ambulance trust in England, for example. Even the well performing trusts in England are having trouble at the moment because they are in the inevitable turmoil of organisational change. It does not apply in Wales, so there is scope there.

[14] This might be regarded as a surprising statement—or at least it might have been a

surprise if you had not already read it or heard it—but our analysis showed really very conclusively that there is not a problem of resources in the trust; it has not been underfunded, and it has not been starved of capital in the past. I will qualify that remark in a very important way. It is not for me to give an opinion on how much money should be spent on any particular part of the public service. When I say in this report that the trust has enough resources, what I mean is that the resources with which it has been provided ought to have been enough to deliver a service well up to the standards regarded as acceptable everywhere else in the UK. However, it is always open to the Assembly to decide that more money could be provided for a yet better service, but I would have no opinion on that. The fundamental issue is that it just is not true that the problem was a shortage of resources; the problem was the way in which those resources were managed and deployed.

[15] That was part 2, on our analysis of the reasons for the failings. I think that it is very notable that our analysis is not in line with that of the former management of the trust, which attributed the problems almost entirely to a shortage of money, despite, in our view, very clear evidence that that was not the problem. The clear evidence took the form, for example, of a report from as long ago as 2000 by a consultancy firm engaged by the trust, which pointed out—though the message was not taken on board—that significant improvements in efficiency were possible within existing resources, and it told them how to do it. No action was taken on those opportunities.

[16] In part 3, we look to the future of, or to the prospects for, the trust, given the situation that it is now in. In part 3, we present evidence that, in my view, justifies an optimistic conclusion about the future of the trust. I am optimistic because, serious as the problems are, other ambulance trusts have been in this situation and have turned themselves around—London is a notable example of that, as is Merseyside, the relevance of which I will come back to. A draft modernisation plan is now in place that, in our view, addresses all of the issues that are identified as problem areas. A plan is, of course, the first step, and it has to be delivered. We will obviously be watching that as time goes on.

[17] Part 3 also points out a number of the challenges that need to be addressed. We start with external challenges. One of the characteristics that we detected in the trust was that it was a very inward-looking organisation. It was focused on collecting information about performance, although perhaps that information was not fully understood. A great deal of time was spent on collecting information on what was going on on the inside, but maybe not enough effort was devoted to influencing the outside world. The trust is not simply a taxi service that picks up passengers when they call; it is an integral part of the NHS. Its workload is hugely affected by decisions taken elsewhere in the NHS and it is the job of the ambulance trust, in my view, to influence those decisions. We cannot expect it to be decisive, but there is a very strong role for the trust externally.

[18] I list here a number of the external challenges that will need to be faced, including the reconfiguration of the NHS. Moving services around and closing services in particular places obviously has a big impact. Generally, interfaces between the trust and the rest of the NHS need attention. A considerable problem area is the turnaround times at some hospitals. The target turnaround time from when an emergency ambulance arrives is 15 minutes, but there are major hospitals not far from here where the figure is regularly over half an hour on average. That average covers a wide range of experience, including some very long turnaround times. That is one interface. Another is the interface with general practitioners. We heard evidence that GPs call emergency ambulances when, in the opinion of the ambulance service, they should not do so. Why is that happening and what needs to be done to stop it? The modernisation plan has some thoughts on that. That is one of the challenges to be faced. So, interface is very important.

[19] A rather confusing piece of jargon is the term PCS, which stands for patient care

services, which was formerly known as patient transport services. Patient transport services transport non-emergency patients to hospital, such as people who cannot get there for regular appointments or those needing to go for dialysis treatment—namely, regular, non-emergency trips. This operates in a competitive market in the sense that the decisions on whether the ambulance trust is engaged to deliver these services rests with local bodies in the NHS. If they do not like the service that they are getting, they could move their business elsewhere. That is obviously a threat to the trust. Dodging back, if I may, we found the management systems for the PCS to be particularly weak, with almost no performance information at all. As members of the committee will certainly know, there were a number of extremely alarming individual cases of patients being left in the wrong place and so on.

[20] A significant external challenge is the management of stakeholder expectations. There is an expectation among many citizens that having an ambulance station in their locality is a good thing. Also, when they dial 999 and ask for an ambulance, an ambulance is what they want, and quickly. Neither of those statements is necessarily true. Those expectations will need to be managed carefully. I have referred to GPs allegedly misusing the service; for their part, GPs are pretty dissatisfied with the service, and they have reason to be. However, the relationship between the service and GPs needs to be managed actively by the trust. These are challenges, none of which I regard to be insuperable, but they need to be addressed, and they have not been addressed very effectively in the past.

[21] I will now move on to internal challenges. These follow from the diagnoses of areas of weakness in the past. Therefore, if there is a lack of strategic direction, there clearly needs to be strategic direction. If there are poor processes, there need to be sound operational processes, and so forth. The financial position is difficult and needs to be addressed. It is difficult, as I said, because resources may have been mismanaged in the past, but the current position is not straightforward. One has seen worse, but it is not straightforward. There is also a need to improve the estate. Anyone who has visited an ambulance station will know that some of them are in a bad way, and there is clearly a need to do something about that.

9.20 a.m.

[22] In conclusion, if I can take a step back from it, I think that there is an optimistic view of the future. A new management team is in place. It is more numerous than the old management team, which is not a bad thing. The report shows that the top team was previously small in number, and prone to absences and interim appointments. It is an unsatisfactory way of running an organisation to have gaps in the management team, or if people are not quite sure whether they are in it for the full term. So, simply having a stable top management team is an enormous step forward. That it has a plan that addresses what we have found to be the main issues is another important step forward, and I hope that the attention that has come from this work, and that will come from this committee's work today and its report, will positively help it to deliver the important task ahead.

[23] At that point, I will stop, and I would be happy to answer any questions.

[24] **Janet Davies:** Thank you, Jeremy. I will ask Members to come in with their questions now, but, first of all, I will remind them that this committee's role is to look into the management of resources and how outcomes are achieved—or, indeed, whether they are achieved. If we try to go into policy matters, we will be usurping the role of the Health and Social Services Committee. We should not do that, and neither should it try to usurp our role. So, who would like to start with a question?

[25] **Jocelyn Davies:** I will start. On management, you mention on page 13, paragraph 12, that,

[26] ‘the Trust has been let down by important failures in all the key areas of business management’.

[27] Throughout the report, you refer to weaknesses in management. Each of those stations requires management, I suppose, and there will be regional and local management as well as management higher up. On the lower level, however, have any of the staff had management training?

[28] **Mr Colman:** They have. This interacts closely with the question of the culture in the organisation. We found that, locally, people look up to the local managers. The style of management has been rather old fashioned. The ambulance service, in common with the fire and rescue service and also the police, comes from a military tradition. In the fire service, considerable steps have been taken to move away from that. In the ambulance trust, however, there has tended to be a command-and-control style rather than a participative style of management.

[29] However, in recent years, the trust has developed a leadership development scheme and progress is being made. We are not dealing with a case of untrained managers just being left untrained forever, but a lot of attention is needed there. To be frank, the weaknesses have been at a higher level of management, and it is more an issue of direction. Allow me to illustrate that. If I say that the object of an ambulance service should be to deliver ambulance services when and where they are needed, that would sound obvious, but that is not the system that this trust has been using to supply ambulances. Ambulances are rostered as they have been rostered for many years, and that now bears little relation to demand. So, ambulances are fully crewed when they do not need to be, and, when they are needed, they are not there.

[30] **Jocelyn Davies:** On that issue of culture, that is the hardest thing to change.

[31] **Mr Colman:** It certainly is.

[32] **Jocelyn Davies:** It is difficult to change in any organisation. You are optimistic because other ambulance trusts have managed to turn themselves around, but there has been very little evidence that lessons learned elsewhere have been transferred, so I do not know how you can be as optimistic as you are.

[33] **Mr Colman:** Part of the reason for optimism is the fact that one of the trusts that has considerably turned itself around in England is Merseyside, and it did so under the leadership of Alan Murray, who is now the chief executive here. So, not only has it been done by other trusts, but also by this chap. That must be a good sign. It is not a guarantee, and no doubt he will speak for himself, but I do not think that he regards it as a straightforward task. However, he seems to be going about it in a way that has worked for him in the past.

[34] **Jenny Randerson:** If you could sum this report up in one word, it would be ‘management’. It seems to me that changing bad management into good management is difficult. It would be much easier to say that it was down to a lack of money, but that is not the case. Following on from Jocelyn’s question, you have talked about management style, but in terms of the selection of managers, has it been a rigorous process? Have people been selected as managers after advertising? Have they had interviews and has a proper appointment process been followed, or have people slipped into management roles because their faces fitted or because they had been there for a long time? You talk about reasons for optimism, but in terms of higher-level management, you said that there were more people now. So, are new people being recruited to the service or does it rely on training existing people to be better managers, because Alan Murray alone clearly cannot pay attention to every tiny detail and that would not be appropriate?

[35] **Mr Colman:** It is a mixture of both. He has recently recruited a number of senior people from outside Wales to the top management team. There clearly will need to be a process of management training. There is a huge amount of enthusiasm to want to improve within the organisation. In our focus groups for staff, for example, some of my colleagues were astounded by the number of ideas that were generated on improvement and when we asked why they were so full of ideas, they said that no-one had ever asked them for ideas before. So, I do not want to underestimate the difficulty, but my optimism is related to the direction in which they are going. I have repeatedly said that plans have to be delivered, but there are reasons to believe that it is doable, but that the task is not easy.

[36] We did not find any evidence of failure in process in terms of selecting managers, but many managers are former front-line staff who, for one reason or another, do not like being on the front-line now, in some cases, through ill health. This is not necessarily the best way of selecting managers, although they obviously know the business—many of them are paramedics and are equipped with such training. It is very important not to underestimate the impact of the top management team, who have been blind to opportunities for improvement in their organisation.

[37] I mentioned, in answer to Jocelyn earlier, the seemingly obvious point that you should aim to provide ambulances when and where they are needed and to do that, you need to understand what factors affect the availability of ambulances at particular places at particular times. That includes working out, in a 12-hour shift, how many of those hours are available for use and how many are taken up by other things, such as travelling back to the station for meal breaks.

9.30 a.m.

[38] I did not realise that ambulances were in the habit of travelling back to the station for meal breaks. Some of them do that as part of their practice, but it means that time is lost. Time is also lost at the beginning of the shift because the crew is expected to clean the ambulance and check that it is ready to go. Is that a good use of highly skilled, highly trained crews' time? Probably not, but these issues have not really been thought about by the top management; the more junior management did not do it either as it was not part of their job. So, getting the systems right is really important. I do not think that we saw evidence that the middle management is especially weak. I would say that the principal problem has been senior management.

[39] **Irene James:** I think, Chair, that part of my question has already been answered, because you actually said that trusts appear to meet their targets, but you went on to mention staff, and those of us who have had contact with front-line staff would all totally agree with you that they are excellent, and that they have had sufficient funding. How can performance be so bad in some areas when the resources are actually being provided?

[40] **Mr Colman:** As you suggest, some of my earlier answers partly dealt with that matter. In my early career, I took a masters degree in operational research, so when I came to this problem, I thought that it was obviously an operational research problem. Like many glimpses of the blindingly obvious, it turned out that other people had thought the same previously, and we found that the trust had engaged a firm of operational research specialists six years ago to examine how to improve performance. It is quite complicated, because many factors need to be taken into consideration, but the demand for emergency ambulance services is reasonably predictable. There are people who understand what it takes to get the maximum use out of an ambulance and its crew, to make sure that they are doing what they are supposed to be doing—I would not suggest that they are lazy, but that they be put to use in a way that gives the most benefit to patients. That is understood by people. With this trust, as I said

before, we could see that no action was taken on implementing the operational research proposals, and there did not seem to be an understanding of how to get the best out of the resources that were available. If you do not even think about getting the best out of the resources that are available, it is not surprising that performance is not as good as it could be with those resources.

[41] **Irene James:** Would you actually see that as the main priority to moving everything forward?

[42] **Mr Colman:** Without any question, the main priority at the moment is that of getting better use out of the existing resources—we shall no doubt hear what Mr Murray says later on. However, I expect him to say that he expects to see a very rapid improvement in performance. Frankly, because it is starting from such a low base, and the way in which the resources are deployed is so different from what is needed, almost any change will create some improvement. In the longer term, he has to do a lot more besides, and that is the challenge referred to in part 3 of the report, but there are some quick wins on processes that I have no doubt he will seek to take.

[43] **Jenny Randerson:** May I ask a quick question?

[44] **Janet Davies:** Quickly, then. Remember, our time is limited, and there are more questions to be asked.

[45] **Jenny Randerson:** Why was no action taken on the operational research?

[46] **Mr Colman:** This is speculation rather than an evidence-based remark. The report had two principal conclusions, one of which was that a 5 per cent improvement in efficiency was possible within existing resources, and within the existing business model. I will come back to that, but it basically means using ambulances rather than some other kind of response. Conclusion 1 was that the trust could improve efficiency. Conclusion 2 was that, to reach the target, it needed more money. It is the second conclusion that was leapt on by the trust, and it forgot about the other one.

[47] **Irene James:** Did you say that it was 5 per cent?

[48] **Mr Colman:** I think that I am right. I did say 5 per cent.

[49] **Irene James:** I just wondered whether it was 5 per cent, because I did not quite catch what you said.

[50] **Mr Colman:** I am just wondering whether it is 5 per cent.

[51] **Mr Powell:** It was 5 per cent to 6 per cent.

[52] **Mark Isherwood:** The management culture described seems to be one that was commonplace in the public, private and voluntary sector 30 years ago, but there has been a bit of a change since then. To what extent did the historic management culture that you describe have an effect on employee relations and how embedded is that? What challenge does that present at a formal level between the representative bodies and management?

[53] **Mr Colman:** I absolutely agree that what we were seeing looked like something going back 30 years. There were quite rigid ideas about how things should be, and a strongly unionised workforce—that is not a bad thing in itself, but, because of weak management, the unions become a major means of communication within the organisation. The unions quite rightly see their job as defending their members' rights and tend to be somewhat conservative

in attitude—on the whole, change is to be looked at very carefully. There is nothing wrong with any of this, but if you have reasonably well organised, effective unions and weak management, it is not a good situation to be in.

[54] We took a lot of evidence on this and met the unions several times in various forms. They are definitely part of the solution rather than the problem. It seems to us that we are not dealing with a situation in which you have obstructive unions making life difficult for the sake of it, as has occurred in the past, but you have unions that have some good ideas for improvement and are an important source of communication. I would expect, over time, that that role will diminish, because I would expect a strong management to be more active in communicating. I do not see the unions as an obstacle.

[55] However, I should say that changing rosters in an ambulance service is a really big task. The rosters that they have are not efficient but rosters are really important to the staff. I mentioned 12-hour shifts, which are very commonly used; they are known to be inefficient but they are quite popular with the staff. Changing that will be extremely difficult. The London Ambulance Service NHS Trust has staged a remarkable turnaround over the last eight years, but even there it still has 12-hour shifts. So, I would expect the unions to be heavily involved in discussions about those kinds of changes, and it is proper that they should be. That is not a reason for concern about the future. I do not see the unions as something that will stop the improvement that we all want to see happening.

[56] **Jonathan Morgan:** The report refers to the damage that has been done through the rapid changes in leadership. Did you discover any evidence as to the way in which the nature of the relationship between board members had altered, perhaps, during that 12 to 18-month period where there had been that rapid change in leadership? I know that Dr van Dellen—you have alluded to this in your report—stated quite clearly that there was a lack of understanding among board members as to the seriousness of the problem, and also a lack of support among board members for taking some difficult decisions. I am interested in this lack of team effort. Does it relate only to that 12 to 18-month period, or is there evidence of a weakness in the relationship between board members stemming further back, perhaps to 1998-99?

9.40 a.m.

[57] **Mr Colman:** I found that the problems were long standing. The causes have essentially been the same causes throughout, namely weaknesses in strategic direction, management and governance, including the relationship between the officers of the trust and the board. Until this year, the board met only five times a year and the board members, none of whom had previous experience of the ambulance service, were not well placed to ask probing questions of the management, who did not understand the business that they were in either. So, it was not a recipe for success. If one was asked to pin the blame on someone, it would be on a large number of people. One could imagine cases in which you would say that the fundamental problem was the chief executive or the chairman, or whatever. In this case, the principal weaknesses were in the system at the top of the organisation, namely the relationship between the officers and the board, the board's ability to ask questions and to hold the management to account. That did not seem to have operated effectively. Since April, with the new chair, the board meets monthly and it is in a much better position to do its job properly.

[58] **Janet Davies:** Okay, thank you. I think that we have time for one more question.

[59] **Carl Sargeant:** I have a very brief question. Putting more money into this, as we have done over the past couple of weeks, may have been at the behest of this report coming out, but I may be wrong on that. You have said that the funding that was in place was adequate. Should we have held back on putting more money into this until some real

managerial decisions were taken that made a change to the service?

[60] **Mr Colman:** There were two weaknesses in capital spending in the past. The first weakness was that, in the absence of a proper strategy for business, it is very difficult to spend capital money wisely—there is a fundamental problem. Capital spending should always link with strategy. The second point which, hopefully, comes out clearly in the report, is that money has been, frankly, wasted on bad procurements, and not just once either. Large numbers of ambulances have been procured that were not fit for purpose on more than one occasion. That clearly leaves a gap that needs to be filled. I have no evidence, and I would not wish to comment, on the motives for announcing more money for ambulances as early as was the case. However, we did ask some questions to satisfy ourselves that there was a clear strategy for spending that money. Our understanding from Alan Murray is that there is such a strategy, and that it is not simply a case of someone writing him a cheque for so many million pounds that he will spend tomorrow. He has a properly staged plan for deploying those resources. So I think that you have spotted something that might have been an issue, but I think that it probably is not.

[61] **Janet Davies:** I have a very brief question, on a factual matter that I am not completely clear about after reading this report. In terms of category A patients, it seemed to me from the report that they were just heart attack patients, but it should be far wider than that. Can you assure me that it is?

[62] **Mr Colman:** It is, yes. Heart attack is mentioned so much because there are well known things that can be done that have a dramatic effect on heart attack cases, which the trust has been quite slow to adopt. Speed of response is one of them, and we know that it has performed poorly in that regard. A treatment called thrombolysis is also an example of a practice that, at the beginning of the period covered by this report, was not being done as much as it should. The rate of thrombolysis has increased enormously, which has had a very big effect on heart attack cases. However, there are many other category A cases that are not heart attacks.

[63] **Janet Davies:** I am relieved to hear that, because I was getting quite confused about that.

[64] **Mr Colman:** I am sorry about that.

[65] **Janet Davies:** We now need to ask the witnesses to come in to the committee room, in order to go on to the next item in our agenda.

9.47 a.m.

Gwasanaethau Ambiwlans yng Nghymru: Tystiolaeth gan yr Ymddiriedolaeth
Ambulance Services in Wales: Evidence from the Trust

[66] **Janet Davies:** Welcome. First, I will point out that this is a bilingual committee. I hope that your headsets are working as they should.

[67] Mae adroddiad pwysig yr archwilydd cyffredinol yn disgrifio'n fanwl wendidau gwasanaeth ambiwlans Cymru, o fewn yr ymddiriedolaeth ei hun a'r system ehangach y mae'n gweithredu ynddi. Mae'r adroddiad hefyd yn nodi bod sail i fod yn optimistig y caiff y problemau hyn eu datrys

The auditor general's important report describes in detail the deficiencies in the Welsh ambulance service, within the trust itself and within the wider system in which it operates. The report also finds grounds for optimism about the resolution of these problems over time, provided that key

dros amser, ar yr amod yr eir i'r afael â heriau allweddol.

challenges are tackled.

[68] Mae'r sesiwn hir hwn yn gyfle pwysig i'r pwyllgor ymchwilio i'r materion difrifol iawn a amlinellir yn adroddiad yr archwilydd cyffredinol. Mae'n hollbwysig ein bod yn mynd ar drywydd beth aeth o'i le a pham, ond hefyd ein bod yn canolbwyntio ar y dyfodol, er mwyn i'r sesiwn hwn, a'r adroddiad a ddaw allan ohono, hybu'r broses o wella'r gwasanaeth ambiwlans yng Nghymru.

This extended session provides an important opportunity for the committee to investigate the very serious issues that are raised in the auditor general's report. It is vital that we not only seek to discover what has gone wrong and why, but also to focus on the future, so that this session and our subsequent report support the improvement of ambulance services in Wales.

[69] Hoffwn ganmol Ymddiriedolaeth GIG Gwasanaeth Ambiwlans Cymru am yr hyn a alwodd yr archwilydd cyffredinol yn ei ragair yn gydweithio penigamp â thîm Swyddfa Archwilio Cymru yn ystod yr ymchwiliad.

I would like to commend the Welsh Ambulance Services NHS Trust for what the auditor general describes in his foreword as exemplary co-operation with the Wales Audit Office team during the investigation.

[70] Croeso, Mr Murray. A wnewch chi a'ch cydweithiwr gyflwyno eich hunain ar gyfer y cofnod, os gwelwch yn dda?

Welcome, Mr Murray. Will you and your colleague please formally introduce yourselves for the record?

[71] **Mr Murray:** Thank you, Chair. My name is Alan Murray, and I am the chief executive of the Welsh Ambulance Services NHS Trust.

