Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Archwilio
The Audit Committee

Dydd Iau, 17 Gorffennaf 2008
Thursday, 17 July 2008

Cynnwys
Contents

Aelodau Cynulliad yn bresennol
Assembly Members in attendance

Lorraine Barrett	Llafur Labour
Eleanor Burnham	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Chris Franks	Plaid Cymru The Party of Wales
Janice Gregory	Llafur Labour
Lesley Griffiths	Llafur Labour
Irene James	Llafur Labour
Bethan Jenkins	Plaid Cymru The Party of Wales
David Melding	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives

Eraill yn bresennol
Others in attendance

Jeremy Colman	Archwilydd Cyffredinol Cymru Auditor General for Wales
Paul Dimblebee	Swyddfa Archwilio Cymru Wales Audit Office
Ian Gibson	Dirprwy bennaeth Uned Llywodraethu Corfforaethol, Llywodraeth Cynulliad Cymru Deputy Head of Corporate Governance Unit, Welsh Assembly Government
Ann Lloyd	Pennaeth, Adran Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cynulliad Cymru Head, Department of Health and Social Services, Welsh Assembly Government
Alan Murray	Prif Swyddog Gweithredol, Ymddiriedolaeth GIG Gwasanaeth Ambiwlans Cymru Chief Executive Officer, Welsh Ambulance Services NHS Trust
Rob Powell	Swyddfa Archwilio Cymru Wales Audit Office
Huw Rees	Swyddfa Archwilio Cymru Wales Audit Office
Tim Woodhead	Cyfarwyddwr Cyllid, Ymddiriedolaeth GIG Gwasanaeth Ambiwlans Cymru Director of Finance, Welsh Ambulance Services NHS Trust

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

John Grimes	Clerc Clerk

Abigail Phillips — Dirprwy Glerc
Deputy Clerk

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

Ymddiheuriadau a Dirprwyon
Apologies and Substitutions

[1] **David Melding:** Good morning and welcome to this meeting of the Audit Committee. I will start with the usual housekeeping announcements. These proceedings will be conducted in both Welsh and English; when Welsh is spoken, a simultaneous translation is available on channel 1 of the headset. If you are hard of hearing, you can get an amplification of proceedings on channel 0. Please switch off all electronic equipment completely, because even if it is left in silent mode, it will interfere with our recording equipment. We do not anticipate a fire drill this morning, so if you hear the alarm, please treat it with all seriousness—the ushers will give you instructions on how to leave the building safely.

[2] I have received an apology from Huw Lewis, and I am sure that all committee Members will want to join me in congratulating Lynne Neagle and Huw on the birth of their second son.

9.32 a.m.

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

[3] **David Melding:** We now move on to the main substantive item on the agenda, which is our discussion on the findings of the Auditor General for Wales's report, 'Follow up review: Ambulance Services in Wales'. As the name suggests, the report follows up an earlier report from December 2006 and addresses the serious concerns raised in our own report of March 2007. The current report has been delivered as part of the Wales Audit Office's contribution to the wider review of Welsh ambulance services and the trust. It was called for by the Minister for Health and Social Services, and it was led by the trust's chairman, Stuart Fletcher. The Minister reported the findings of the wider review to Plenary on 24 June. In this session, we will examine whether the trust is now well placed to deliver the improvements required by the auditor general's original report and by the trust's modernisation plan. Members should be mindful of the seriousness of the previous Audit Committee's concerns and the time that it might take to address them.

[4] I welcome the witnesses, and I ask them to state their names and positions for the record.

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

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

[7] **Ms Lloyd:** I am Ann Lloyd, head of Health and Social Services in the Welsh Assembly Government.

[8] **David Melding:** Good morning to you all. We will now work through the set of questions that we wish to raise with you. I will start by putting a general question to you, Mr

Murray; we will of course be drilling down to detail during the course of this morning's evidence session. In general, are you satisfied with the extent of the improvement and the progress that has been made by the trust since December 2006?

[9] **Mr Murray:** I would generally agree with the summary in the auditor general's report, which says that:

[10] 'Overall, although we found significant evidence of positive improvements within the Trust… some difficult problems remain. We judge that these problems are only to be expected at this stage of a process of transformational change'.

[11] I have been with the organisation for slightly less than two years. We started our modernisation plan in January 2007, so it is a relatively young plan. We have been fairly extensively externally reviewed in that period, and one of our external reviewers described our task as not so much turning the ship around as dragging it up from the bottom of the Atlantic—that is pretty much where we started. Therefore, we took an organisation that was in a parlous condition, financially, operationally and clinically, and that already had low morale, and, on top of that, we placed a fairly heavy burden of modernisation upon it.