[72] **Mr Selwood:** I am Philip Selwood, and I am an adviser to the Welsh ambulance service. I arrived in the service when the last interim chief executive resigned in order to assist the service, and I have stayed on to assist Alan. Before that, I was chief executive of an ambulance trust in England, and, before that, I was a director of operations in London.

9.50 a.m.

[73] **Janet Davies:** Thank you. I will ask the first question and then the other Members will come in with their own questions as we work through the report. As you know, parts 1 and 2 describe a number of very serious deficiencies in the ambulance service. Mr Murray, you have been chief executive for four months. Does your diagnosis of the current state of the trust accord with the auditor general's and could you summarise the main reasons for the current state of the service and the main priorities for improvement? I would just like a summary at the moment, please; there will be more detailed questions later.

[74] **Mr Murray:** It is fair to say that I and my colleagues on the Welsh Ambulance Services NHS Trust board accept the diagnosis of the auditor general's report. It would be unusual if we did not, because of the process by which the report was developed. It was developed iteratively between us and the auditor general's team. A lot of the information that informed the auditor general's conclusions came from work that I initiated when I came into the trust on 7 August. When I came into the trust, there was a very ambitious timetable for the presentation of our modernisation report. In fact, at that time, the view was that the modernisation report should be presented at the beginning of September. Clearly, that was not feasible. So, we set about developing the modernisation report with a view to having it approved by the trust board at a December meeting, and there is a special meeting on 21 December to approve the plan.

[75] We have not waited for the formal approval of the plan to get on with one of the work streams. The two main work streams are putting things right, and preparing to do things differently in the future. As part of that process, we did our own diagnosis of what had gone wrong in the past and we agree with the auditor general's summary. The ingredients for success in any organisation are that there is a clear view of what the mandates operating in the organisation are, and our mandates come from sources such as the Welsh Assembly Government's response-time standards for category A and B emergencies and urgent cases, 'Designed for Life', and the developing emergency care services strategy, which are particularly important to us in both of the plan's streams. Having identified those mandates, the organisation must translate them into clear goals. Those goals must be supported by a clear strategy and that strategy implemented using disciplined project or programme management processes, and the staff must be engaged in the delivery of the strategy and understand the goals. I could summarise the reasons for the problems in the Welsh ambulance service as being the lack of every one of those ingredients for success.

[76] **Janet Davies:** I have just one question to follow on from that. Things seem to have got rather worse in the last quarter when you look at the figures for emergency response, which is a bit unfortunate. How quickly do you think there can be an improvement on what is happening at present?

[77] **Mr Murray:** I welcome that question, because the last quarter that was published ended in September. I took up post on 7 August. There have been some modest improvements in performance in October and November. They are nowhere near where we would want them to be, but the service's performance has begun to stabilise. I have read various reports of how the trust and I should be feeling about the last quarter's reports. I am not a nervous individual by constitution and, if I had been, I probably would not have taken this job. [*Laughter.*] That quarter's figures did not alarm me. The new team inherited a service—and we are a substantially new team—with a declining performance.

[78] It will take some time to stabilise and turn around that performance, principally in the south east, where performance is at its worst. The auditor general would expect to hear me say this, but there is no blindingly obvious reason why performance in the south east should be particularly bad. It is the most urban region in the service and, if anything, it would be easier to produce good performance there than in the north, west and central areas. Given that performance in the south east is at its worst and is still in decline, we have put in a simplified version of the performance management framework, which we will implement across Wales early in the new year—that is, the new calendar year. We have started using that simplified performance management framework in the south east. I would expect to see improvements in the south east, with concomitant improvements in the overall performance of the trust, probably before the end of this month, certainly by early next month.

[79] We have a tender out at the moment for a larger piece of work in the new calendar year to extend the full performance management framework across Wales. In my experience in the former Mersey Regional Ambulance Service NHS Trust, it took four to five months to lay the foundations of improved performance. In Mersey regional ambulance service, the improved performance occurred within weeks of that, although there were some rollercoasters, I have to say. Sometimes, performance slumped and we would have to wrestle it back up again. It took us several months to stabilise it, and to get the point where we could say that we had sustainable compliant performance.

[80] I cannot say yet exactly how long that part of the process will take in Wales, because there are two sets of circumstances in Wales that did not exist in Merseyside and Cheshire. The Mersey regional ambulance service had invested well in information and communications technology, and so its ICT systems were good. Therefore, we did not have a barrier to accelerating performance improvement. Secondly, to be frank, I do not think that

there is an ambulance region anywhere in England that would recognise the level of population sparsity that exists in certain parts of Wales. There might be some similar areas in East Anglia and the west country, but those could not be compared with the population sparsity of Powys, Ceredigion or south Gwynedd. Therefore, it will be necessary for us to devise new models of delivery for those areas. Later in the meeting, I would be very happy to take questions about what those models are.

[81] **Janet Davies:** Yes, and we will come to those later. Jonathan wanted to come in quickly on what has just been said.

[82] **Jonathan Morgan:** Yes. Looking at the provision of services in south-east Wales, particularly accident-and-emergency services—and looking perhaps at the role of the Royal Gwent Hospital and the University Hospital of Wales here in Cardiff— I am wondering how much of the ambulance service's performance was affected by issues that need to be resolved within accident-and-emergency departments in the acute sector. Earlier, we were talking about the target turnaround time of 15 minutes. The average turnaround time is roughly 25 minutes. What particular pressures does the ambulance service face when coming up against pressures that are faced elsewhere in the healthcare system?

[83] **Mr Murray:** There is no doubt that we cannot solve this problem on our own. I should begin by acknowledging the support and friendship that the trust in general, and I in particular, have had from chief executives and managers in NHS trusts throughout Wales, local health boards, the regional director in north Wales, who is our performance manager, and various other parties who have a part to play in improving the performance of the service. I should record formally my thanks to those people for their help.

[84] I wish to start by introducing you to a key piece of jargon: unit hours. A unit hour is an emergency ambulance, fully equipped for a shift, which has a properly qualified crew on board and is available to ambulance control for one hour. We measure our resources in unit hours. There are all sorts of black holes in the job-cycle process, which swallow up those unit hours, from the receipt of the 999 call to the ultimate availability of the crew for another emergency. The Auditor General for Wales referred to one of these black holes already, namely the practice of driving back to stations for meal breaks, which we are discussing with staff organisations at the moment.

10.00 a.m.

[85] So, the long call-taking time from pick-up to verification of the incident location is a black hole. The long allocation time from identification of the incident location to selection and allocation of the responding crew, or rapid-response paramedic, is another. This carries on throughout the entire job cycle until we get to the last part—that is, the last part in all but Powys, and parts of north Wales, where there is an additional stage. However, for most of Wales, the last part of the cycle and the last black hole is the period from arrival at the hospital to the availability for the next piece of work. So, putting it in the context of that entire job cycle, turnaround time is an important part, but it is not the only black hole that we have to remove.

[86] I would be at pains to say that there are probably things that the ambulance trust can do to help hospital trusts to deal with some of those turnaround time issues. Certainly, one of the things that we can do is improve our process for identifying emergencies that are neither life-threatening nor serious, and gradually and safely set up a telephone-based clinical assessment process, and face-to-face clinical assessment processes, which would allow us to offer more appropriate alternatives of transport to an accident-and-emergency department for patients who do not need to be there in the first place. The motive here is not saving resources, although that is one of the results; it is about offering more appropriate care to

people who will not benefit from being in hospital in the first place.

[87] So, there are things that we can do at the front door, and there are things that we can do at the back door to help with the discharge process, but, yes, turnaround time is the cause of a significant loss of unit hours.

[88] **Janet Davies:** We now go on to paragraphs 1.4 to 1.25, and then to part 2 of the report. Do you have a question, Carl?

[89] **Carl Sargeant:** Yes. Good morning, Alan. I think that we probably see you as the Alan Sugar of the ambulance service now.

[90] **Mr Murray:** I have not fired anybody. [*Laughter.*]

[91] **Carl Sargeant:** No, absolutely not. To drill down through those paragraphs, Alan, why has performance been so poor, and why has the trust failed to improve performance if it has been relatively well resourced in terms of revenue funding and staff? Can you give us some clarity on that?

[92] **Mr Murray:** Yes. We do have more than enough people in green suits to deliver the seventy-fifth percentile standard, ultimately—not just the sixtieth percentile, but the seventy-fifth, which is obtained in England. Why, then, do we have such a problem? I think that the auditor general has referred to basic operational research methodology matching activity to resources. There are industry-standard methods that have been used in ambulance services in the developed world for a couple of decades, which have been very slow to make their way into not just Wales, but the UK.

[93] The auditor general also referred to people coming from an ambulance background understanding the business; in fact, I would say that that is not invariable. Across the UK, there is a variable standard of understanding the business by professional ambulance people. One of the keys to improving performance is good demand analysis, and then, as the auditor general also said, it is important that rosters are changed to match the demand analysis. Rosters seem to have grown like Topsy in Wales. People have been placed on a roster without any consideration of whether they need to be there. They have been put on at times of the day when they are not needed; they have not been put on at times of the day when they are needed. If we take Cardiff as a prime example, we see that, overall, it probably has adequate resources. However, if you look at the resourcing that it has on Friday and Saturday nights, you see that there is a significant gap in the resources available to deal with that busiest time of the week. Therefore, night shifts and weekends in general are poorly resourced.

[94] We have anomalies such as the one that has been referred to in the report, which, again, came from my initial demand analysis when I came in in early August—in Swansea, we have compliant standards, at over 60 per cent. We have significant shortfalls in resources at all times of the week, and the unit hours in Swansea are not particularly productive. That seems like a complete conundrum. You have relatively unproductive unit hours, relatively good performance, and a significant gap in the resources at all times of the week. How does one explain that? If you look next door, at Carmarthenshire, you will find that Carmarthenshire has an excess of resources, its unit hours are relatively productive, and its performance is well below 60 per cent. You really do not have to be an ambulance professional or an operational researcher to form a hypothesis that explains those two situations. The crews from Carmarthenshire go into Swansea hospitals, and that is the last they see of Carmarthenshire for the rest of their shift. Swansea is a whirlpool—it drags in unit hours from the surrounding rural areas, and locks them in for the entire shift.

[95] To put that right, we must match our rosters to our demand analysis. We have to

prepare ourselves for the political difficulties of that, because there are rural areas that are doing badly, which are overresourced, and there are urban areas that are doing reasonably well, which are underresourced. How does one explain the removal of unit hours from the rural areas to put them into the urban areas? People will want to see performance in those rural areas improve, and they may find it difficult to understand why we are moving those unit hours. However, I hope that, through the explanation that I have given you, and from the information contained in the auditor general's report, I have at least begun to prepare you for that eventuality.

[96] **Carl Sargeant:** So, do you think that it was reasonable of the trust to cite unfunded increased demand as the root cause of the consistent failures to achieve performance targets?

[97] **Mr Murray:** No, it was not.

[98] **Carl Sargeant:** So, what was that root cause, aside from what you said in your first response?

[99] **Mr Murray:** The root causes were a lack of clear and coherent goals and strategies that addressed the mandates acting in the organisation, and on the trust. There was also a lack of understanding of the methodology that I described. Demand analysis is a well worn path for ambulance services and emergency medical services in most parts of the developed world—in North America, Australia, New Zealand, and such places. It works by taking 50 weeks of activity by hour of the week, it breaks that activity into 10-week blocks, it takes the top hour from each 10-week block, for each hour of the week, it adds them together, and it averages them to produce what is known as an 'average peak'. That average peak gets you to the point at which you can say that, in the previous 50-week period, on 90 per cent of occasions, that hour of the week was no busier than shown in the demand analysis. So, for any given hour of the week, there should not be more than between two and four weeks exceeding that level of activity. That has been shown to be a basic recipe for clinically effective response-time performance. So, demand analysis is at the root. It is about changing rosters, and establishing the number of unit hours that you need in a week to achieve that average peak level of staffing.

10.10 a.m.

[100] The next task is to ensure that you produce those unit hours reliably. That is an area where we have made some significant progress, because, throughout Wales now, we are typically in the mid to high 90s in terms of percentage of compliance with the unit hours that we currently plan, although those unit hours, as I have said, are actually wrong. They may be in the wrong place at the wrong time but our production methodology is beginning to improve. So, it is about producing those unit hours reliably; the target that we have set for that is at least 97 per cent measured weekly.

[101] Once you have produced the unit hours, the next task is about distribution. The American health economist who developed the concept known as system status management, which, I suppose, is the foundation of what we are doing here—a gentleman called Jack Stout—said that there are two statements that you can make about emergency ambulance demand and they are both wrong; one is that it can be predicted and the other is that it cannot. Therefore, the truth is somewhere in between; it cannot be predicted but it can be modelled. Having modelled it by hour of the week, it is important to look at where that activity is likely to arise and build deployment plans.

[102] Deployment plans are widely misunderstood, both inside and outside the ambulance service. In 1989, a gentleman called Robert Maxwell—although not that Robert Maxwell—who was, at the time, the director of the King's Fund in London, published a seminal paper

called 'Six Aspects of Healthcare Quality', where he pointed out that you cannot take one measure of quality and exclude all of the others. He was looking at issues like equity, efficiency, responsiveness and so forth. The tension in deployment plans is between efficiency and equity. You can build a deployment plan wholly for efficiency by taking resources out of rural areas and putting them into urban areas. If you have read the draft modernisation plan, 'Time to Make a Difference', you will have seen that we have emphasised very strongly that it is a patient-care-led plan, rather than a standards-led plan. What we mean by that is that we have to remember what the objectives of those standards were. They were, first, clinically effective response to life-threatening and serious emergencies in the category A and B areas, and, in the category C area, improved appropriateness—improved choice of point of care—for patients.

[103] Therefore, if we build our plans entirely for efficiency, and take our resources out of rural areas entirely and put them into urban areas, people will die. Clearly, that is not the objective of the exercise. So, deployment plans also have to have a degree of equity built into them. In urban areas, they will be largely following demand, because that is the way that one operates most clinically effectively in urban areas. It is easy to do because of the volume of activity. In rural areas, there will be demand hot spots and there will also be a need to cover territorial footprints, so that, if a cardiac arrest occurs in a low-activity area, you can have a reasonable expectation that you will get an ambulance, a solo responder in a car or an emergency community first responder to that person in time to do something productive for them.

[104] I will leave the issue of sparsely populated areas for the time being; we may want to talk about those separately, as they are a special case.

[105] Therefore, unit hour distribution is the next key to success. Following distribution we get to utilisation, which is about cleaning up the black holes. We are setting norms and standards for each sub-element of the job-cycle process. Those norms, in seconds or minutes, will stay constant throughout the process and the standards will move from 60 per cent to 75 per cent to 90 per cent and 95 per cent as we get more accomplished. It is important that everyone understands the norms. For call pick up to verification of incident location, the norm is 30 seconds. We will be starting with a 60 per cent standard on that and moving up towards the 95 per cent standard. We cannot get all the way to 95 per cent until we get some better technology in place and we have to acknowledge that. However, that is the finish line; it is not the start line. It will be 30 seconds for allocation, 30 seconds for the crew to mobilise and we will then set seen times and turnaround times at hospitals. So, I suppose that those are the mechanics of improving performance.

[106] **Carl Sargeant:** I will now concentrate on some of the targets and performance related figures. Why has there been such deterioration in performance against GP urgent targets? How will you address this?

[107] **Mr Murray:** In the emergency care business, whether it is an ambulance service or surgery in hospitals, my experience is that there is no hierarchy of priorities. There is the priority and nothing else as a priority. For example, where attempts have been made to use the same surgeons and the same facilities to do elective and emergency surgery, people have ended up packing their bags and going home two or three times, because road traffic collisions always take priority.

[108] The ambulance service is no exception to that, and, for years, we have been attempting to use the same resources, and the same emergency medical service ambulances, to deal with 999 calls and urgent calls. We have to acknowledge that there is a very high overlap in acuity between emergency and urgent patients, and, often, the only difference is that the urgent patient has either been seen or triaged on the telephone by their general

practitioner, and the call comes in through a different route. However, 999 calls are the priority, and urgent calls are not a priority. I found exactly the same thing in Mersey Regional Ambulance Service NHS Trust when I took it over. It had the worst performance on urgent calls in the country, and the second lowest incidence of urgent patients in its EMS caseload after London. I did a fairly simple regression analysis looking at the whole of England and discovered that, for every 10 per cent improvement in compliance with the urgent punctuality standards, there was 12 per cent higher incidence of urgent patients in their workload. The question is: why you would want 12 per cent more urgent patients? The answer to that is that they are, to a large extent, in the 999 workload.

[109] Mersey regional ambulance service had a 13 per cent incidence of urgent calls in its EMS workload. In Wales, we have 14 per cent. Our performance on urgent calls is not as bad as it was in Merseyside; it was, at lowest, down to 48 per cent at one point in Merseyside. We got it very quickly up to 92 per cent, and I understand that it is now over the 95 per cent standard, by streaming the two workloads and by creating a new service that we referred to as a high-dependency service with intermediate grades of staff.

[110] It is very important that this service does not have blue lights, because if it has blue lights, it is an emergency service, and we go back to where we started. These people prioritise the urgent patients. We put in what I would describe as operational rather than clinical filters, to ensure that we did not give these intermediate crews patients who would be over their training capabilities; some urgent patients still have to be transported by EMS crews. However, once you create a stream within the service that has no higher priority than urgent patients, you start to get improved performance.

[111] We have a different problem in Wales. In Merseyside, there was a slight under-resourcing, so, instead of putting in additional EMS crews, we created this new service. Here, our approach will be to offer high-dependency positions to volunteers among our paramedic and technician workforces, and, initially, we will staff those units with people who are being paid as paramedics and technicians, and, as those people retire or move on, we will replace them with people at a different skill level and at a different grade.

10.20 a.m.

[112] When you see a thin strip of urgent workload across the demand analysis, you see a very vivid picture of GP disaffection. I have discussed this in north Wales, and I have been told by local health boards in north Wales that they are very satisfied with the service that they have there, and by GPs directly that they are very happy with that service. Again, this is principally a south-east problem and, to some extent, it is a problem in central and west Wales. GPs lost confidence in us a long time ago in those areas, so they either get the patients to dial 999 or they dial 999 themselves. I do not blame them for that. Our task is to get that confidence back. I am not going to go to them and say, ‘I promise you that if you start obeying the rules, we will get better’. What I would prefer to do is what I did in Merseyside and Cheshire, which is to get better and then go to GP leaders, such as local medical committee chairs, point to the improvements that we have achieved and say, ‘Now you can have confidence in us. Can we talk about how we improve the relationship and get back to where we should be?’.

[113] **Janet Davies:** We need to get a detailed understanding but we are also time-limited for quite a long report. So, perhaps we could try to achieve a balance. Do you want to ask a question, Carl?

[114] **Carl Sargeant:** On paragraphs 1.16 and 1.21 and regional performance, why are there such substantial differences in response-time performance, both on a regional basis and between individual unitary authority areas?

[115] **Mr Murray:** It is probably fair to say that there have been differences in the quality of leadership in the different regions. That is the principal reason for the variability.

[116] **Carl Sargeant:** That was short. How do you propose to tackle the particular challenges in rural areas? You mentioned earlier that patients are more likely to die in those areas.

[117] **Mr Murray:** I did not say that; I said that if we made the wrong strategic choice, patients would die.

[118] **Carl Sargeant:** Okay, I will rephrase that. Are patients more likely to die in those areas?

[119] **Mr Murray:** There is no reason why they should. Emergency response time standards are divided into two. There is an eight-minute standard and a population-density-banded standard. The first of those standards is for the arrival of resuscitation, the second standard is for the arrival of the transporting ambulance. Resuscitation can arrive in many different forms: it can be an emergency ambulance, and our response time should be better in rural areas and we are working towards that; a community first responder with a defibrillator equipped to treat the patient and provide life-saving care; or an emergency service co-responder in a police car or a fire appliance. So, there is no particular reason why people in rural areas should die if they have a life-threatening emergency.

[120] **Jenny Randerson:** You have referred to some of the issues that I wanted to ask you about, but it would be good to have it in a single answer. I am referring to paragraphs 1.33 to 1.34 and figure 16. Given the long distances that you need to travel in Wales to transport patients to hospital, why does the trust have such a high rate of transporting patients to hospital relative to English services and what do you plan to do about that?

[121] **Mr Murray:** In England, most ambulance trusts triage between 28 and 32 per cent of their 999 calls into the potentially life-threatening category, and, in Wales, it has been as high as 50 per cent. In England, typically, category C—the neither life-threatening nor serious category—runs at around 16 per cent; in Wales, before we stopped counting category C, it was as low as 6 per cent. So, the first problem is oversensitivity of call categorisation and we have to address that at the beginning. We need to reintroduce category C, the neither life-threatening nor serious category, for measurement purposes. We have had several reported adverse incidents with category C triage, so we want to be sure that our staff in the control centres are properly trained and that the control centres are properly staffed. We have had an analysis done of our call-taking numbers using erlang, which is a call-centre methodology that looks at the incoming activity and the standards that have to be met and converts it into staffing rotas. I believe that the result of that has been that we need some additional call-takers in all of our centres. So, we have to get the staffing right and business cases will be coming forward to the executive team for that. We have to ensure that we improve the training of our call-takers and the audit and quality assurance of our call-taking processes, re-introduce category C for measurement purposes, do a proper audit of the safety and effectiveness of that categorisation then make the case for a return to the 60-minute, ninety-fifth-percentile response time standard for those that we are going to send an ambulance to, and then, using our new alliance with NHS Direct, put into place some telephone-based clinical assessment services. We did this in Liverpool last year, using nurses and emergency care practitioners, and that showed signs of being very effective while I was there. That means that we do not send ambulances to people in that category unless the clinical telephone assessment indicates that an ambulance is necessary. We find alternatives for the remainder.

[122] The second chance that we get is when we see the patient face to face. We have now

put something into the latest version of the modernisation plan about using some paramedic training moneys for developing clinical guidelines for treatment and referral. Patients will be seen and treated by—if you will forgive the word—'ordinary' paramedics as opposed to emergency care practitioners. This means giving them training to support work that they are already doing in many cases without proper guidelines—and they are doing it very well. This means that we will encourage them and give them the skills to offer appropriate alternatives to the patients that they see.

[123] After that, there is a more complex set of issues, in conjunction with local health boards and other trusts, to do with developing an enhanced range of unscheduled care services. This means converting some of our surplus green-suit people from paramedics into various types of practitioner, so that they can deliver a wider range of healthcare in the community, closer to or in people's homes. We can also use those people to improve the appropriateness of care and for admission avoidance purposes.

[124] **Jenny Randerson:** You are outlining a bit of a brave new world. Are your service users and staff ready to accept new models of service that would mean, for the public, that they might not always be transported by ambulance and, for staff, that they would take on the different roles that you outline?

[125] **Mr Murray:** On service users, the trust has just been through the biggest consultation process in its history on the 'Time to Make a Difference' plan. We have had a huge internal consultation process, including the staff side as well as the staff themselves. Philip and I have met a wide range of external interest groups, including groups of community health councils. We have had communication with citizens' groups about the plan. My summary of that would be that people are certainly ready for an enhanced range of services in the community, but there is still some convincing to be done. We know that we still have a great deal of work to do on that. There is a variable level of understanding.

[126] We are probably more than 50 per cent of the way there, but we still have some tough messages to sell. For example, the auditor general said that ambulance stations do not necessarily equate to ambulance services, but people are very attached to their local ambulance stations. In my experience, I have seen only about 1 per cent of ambulance stations that do anything other than impede good response times, because they are in cul-de-sacs, the staff are up the stairs, and the station is at the back end of a one-way system or a hospital. There is a hard sell to be done on that. I have discussed that with Assembly Members among others recently. So, I do not underestimate the work to be done.

[127] As far as staff are concerned, I have had the response that I expected. If you scratch the surface of a manager or a member of staff in the ambulance service, you do not go very deep before you find the same things. As long as the staff understand, as I believe that they now do, that this is about patient care and not about minutes and seconds, and that the minutes and seconds are important because of their relationship to good outcomes, they are on board. There is an e-learning package that was sent out just last week to all staff in the service and in NHS Direct, whether uniformed or non-uniformed, which provides the education base for the communications programme that will follow, on the implementation of the plan.

10.30 a.m.

[128] The staff have been very positive; they have come forward with lots of good ideas. We have given them evidence that those good ideas have found their way into the modernisation plan. We have had two major meetings with staff side: one with our national joint consultative committee, at the beginning of the process, to set out the basic principles of the plan and to discuss what the process would be for consultation, and the other was a formal consultation process that was undertaken last week. It is clear that staff side is convinced of

the need for modernisation. There are difficult decisions to be made about matters such as how we deal with meal breaks under 'Agenda for Change' and, in fact, I think that we are on the road to resolving those issues, but it is evident from the discussions that we have had that staff side has no desire to impede modernisation.

[129] **Jocelyn Davies:** I just have a very brief question, if I may. This report points to very poor procurement by the trust—many millions of pounds have been wasted. Are staff not just a little resentful that you want to take something away from them that they have enjoyed, when they have seen the trust waste so much money?

[130] **Mr Murray:** I am not sure that I understand what we are taking away from the staff.

[131] **Jocelyn Davies:** You want to make changes, and that cultural change will be difficult—it will not be welcomed by everyone—and you will have difficult negotiations. Therefore, are they not a bit resentful of the fact that you want to make changes to them, when so much money has been wasted?

[132] **Mr Murray:** I have not seen any evidence of resentment and I have talked to a lot of staff, in both formal and informal settings. I have spoken to only two individuals who sounded negative about the process and I think that even they are capable of being convinced. You should imagine what it is like to be the paramedic on an emergency crew that arrives 20 minutes late to an emergency; it is not the chief executive who has to explain to that family, it is the crew. They see the benefits in this for them and their patients. I am not living in cloud-cuckoo-land; I know that there is a big difference between accepting and supporting the plan and accepting changes that would affect my shift, my place of work or my meal breaks. I understand that there is a difference between those things and I can assure you that we are handling those issues very sensitively. However, there are huge benefits for the staff in this as well and, ultimately, they are there for the same reason that I am: to provide good services for patients.

[133] **Janet Davies:** Irene, we will now go on to part 2.

[134] **Irene James:** Good morning, Mr Murray. I am looking at paragraphs 2.2 to 2.53, pages 43 to 59, which show that the trust has a number of key strengths, particularly the strategic framework and the potential benefits of a merger with NHS Direct, which is obviously a key challenge. What do you consider to be the main opportunities presented by the delivering emergency care services strategy and how prepared is the ambulance service to take those on?

[135] **Mr Murray:** The delivering emergency care services strategy mirrors, in many respects, a policy in England called 'Taking Healthcare to the Patient'. The particular strength of the delivering emergency care services strategy over 'Taking Healthcare to the Patient' is that the latter is perceived to be an ambulance strategy and it is therefore necessary for ambulance trusts to market it to primary care trusts and other parts of the NHS that may or may not be interested in a partnership. DECS is a system-wide strategy, therefore, it is as much a local health board or a hospital trust strategy as it is an NHS Direct or an ambulance strategy. So, I think that that sets the context for easier partnership. Had I come in to the Welsh ambulance service without DECS as part of the context, I would have been worried by the surplus of clinicians—the people in green suits—I would have seen that as being a problem that I had to solve. Given DECS and 'Designed for Life', and the need to develop a new range of enhanced community and unscheduled care services, I see it, as I think that all my colleagues in the trust do, as an opportunity. We have a large group of well trained, knowledgeable clinical staff, who are capable of acquiring additional knowledge and skills and taking on a new range of activities.

[136] We have known for a long time that we are best at doing the things that we do the least often. There is nothing nuanced about a cardiac arrest—people are either breathing or not. They either have a pulse or they do not. We are good at those things; we are very good at dealing with trauma. We are very good at dealing with other frank emergencies, but I have not done a shift on an ambulance anywhere in the UK in recent years where I have not seen at least one very old patient with a complex range of healthcare needs and at least one patient presenting as a physical emergency who was actually experiencing an entirely mental-health-related emergency. Those are things that we have not done so well, although, watching paramedics deal with them, I have always been impressed by their interpersonal skills. Those are areas where we have always known that we have to do better. Here we have an opportunity, through the delivering emergency care services strategy, to acquire those new skills.

[137] In places such as Powys, where your average peak on a Wednesday afternoon is 3 p.m., and you have 13 ambulance crews, you are covering territory all day, not covering activity. I called into Machynlleth ambulance station—forgive my pronunciation—a few weeks ago and talked to the crew there, a paramedic and a technician, who said, 'We get very little emergency work to do. We fill our time productively by doing things like co-ordinating first responder schemes. We want to do more'. They are based at the back of a community hospital, at the front of which is a minor injuries unit. Why is the paramedic not running the minor injuries unit? Why is the technician not out doing diagnostics in the community? Why do we bring patients in to haematology clinics instead of bringing the blood in to them, particularly from places far afield? Patients from mid Wales may have to travel to Hereford or Shrewsbury to have those tests done.

[138] In summary, DECS provides us with a huge range of opportunities to improve healthcare for the people of Wales and to deliver our strategic change and efficiency plan, which, as you will have noticed, is a fairly major piece of work in itself. I consider it to be a perfect marriage.

[139] **Irene James:** Thank you for that response. From what you have said, can I take it that you believe that there would be benefits to the proposed merger with NHS Direct and working with other organisations?

[140] **Mr Murray:** There would be huge benefits. I have had a welcoming response from local health boards and other NHS trusts to the proposals that I have just summarised for you. We are proceeding apace with the transfer of NHS Direct at the moment. Obviously, as with any transfer, there are some issues to be resolved, but Swansea NHS Trust has been working closely with us on them. When NHS Direct was first set up—and I was involved in setting it up in Hampshire and the Isle of Wight, it was mainly hosted in England by ambulance trusts and there was a definite synergy there that was not capitalised upon. I found it frustrating, looking at it from the outside, from the private sector, and thinking what I would do if I were the chief executive of a trust. Now, someone is smiling upon me and I am being given the opportunity to demonstrate that synergy.

[141] **Janet Davies:** I accept what you are saying and I am pleased to hear that you are acknowledging the need for training. Undoubtedly, ambulance crews have huge experience. In my mind, I accept it all and I think that it is very good, but I still have some apprehensions about it, because I was very pleased when NHS Direct was set up, but my experience of it is absolutely terrible. I have talked to other people who seem to have had similar experiences. It seems to me that there is rigidity there, and that it is more about following a list and ticking things off than looking at what the issue is. Do you feel that you will be able to overcome that, as you go ahead along these lines?

10.40 a.m.

[142] **Mr Murray:** First of all, I agree with you. I was involved in setting it up, and when we did so, there were nurses at the front end and we were using a range of different clinical decision support systems. The circle that you have to square when you are using professionals like nurses and giving them an algorithm to operate to is that those professionals want to use their full range of professional skills and knowledge, but you are constraining them by giving them the algorithm. By the way, there is research that demonstrates the need for an algorithm in this kind of assessment and triage process. The key to solving the problems that you just described is getting that balance right.

[143] Briefly, I will just say that two wrong turnings were taken with NHS Direct in England, which produced the results that we have today. One of those wrong turns was that the organisation was taken away from local host organisations—from the NHS, in fact—and a special health authority was created. It stopped doing some of the important things, like engaging with local primary care, which was one of the most sceptical constituencies for NHS Direct. The other wrong turn was that a very good algorithm was brought in. A national procurement exercise was undertaken, and an algorithm was brought in that was not in use on any of the sites in England. It was basically a good algorithm. I looked at it, and was impressed by it, but it was then turned into a risk-avoidance tool. So, what we have there is a large degree of oversensitivity.

[144] In the early days of NHS Direct, about 42 per cent of callers were triaged to self-care. It is notable that no NHS Direct site in England now publishes its end-point dispositions, but the information that I have is that, in England, self-care has now been reduced to below 20 per cent since the clinical assessment system was introduced. So, there is a default upwards, and a degree of rigidity has been introduced. I think that the good news is that, in my discussions with Sara Jones, the director of NHS Direct Wales, and her nurse advisers and senior managers, there is an equal recognition in NHS Direct that that is a problem, and that it has to be resolved. The fact that we all recognise that allows us to make the argument that we should examine the algorithm that is in use and examine the processes. We should set ourselves some targets for improved specificity and loosen up some of that rigidity.

[145] **Lorraine Barrett:** It is quite refreshing to hear your remarks, Mr Murray. Looking at paragraphs 2.17 to 2.21, with regard to the issue of the single trust for Wales, we see that the auditor general concludes that it is a strength. Do you agree that having a single trust is a strength, or do you feel that it is too big to be managed effectively?

[146] **Mr Murray:** I have to declare an interest, as I was in the private sector in 1997 as a specialist ambulance consultant. I was the project leader for the review of the Welsh ambulance services. I did not make the decision, but I set up and managed the process that led to the decision. The biggest debate was about having three trusts or one trust, and community health councils in particular had two concerns over whichever option we chose. One concern was that they wanted someone strong locally who would resolve their problems for them locally, and, if that did not work, they wanted to be able to get to the chief executive. Clearly, the three-trust model would have helped them significantly with the second of those two concerns, but the view that the project board took and, ultimately, the Welsh Office was that the benefits of having a single trust were such that it would be worth trying to achieve the benefits of the three-trust model within the single-trust option. We used to talk about headquarters being a bungalow and the real powerhouses of service delivery being the regions.

[147] Somehow or other, however, that did not happen; regional general managers were appointed initially, but they were then removed and replaced by regional ambulance officers. The regional ambulance officers were given accountability without authority. For example, their human resource and finance managers reported to St Asaph, and not to the regional

ambulance officers. The posts were not particularly highly graded, and it was almost a recipe for centralisation to St Asaph. The shorthand that we are now using in the context of the modernisation plan is that we are 'building the bungalow'.

[148] Internal advertising has now gone out for three regional directors, and, if we do not fill those posts internally, I can assure you that we will search assiduously for the best candidates externally. It would be very nice if those candidates came from an ambulance background, but they do not have to. I have an excellent operations director in Mike Cassidy, who worked with me in Merseyside. He is a superb executive director and manager, and an ambulance professional. I am sure that he will be able to work with good leaders at regional level whether they are ambulance professionals or not. So, we are building the bungalow, and we are devolving to the regions the authority to go with the accountability. Everything in the regions will report into the regional directors, including clinical effectiveness, finance and human resources, with one exception at present, which is the patient care service, which you probably know better as the patient transport service.

[149] Patient transport services are not the shiniest part of ambulance services. They tend to be treated as a necessary evil, a secondary priority or as no priority at all. NHS ambulance services do not do well at providing them, but there are many reasons why they should provide them, not least the ability to manage the boundaries between emergency medical services and patient transport services, so that we do not end up with lots of patient transport service patients on our emergency ambulances.

[150] For the interim, which may last for two or three years, we will have a central management structure for patient care services reporting into St Asaph, because we believe that the interests of PCS will get lost in the new regional teams. We want to see them develop a degree of maturity and knock down some of the really big challenges for EMS and unscheduled care before we put PCS back into regional management.

[151] **Lorraine Barrett:** Thank you. I think that you have answered my other question, which was about how you propose to strengthen the regions. I think that you have given us a flavour of what you want to do there. I also wanted to ask how you will ensure that your headquarters has a more strategic role, but I think that we have covered that, Chair. I will leave it at that.

[152] **Jenny Randerson:** My question refers to paragraphs 2.41 and 2.42 and to various other references in the report to the management of capital infrastructure. Why has the trust's capital infrastructure been so poor? Why is it so poor given that the levels of capital expenditure are comparable with those in other rural ambulance trusts in the UK?

[153] **Mr Murray:** I think that the answer to that is that it is similar in other ambulance trusts that I have seen with the same problem, those with a very poor capital base. There has been a history in the trust of doing capital-to-revenue transfers to fund revenue issues because it had not actually been managing its costs properly. That is the simple and straightforward answer.

[154] **Jenny Randerson:** How are you planning to improve the management of capital within the trust?

[155] **Mr Murray:** We have already started doing that. I brought Tim Woodhead, the immediate past finance director of Cumbria Ambulance Service NHS Trust, onto the finance team as deputy finance director in charge of capital programmes. He is now acting as interim chief executive—although I should not say that, because I will frighten my chairman. [*Laughter.*] He is now acting as interim finance director, because our finance director is on sick leave. However, he is still keeping his capital management brief.

[156] We have prioritised our capital needs in our strategic outline programme, which is entirely related to our strategy. So, right from the top, the capital programme is now related to the strategy. We have Tim Woodhead giving attention to managing the capital programme. We have significantly strengthened our procurement process. I think that the first part of that was actually allowing the procurement manager to be part of that process, and he now very firmly is part of it.

10.50 a.m.

[157] Major capital investment programmes, such as the new ambulances that we have put in, require a very strong element of project management. We have mapped out the entire process from start to finish, we have put in a dedicated project manager to manage that project right through, because of its size, and we have now appointed an absolutely superb highly experienced fleet manager, who is also very much part of that process, playing a leading role in it. Those are the kinds of measures that we have put in to improve our procurement process and to improve our use of capital.

[158] Through the fleet manager, we have also found some solutions to earlier problems, such as the Renault ambulances. The fleet manager has suggested that they would be entirely suitable for use as high dependency ambulances. We will be redesigning them for that purpose, taking the blue lights off them, taking a degree of weight of equipment off them, and getting some return for that investment.

[159] **Jenny Randerson:** Elsewhere in the report, there is a reference to the tendency over the years to spend a lot of money at the end of the financial year. Are you putting in systems to avoid that in future?

[160] **Mr Murray:** Yes. I guess that this goes back to the strategic outline programme again. We now have a proper capital programme. We are using the five-case model for business case development. We have streamlined our business case development process, and we are putting in proper business cases hung on to the strategic outline programme and, ultimately, to the modernisation plan.

[161] **Janet Davies:** Thank you. We will now take a coffee break for 15 minutes. I ask everyone to be back here by 11.05 a.m.. The ushers outside will show you where coffee and tea is being served. We will see you back here shortly.

Gohiriwyd y cyfarfod rhwng 10.52 a.m. a 11.07 a.m.
The meeting adjourned between 10.52 a.m. and 11.07 a.m.

[162] **Janet Davies:** We will now move on to the part of the report that deals with the trust's having been let down by failures in several key areas. Jonathan, will you start?

[163] **Jonathan Morgan:** With reference to paragraphs 2.55 to 2.61 and the lack of an effective, strategic direction, the trust has produced—and this was alluded to in the report—a variety of strategic documents. Why has the trust been in a state of the almost perpetual production of paper strategies without being able to deliver change? Many people who, from a policy perspective, accept the need for strategic documents, question why those documents were not put into practice.

[164] **Mr Murray:** While I know that you will accept that my knowledge of that is limited, because I joined the trust on 7 August, I also know that you will expect me to have given it some thought. I think that it tracks back to a lack of an underpinning strategy and view of what the trust is there for and what its mission is, as well as leadership structures that were

almost calculated to cause confusion. To give an example of that, there are three regional ambulance officers, each of whom has at least one ambulance control within his purview and there was also a national control-services manager. That is a perfect example of where confusion lay about who had accountability for delivering a key part of service performance. It was about who had the authority to deliver it and who had the accountability for it. There were several different layers of confusion in the trust.

[165] I have spent the last nine years, since I went into the private sector, as a consultant specialising in ambulance services and their strategic and operational improvement, and every failing or challenged organisation that I have ever been in has exhibited some of those characteristics. One of the things that they all had in common was that if they had delivered half of the wonderful things that they had written down, they would have been twice as good. The difference in this regime will be that, while we have what I hope is a very well written and readable plan, we also have a strategy for delivering it.

11.10 a.m.

[166] **Jonathan Morgan:** I have one follow-up issue. What are the main differences between your strategy and the 2005-09 strategy, which it superseded? How confident can we be that you will have the appropriate mix of skills in place to implement that, and that it is not just a case of having the appropriate people on the board who can approve this strategic direction?

[167] **Mr Murray:** I have to say that, although I have read the 2005-09 strategy, I have not paid a great deal of attention to it, because we have been so busy developing the new strategy. So, I find it difficult to comment in detail on that. How will our strategy be different? Our strategy is different in several respects. It is being done with staff and stakeholders in the very extensive consultation exercise that I mentioned earlier. It deals with many of the soft issues as well as the hard issues. For example, it deals with cultural issues. It expresses our cultural goals in ways that everyone can understand.

[168] The questions that I have been putting to staff are, 'Are you spoken to as an adult and treated with respect in your own home?'; 'Are you spoken to as an adult and treated with respect in your outside activities?'; and 'If that does not happen when you put on a green suit, is that because you have become a different person?'. There may be some changes when people put on the green suit, because these things are always two-way, are they not? However, I have made it very clear to managers in the trust, and to the staff—because this is a two-way compact—that the price that managers pay for having the authority to match their accountability is that they must obey those rules. They must treat staff with respect at all times, and they must speak to them as adults and listen to what they have to say. In my experience, most staff will reciprocate—some will not, but even then the rules still apply. Due process must be used to deal with that, but the rules still apply.

[169] So, we are dealing with cultural issues and styles of leadership and sources of authority. I have made no secret of my aspiration to remove rank markings and move away from being a rank-based organisation to different sources of authority. At the front line, that source of authority must, largely, be expertise. It has to be a case of asking what can be done to develop and prepare staff to do their jobs and what can be done to remove the factors that stop staff doing their jobs. So, there is a range of leadership-based and cultural issues involved in this plan as well as the hard objectives.

[170] What you see here is the first of two major documents. The second document will be a programme plan. In order to deliver the plan we will be developing a programme plan with a set of project plans hanging off it. We will be bringing in an experienced programme manager to support our in-house resources—we do have some in-house resources for this.

One of our executive directors will be taking over all programme responsibility. The outside programme manager will help us to develop the plan and coach our in-house people through the early stages of delivering it and leave them with some skills.

[171] In January, we will be embarking on a programme of training in a methodology called managing successful programmes, which I successfully used in the Mersey Regional Ambulance Service NHS Trust. It is a product of the Office of Government Commerce, and it is therefore a sister product to PRINCE 2. However, it is very different—it is a lot simpler and less bureaucratic. We will still use PRINCE 2 for information-and-communications-technology-based projects, as we are mandated to do. We believe that the two methods will hang together quite well. So, we have a plan for delivering the plan, and that will be done in a disciplined way.

[172] The executive team will be the programme sponsoring group—the steering group in other words. The first part of every executive team meeting will be progress against the project plan. My monthly one-to-one meetings with my executive directors will begin with a review of their personal progress on delivering their aspects of the programme plan, and we also have a modernisation committee chaired by a non-executive director, which meets monthly and will be the programme board.

[173] **Jocelyn Davies:** May I ask you about governance issues? I take you to page 63 of the report. Poor governance will lead to ineffective decision making—it will definitely lead to poor accountability. It seems from reading this report that, historically, the trust has not held the board members in the highest esteem. I suppose that it is an old trick that if someone asks you for more information, you just swamp them with paper and then they do not come back and ask for any more. It certainly seems that the relationship with the board did not benefit anyone. Have you begun to address the weaknesses in internal governance?

[174] External governance certainly needed some improvement, as evidenced on page 69 in terms of the relationship with Health Commission Wales. HCW was not involved with the terms of reference for the benchmarking review and did not receive a copy of the benchmarking report, which was produced in April, until December. There are also claims that the trust adopted a confrontational approach. Can you give us some assurances that those things have changed? Again, I know that we are talking about cultural change, but perhaps you could outline any changes in the roles of non-executive members.

[175] **Mr Murray:** I draw your attention to the latest version of our modernisation plan. It is a changing document that is being finished today and sent to the board in preparation for the meeting on 21 December. Under organisational staff development, we have a goal of ensuring that the trust board functions with maximum effectiveness and benchmarks its performance against best practice, based on models that are currently being developed, for example, the intelligent ambulance board, which is being developed by Dr Foster in England. There are elements of the intelligent ambulance board that do not apply to Wales—the more competitive, commercial elements that relate to the English NHS ethos, not the Welsh one. However, from looking at that document, most of what is in it applies very well to Wales.

[176] We have a series of detailed objectives underneath that about things like reviewing our standing orders and standing financial instructions. We have appointed an experienced corporate secretary on an interim basis; he has worked for health authorities and other public bodies in Wales. He is there not just as interim board secretary, but to advise us on how we should take forward that role. His advice is that we should be seeking to appoint a full-time corporate secretary, with the status of an executive director, but not being an executive director. That recognises that that role sits between the executives and non-executives and has the responsibility and the right to have the ear of the chair, as well as the chief executive, if he or she feels that the public service values of openness, probity, and accountability are being

compromised in any way.

[177] We have brought in the Mersey Internal Audit Agency to conduct a programme of board development and corporate governance development. It might seem strange, saving the presence of our colleagues from the Wales Audit Office, to bring in an auditor to advise on board development, but Tim Crowley, the director of the Mersey Internal Audit Agency, is a nationally acknowledged expert on board development. He will be working with our board secretary, the chair, me, executives, non-executives and me on a six-month programme of corporate governance development.

[178] There are a number of measures there that we believe will improve internal governance. The chairmanship of committees will now be with non-executive directors, as it always should have been. Sara Jones from NHS Direct Wales has taken an interim responsibility for reviewing and developing the clinical governance aspects of our governance regime.

11.20 a.m.

[179] As far as external governance is concerned, we have made significant progress with the regional office and HCW on our strategic change and efficiency plan and our service and financial framework. The service and financial framework is now agreed, which is a major step forward. The SCEP has been mostly agreed, subject to some further detailed work on the £3 million of savings that we have to make next year, because, clearly, the regional office wants an assurance that we will be able to deliver that. My finance director and the regional officer are working through that in detail at the moment, but it is a positive discussion. So, the relationship with HCW and the effectiveness of that relationship have both improved immensely. The regional office has been supportive and we are beginning to deliver.

[180] **Jocelyn Davies:** I have a quick comment rather than a question. I noted that you mentioned changes to your standing orders, but it seems to me that the standing orders were completely ignored—it did not matter what they said in the past, as they were ignored anyway. I hope that what you have said will now take place. It is nice to hear that you will have non-executive members chairing committees, but it is important that information goes to the committees, so that that chairs and the committees are aware of it. We will see what happens in the future, but I am sure that some of the things that you have said will make a difference.

[181] **Mr Murray:** To respond briefly to that, we are now bringing better information to the board, but we will be developing that in line with Dr Foster's recommendations. I suppose that less is more, and that, in fact, what we should be doing is bringing a small and focused range of strategically orientated information to the board that enables it to measure the delivery of the plan and also gives it the wherewithal to ask for further and better information where it needs it.

[182] **Janet Davies:** Jonathan, you wanted to take the next section.

[183] **Jonathan Morgan:** On the issue of leadership and management capacity, particularly paragraphs 1.37 through to 2.167, there is a clear need, according to the report, to improve clinical performance. You have already touched on this, but can you further outline how you plan to improve clinical performance, leadership and governance? Given the trust's poor response-time performance, could the trust save more lives, as Mr Thayne suggested?

[184] **Mr Murray:** I will start with the last of those questions, because that is the clincher, is it not? We have been clear that there is a relationship between a good response time and a good outcome in life-threatening and serious emergencies. That has come from this team

proactively, not in response to anything that previous chief executives may have said, and it has been the key to success in previous organisations that I have led, such as the Mersey regional ambulance service. Staff get quickly fed up of having minutes and seconds forced down their throats. They want to know whether they are making a difference for patients. If you make two statements in any ambulance trust in the UK that has not been through this process, the staff will finish them for you: if I get there in eight minutes and one second and the patient lives, that is a failure, and if I get there in seven minutes and 59 seconds and the patient dies, that is a success. That mythology has to be challenged. The fact is that if you get there in less than eight minutes, the patient is more likely to be capable of being resuscitated than if you get there late. We have been very clear about that.

[185] We have adduced studies such as Heartstart in Scotland, which demonstrates that, from a large cohort of patients in cardiac arrest, 10 per cent overall left hospital alive. If the ambulance crew was with the patient when arrest occurred, 39 per cent left hospital alive. If the first shock was delivered within four minutes of arrest through first responders, emergency service co-responders and public access defibrillation, 43 per cent of people left hospital alive. There is a similar study for trauma, which we are using. That is in our e-learning package as well, because we want staff to understand that relationship.

[186] Coming to the first part of your question, there are two components to clinical effectiveness for people who are having life-threatening and serious emergencies. One of them is getting there in time to make a difference, hence the name of the modernisation plan. The other is what you do when you get there. Clinical governance in its early days in the NHS was done extremely well in the boardroom, but, unfortunately, it did not make its way outside the door of the boardroom. To some extent, that is the position that we are starting from in the Welsh Ambulance Services NHS Trust. We have to find a way of having our clinical governance regime make an impact on the ground.

[187] It is therefore a part of our plan to appoint an executive director with responsibility for clinical governance, a consultant paramedic who will take management responsibility for the clinical governance regime—for the people in the green suits—and who will also have a professional line of responsibility for the clinical team leaders that we will put in place. We are planning to put team leaders in on an average ratio of one team leader to every 10 staff. These are not additional staff; they will be appointed from within the existing workforce. Their role will not be that of a boss, but as a senior colleague to teach, assess and act as mentors and guides. They will have some protected time each week, but their principal responsibility will be running emergency calls with their colleagues, and they will rotate around the team and spending time with each member of the team. They will also play a role in important new developments, such as regular case reviews with each member of their team, so that lessons can be learned in clinical audit.

[188] Returning briefly to the lessons-learned issue, one message that we have been delivering very clearly is that we are into an improvement culture, not a blame culture. I am very cautious about saying ‘no blame’, because people get confused between there being no blame for honest mistakes and there being no blame for negligence. I prefer to use the term improvement culture, whereby we are not seeking blame. We are not asking, ‘Who did that?’, but ‘What happened; how did it happen, and how do we prevent it from happening again?’. We are encouraging people to admit, for example, if they give a drug through the wrong route, and get them to tell the accident-and-emergency department and their line manager. The training department will then be made aware and the message communicated to the rest of the team and the wider service. The important message is not to cover things up, but to admit them and learn from them. Those are some of the measures that we are putting in to improve clinical performance on the ground.

[189] **Jonathan Morgan:** Are you on target to have trained all paramedics by the end of

the year?

[190] **Mr Murray:** Can you explain that question a little bit more? I am not sure—

[191] **Jonathan Morgan:** Paragraphs 1.37 and 1.38 state that there is a need to improve clinical performance by further training staff in thrombolysis.

[192] **Mr Murray:** We are on course to meet the thrombolysis target.

[193] **Denise Idris Jones:** Turning to pages 78 and 79 of the report, and looking at figure 26, I will be asking about sickness absences, outlined in paragraphs 2.123 to 2.128. Figure 26 shows that, despite a reduction since 2002-03, there was a sharp increase in sickness absence to 6.32 per cent of contracted hours in 2005-06. To what extent is the recent increase in sickness absence a symptom of, or a contributory factor to, the trust's wider problems over the past 18 months?

[194] **Mr Murray:** As in any organisation, increased sickness absence is an indicator of poor morale—I assume that that is what you are asking me about. It is an indicator of poor morale, and it is also an indicator to a similar extent of the perception that the organisation does not consider sickness absence to be a problem. In the past, I have worked with organisations that had 14 per cent sickness absence, and when attendance management processes were being introduced—and even before they came in—sickness suddenly reduced to 7 per cent. I think that that gives you an indicator of how much of it is down to people's not believing that the organisation considers absence to be an operational problem.

[195] We have to fight that on two fronts. We have attendance management policies, and I do not think that the policies are a problem. The management of those policies and their delivery through line managers has been the problem. We have targets within 'Time To Make A Difference' for a reduction in sickness absence, which is, in many respects, higher than is reported here, because we have a number of people on light duties who would otherwise be off sick. They will be counted now in our sickness absence figures, so I think that you can assume that the rate is higher than is reported here. We are taking steps to improve morale by engaging staff, listening to what they have to say, and incorporating that into our future plans.

11.30 a.m.

[196] **Denise Idris Jones:** I would imagine that if they were working 12-hour shifts, as you mentioned earlier, and might have been doing three sessions of that, consequently, over time, they would become reasonably tired, would they not? You would have to look at those kinds of things.

[197] **Mr Murray:** There is very little evidence that the move to 12-hour shifts has increased sickness absence. However, if you take a 12-hour shift off, that is a 50 per cent greater sickness absence than if you take an eight-hour shift off. I think that 12-hour shifts are a particular problem in ambulance control where people are on watch all of the time. They are a variable problem on the ground, depending on how busy the crews are. There is no doubt that we will have to introduce a number of shorter shifts if we are to tailor our cover to our demand.

[198] **Denise Idris Jones:** Therefore, you are quite confident that the policy and procedures for managing sickness absence are being implemented effectively. You are seeing a reduction in it, so that is the answer, is it not?

[199] **Mr Murray:** You are asking me whether I am confident that they are being implemented effectively. I am not entirely confident of that yet.

[200] **Denise Idris Jones:** You are not sure yet.

[201] **Mr Murray:** However, if you were to ask whether I am confident that they will be implemented effectively, the answer would be ‘yes’.

[202] **Denise Idris Jones:** Good. Thank you.

[203] **Janet Davies:** Thank you, Denise. We will move on to look at the design and management of processes.

[204] **Jenny Randerson:** I want to ask about paragraphs 2.134 to 2.146, and, in particular, figure 29, which shows that you have significantly more rostered hours than are needed. I believe that it is 55 per cent more hours than the trust needs. Given its poor performance, that is a fairly interesting figure. What is happening to the spare capacity? You referred earlier to black holes, but what steps will you take at this stage to deliver significant efficiency improvements?

[205] **Mr Murray:** That is central to our SCEP. We have plans to reduce our expenses by £3 million next year as the first part of delivering that SCEP. Central to that is moving clinical staff into new roles to be commissioned by other NHS bodies—local health boards and other NHS trusts in Wales. It is a mixed economy. As you know, in some parts of Wales, such as Powys, services are provided and commissioned by the local health board. In other parts, services are partly commissioned by NHS trusts as well as being provided by the trusts themselves. Therefore, it is a mixed economy and we are talking to NHS trusts and local health boards about developing those new roles and moving the people in green suits to those roles, switching the commissioning of those people to the local health board, principally, and then using the funding that we get from the local health board to pay back our SCEP to Health Commission Wales. That is the principal plank.

[206] The secondary plank—and I have already mentioned that it will be a transitional, staged approach in Wales—is to change the skills mix on the ground and to make much more use of intermediate crews, focusing them primarily on urgent patients, but also using them to improve the discharge process for acute hospitals.

[207] **Jenny Randerson:** You talked earlier about having changed meal break patterns, and also about crews checking vehicles and the time lost in doing so. I seem to recall that I was told that, years ago, crews did not check their own vehicles and now they are expected to. Are you thinking of employing new people, with a different skill set, to check and clean the vehicles, or will you give dedicated time for that?

[208] **Mr Murray:** To my knowledge, I do not think that there ever were dedicated stocking and washing teams. I think that crews in Wales have always checked and washed their own ambulances. There may have been some limited exceptions to that, but I cannot see how it would have worked over such a large number of small start and finish points. That is intimately linked with our estates strategy, and our plan is to move from having starting and finishing crews at a wide range of small stations to having starting and finishing within a far smaller range of large make-ready depots. Those make-ready depots would have maintenance facilities, storage facilities, and dedicated stocking and washing teams. We lose a lot of unit hours at the moment simply driving ambulances backwards and forwards to maintenance depots.

[209] We also lose a lot of unit hours changing over from one ambulance to another, because it is impossible to keep a fully stocked spare ambulance in an ambulance station. When ambulance crews come in and find that no-one working on the shift has a key to the

store, they will use the six-wheeled store in the corner—the ambulance. That means that when the time comes to move to work in that ambulance, because theirs is going in for scheduled maintenance, there is absolutely nothing on it except the stretchers, so it takes an hour or more to switch across. You cannot do anything about that in the current configuration. If we take the responsibility away from the crews for stocking and washing the ambulances, we save the 15 to 20 minutes at the start and at the end of each shift that they currently take doing that, we save on the driving backwards and forwards to maintenance depots, and we save the hour that it takes to change over, because they can just come in and pick up the ambulance that they are allocated for the day. Everything is in the same place in every ambulance, so there is no confusion. The equipment is all well maintained and, as soon as they get in it, they put their personal kit on, they check a signature on a sheet of paper that says that their ambulance is fully stocked, washed and checked for roadworthiness, they press a button on their radio, transmit a status code to control, which says that they are ready for work, and control then puts them where it wants them for the rest of the day.

[210] Shifts are important to that as well, because if you are moving large numbers of people in and out of a small number of start and finish points, it is important that the shift start and finish times are staggered, so that you are starting only one crew at a time at any given station. The second type of facility that we will then need is a series of small deployment points, and, for the most part, we will aim not to own those. Through 'Making the Connections', we will want to share facilities with other NHS organisations and with fire and police services. However, as the last resort, we will invest and put facilities in where we cannot find them elsewhere.

[211] **Irene James:** Could we look at paragraphs 2.147 to 2.158, which describe the weaknesses in the management of the trust's four control centres? The control function is critical to the provision of an effective ambulance service. However, there seem to be many problems, including staff morale and ICT just to mention a couple. How has the situation reached this point, and what do you plan to do to address that?

[212] **Mr Murray:** I can give you only a limited answer to the first part of your question, but I have seen it in a lot of other organisations, and I think that it is a failure to realise the importance of control. There is a variable understanding among leaders in ambulance services of the key processes that go towards providing a clinically effective response, and even things like the management of the job-cycle process are sometimes very poorly understood. You cannot blame the middle managers if the people who are running the organisation do not understand those things, or do not put any emphasis on them. So, what I am saying is not a criticism of individual control centre managers, and it is certainly not a criticism of the control centre staff, who I think have been the victims of this, to a large extent.

[213] Our ICT infrastructure is poor. In most of our ambulance control centres, we cannot use technology to pinpoint exactly where the nearest responding ambulance is, which is part of our plan. We have to improve that. However, let us be clear that it is not an excuse for not improving our performance. If I were describing the hierarchy of needs for improvement, I would say that the first thing is that you have to have a clear strategy. The second is that you have to have your people well developed to deliver that strategy. The third is that you have to have well designed and well managed processes. Only then do you think about good technology systems. Well, you think about them before, but only then do you weigh in with the importance of them. You can produce a reasonably creditable performance with a good strategy, good people, good processes and bad systems. However, no matter how good your systems are, if the other things are not right, you will never be able to deliver.

11.40 a.m.

[214] We are planning to improve our information and communications technology. We

believe that we will have the ambulance radio re-procurement project substantially in place within around 18 months to two years. That is a very major project. We are planning to put automatic vehicle-location systems in place and caller-line identification systems, which will enable us to get the address of the caller from the telephone number, and other technology systems that will speed up those processes. One of the quick-win projects that we are doing in the south east at present is the limited performance management framework, and that is a very good example of this. We are focusing on the people and the processes. The people in control need to understand the relationship between the speed of the call-taking time and the speed of allocation and good outcome. As I said, the e-learning package is dealing with that, trust-wide, but we are putting specific effort into control in that respect.

[215] We are redesigning the call-taking processes to ensure that they are as good as they can be, and that involves simple things like changing the first question that you ask when you pick up the phone. There is only one right question, namely, 'Where do you want the ambulance to come to?', because the first thing that you have to do is find out where you have to send the ambulance. At that point, it really does not matter what that call is, whether it is for a broken toe or a cardiac arrest. The call goes to the dispatcher who can then allocate a responder to that call, and he or she should do that within 30 seconds or so. If it turns out to be a broken toenail rather than a cardiac arrest, the ambulance can be pulled back, but if it turns out to be a cardiac arrest and you have not done it that way, you really do not have any hope of getting there in time. We are putting some effort into ensuring that we put on the crews that we planned to have, and we are putting effort into improving our deployment plans. When you put in a deployment plan, the most difficult thing of all is not the deployment plan itself—you could develop a deployment plan on the back of an envelope that would improve response-time performance—but ensuring compliance with that plan. In my experience, the only way of doing that is by involving the people in control and those on the road in developing and reviewing the plans. That is what we will be doing.

[216] **Irene James:** You mentioned that you plan to improve information systems, but how are you going to do that?

[217] **Mr Murray:** It is in our strategic outline programme. We have plans in place in common with the rest of the UK to put in the ambulance radio re-procurement project, namely digital radio systems that will improve our radio coverage and reliability. We have plans in place to make some fairly quick improvements to our information and communications technology and control. The computer-aided dispatch systems that we have in our four control centres are actually quite good. They need to be upgraded to the latest model, but they do not need to be replaced at huge cost. We need to put our investment in control into things like caller-line identification, which I have already described and which speeds up the call-taking process; into good geographic information systems so that we can verify the incident location quickly; the good training of staff in the efficient use of those systems; and digital mapping and automatic vehicle location so that, when a call comes in, you do not have to look at the map, as the system will throw up a system-advised response to the emergency call, which will show you the nearest responding unit in terms of travel time, and you will then be able to dispatch automatically on that basis and think about it afterwards. Do it first; think about it afterwards. Ask whether that was the right thing to do, whether it was the right kind of response and whether you want to make any changes to it, but at least the ambulance is on the way to the emergency. We also need to invest in satellite navigation systems linked to a mobile data system so that, when the crew comes out to the ambulance and sits down in it, it does not have to wait for the call to come in, as it does now. The crew has to sit and wait for the call to come in, after pressing the button.

[218] The mobile data system then feeds into the automatic vehicle-location system, which gives the crew driving directions. From personal experience, I must say that satellite navigation systems are not 100 per cent effective, but they give us some advantages,

particularly in allowing us to use crews in areas with which they are not 100 per cent familiar. It gives us some flexibility in how we use our resources. So, those are the kinds of investments that we are planning to make.

[219] **Irene James:** If we were to look at the responses provided by your control rooms, would they actually tell us how well they are operating?

[220] **Mr Murray:** Yes, they would. At the moment, they are not good, but that is not down to the staff; it is down to the system design. It is not principally down to the technology. The technology will help, but, with good processes and staff who are well trained in managing those processes, we can make huge improvements. Frankly, that is where we are putting our first efforts at the moment. That is where I would always start when trying to improve performance. Start with control, because that is where you will make some of the quickest wins.

[221] **Irene James:** Do you think that we need more or fewer control centres?

[222] **Mr Murray:** We need one control centre per region. We currently have four, and I think that we need three. There is an argument for having one, but, to go back to my earlier argument, it is important that the regional directors have the authority to match their accountability. My view is that each regional director needs to have a control centre, and they need to have authority over the control centre and accountability for its performance. So, I think that three is the right number. As I have already said, I do not believe that we have the correct number of staff in those control centres. I do not believe that the shifts are right, but we have already conducted an erlang analysis to look at the numbers of staff that we need and to help to inform the building of those shifts. I understand that business cases will be coming to the executive team soon for an increase in staffing, principally for call taking.

[223] **Janet Davies:** I just want to point out that we have had very bad experiences in Wales over the years, with call staff who do not have the slightest idea where anyone is, so having fewer than three control centres could cause some problems.

[224] **Mark Isherwood:** You referred to the ambulance radio re-procurement programme, but we are told that the draft strategic change and efficiency programme excluded the projected funding gaps thusfar for that programme. Will that be resolved? When do you think the SCEP will be agreed? What impact will this have on the statutory duty to break even year-end and to deliver your new service model?

[225] **Mr Murray:** I assume that you are referring to the profiling problem with the funding of the ambulance radio re-procurement project. The issue was not the total amount of money that was available. The money that the Assembly Government was making available for ARRP was adequate over the period of years; it was just that it was a fairly flat profile. A lot of the costs came at the beginning of the programme. That left us in the position of being potentially £7 million adrift in year 2 of the programme. My finance director confirms that the profiling issue has been resolved, and that we are not now looking at any overspend on the programme in the early years. So, that issue has been resolved outside the SCEP.

[226] **Mark Isherwood:** Will it be resolved within the SCEP, though?

[227] **Mr Murray:** I will have to come back to you on that. I am not absolutely certain whether it should be included in the SCEP or dealt with separately. If you will excuse me, I will send you a note to answer that.

[228] **Mark Isherwood:** Could you refer that to the Chair of the committee?

[229] **Mr Murray:** Yes, of course.

[230] **Janet Davies:** Yes. It will be sent around to members of the committee. Thank you.

[231] **Denise Idris Jones:** I am looking at page 87 of the report, which starts with the sentence,

[232] 'PCS processes are weak and inconsistent'.

[233] The position of patient care services looks very poor, and it is clear from the auditor general's report that the trust has not prioritised this service, despite the fact that it provides 1.4 million patient journeys a year. Has the trust taken its eye off the ball in respect of PCS? How will you improve service standards to develop robust and effective processes for PCS?

[234] **Mr Murray:** The answer to the first question is 'yes'.

[235] **Denise Idris Jones:** Good, that is what I like to hear.

11.50 a.m.

[236] **Mr Murray:** As for the second question, we are planning, early in the plan, next year, to put in a modern web-enabled patient care service technology system for booking, planning and day control. In terms of leadership of the patient care service, we are planning to put customer service managers in each of the major hospitals. Those customer service managers are not ambulance liaison officers in the old style, in the sense that there are three sets of tasks to deliver patient care services, where the first is booking, the second is planning inward to the clinic or ward, and the third is day control, which is dealing with on-the-day changes, moving your assets around the map and getting people home. Our plan is that the first two will be done centrally and, to one extent or another, the booking will be web based, allowing people in hospitals to make repeat bookings by going on to the patient administration screen in the ward or clinic and going into our system. For GP patients, we agree with GPs that they should not be taking the responsibility for booking patient transport. There is a nation-wide set of eligibility criteria now, which we have adopted, and the plan is that we will apply those criteria directly with GP patients when they make their first booking. GPs will give them our number and ask them to ring us, we will take them through the eligibility criteria and, if they meet the criteria, we will organise the appropriate kind of patient transport.

[237] I must say at this point that it is important that those criteria are applied with common sense and humanity. I have been involved in designing and implementing patient transport service criteria in Kent and Medway and staff need to be given discretion when they are using eligibility criteria—we do not want to implement the kind of rigidity that the Chair described earlier in another context. I have witnessed a caller going through the criteria with a call taker, not meeting them and, as the caller was 93 years of age, the call taker did absolutely the right thing and authorised an ambulance for the patient. These criteria must be applied with a degree of common sense and humanity and that is part of what we plan.

[238] Booking and planning inwards will be centralised in the three regions and day control and planning homewards will be done from the desks in the hospitals—the customer service managers will be responsible for that. They will also be responsible for working in partnership with the hospital trusts on things like discharge planning and the roll-out of web booking. Crucially, they will be the line managers for the crews. Until now, in most NHS ambulance trusts, there has been an attempt to have emergency medical service managers manage patient care service staff and, frankly, they are not interested and, why should they be?

[239] **Denise Idris Jones:** It is important that you communicate with patients. I am a north Wales Assembly Member and some of my constituents have come to me and said that, because there are car parking charges in some of our hospitals, they are worried that if they drive themselves to hospital and have to leave the car there, it will be expensive. In fact, they do not have to pay at all, but if they do not communicate with their GP or someone in the hospital, that is an added worry for them as patients.

[240] **Mr Murray:** My experience in Cheshire was that when the Countess of Chester Hospital introduced car park charges, the demand on our patient transport service rocketed. Eligibility criteria are very important in that context, to ensure that people get ambulances for the right reasons. There is another—

[241] **Denise Idris Jones:** They—[*Inaudible*.]

[242] **Mr Murray:** No, they do not. In fact, I was just going to say that the other important news about our patient transport service strategy is that we plan to make the ambulance car service the service of choice. We would like to move as many as possible of our patients by car service, because it is punctual, discreet and comfortable and sometimes older people do not like their neighbours knowing their business, therefore, an anonymous car pulling up at the door is more welcome than an ambulance.

[243] Patients like the ambulance car service immensely. With those people who cannot travel by car, because they cannot walk due to painful joints or some other factor, or because they live in a very densely populated urban area, it makes more sense to send an eight-seater ambulance to collect them. Those people, who do not travel by car, should mostly travel in single-operator ambulances, which include most wheelchair patients, as long as we get our risk assessment right. That is not difficult because it is a question of how many steps that they have at their front doors, whether they have a 4 tonne electric wheelchair, whether they need a stretcher or whether they have some care needs en route. Those people then move upwards to a more specialised double-crewed ambulance. However, it is very important to say that if we are going to make this work, we need to improve the remuneration rates for car-service drivers. We are paying most of them 32p per mile at the moment, while most other organisations pay at least 42p per mile. We must ensure that we start to bring in some of the cost improvements so that we can afford to make those payments, but we plan to undertake a remuneration review.

[244] **Denise Idris Jones:** That sounds good; thank you, Chair.

[245] **Lorraine Barrett:** Looking at the trust's estate in paragraphs 2.175 to 2.185, I will combine my questions. Does the trust need so many ambulance stations and how far have you progressed in firming up your estates strategy? If you need to close any stations as a result of the new model, how do you think that staff and the public will react? Earlier, you mentioned sharing resources, so, as part of your estates strategy, would you be looking more at sharing sites or other things that are in place?

[246] **Mr Murray:** We certainly will. As I said, our estates strategy will be to move our start and finish points. I think that the number 17 has been mentioned and that is probably broadly right across Wales. The important thing about those buildings is not that they make good response points—in fact, in my more Machiavellian moments, I would probably say that it was better that they did not, because if they are big enough and are being used as a response point, there is always a temptation to stack ambulances on top of each other rather than spread them out across the map. So, we should not be thinking of those as response or deployment points.

[247] Our plan is to spread the resources out so that, even in low-demand areas, they are covering a balance of geography and demand. As far as the 17 are concerned, if we end up with the number 17, we are very much open to sharing estates with other organisations. At this point, I should say that I missed out, from my earlier thanks, my colleagues in the emergency services, including the police and fire service, who have also been very welcoming and very helpful as well as very keen to develop 'Making the Connections'.

[248] When we get to the response points or the smaller deployment points, we are really only looking for a comfortable room that allows the ambulance crew to get to the ambulance within 30 seconds and gets them out onto a decent road network, going in at least three different directions. Our preference will be to share those rather than own them, but we would be prepared to own them if we absolutely had to. Will we close ambulance stations? Yes, we will. Some of our ambulance stations are in an abysmal condition; some are in absolutely the wrong place. Even in Liverpool, I have seen only one ambulance station that met my three criteria for being where I would put an ambulance if I had an investment for bricks and mortar in terms of being able to get out in 30 seconds and hitting a good road network. So, I suspect that we will close ambulance stations. Will we take resources out of local areas? No, we will not. We will look at other ways of keeping them in local areas and that will be a hard sell. I would ask for your assistance in that. I have heard the message that you gave me at the meeting that I had with you a few weeks ago—that if we are going to do something like that, we should set a benchmark for the NHS and tell you first; I assure you that we will.

[249] **Jocelyn Davies:** On procurement, on page 93, there is talk about the state of the fleet. It seems that you are about to undertake a major procurement of ambulances and you have said that you will need £132 million over the next 10 years. However, previous procurement exercises, particularly of ambulances, seem to have had one or two problems, although I was delighted to hear earlier that you will be able to find alternative uses for those vehicles that are not suitable for emergency journeys. With an ambulance service staffed by professional ambulance and fleet personnel, how could you get that procurement so badly wrong?

12.00 p.m.

[250] **Mr Murray:** I might want to challenge part of your assumption, because we did not have a lot of professional fleet management input to that procurement. It is very important that, when you are procuring ambulances, whether they are for non-emergency or emergency use, you involve the people who are going to use them. Although there are national elements to the specification, such as the excellent European Committee for Standardisation standard, which introduces laudable safety features that were not previously part of the specification, and although you have to involve the users in designing the ambulance, it is important that you have a professional fleet person there to temper the user requirements with a dose of reality. That person would be there to ask, for example, whether it would be technically achievable and legally compliant. That was the principal missing part, and we now have an excellent fleet manager who worked with me in Mersey regional ambulance service, and was absolutely central to the success of that turnaround.

[251] **Jocelyn Davies:** That will mean, of course, that lessons have been learnt from that mistake, so that the next procurement will be much—

[252] **Mr Murray:** They have definitely been learnt.

[253] **Jocelyn Davies:** We were talking earlier about possible station closures and changes to service models, so do you need so many new ambulances?

[254] **Mr Murray:** I think that, as time goes on, the number of ambulances needed will reduce, and we will move from ambulances to cars. I do not know to what extent that will be

yet, because, while some work is being done in other parts of the UK, I do not think that anything definitive has come out of that. However, I think that there will be a reduction in the number of ambulances that we deploy and an increase in the number of cars. There are two reasons for that: as I said, our standards are split into time to resuscitation and time to transportation, and, very often, the patients do not need to be transported. Even where resuscitation is required, the important thing is always to get clinical care to the patient quickly. Even at the moment, with all our performance difficulties, the average contribution and the average compliance of our rapid response cars, with the eight-minute target, is 80 per cent; we just do not have enough of those cars at the moment. However, there will be a move to more cars and fewer ambulances. As far as the number of ambulances is concerned, what we really need to do is get to the point where, whatever number of ambulances we have on at the peak of the day, we actually have 50 per cent additional ambulances in the fleet. That is what we have found to be necessary to keep the fleet going and to maintain our work programmes, as well as to ensure that an ambulance is available for crews coming in who find that the crews who they are relieving are still out on an emergency call.

[255] **Jocelyn Davies:** Can you clarify a point? On page 62, paragraph 2.72 talks about a business case. There is this announcement of £16 million to purchase 119 emergency ambulances and so on; was the business case submitted before or after the Welsh Assembly Government approved it? I know that it sounds daft, that you would approve something before you had it, but the last sentence suggests that the Assembly Government had only recently received a business case to purchase additional vehicles that it had approved.

[256] **Mr Murray:** I can see the ambiguity in the construction of the sentence. I apologise for that, but the business case was submitted before its approval.

[257] **Jocelyn Davies:** That is good to hear.

[258] Turning to page 99, procurement is not what the ambulance trust has done best, I do not think. Under paragraph 2.199, this is very poor procurement procedures, and it is obvious that that continued into 2006 with the awarding of contracts and so on. This is stuff that the usual members of this committee are all too familiar with, and the reason for proper procurement procedures is so that no-one can suspect that anything corrupt is going on, people are properly protected, that there is good value for money, and that it is all seen as being transparent. This is not the case here, which leads to all sorts of suspicions. It is not fair on the public purse and it is not fair on the officials who have to deal with it. It is very important that you adhere to the financial standing orders. I suppose that this is a stupid question, but I will ask it anyway. As the accounting officer, can you defend any of this?

[259] **Mr Murray:** No. Would I repeat it? Absolutely not.

[260] **Jocelyn Davies:** Good. Looking at case study K and L, which is about the automatic chest compression devices, there was an attempt to retrospectively legitimise the contract. The argument put forward was that these were urgently needed. However, we find that the urgency was to spend the money before the end of the financial year. From looking at your face, I do not think that you are going to defend that.

[261] **Mr Murray:** No.

[262] **Jocelyn Davies:** This clearly broke the rules.

[263] **Mr Murray:** Absolutely.

[264] **Jocelyn Davies:** We also have the approaching of single suppliers, rather than the inviting of several people to tender. Most people, when spending a lot of money—say, £2

million, on something or other—or even when spending a lot less than that, would never invite just one person to give a price for something, because it is not in their best interests.

[265] There are different views about the clinical effectiveness and safety of automatic chest compressors, and I would like to hear your opinion on that. Are they currently in use?

[266] **Mr Murray:** They are currently in use. There is no convincing randomised control trial that demonstrates the efficacy of automatic chest compression devices of any kind. However, there is convincing evidence of the very variable efficacy of manual compressions. There are two circumstances in which manual compressions are definitely not efficacious and perhaps even hazardous. They are definitely not efficacious when you have a single responder, such as a solo paramedic going out in a car, and, in that case, there is a strong argument that a device is needed to supplement the resuscitation efforts of the solo responder.

[267] The other case in which they are proven not to be efficacious and can, potentially, be hazardous to the person being resuscitated, is when patients are being transported in cardiac arrest, and sometimes patients do have to be transported in cardiac arrest. I guess that it is true to say that there is no demonstration that they provide additional efficacy in other circumstances, therefore it is very important that we look at what is being planned for this type of device. An international randomised control trial is planned for automatic chest compression devices, and the Joint Royal Colleges Ambulance Liaison Committee, which is a statutory body that acts as the national consensus body on paramedic practice in the UK, has agreed, within the last two weeks, I believe, that it will participate in a UK-wide audit of the efficacy of the LUCAS device, which is the particular device that we are talking about. The Welsh Ambulance Services NHS Trust, being the biggest user of the LUCAS device, has been accepted into that audit. In fact, the terms of the audit will be very specific. The use of the device will have to be changed and limited for the period of the audit—I apologise to any of my colleagues in the trust who may be listening to this and do not know about this yet; it really is straight off the press—so the device will be used only in the limited circumstances that I have described. It will be used only where there is a solo responder or where the patient is being resuscitated, that is, given cardiopulmonary resuscitation en route. Therefore, the results of that will be openly available.

[268] **Jocelyn Davies:** I just have one last question. As a chief executive, do you ever approach suppliers yourself?

[269] **Mr Murray:** No.

[270] **Jocelyn Davies:** I did not think that you would.

12.10 a.m.

[271] **Janet Davies:** Thank you, Jocelyn. We will turn to part 3 of the report for the last part of the morning's session. Mr Murray, you talked about the reasons for poor hospital turnarounds earlier in the meeting, but there seem to be particular problems with the University Hospital of Wales and the Royal Gwent Hospital. Can you expand on those problems? Why is there a better turnaround in some hospitals than in others?

[272] **Mr Murray:** I would not profess to have a detailed knowledge of that. If you will forgive me for saying so, it probably demonstrates the importance of having regional directors in place. I would consider this to be an issue that the regional directors of south-east Wales, and, to a lesser extent, of the central and west Wales regions, would get involved in the detail of. I did a review for the Oxfordshire ambulance service in 1999, and at the time it was losing up to 12 per cent of its planned unit hours in the corridors of the John Radcliffe Hospital. There were terrible queues outside that hospital, and we had paramedics doing entire 12-hour

shifts nursing patients in corridors. A number of measures were taken by John Radcliffe Hospital to correct that, including opening up new front doors to a medical assessment unit, speeding up the processes behind the accident-and-emergency department door, that is, improving the management processes within the hospital. I am sure that you know better than I do that the problem seldom rests in the accident-and-emergency department—there are usually problems further in and at the back end. The issue of the increased incidence of delayed transfers of care has been very well rehearsed, and I am sure that you have been taking an interest in it. It is a very complex issue, and it is too complex to be dealt with from St Asaph. It will be high on the agenda of the regional directors when they come in.

[273] **Janet Davies:** Thank you. Mark, would you like to come in and take over the next part?

[274] **Mark Isherwood:** Yes, certainly. We understand that the trust appears to lack basic information on which to plan matching demand with the services available. We have been told that you have started to address this issue, but when will the trust stop being generously funded to provide poor services and start matching the supply of resources with the need for services, based on that basic management information, relating to lost hours or instances of resources being moved between localities?

[275] **Mr Murray:** We are already beyond the first stage of that. We have good demand analysis information for each of the regions and the local health board areas in Wales. So, we have already made significant strides towards knowing where we need our resources. We have agreed with our staff organisations that a rota review should be conducted, and it is being conducted at the moment, and the results of that should be delivered from 1 February. The new rotas will, necessarily, still include the surplus staff, but we are endeavouring to ensure that our staff cover the gaps that we have identified. So, that is the next step in the process. It can only be an interim rota, because, ultimately, we are planning, through our strategic change and efficiency plan, to move those surplus people out of the rota and into new roles. So, that is the short order answer to your question.

[276] **Mark Isherwood:** Moving on, how do you plan to maintain cover in all areas to avoid what has been referred to as the whirlpool effect in case study Q in the report? Beyond that, do you believe that you need a new redeployment plan, and are your staff prepared to work in a more patient-focused way?

[277] **Mr Murray:** The rotas are the first key to that also. The Swansea problem is not unique, but it is probably the biggest and most stark example of the problem. It starts because we do not have enough resources in Swansea to begin with, and we need to boost those resources from within our existing pool. We need to do that in other areas where we have a resource deficit.

[278] We also need to move the resources that we have around the clock to ensure that the night-time hours and the weekend hours are adequately covered. So, getting the rosters in place is the first bit. That removes the need to pull resources in from outside, but only if we produce the unit hours that we plan. Each region is developing a regional resource centre with dedicated people whose jobs are to work with local managers to fill shifts and to ensure that we have the green suits to put into the ambulances and cars. They will also be taking responsibility for control staffing and for patient care services staffing, which is the second part of the jigsaw puzzle.

[279] As you rightly say, the third part is the deployment plan. You asked whether we will have new deployment plans. We already have new deployment plans, to an extent. The real challenge that we have is compliance with those plans. The processes in our control centres are not yet fit for purpose to ensure that compliance. So, we need to put in an injection of

training for the control staff and for control-centre managers in tactical-plan management. There are two things that you can do that are badly wrong, and which upset staff tremendously when you are managing deployment plans. One is to move one unit 40 miles, knowing that it will never get there, and the other is to move everyone half a mile up the map. There are tactics that can be used to improve performance on that. We need to train our control staff and have plans to do so.

[280] In the end, people will not comply with the plan, however good it is, unless they feel that it is their plan. If you bring a consultant in to do your deployment plan, even managers will refer to it as 'the consultant's stupid plan'. If you allow managers to develop the plan, staff will call it 'management's stupid plan'. If you involve staff in developing the plan, review it monthly, and involve staff in reviewing it, it will not be perfect, but at least staff will not be calling it a 'stupid' plan. They will say that it is not perfect, but that it can be fixed, and that they know that people like themselves will be involved in fixing it. That is the only way of doing deployment plans. Even if you use fancy systems to help inform that process, the human beings involved have to own the plan.

[281] **Mark Isherwood:** I fully endorse that. Sharing corporate goals with employees is vital if something is to work. To develop the issue of matching demand with services, and to revisit the issue of joint working in three contexts, I do not think that you have yet mentioned cross-border working. I am aware, as I am sure that many of your colleagues in north Wales are, of cross-border working affecting ambulance service delivery there. Also, on having joint control centres with the fire and police services, I know that in north Wales there was an issue in that the other two services were happy to sign up, but that the ambulance service was reluctant. Finally, you could comment on where rapid response could be delivered in partnership with the fire and rescue service, in the use of defibrillators, for example?

[282] **Mr Murray:** The North Wales Fire and Rescue Service already provides co-response for us, which is very welcome. I believe that there may be other examples throughout Wales of fire services providing co-response, and other fire services want to provide it. There has been a problem with the Fire Brigades Union, but I understand that that is now close to resolution, and it certainly has not been a barrier to fire service co-response in north Wales.

[283] As far as cross-boundary working is concerned, if you are referring to supporting other services across the border, my experience in the past is that is a necessary part of providing emergency medical services. It tends to be broadly reciprocated; services help each other to a largely equal extent across boundaries. However, there is another cross-boundary issue that is a problem. I was talking earlier about the job cycle and that when you get to places such as Powys and parts of north Wales, there is an added element in the call cycle, and that, in most parts of Wales, the last point in the cycle is green and available. In Powys and parts of north Wales, it is green but not available, and there is another hour or more that goes past before availability occurs. One development that we are keen to pursue is the separation of assessment and treatment from transportation where that is appropriate, so that we can keep our advanced life support resources in their localities for the next life-threatening emergency that occurs.

[284] I am sorry, I may have missed part of your question so, if there is something that I have not answered, please let me know.

12.20 p.m.

[285] **Mark Isherwood:** The only other question was on the shared control room.

[286] **Mr Murray:** I put on record my support for the principles of 'Making the Connections' and shared control rooms. The issue in north Wales is not a lack of willingness.

We have a very effective control operation at Llanfairfechan, which has been there for seven years. We created it by combining three existing control centres. In the process of doing that, staff attrition was almost total and we had to re-staff. We have a lot of very good, highly valued staff there, and many of them, because they have joined since the merger, live to the west, as far as Anglesey. My concern at present is whether, if we move to St Asaph, we will lose a significant number of those highly valued staff. That is the main impediment. Dafydd Jones-Morris, the regional ambulance officer for the north, has offered opportunities to all of the staff at the north control centre to visit St Asaph, which is a marvellous facility. It has stunning technology but, if anything, the quality of the leadership there impresses me far more than the technology, however impressive that may be. The facilities there provide the staff with great benefits and I would like my control staff to be able to avail themselves of those benefits but, with all of the other issues that the trust is having to face, frankly, the impact of losing a significant number of trained and committed staff would be more than the trust could bear. I have to establish that that will not be the case before I can make a decision to commit the trust to a tri-service control centre.

[287] **Janet Davies:** Lastly, we have to consider ‘Agenda for Change’ briefly, because it seems to be significantly increasing costs without delivering any benefits. What are your plans to deliver modernisation through ‘Agenda for Change’? Staff have already been paid the additional pay, but we have not had the modernisation, so what are the prospects for delivering benefits for the 29 per cent increase in costs?

[288] **Mr Murray:** We are not alone; it has been a problem for a lot of NHS trusts. ‘Agenda for Change’ has been disproportionately expensive for ambulance trusts. I do not believe that there is an ambulance trust in the country that has not found itself in a broadly similar position to ours. Our plan for delivering the benefits of ‘Agenda for Change’ is contained in this document. To give a prime example, in 1986, a new salary structure was introduced, which removed unsocial hours payments from the ambulance salary package and, effectively, consolidated them, and everybody, notionally, was paid for unsocial hours whether they worked them or not. We need new shift patterns, which will not be entirely congenial. Finishing at 3 a.m. is probably not welcome for most people, but that is when our demand begins to tail off and we have to match our resources to our demand. That is the first consideration. There are good unsocial hours provisions within ‘Agenda for Change’, which will enable us to do that. So, that is a prime example of where we are starting to deliver modernisation. In fact, ‘modernisation’ is probably the wrong word at that point; it is about getting basic services right, using ‘Agenda for Change’ as the vehicle.

[289] Other examples will emerge as we move from having the same response to every 999 call to having a variation in responses according to people’s needs, and we will be able to use ‘Agenda for Change’, the knowledge and skills framework, and the remuneration packages to reward people for becoming practitioners. I am avoiding title here, because it is sometimes a barrier to role and function. It might be nurses, paramedics, or a mixture of both—predominantly paramedics, probably—but we will use ‘Agenda for Change’ to enable us to develop new roles for ambulance staff, and to move them away from being simply responsive to being, in some cases, proactive. I can give an example of that, if I have time.

[290] **Janet Davies:** Yes, you have a minute.

[291] **Mr Murray:** About this time last year, in the former Mersey Regional Ambulance Service NHS Trust, we had a sudden, unexplained upsurge of activity. We used our information systems—systems that we are putting in place here—to examine why that was. We found that the problem was confined to three rural primary care trusts, and that the major factors were chest pains, chronic obstructive pulmonary disease, and falls. By far the biggest cause was chest pains, with most of the incidents occurring between 2 a.m. and 5 a.m.. There was also a very high correlation with night-time temperature. In the old days, we would have

said that we needed more paramedics to respond to those calls. With the new roles that we are beginning to develop, the questions that we need to ask change. What can we do to protect the public health in those circumstances? How do we identify vulnerable people? What questions do we ask? Who has a mobile workforce? Emergency care practitioners, the police, the fire service, and social services. What questions do we ask people to establish their vulnerability? What services can we offer them to prevent that epidemiology from occurring? Developing new roles for ambulance practitioners and developing 'hear and treat' in our control centres and through NHS Direct will enable us to be much more proactive about protecting the public health.

[292] **Janet Davies:** Thank you. I am bringing this session to an end. I thank you and Mr Selwood very much for your helpful answers. I am sure that we have all learned a lot this morning. You will receive a transcript of this meeting, and, if you feel that anything is inaccurate, you may go back to the Wales Audit Office and discuss that with it.

[293] There is a buffet lunch available now for Members, witnesses and officials, and we shall start promptly at 1p.m., because that is when Mrs Lloyd will be here for the next session. Thank you.

Gohiriwyd y cyfarfod rhwng 12.27 p.m. a 1.03 p.m.
The meeting adjourned between 12.27 p.m. and 1.03 p.m.

'Gwasanaethau Ambiwlans yng Nghymru'—
Tystiolaeth gan Lywodraeth Cynulliad Cymru
'Ambulance Service in Wales'—
Evidence from the Welsh Assembly Government

[294] **Janet Davies:** Welcome back to the people who have come back, and welcome to everybody who is joining us for the first time today. As you know, this morning, we heard from Mr Murray, the new chief executive of the Welsh Ambulance Services NHS Trust, and we are grateful to him for remaining for the duration of the committee meeting. This afternoon, however, the principal witness is Mrs Lloyd, director of the Department for Health and Social Services and chief executive of NHS Wales.

[295] While many of the issues raised in the auditor general's report relate to the internal operations of the trust, the report also covers wider issues about the way in which policy has been implemented, about performance management, and commissioning. So, I am delighted to welcome officials from the Welsh Assembly Government, and I look forward to a constructive and focused discussion on ambulance services in Wales and their improvement. So, I welcome you, Mrs Lloyd. Would you and your officials please introduce yourselves for the Record?

[296] **Ms Lloyd:** I am Ann Lloyd. I am the head of the Department for Health and Social Services and am chief executive of the NHS in Wales.

[297] **Mr Marples:** I am Stuart Marples, director of performance and operations.

[298] **Mr Griffin:** I am Derek Griffin, the regional director for north Wales.

[299] **Mr Dean:** I am Simon Dean, the chief executive of Health Commission Wales.

[300] **Janet Davies:** Thank you. I have a question for Mrs Lloyd, to start. You are the accounting officer for the NHS trusts. The auditor general's report identifies long-standing and severe problems with the ambulance service. How were these allowed to emerge, and

what did the Assembly Government do to address them, as you saw all this beginning to happen?

[301] **Ms Lloyd:** You will recall that, when I arrived here, there was no fundamental performance management of the NHS in Wales. So, one of the first jobs that we had to do was get into place, during 2002 and 2003, a sustainable performance management system, so that we would have, centrally held, a range of data on which we could adjudge the performance of organisations. As a consequence, the regional offices were set up in 2003 to exercise performance monitoring on our behalf, because they would be much nearer to the organisations concerned. It was following the bedding-in of those regional offices, and the first full year's performance reports coming forward from all the organisations in the health service, that our real concerns about this organisation's competence to manage targets and governance came to the fore.

[302] As you have seen from the auditor general's report, we had a meeting in July 2004 to outline the concerns of those organisations that interfaced with the Welsh Ambulance Services NHS Trust—Health Commission Wales, the regional office, and our own central departments—to lay out our concerns regarding clinical governance, general governance, financial control and the targeted performance. As a consequence of that meeting, the resolution of the issue came to me; I decided that it was essential that there was some intervention within this organisation, so that we could get a clear view, as an Assembly department, of what was going to be necessary to turn this organisation around, and to provide improved patient care services.

[303] However, we thought that it might be more sustainable if the trust itself was asked to ask for intervention, as it would then own the results, rather than the results being imposed, where there could be some resistance. I asked Derek to negotiate that with the trust, as well as to provide the trust with a short list of suitable people to undertake such an intervention and review on our behalf. However, the trust was, basically, asked to commission it, but it was under no illusion that, if it did not commission it, I would do so, and it would be imposed.

[304] We were fortunate at that time to have received the advice of Mr Bradley from the London Ambulance Service NHS Trust about who were the suitable people who might be able to undertake this. However, it was a question of who had the time to undertake this review; Mr Thayne came forward as the person who had the time to do it. He did so, and we received his report in April 2005. That report did not go into the nuts and bolts of the organisation, but it stated that a complete remodernisation of the service was necessary—it being rather traditional in its approach. If it did not modernise, then we would have to increase enormously the amount of money that we would have to spend on running a traditional service, which, in the end, would be unsustainable.

[305] This report was given to the trust, and I called in the chair and the chief executive in the middle of 2005 to ask them for their modernisation plan. I also asked them straightforwardly whether they were up for the change, and whether they believed they had the competence within their staff groups, their executives, and their managers, to undertake this change. They both assured me that they did. However, we were still extremely concerned that, despite this intervention, and despite the evidence that had been presented by Mr Thayne about the cost of the service, its efficiency, its performance, and what could be improved, that there had been no improvement in performance. Therefore, the chair and I subsequently had a very long and serious discussion about the situation and, again, I posed the question about whether he and the trust board believed that they had the competence and the capacity within their management side to make the necessary changes, bearing in mind that there was a strong trade union side that would need to be negotiated with constructively, to ensure that the staff were well aware of their input into any improvements and modernisation, and the consequences of change.

1.10 p.m.

[306] As a consequence, the chief executive went off sick and the chair suggested to me that it would be perfectly alright if the finance director, who was the deputy, acted up as the chief executive. He had been pleased with his apparent enthusiasm for change and development, but I felt that that was just stripping out another person from within the organisation, leaving yet another hole, and I was concerned about their performance management in terms of financial control. That is how we came to have our first interim chief executive, namely Mr Thayne. We could not, of course, appoint a chief executive because there was one in post, even though he was off sick.

[307] We received a very full report from Mr Thayne about the problems of that service and what he intended to do about them: he presented his modernisation plan to us. He came to see me about his concerns about the service and I think that we had every confidence that he would undertake the necessary job, in the interim period, to start to turn the organisation around. He had a tremendous respect for the staff, which was extremely encouraging—throughout all reports the staff are accredited with really good performances and attitudes and I think that we would all understand and appreciate that. He then decided to resign; there has been some conflict about his reasons for doing that, but it was up to him.

[308] We were about to appoint a chief executive—the retirement of the then chief executive having reached a conclusion—and as we had to ensure that we kept some stability, the deputy that Mr Thayne had brought with him from Staffordshire was asked to act as an interim chief executive. Dr van Dellen was a most enthusiastic young man. He, again, outlined the issues that he felt needed to be tackled immediately. However, I was concerned, with Mr Thayne and Dr van Dellen, that although they might have the ideas, they might not be able to take the staff, their executives and the board with them. I was also concerned about whether the executives had enough capacity in order to put their backs into making the changes, to enable the staff side to come with them, and to enable the patients to understand the changes that were likely to be afoot in the ambulance service and what they would mean for them.

[309] I was pleased when, eventually, we got Mr Murray, because in him I felt that I had considerable security; there was an organisation with a new chair, some new non-executives and a new chief executive who was very clear about what needed to be done, and we had a much more stable organisation. Since the chair and the chief executive have come into post, there has been a stabilisation of that organisation, with the input of more executives and help.

[310] Basically, we tried to push the organisation into understanding the real concerns that we had about its performance and capabilities, the reasons why we were so concerned about what was happening in terms of patient outcomes, and the need to ensure that, whatever resolution was reached, we would have a stable management that could communicate effectively with the staff, had the right ideas about modernisation, had the capacity and competence to move the modernisation of the service forward and was mindful of the issues of patient care, patient safety and of governance affecting it. I would, of course, have loved to do it much faster, because I tend to get very impatient, but our big concern was that we had to have evidence on which to act; we might have been criticised for only having had that evidence for three months before starting to act, but we felt that it was imperative. Finding the skilled individuals among the UK service managers to have the foresight and the capacity to make the changes proved to be very difficult.

[311] **Janet Davies:** Thank you. That was a very long and detailed explanation, and many issues have come out of that. I have one question, and I am sure that other Members will ask you other questions as we go along. I understand from the auditor general’s report that there

was very poor communication between the chair of the board and the rest of the board. Were you aware of this while you were trying to get all the different actions into place?

[312] **Ms Lloyd:** I personally was not aware. However, when I went to see the board in February 2006 to make perfectly clear why I was so concerned about the organisation and why we had basically said, 'You must have an interim chief executive', rather than allowing the executives to be stretched even further, I was extremely concerned that much of what I had to say came as a bit of a surprise.

[313] **Jonathan Morgan:** I am trying to put into my mind a timeline from about 1999 up until where we are now. You have already said that, until you arrived, there was no fundamental performance management of NHS Wales, and I assume that that relates as much to the ambulance service as it does to the rest of the NHS.

[314] **Ms Lloyd:** All of it.

[315] **Jonathan Morgan:** When I look at this report, two things jump out. The first of those things is the problems created by the rapid changes of leadership during the past year to 18 months, but there are also some wider issues, which probably span further than that period, specifically on the lack of clinical leadership and the lack of management capacity. So, I assume that the problems did not suddenly arrive in 2003-04, and that they were probably there before that. The concern that I have is that, while you picked up this issue in 2003-04, did the health and social care department pick up any of these problems between 1999 and the point at which you arrived in Wales?

[316] **Ms Lloyd:** In my handover, I had no indication that there were problems of performance within Wales. You must recognise that I was brought in specifically because Ministers were concerned about the information that they were getting about the control of organisations in Wales and how well they were doing. That was one of the reasons why an external NHS person was sought to do my job, rather than a pure policy person. It had been a stable organisation in terms of staff until November 2005, but there were underlying trends where people were going off sick and people were being acted up. There did not seem to be any effective backfilling of key posts within the organisation. When I got here in 2001 and started to performance-review some of the organisations, the data on which we were trying to do that seemed to be rather inadequate, and it did not appear either that the services were very used to being held to account in that way.

[317] That is why you started to see more targets being set. Although targets had been set previously, they had not been rigorously monitored or reviewed, despite everyone's good intentions and efforts. So, one of the first jobs that I was asked to do by the Ministers was to establish a competent performance management system. As part of the reorganisation of the service that we did at that time, arising from 'Improving Health in Wales', back in February 2001, that started to put that into place. It sounds easy, but it is not if the fundamental information systems are not in place to be able to inform everyone. The statistics people must also believe the information and sign it off—they are independent of us, but they are an important factor in this. So, I cannot tell you what went on before I got here and I probably cannot, hand on heart, tell you what was going on during the first year that I was here, but I knew that I did not have the information to advise Ministers or the organisations on where they stood in the benchmarking performance management leagues.

1.20 p.m.

[318] **Jonathan Morgan:** May I just raise one point for clarification? I accept that until you started looking at the problem, you did not have the data and the information but, presumably, given the relationship between the ambulance service and the Welsh Assembly

Government—you arrived in 2001—between 1999 and 2001 someone would have been responsible for ensuring that data were made available on the performance of the ambulance service. Whose responsibility would it have been? Would it have been the responsibility of the Department for Health and Social Services, or was it the responsibility of the ambulance service to ensure that the department had all the necessary data?

[319] **Ms Lloyd:** Well, it was both. One of the problems was that the available data were very sparse and I was not assured of their competence, basically. However, both would have been responsible.

[320] **Jocelyn Davies:** The report tells us clearly of the problems in the trust. On external governance, do you feel that it has failed and could it possibly be simplified and made more effective?

[321] **Ms Lloyd:** I think that it could be simplified. There is a distinct role for a commissioner such as Health Commission Wales and local health boards and what they do, because their basic responsibilities are to ensure that they commission effective care, that is, good quality, timely care to match the needs of a population. Since Mr Dean came, which was in December, was it?

[322] **Mr Dean:** January this year.

[323] **Ms Lloyd:** Since then, he has been building up a relationship with the local health boards to ensure that those nuances about local requirements are built into his commissioning plan.

[324] My regional offices are there to monitor and performance-manage the whole organisation, which is why we set up a balanced scorecard. If you would like to see what its scorecard looks like, I will send you a copy of it, because it is quite interesting. It looks at much more than just the targets. I have just held a meeting between my regional directors and Mr Marples and Mr Hill-Tout, who job-share the performance management role centrally until the end of December, in order to streamline how they interact together to ensure that Health Commission Wales, and its work and evidence, is pulled into the performance management group, and to look at how the inspectorates, the Social Services Inspectorate for Wales and the Healthcare Inspectorate Wales, also impact on the performance management group, which I chair within my department. That is so that everyone concerned is fully briefed about the issues, and the good and bad things about all the organisations. So, from April of next year—I asked Mr Marples and Mr Hill-Tout to look at this for us, and these are their recommendations—performance management will be exercised more simply within Wales. We will produce the operational plan that outlines that within the next two to three weeks.

[325] **Jocelyn Davies:** Can I take it from that that you were satisfied with the performance of Health Commission Wales and the regional offices with regard to commissioning and performance management? Do you think that that commissioning framework is right? I note that paragraph 2.88 states that Health Commission Wales is responsible for ensuring the achievement of the service specification that it commissions, which covers quality, targets, funding and activity.

[326] **Ms Lloyd:** We must recognise that these were the early days of performance management, and I think that these days, we would have a better, all-encompassing approach to this. One of the problems with the work undertaken by Mr Thayne and HCW's involvement in that—and of course there was informal contact there, because it is part of the Assembly, after all—was that because this review was purposefully being directed by the trust itself, I do not think that the relationship between the trust and its commissioner was at all good at that time, and there was therefore a reluctance to share information. That was not

appropriate, and it has improved enormously over the past 18 months. However, in looking at how the regional office, Health Commission Wales, and we can work together better, the commissioning framework and the operational plan will certainly clarify how that is to be done, and will show how the relationship between regional commissioning and local health boards is going to work.

[327] **Jocelyn Davies:** Do you think, then, that you have the right tools to intervene when there are serious problems with the performance and management of a trust?

[328] **Ms Lloyd:** That is a very interesting question. To be perfectly honest, I do not think that we do. The reason why I do not think that we have the necessary tools is that, at the end of the day, these organisations are statutory bodies, and should the trust board not agree with our assessment of its problems and performance, I have to start to performance-manage much more closely with the regional office and Health Commission Wales, and the executive of that organisation, and that takes far too long. That does not help the situation, because people get distracted by it instead of getting on with their jobs. It has to be understood that, in contrast to the situation in England, the authority that I have is solely in the accountable officer line, from accounting officer to accountable officer. There have been times when chief executives have been appointed when I have refused to appoint them as accountable officers until I was satisfied that they understood what that meant and I had an external review as to whether they were competent to do that. I do not want to be placed in that situation too often, because that automatically creates barriers and difficulties with organisations. However, I feel quite strongly that if I believe that people are not fully rounded for the job then I cannot, in honesty, appoint them as accountable officers. That is not as strong a line as I think is necessary when we find that organisations are failing. We have a range of interventions—we have not gone down the heavy, jack-booted line. In our interventions, we try to ensure that the organisation itself adopts good practice and is itself sustainable in achieving what is necessary. We have the Delivery and Support Unit, as you know, which we will put into those places where we feel that the performance is not right and the organisation has not turned itself around, and we do what we can in that regard.

[329] There is the nuclear option, whereby the Minister can remove a whole trust board. If concerns persist, that is an option, but, for the sake of patient care, the staff and everything else, you try to avoid that option, and to sort problems out before you get anywhere near that. However, we do not have the same abilities to remove the leaders of organisations as England has, through an interesting provision, which Jeremy told me about, that was written into the memoranda of performance for NHS trusts in England. We do not have that.

[330] **Leighton Andrews:** Picking up on that particular point about England, are you suggesting that this came to light only because of something that the auditor general identified?

[331] **Ms Lloyd:** Well, the technicalities came to light only because of that. Having worked for a long time in England, I knew that, if the Minister rang up and said to my chairman, ‘She goes tomorrow’, I would have gone the following day. There would have been a power and authority behind that instruction that does not exist in Wales.

[332] **Leighton Andrews:** It does not exist in Wales? I just want to be precise.

[333] **Ms Lloyd:** No, because it was never written in.

[334] **Leighton Andrews:** It was never written in. Okay.

[335] **Janet Davies:** I will ask Jeremy to come in at this point, and then I will you bring you back in, Leighton.

1.30 p.m.

[336] **Mr Colman:** Just to clarify the point, I happened to be involved, many years ago, at the time when NHS trusts were being invented as a concept. They were modelled very closely on the structure of nationalised industries. For the reasons that Mrs Lloyd has explained, the statutory independence of a nationalised industry stood in the way of close management of the industry by the Minister or its officials. To overcome that problem in nationalised industries, the concept of a memorandum of understanding was developed. The Minister and the chairman, as it usually was, of the nationalised industry, would have a memorandum of understanding that gave the Minister, and officials on his behalf, certain rights of day-to-day intervention. That was part of the structure of NHS trusts. The original concept has been applied in England, and as far as I know, still continues, but it was never applied in Wales. Therefore, that rather vital control, if you are going to have any kind of central executive authority, has never existed in the NHS in Wales since trusts came in.

[337] **Leighton Andrews:** When was it created in England?

[338] **Mr Colman:** A long time ago.

[339] **Ms Lloyd:** In 1991.

[340] **Leighton Andrews:** Therefore, the then Government did not introduce it in Wales.

[341] You talked about chief executives being appointed but you not confirming them as accountable officers. Does that happen regularly in Wales?

[342] **Ms Lloyd:** No, thank goodness, but it has happened.

[343] **Leighton Andrews:** Okay. I just wanted to be clear. You also referred to the nuclear option of sacking an entire trust board being open to the Minister. Has that ever happened?

[344] **Ms Lloyd:** No.

[345] **Leighton Andrews:** Okay. That is all.

[346] **Ms Lloyd:** We have always managed to solve the problem before we got there.

[347] **Jocelyn Davies:** Do you think that the mechanism that exists in England would be a useful tool for intervention, and that it should be considered? Obviously, you would have to consider the pros and the cons and we would have to find out whether it was just an oversight that that has never been applied in Wales, but do you think that that it is perhaps worth considering?

[348] **Ms Lloyd:** I think that it is worth considering. You would very rarely use anything like that, but it just might help the relationship between a trust board, us and the Minister.

[349] **Jocelyn Davies:** You say ‘help’; it would crystallise—[*Inaudible.*]

[350] **Ms Lloyd:** Most places are really great, but some—[*Inaudible.*]

[351] **Jocelyn Davies:** So, in terms of the problems now with the ambulance service, do you think that some of those exist because it is a unique trust? It is an all-Wales body, and it is so difficult to compare it with any other trust.

[352] **Ms Lloyd:** I do not think so. I think that the problems that are outlined in the report could happen in any organisation. It is all about good management, and good scrutiny and governance within an organisation. It is unique as an organisation but the problems that we knew about and that the auditor general has so clearly outlined, are problems that could affect any organisation. It is just a bit bigger than some in terms of geography and complexity.

[353] **Jocelyn Davies:** Are you, Mr Griffin, satisfied with your performance management of the trust?

[354] **Mr Griffin:** Within the framework within which we operate, I think that we did everything that we could. Sometimes, that meant helping; at other times, it was there to be quite forceful with the senior executives, as we were on more than one occasion. We did everything that we could within the framework.

[355] **Jocelyn Davies:** Mr Dean, why do you think that Health Commission Wales experienced such difficulties in obtaining a copy of Mr Thayne's benchmarking report? I think that it was produced in April 2005. I do not think that you got it until the winter—in December or something like that. Did you know that it existed in April, and did you request a copy?

[356] **Mr Dean:** I was not in post at the time; therefore I am reporting what colleagues have briefed me on. We were aware that the report existed. As Mrs Lloyd has indicated, it was a report that was commissioned by the trust and for the trust's use. It would have been extremely helpful had we had sight of it earlier. It is a little disappointing that we did not have sight of it earlier. However, once we got sight of it, we were able to make quite constructive use of it.

[357] **Jocelyn Davies:** So, is there any idea why you did not—

[358] **Mr Dean:** I am afraid that I would be speculating to try to give you a reason. Having not been in post at the time, I was not party to any direct discussions.

[359] **Jocelyn Davies:** Okay. Mr Griffin, why did the regional office express concern about the Health Commission Wales proposal to use incentives and sanctions in the 2004-05 heads of agreement?

[360] **Mr Griffin:** Sanctions and incentives are very important. Incentives need to incentivise rather than act as a barrier, which is one issue in my mind. The situation at the time—and Simon was not there then—was that HCW was seeking to incentivise the ambulance trust to operate in a way that improved its ministerial target performance. The device that HCW proposed was that it would withhold money that the trust would receive in the normal run of things, and give it that money on a monthly basis only if the target was hit. There was a round-table discussion on it, and the question was that, given the trust's circumstances and culture, and the way in which it was operating at the time, would it actually have helped or not? It was a matter of judgment and my view was, on a behavioural response expectation, it would probably have forced the trust to close down the hatches even further, and it would probably have affected its performance rather than its rising to the challenge. That is the behaviour that it was exhibiting at the time. So, we had a discussion about it. That was my view at the time, and it still is, but it was a matter for HCW to take a view on in the round, and to decide whether one of the ideas that it was considering at the time was the one to go with. In the event, it decided not to go with it for the reasons that it would have considered in the round.

[361] **Jocelyn Davies:** Do you want to expand on the reasons that you considered in the round, on why the trust would not have responded well to sanctions and incentives?

[362] **Mr Dean:** Again, I was not in post at the time, so my response is partly a reflection of briefing and partly of my personal views, which would not have impacted at the time. I agree with Derek. An incentives and sanctions framework is extremely important, and financial sanctions certainly serve to concentrate the mind. They can do that in a positive or negative way, and you must make a judgment within the context in which you are operating at any particular point in time. I see the relationship with the trust in terms of the fact that HCW and the regional office have complementary roles, because both have performance management roles and we must work together in partnership with the trust and local health boards.

[363] In any partnership-type arrangement, you get tensions and issues debated and discussed, and people will have differing views. That is entirely healthy, so I think that it is entirely healthy for us as an organisation to say that we want to tackle this issue in a particular way, and seek the views of others involved in the partnership—in this case, the regional office and the trust, but different partnerships in other cases. I have been party to some energetic discussions of that nature in various areas, not necessarily in relation to the ambulance trust, and I think that that is entirely healthy. So, it is good that there is a debate and that we are looking at options, but it is also important that we exercise judgment and that we ensure that whichever option we choose gives us a chance of improving the position, rather than worsening it.

[364] **Jocelyn Davies:** So, you dropped this idea of rewards and penalties, which are usually a last resort. What did you decide to do instead?

[365] **Mr Dean:** We were trying to work with the trust, and, for some of the reasons outlined in the report, that has been a little difficult in the recent past. I can reflect only on my personal experience over the past few months, but I certainly welcome Alan's appointment. We have developed a very constructive relationship. There will be some difficult discussions in that relationship, we will debate some challenging issues, and there will be some robust exchanges, but I would expect—and want—to develop a relationship with the ambulance service that is based on partnership. The regional office has a key role to play in that partnership on behalf of Mrs Lloyd.

[366] **Jocelyn Davies:** However, it was not based on partnership at that time, in 2004-05. In fact, you claimed that the trust had a confrontational approach, and it seems that it was not prepared to give you this document, although you do not know whether you ever requested it. The last resort had been dropped because it was not considered to be the right thing to do. Can you give us any examples of this 'working together'?

1.40 p.m.

[367] **Mr Dean:** Just to clarify, we had requested the report, and I apologise if I was being unfair. It certainly was the case that the working relationship between Health Commission Wales and the trust was not good at that time. It needed development, and we had difficulties in finding the sort of information that we needed to develop an effective commissioning arrangement with that organisation. That has dramatically improved, but some of the reasons for the position at the time are very well articulated in the report before the committee. Things have moved on. We have talked, for example, with Alan and his team about developing this year's long-term agreement, so we are putting the quality measures and our expectations around performance into that.

[368] We have had a very interesting and robust engagement, which we will continue to have on the trust modernisation plan. I am very clear that there are some things that are for the trust to do, and not us, while the trust is very clear that there are some things for us to do, and

not it. We are working together through that, and will continue to do so as the modernisation plan develops. I will want assurances from the trust that the actions that it proposes to take will improve the services that it offers, and that they will not just be about saving money, but about improving the whole range of services, including the delivery of performance targets.

[369] **Jocelyn Davies:** Mrs Lloyd, I have one last question. You mentioned the meeting that was held in July 2004, and the report says in paragraph 2.87 that there were problems agreeing the minutes of that meeting between the external governance bodies, and, of course, the actions that were supposed to arise from it. You had to intervene in that instance. Do you often have to intervene to get two parts of your organisation to agree on minutes?

[370] **Ms Lloyd:** No, it was unique.

[371] **Janet Davies:** We will now move on to Carl's comments. I ask Members to keep to their main questions from now on, please.

[372] **Carl Sargeant:** Good afternoon, Mrs Lloyd. We had a very good morning session with Mr Murray, and I think that colleagues pointed out the direction in which they want to see the ambulance service and the trust going in the future. It appears to me—though I may be wrong—as though lots of the people who were accountable are no longer in place, and that lots of new people are in place. I think that someone has been pulling the wool over someone's eyes. Are you sure that we now have a grip on this, following this report? Are we sure that we have a hold on where we are with the ambulance service and the trust's future?

[373] **Ms Lloyd:** Yes, I am. I have had very many discussions with Mr Murray and the new chair about the direction of the trust, and, in talking to the trust board itself, I know that the non-executives are also clear about the direction. We have had some very honest discussions on perceptions and performance information, which is now shared and acknowledged by everyone.

[374] Mr Murray gave me at least three drafts of the draft modernisation plan before it was published, to ensure that we all had a go at it. I think that that clearly outlines the way forward for this service, in talking to the staff side and senior officials, who endorse the need for modernisation. The way in which Mr Murray is constructing a proper communications strategy and is actually doing the communications within the trust certainly seems to be reaping rewards. I think that staff feel far more engaged than they did before, and the staff side certainly acknowledges the issues that have to be tackled. So, in almost triangulating the evidence that we have before us at the moment, and the fact that the service change and efficiency plan and the service and financial framework have been agreed at long last, we feel that, although that there is still a gap in the service change and efficiency plan, Alan is still working on closing that gap next year. All parties to that—Simon, Derek and my department—are confident that that is achievable and that we have the right people in place to achieve it. There has been a huge change in the executive since it has been brought in, and we have brought in the best people from England to form part of that team.

[375] **Carl Sargeant:** In brief response, I think that Mr Murray told us this morning why he thought that the service was so poor and why the trust had failed to improve performance. On the basis that it was reasonably well resourced, what is your view on that and what was the reason behind it?

[376] **Ms Lloyd:** I do not think that there was a grip on it at all.

[377] **Carl Sargeant:** That is fine.

[378] **Janet Davies:** Would you like to go on with the next part, paragraphs 1.26 to 1.28,

Carl?

[379] **Carl Sargeant:** Thank you. Is it acceptable that other emergency services transported 90 patients to hospital between January and August 2006? Do you think that that is reasonable?

[380] **Ms Lloyd:** No, I do not. They are not equipped to do it. They have their own governance arrangements, and it is not satisfactory.

[381] **Carl Sargeant:** So, what will the Assembly Government do to minimise the significant number of poor incidents that have occurred? How can we encourage better systems and working relationships between the services?

[382] **Ms Lloyd:** There are several things. We have been given some money to work with the other emergency services, to look at the question of joint controls. The recommendation will lie with Alan and the other joint-service chiefs in terms of what they think we should be doing, given the advantages and disadvantages of that. We are encouraging Alan and his teams to think very carefully about how they extend the roles of the individual ambulance personnel, as has been done elsewhere. In fairness to them, we have really well qualified staff and we should use their skills better than we have been doing, to have a much more flexible approach to response.

[383] We have also been given a little money from 'Making the Connections' to look at shared sites with the fire service, so that is positive engagement. We have got to have much better communications. There should not be any necessity for other services to be asked to transport our patients to hospital. It is reasonable that other services should be in a position to be first responders because, often, they are the first response. Certainly, North Wales Police used to be first responders, and I think that there are discussions going on about that with the other emergency services, so there is a great deal that can be done. However, the last thing that we want is for them to be forced into a position in which they have to transport people to get care.

[384] **Janet Davies:** Thank you. Jeff, will you go on to look at the trust's strengths and the problems that it is having?

[385] **Jeff Cuthbert:** I apologise again for not being here for this morning's session. It means that I have not had the benefit of listening to the comments made this morning, and I am sorry about that. Nevertheless, these questions are about the trust's strengths. My first question relates to paragraphs 2.3 to 2.8. What do you see as the main opportunities within the emerging delivering emergency care services framework to develop unscheduled care services in Wales, and what does the Welsh Ambulance Services NHS Trust need to do to maximise its use of these opportunities?

[386] **Ms Lloyd:** This strategic framework is a really important development, bringing together, as it will, NHS Direct, the out-of-hours services and other unscheduled care services, to get them to work much more cohesively. I think that patients have been confused about whom to call in a crisis, and an awful lot of them land up in accident-and-emergency departments when they do not necessarily have to be there. They could have had a better response to the problems that they were facing. So, there is an opportunity to give patients one point of access, and they will be directed appropriately. We will have an evaluation framework behind this. With the ambulance services as linchpin in all of this implementation, we should be able to roll out the schemes that have started in some parts of Wales and England, looking at how the emergency care practitioners in the ambulance service work with the out-of-hours service to manage chronic diseases throughout weekends, for example. In Gloucestershire, I know that the new emergency care practitioners that have been trained for

over four years for that purpose are working with the out-of-hours services, which correlate with Gwent's services to provide that sort of service throughout weekends, or, at the request of an out-of-hours service, over a longer period of time.

1.50 p.m.

[387] It is about how we get first responders closely enmeshed in some of this work and how we get the rapid response individuals to be additionally skilled in order to ensure that, in rural areas in particular, there is a very quick response to an emergency and that care is given immediately and effectively, and to use telemedicine so that, from ambulances, we have systems that flash pictures or test results back to a major accident unit and the ambulance paramedic receives back-up advice.

[388] So, with regard to what the potential of this is, I think that this will be the making of the ambulance service as a true part of the clinical service, and not just as a transport system. That is why our staff have been very well trained indeed. Mr Thayne supported the fact that they were extremely well trained. They seemed to be keen to extend their roles and to provide a high quality clinical service, as they do already. The ambulance service is the key to delivering the emergency care services strategic framework.

[389] **Jeff Cuthbert:** May I come back on that?

[390] **Janet Davies:** Yes, of course.

[391] **Jeff Cuthbert:** There were excellent ideas there, all of which seem highly practical to me, although I am not a practitioner. It seems that you believe that the ambulance service ought to be capable of playing a leading role in the development of these services, but how confident are you at this moment that the ambulance service can do it?

[392] **Ms Lloyd:** If it continues to run in its traditional way, it will not. However, I do not think that it will continue to run in that traditional mode. There has been enough sign-up, and there is lots of positive support for Mr Murray's modernisation plan, which encapsulates this approach to delivering the DECS system. So, if the actions are as good as the words, the service will be given that opportunity.

[393] **Jeff Cuthbert:** May I go on?

[394] **Janet Davies:** Yes, with just the main question, please.

[395] **Jeff Cuthbert:** Many people have argued for a while that one all-Wales trust would be too big. I note from the auditor general's report that he does not share that view. What is your view on that?

[396] **Ms Lloyd:** The last thing that the ambulance service needs at the moment is reorganisation. We need to settle it down, get it focused on what it is there to do, and to strengthen those regional offices so that they can deliver more localised steerage to the service. I do not think that reorganisation will help it one bit.

[397] **Leighton Andrews:** You covered some of this in your first answer to the Chair. I am looking at paragraphs 2.22 to 2.42. The response time performance is poor, despite the fact that the trust is relatively well funded, although there is perhaps a need on the capital side. Do you agree that, broadly speaking, it has the funds that it needs?

[398] **Ms Lloyd:** Yes, I think that it does. All the reports that we have received on it say that it could be more efficient and that it could deploy its staff better. It has had an absence of

capital resource, but I shall not go into that now as I am sure that someone will ask about it. It has a fair amount of resource to be able to manage. If, as we go through modernisation, it transpires that it will need additional revenue support, we will discuss that matter with it.

[399] **Leighton Andrews:** Do you think that the Welsh public has had value for money?

[400] **Ms Lloyd:** Mr Thayne did not think that it had. If it is the most expensive ambulance service, and the performance is like this, there is no wonder that we were all concerned.

[401] **Leighton Andrews:** So, the Welsh public has not had value for money from the trust?

[402] **Ms Lloyd:** Not from the trust. It has very good value from its staff.

[403] **Leighton Andrews:** Yes. I do not think that any of us are challenging that. The only benchmarking exercise that seems to have been conducted in the trust was Mr Thayne's. Benchmarking has been around for decades. Is that situation therefore not odd?

[404] **Ms Lloyd:** It is not an efficient way to manage an organisation. It should have been benchmarking.

[405] **Janet Davies:** Thank you, Leighton. Denise, will you take up the strategy and financial management?

[406] **Denise Idris Jones:** I am going to look at strategy and financial management, Mrs Lloyd. If we look at paragraphs 2.58 and 2.59 in the report—are you with me?

[407] **Ms Lloyd:** Yes, I am.

[408] **Denise Idris Jones:** Good. Why has the trust been so slow to modernise, and why did it require external pressure to produce an initial modernisation strategy?

[409] **Ms Lloyd:** My own view is that I do not think that it believed that it was doing anything wrong. If it had thought that it could have done something better, it would have done so. Managers are put in place not only to maintain performance, but to change things that are not right. I do not think that the board was given the information to allow it to take a view on whether it was running an effective service.

[410] **Denise Idris Jones:** So, where would you put the blame?

[411] **Ms Lloyd:** Well—

[412] **Denise Idris Jones:** You do not want to do that, do you?

[413] **Ms Lloyd:** I do not mind doing it, but— [*Laughter.*]

[414] **Janet Davies:** Although this might be profitable, on the other hand it might not. We are short of time this afternoon, so that may not be one of the committee's priorities as of this moment. [*Laughter.*]

[415] **Denise Idris Jones:** Is it common for the Assembly Government to intervene to secure a strategic plan? Why did you not ensure that the trust produced realistic implementation plans to deliver the strategy?

[416] **Ms Lloyd:** Taking the last question first, I think that we did try extremely hard to get

them to produce realistic plans. It is not often that I will pull down a chair and a chief executive to Cardiff to explain what their modernisation proposals might be, when, basically, they had been given the blueprint three or four months before. Why did we have to do this? We had to do it because there was no evidence that the trust itself was going to produce a modernisation plan, and we challenged the organisation about whether it really believed that, with the senior staff that were in post at that time, it would be capable of producing and then delivering a change of direction.

[417] **Denise Idris Jones:** The Assembly Government and Health Commission Wales pushed the trust to produce a strategy in 2004, yet Mr Murray is currently developing a new modernisation plan. Is the trust in a perpetual state of strategic planning? When will it start to deliver against its plans?

[418] That was a bit nasty, was it not? [*Laughter.*]

[419] **Ms Lloyd:** No, it is not in a perpetual state of strategic planning. It produced a strategic plan, but did nothing about it.

[420] **Denise Idris Jones:** Did anybody ask the trust to do anything about the plan?

[421] **Ms Lloyd:** That is why they were constantly asked what they were doing about modernising the service—against their own strategic plan.

[422] **Denise Idris Jones:** So, now we are moving forward.

[423] **Ms Lloyd:** Yes, and it is three years on, we have new evidence, our own overarching strategy, and we have a new management team.

[424] **Denise Idris Jones:** Are you quite confident that you can take this forward and that it will now happen?

[425] **Ms Lloyd:** Yes.

[426] **Leighton Andrews:** I will ask Mrs Lloyd about the trust's financial planning over the longer term—paragraphs 2.62 and 2.63 to start with. Generally, the trust has achieved its historical targets, but it does not seem to have sustained its long-term financial position. Surely that is not the normal approach that you in the Assembly Government would expect.

[427] **Ms Lloyd:** No, it is not.

[428] **Leighton Andrews:** So, why did it happen in this case?

[429] **Ms Lloyd:** I think that the way in which this trust approached its financial stability was to make short-term adjustments. That is the reason why, when we came round to financial and service change plans, we have always looked, over the last 18 months, to the sustainability of its proposals. It was no use—and it is no use now—making short-term adjustments at the end of a year, because you have to start all over again the next year and the problems usually get worse. So, we were concerned about its ability to sustain its financial performance.

2.00 p.m.

[430] During 2005-06, and even at the end of 2004-05, we were difficult about signing off its financial plans, because, frankly—and I told the trust board this—I could not believe its financial projections; they were moving all over the place, every month, by as much as £2

million or £3 million. How could you possibly sign off a financial plan that shifted by that amount every month, over six months? So, it was a major concern, which is why we asked for independence in the financial auditing of the organisation's ability to properly financially plan.

[431] **Leighton Andrews:** Did that not suggest chronic, dysfunctional financial planning?

[432] **Ms Lloyd:** Where financial projections move like that, it indicates that there is a major problem with financial projections.

[433] **Leighton Andrews:** Were there particular problems with capital at your end?

[434] **Ms Lloyd:** Traditionally, it had capital to revenue transfers, as did much of the ambulance service in England, because, at that time, the idea was prevalent that you revenue-leased your capital stock—your ambulances. So, we were used to capital to revenue transfers, and, in many parts of Wales, capital was transferred to revenue for a variety of reasons. However, that is now barred by the Treasury—you are not allowed to do it—which is why we had to start discussing with the ambulance service how much capital it would need to overcome the problem that it was facing in that it had always used its capital to revenue-lease its ambulances.

[435] **Leighton Andrews:** There is another example here, where the trust suddenly rushed out to buy 155 automatic chest compression devices. On the surface, that seems to be, 'Oh, my God, we have this money, we are not going to spend it, therefore we had better do so'.

[436] **Ms Lloyd:** Yes, it does. However, it is more serious than that. I believe that the whole of that episode, which is clearly described in the auditor general's report, was as a consequence of a real concern. It was more than, 'Oh, goodness, we have got to the end of the year—we have to spend this money'; it was more of a concern about what was necessary to improve the service. That was a hasty decision, which was taken without the proper authorisation and process being used, rather than just, 'Let's get rid of this money'.

[437] **Janet Davies:** It was also done without going through the proper processes required by the European Commission.

[438] **Ms Lloyd:** Exactly; it is very serious.

[439] **Jonathan Morgan:** Dr van Dellen and Mr Thayne agreed with each other on one point, which was that the trust board did not understand the nature and seriousness of the problems. Mr Thayne goes slightly further, in that he accuses the regional office, and the Assembly Government, of also not understanding the seriousness of the trust's problems. Do you agree with that?

[440] **Ms Lloyd:** No.

[441] **Jonathan Morgan:** Why?

[442] **Ms Lloyd:** My notes of what I said to the trust board on two occasions clearly mirror—in terms of the performance of the organisation, and the competence of the management—what Mr Thayne and Dr van Dellen had to say about the organisation.

[443] **Jonathan Morgan:** One criticism in the report, particularly under paragraph 2.92, was that, because of the strength of focus on delivering the 60 per cent response rate for category A calls, that in effect tackled the symptoms rather than the causes of poor performance, because it constrained the delivery of broader improvements in services, and the

way that the organisation operates—that is interesting. That seems to be a criticism, not just of the strategic direction of the trust, but perhaps of how the Assembly Government has enforced the need to meet these targets. Therefore, the result of that was a rather negative impact on the service itself. Do you accept that criticism?

[444] **Ms Lloyd:** Targets are important, because these targets for the ambulance service emanated from the NSF and best practice for how you manage cardiac problems. Therefore, to have an ambulance service that did not have a target performance that mirrored best practice in how you manage patients who suddenly have a coronary would have seemed extremely strange to me because that is a clinical patient governance issue. Trusts are established not just to achieve ministerial targets that happen to be set, but to achieve a whole range of patient care services. They know what their roles and responsibilities are and they know what they are responsible for delivering. Some of those will be in target form—we do not have a huge number of targets—but they know that the whole service that they are delivering has to be up to best-practice standard. So, although targets might apply the mind, and they are there to do so, nevertheless, no trust should take its eye off the whole range of patient care outcomes for which it is responsible.

[445] **Janet Davies:** I will just bring Leighton in for a minute, Jonathan, and then I will come back to you.

[446] **Leighton Andrews:** I have a simple request in relation to the previous answer. Could we have a copy of Mrs Lloyd's notes, which she referred to in relation to what she said?

[447] **Ms Lloyd:** If you can read my handwriting—

[448] **Leighton Andrews:** Well, I would be happy for you to transcribe them.

[449] **Ms Lloyd:** You may have them.

[450] **Jonathan Morgan:** You have already confirmed that, when you arrived in 2001, you identified that there were problems and that those problems became more apparent around 2003-04 with the changing nature of the organisation in terms of staff leaving and changing position. Bearing in mind the criticism of the use of the 60 per cent response rate target for category A calls, which, according to the auditor general, may have constrained the delivery of broader service improvements, why was the potentially negative aspect of attempting to meet that target not considered by your department, in the light of the fact that you knew all of the problems that the ambulance service was facing?

[451] **Ms Lloyd:** We did consider it very carefully. You will notice that, around that time, although the overarching target is still 75 per cent and that is where we are going, we started to have an improvement target of 60 per cent. The response rate was creeping up slowly towards the 60 per cent target, which it reached in April 2004—and that is supported by the Operational Research in Health Ltd report. However, we recognised that, despite the additional revenue that had gone into the organisation, the 75 per cent target was such an enormous leap that it was unlikely to be able to reach that easily without an absolutely huge amount of resources going in. That is why the Minister agreed that a figure of 60 per cent should be proposed as an improvement target, so that we could ensure that, because it would take some effort to even get to there and the trust did look as if it was getting there during 2003-04, before it dropped back again, it would be something that was supported by clinical evidence and could be achieved before taking the next step of trying to improve the response rate to 65 per cent and upwards to the 75 per cent that was achieved in England. We took the decision to recommend that to the Minister because of the challenges faced by the organisation.

[452] **Janet Davies:** We are back with you, Denise.

[453] **Denise Idris Jones:** We are going on now to badly designed and managed processes and we are going to look at paragraphs 2.157 and 2.158. Paragraph 2.157 describes,

[454] 'a lack of clarity about the future of sharing joint controls with other emergency services'.

[455] Paragraph 2.158 states that,

[456] 'the Welsh Assembly Government…is currently evaluating the scope for shared controls'

[457] and that the Assembly Government ,

[458] 'and ambulance service may wish to pursue a different policy direction by aligning the ambulance service more closely with other clinical, rather than emergency, services',

[459] for example, NHS Direct and GP out-of-hours services. We have been looking at this in north Wales. I was at the opening of the police headquarters and the control room is very impressive—we might have the joint control room there. What are your views, Mrs Lloyd? I have given my views on this, so now I am asking for your views on the desirability of sharing control rooms with other emergency services. What are the benefits and risks of doing so?

2.10 p.m.

[460] **Ms Lloyd:** There are benefits. You get a more holistic approach to managing the emergency response, particularly if other emergency services are becoming first responders. Therefore, there is a more holistic and rounded approach to what the nature of the emergency might be, there is better cover, there are possible advantages in terms of the promotion of staff through a system, and our control systems certainly need improvement and support, which is clearly outlined in Mr Murray's modernisation plan. The disadvantage might be—and this is what Alan is evaluating for us at present, and this is why we have this extra £75,000 with the rest of the chiefs of the emergency services, to sit down and evaluate together—that we will not be able to join up the patient care system effectively, and enable the ambulance service to help design a different patient care pathway. That is what some of this work that is being done by the joint chiefs is seeking to solve. Whatever happens, there must be better co-ordination of action and communication between the emergency services; having them sitting in the same place might or might not be the answer. Therefore, until I see the evidence of this research, I do not want to nail my colours to the mast, because I have an open mind on it.

[461] **Denise Idris Jones:** But you might be saying that it would be better if we developed a more clinical focus?

[462] **Ms Lloyd:** I certainly believe that that is the direction for the ambulance service, but that does not preclude it working much more closely with the other emergency services.

[463] **Denise Idris Jones:** Do you believe that the two could be reconciled?

[464] **Ms Lloyd:** Yes.

[465] **Jeff Cuthbert:** I refer to paragraphs 2.159 to 2.164, on patient care services. Those paragraphs mention the poor service, and paragraph 2.159 states that five different systems are in operation in Wales, none of which are fit for purpose. Why have patient care services received so little attention when they involve a large number of patient journeys? They will

also affect other NHS providers, and a large number of trust staff.

[466] **Ms Lloyd:** I believe that they were regarded as being not as important as the emergency service by the trust. It is quite inexplicable that no action was taken by an organisation that merged these five areas in 1999; it never got to grips with the different systems that existed, and the fact that one did not talk to the other. Patients do not stay within boundaries when moving from their homes to wherever it is they have to go, so it could never have been an effective way of delivering this service. The trust was also unwise not to pay attention to patient care services, particularly as the money comes from other trusts, and they can—if they are not satisfied with the services—contract elsewhere, as has happened in other parts of the country. Therefore, I believe that it just did not pay attention to this important patient service.

[467] **Jeff Cuthbert:** I have a follow-up question for Mr Griffin on gathering information, and using it effectively. In terms of your regional office, what have you done to gather more information about patient care services, so that you can ensure that this vital service is used to its best?

[468] **Mr Griffin:** We have not done a great deal about the patient transport service in the sense of gathering information, and gathering new information; we use what is available, which is precious little, and that is the problem. It has probably been considered a secondary service within the ambulance service, and has not been afforded the effort that would have been needed to put it on a proper business footing. We struggle therefore to be able to act in a way that is more challenging to the organisation. The relationships between the ambulance service and the LHBs and the trusts, who are the commissioners of that work, as opposed to HCW, is quite an extended relationship in that there are a lot of them—Alan has a lot of customers. The relationship between the provider and the customers has historic links of different natures. Therefore, the task for the future, as Alan said this morning, is to reconcile all of that and put in place new business-like systems that allow them to manage the process in a modern-day environment.

[469] **Ms Lloyd:** We will ensure that indicators for the quality of this service are included in the operational programmes.

[470] **Jocelyn Davies:** The report points out the very serious procurement deficiencies that have existed. So, Mrs Lloyd, as accounting officer for the NHS, how confident are you that the trust has the ability to make effective use of the £132 million capital that it asks for and will be able to purchase 116 new ambulances that will be fit for purpose?

[471] **Ms Lloyd:** The procurement problems in this organisation almost defy belief. I would have thought, given the audit report back in 2002, which pointed to problems of procurement—and we tested it on that—that it would have put in place sufficient arrangements to ensure that procurement was better effected.

[472] Around nine months ago—and this was nothing to do with this organisation—I asked the then director of finance for the Assembly to start to undertake a governance review that would include procurement practices within Wales for us, and he is doing that at the moment. We have devised a framework so that we have a complete grip on governance within all organisations in the NHS in Wales. Part of that will be about effective procurement practice. We have also ensured that this organisation has a new procurement manager, now that Mr Murray has come, because I was deeply concerned about the purchase of the ambulances that were not fit for purpose, how that had come about and the controls that had or had not been evident in the organisation in order to purchase effectively. That has formed the basis of some of the governance review that we are undertaking, or that Mr Richards is undertaking. However, this is extremely serious and I do not expect any chief executive just to throw out

the rulebook as is described here.

[473] **Jocelyn Davies:** You are confident that that ability now exists?

[474] **Ms Lloyd:** We have a very competent procurement manager, but we will watch Mr Murray like hawks to ensure that this is right.

[475] **Jocelyn Davies:** Okay; thank you.

[476] **Leighton Andrews:** In a sense, much of what I wanted to ask has been covered by what Mrs Lloyd said in answer to Jocelyn, so I will ask a couple of minor, quick questions. Is there any way in which the employment of the consultants, specified earlier in paragraphs 2.199 to 2.204, could have come about because you wanted a quick overview of the trust's position after Mr Thayne started?

[477] **Ms Lloyd:** I did want a quick overview; it was very important that we got to the bottom of the problems that needed sorting out in the organisation as well as of what was good about it. I cannot tell you whether or not that caused the problem. That would be for Mr Thayne to answer, but I cannot see that that is the case. He was already experienced; he had brought a fair team with him from Staffordshire. If he needed extra advice—there are ways in which you can get extra advice without blowing the rules and you can get that advice quickly. Mr Murray and Derek and I got advice from England to help when we knew, after Mr Thayne went, that we needed additional support. We did not break the rules and it was very quickly and appropriately achieved.

[478] **Leighton Andrews:** You are undertaking a governance review. Are you confident that the members of the trust will not be engaged in activities like this again?

[479] **Ms Lloyd:** I am sure, yes. I think that the chair and the non-executive members of the trust board have made it very clear that they wish to be engaged.

[480] **Janet Davies:** Jonathan, did you want to ask a quick question on that?

2.20 p.m.

[481] **Jonathan Morgan:** Yes, thank you, Chair. Looking back at what has happened, do you regret appointing Roger Thayne?

[482] **Ms Lloyd:** I did not appoint him; the trust board appointed him.

[483] **Jonathan Morgan:** Do you regret his being appointed?

[484] **Janet Davies:** I do not think that we can expect you to answer that question, frankly.

[485] **Ms Lloyd:** I think that he provided a benchmark, which was helpful.

[486] **Jenny Randerson:** This morning, the auditor general said that, in many ways, the ambulance service had not interacted well enough with the rest of the NHS. The reconfiguration of hospital services will have an impact on the ambulance service, as will the debt strategy and so on. How will you ensure that the secondary care reviews taking place in individual health communities take full account of the implications for the ambulance service, such as, longer travelling times and the consequent need for an increased staffing resource to cover them?

[487] **Ms Lloyd:** I have asked my regional directors to ensure that the project teams that are

established in each of the regions to define the secondary care configuration involve and include ambulance personnel of sufficient status who are able to do the modelling in those project teams. If the ambulance service is to be an integral and leading part of the implementation of developing emergency care services, they have to be there, because they are going to be so important to achieving some of the changes that are necessary.

[488] **Jenny Randerson:** Do you not think that there is a risk that the secondary care reviews might exacerbate the problems of providing an effective ambulance service?

[489] **Ms Lloyd:** I do not think that the secondary care reviews can be taken in isolation from the implementation of DECS; they have to be looked at as a whole system. We are working with Alan, and he knows what those secondary care reviews say; he is part of the implementation team looking at DECS and its consequences, and as part of his role in those teams, he will have to model the effects of change—and, helpfully, change in DECS—on the way in which he manages and designs his ambulance services. If any consequences arise from that, they will be taken into consideration when how we fund and manage the implementation of these two major strategies is considered.

[490] **Irene James:** Paragraphs 3.15 to 3.20 describe problems with long turnaround times at hospital accident-and-emergency departments. Missing that 20-minute target can upset the whole system. There are particular problems at the University Hospital of Wales and the Royal Gwent Hospital, while others are quite successful with this 20-minute turn around. What are the causes of some hospitals' not meeting that turnaround performance time, while others do so successfully?

[491] **Ms Lloyd:** There are several answers to that and, knowing what both those accident-and-emergency departments are like and how they are constructed, I can say that there are slightly different reasons. To take the Royal Gwent Hospital, a huge number of people are brought by ambulance to its accident-and-emergency department, some of whom would be more effectively treated through another course. Hence, we expect to see that change.

[492] The accident-and-emergency department has gone through quite a change over the last 18 months. First, it established the medical assessment unit at the back of it, and that has taken some of the work, so that medical emergencies do not go through the accident-and-emergency department any more. Secondly, just recently, it has established a surgical assessment unit, which although tiny, is also taking emergency referrals that otherwise would have gone through the accident-and-emergency department. Both those things are starting to help, and if you look at the congestion outside the Royal Gwent Hospital, you will see that it is not quite like it used to be. Nevertheless, the ambulance service cannot manage this on its own; it has to get co-operation from the hospitals and the accident-and-emergency services. So, we have to ensure that only those patients who really do need to go to the accident-and-emergency department get there, and we have to ensure that assessment facilities are allocated within hospitals so that we do not have people going through accident-and-emergency departments who should not be there. We also have to ensure that there is a better communication system between hospitals and the ambulance service, so that the ambulance service knows who is waiting to go home, because that is another issue. We have to ensure that the ambulance service is not tied up for ages, waiting for people because there is that breakdown in communication.

[493] Cardiff trust is also going through quite a transformation. It has effective clinical leadership, and it has its new medical assessment unit, so some of the patients going through the accident-and-emergency department are being diverted. It is an extraordinarily jumbled accident-and-emergency department and it is trying to stream patients and sort that out, and some of that has been effective. It is still not meeting its targets, but it is making steady progress and improvement. I think that there is much more of a synergy now between the

ambulance service and those hospitals particularly. Swansea is no better either. So, it is the big three hospitals along the south M4 corridor that are facing the problem. However, there is no point in the trusts and the ambulance trusts not working together to solve some of these and we are going for a turnaround time of 15 minutes, not 20 minutes.

[494] **Irene James:** You have answered part of what was going to be my next question, so I will throw another one at you. Has the change in the general practitioner contract and the out-of-hours arrangements had an impact on the ambulance service? [*Interruption*.] I am being silenced, so I will be quiet.

[495] **Janet Davies:** If you want to be here until 4 p.m. it is fine by me, but I will not be here.

[496] **Leighton Andrews:** I have questions relating to 'Agenda for Change' and the strategic change and efficiency plan, mentioned in paragraph 3.58 onwards. When we last talked about 'Agenda for Change', I remember some interesting comments being made about the expensive cost of bank holidays. Why has 'Agenda for Change' been a disaster for the ambulance trust?

[497] **Ms Lloyd:** I do not think that I would call it a disaster. The full implementation of the principles of 'Agenda for Change' gives the ambulance trust and its staff some opportunities for the future. If we are really going for using the skills of the staff that we have in different ways for the future, 'Agenda for Change' would provide a benefit. I think that we were disappointed that the trust was so slow in producing its benefits-realisation programme. I have asked Alan to look again at how that moulds with his modernisation plan. However, it has the same shortfall for the same reasons as everyone else. It has been slightly slower at assimilating. Up to around 73 per cent of its staff have now been assimilated and it has to finish that by at least March 2007. Therefore, I think that it has faced the same difficulties as everyone else. One of its problems was the way that it interpreted 'Agenda for Change' and the issue of the meal breaks. I think that it made the problem worse for itself.

[498] **Leighton Andrews:** The report states that the current policy does not conform to the national agreement.

[499] **Ms Lloyd:** Yes. It broke a national agreement and it has to un-break it.

[500] **Leighton Andrews:** What will that entail?

[501] **Ms Lloyd:** Perhaps Mr Murray can tell us that.

[502] **Mr Murray:** We met the National Joint Consultative Committee last week—all of the union representatives in the trust—and we have agreed that, given that the unions balloted their members on a move to exclusive meal breaks on 31 March and we are now saying that we need to move quicker, they are balloting them again on moving on 1 February. We have seen the ballots that have gone out and they are extremely positive. They are exhorting the staff to agree to move on 1 February to exclusive meal breaks and to new shift rotas.

[503] **Leighton Andrews:** Mrs Lloyd, are you satisfied that the national 'Agenda for Change' agreement was as well suited to ambulance services as it was to acute trusts?

[504] **Ms Lloyd:** If we are regarding the ambulance service as a clinical service now, I think that there is scope for it within 'Agenda for Change'. However, given that its benefits-realisation package has to be reviewed by Mr Murray, I think that I would hold my final decision on that until I have seen what he will come up with. It is slightly different, but 'Agenda for Change' covers a vast variety of groups of different types of staff.

2.30 p.m.

[505] **Leighton Andrews:** You mentioned the work that you have been doing on the SCEP. Has that concluded?

[506] **Ms Lloyd:** Yes, the SCEP has been agreed.

[507] **Leighton Andrews:** Okay. How are you doing in terms of addressing the financial position within the SCEP? Seventy-five per cent of the trusts' costs are obviously staff costs, so you had quite challenging savings targets within that. Are they, realistically, going to be achieved?

[508] **Ms Lloyd:** There is confidence among those who agreed the SCEP and the ambulance trust that they will be agreed, and the SCEP has been firmly set against the modernisation plan, because the two things always had to go together. So, we have confidence that the savings will be achieved. I am sure that Mr Murray would not have dreamt of signing up to it if he did not have that confidence.

[509] **Leighton Andrews:** Do we expect job losses as a result of the savings that are required?

[510] **Ms Lloyd:** No.

[511] **Leighton Andrews:** Okay. Why has it taken so long to agree the SCEP?

[512] **Ms Lloyd:** There was a very difficult set of negotiations, and, again, there was a problem: the financial forecast. It was very unclear at the beginning of the year what sort of challenge the ambulance service was facing. We have a new, interim director—

[513] **Mr Griffin:** There have been a number of chief executives.

[514] **Ms Lloyd:** I know that we have had a number of chief executives, but we have also had a change of finance director just latterly. So, it was very difficult to know what the scale of its problems would be, but that has been resolved. Without the modernisation plan prepared by the substantive chief executive, and a reinforcing of what the financial problems were by an interim director of finance, it was difficult for anyone to have total confidence that they knew the scale of the problem that was being faced, and what steps could be taken to overcome those problems.

[515] **Leighton Andrews:** Finally, is the ambulance radio replacement re-procurement project on track?

[516] **Ms Lloyd:** We agreed on that at the capital investment board, which I chair, on Tuesday, and the contract will be signed in January.

[517] **Janet Davies:** Thank you, Leighton. I thank you, Mrs Lloyd, and your colleagues for your very helpful evidence this afternoon. I am sorry that this session has been a bit abbreviated, although we did receive very full evidence from Mr Murray and his colleague this morning, which was very good. As you know, this has been an unusual report in that it was commissioned by Plenary, but it is still an audit report. I hope that our evidence will go on to health and policy early next year, and help in its scrutiny of what has been happening. I would also like to thank the committee staff who have had to do extra running around on this one, and I particularly thank the Wales Audit Office and the auditor general, who have put in very long hours to get this report done in a remarkably short space of time. As you know, Mrs

Lloyd, you will get a verbatim transcript and if you think that there is anything inaccurate in it, it will come back to be discussed. I also thank the committee members for putting in extra time, if I can put it like that.

2.34 p.m.

Ymatebion Llywodraeth y Cynulliad i Adroddiadau'r Pwyllgor Archwilio a Chyngor gan Archwilydd Cyffredinol Cymru
The Welsh Assembly Government Responses to the Audit Committee Reports and Advice from the Auditor General for Wales

[518] **Janet Davies:** This item is on the Assembly Government response to the Audit Committee reports on NHS energy management in Wales and progress in further education sector estates management in procurement. Jeremy, do you have any comments to make?

[519] **Mr Colman:** Hardly any at all, Chair. On the first report on energy management, the Assembly Government has accepted all the recommendations apart from one, which has been partially accepted. It has been partially accepted because it thinks that it can do better by varying its proposal, and, having looked at it, we agree. So, its suggested response is, in our view, even better than the committee's recommendations—it is amazing that that should be possible. We will, as ever, keep a close eye on how this proceeds, reporting back, if needs be.

[520] The second one is completely straightforward, because the Welsh Assembly Government's response is very positive on the subject of estates management and procurement in further education. We will monitor it, as ever, but there are no issues that I need to bring to the committee's attention.

[521] **Janet Davies:** Is everyone happy to accept those responses? Everyone seems to be happy, so we will move on.

2.36 p.m.

Cofnodion y Cyfarfod Diwethaf
Minutes of the Previous Meeting

[522] **Janet Davies:** Is everyone happy with the minutes? I see that everyone is.

Cadarnhawyd cofnodion y cyfarfod blaenorol.
The minutes of the previous meeting were ratified.

Cynnig Trefniadol
Procedural Motion

[523] **Janet Davies:** At this point, we need to bring the public part of the meeting to an end. I ask a Member to propose the appropriate motion.

[524] **Leighton Andrews:** I propose that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 8.24(vi).

[525] **Janet Davies:** I see that the committee is in agreement.

Derbyniwyd y cynnig.

Motion carried.

Daeth rhan gyhoeddus y cyfarfod i ben am 2.36 p.m.
The public part of the meeting ended at 2.36 p.m.