[12] So, while I would not claim that there were not things that we could have done better—I would be happy to talk to the committee about the things that I would do differently, or earlier, if I were starting again—we would agree with the auditor general, and other participants in Stuart Fletcher's external review, that doing better and feeling worse is probably where we would have expected the organisation to be at this stage.

[13] **David Melding:** Thank you for that concise opening response. Still at the general level, I have a question for Ann Lloyd, and Mr Murray, again. Looking at the performance since December 2006, what have been the greatest achievements, and are there any disappointments, even given where you would expect to be at the moment?

[14] **Ms Lloyd:** It is obvious that the systems and the processes in this organisation have improved, as the auditor general clearly outlines in his report. The performance management of the organisation has improved, the response times have improved—although there is some way to go in some parts of the country—and the equipment has improved. However, several issues remain. From my point of view, the great ones are: how much will it cost to ensure that there is excellent performance across Wales? To what extent must the Welsh Assembly Government press forward with our delivering emergency care processes, to ensure that appropriate care pathways are available to people throughout Wales? Those care pathways will be served by the ambulance service. Within the trust itself, we need to address the concerns that are clear in this report, and about which we know very well, including those concerns coming forward from the staff, in order to engage with them more effectively for the future.

[15] So, enormous strides have been taken by this organisation, which is clear in the chairman's report, but there are still serious issues that need to be addressed, which we are going to have to address together.

[16] **Mr Murray:** I would want to start with performance. If you look at the auditor general's report, you will see that, from early 2004 through to February 2007, at no time did the trust achieve its 60th percentile eight-minute standard. At that time, the mandate was to achieve an average of 60 per cent across Wales monthly, and to achieve continuous improvement in each local health board area. We achieved both of those, and they are both evidenced in the auditor general's report. In only two months out of the 12 months in 2007-08 did we fail to achieve the 60th percentile standard—I would be happy to go into why that was; it was certainly a staff-related issue. However, we achieved 62.3 per cent for the whole

year. We achieved the 60th percentile in all three regions of Wales, and, from a start point of four compliant local health board areas, we took our compliance up as high as 16 in some of those months. I am sure that we will explore the reasons for the decline to 11 at a later stage.

9.40 a.m.

[17] I am also particularly happy with the significant strides that we have made in clinical governance. We have appointed a full-time clinical director at executive level—a board member. That clinical director has completely turned around our clinical governance. We have new procedures for things like scope of practice, the transfer of care and the discharge of duty of care, which we did not have before. Staff are much clearer about what they can and cannot do, and they are much clearer about how to do things, like the discharge of the duty of care. As Dr Nick Looker's report has demonstrated, our infection control has improved significantly. To a large extent, that is also one of the benefits of the infrastructure investments that have been made by the Welsh Assembly Government. The new ambulances are designed to be easy to keep clean. I would certainly cite that as being one of the benefits coming from infrastructure investment.

[18] We are also making huge strides with our control agenda, with the development of Vantage Point House, which is a joint ambulance service, NHS Direct, and out-of-hours centre, which we are developing in Cwmbran, and which should be fully operational by 1 October. Those are some of the things that I believe we have done particularly well.

[19] **David Melding:** Are you going to mention the biggest disappointment? Will you be brave enough? It is likely to come up during the course of the evidence session, but now is your chance to come clean.

[20] **Mr Murray:** There are two areas that I would like to touch upon. The first is top-level leadership. Broadly, we have introduced a much better level of executive leadership than was previously the case, but there is one big hole in the team, namely human resources. We appointed a HR director, who was due to take up the post in September; on the very day that he was due to take up the post, he contacted me to tell me that, for family reasons, he would not be able to do so. We then negotiated an agreement with Gwent Healthcare NHS Trust for its deputy director to come in to act as our director of HR; because of movements at the top of Gwent, she was recalled. So, we lost that benefit as well. As part of our capacity agreement with the National Leadership and Innovation Agency for Healthcare, we have negotiated a replacement until we can appoint a full-time director. Our HR agenda, including things like the ability to implement the clinical team leadership and the knowledge and skills framework appraisal, has gone distinctly askew as a result. In the same vein, the delay in getting an appointment for a regional director for south-east Wales has been particularly unfortunate. However, given the quality of the candidate that we now have in post, I would almost, but not quite, say that it was worth waiting. Those are the two major disappointments as far as leadership is concerned.

[21] The other sting in the tail was that a number of people told me, including Assembly Members—members of Assembly committees—that extended hospital delays would be a major problem. I do not think that I gave enough credence to that at the time, because what has happened since has been almost entirely outside my experience.

[22] **David Melding:** Thank you. We will move on.

[23] **Darren Millar:** Thank you for your opening remarks. Ann, in paragraph 4 of the summary that Alan referred to in his opening remarks, there is an expectation of improvement. Very often, the expectations do not match the timetable that you might have within your organisation. Expectations for change are quite high. Do you think that the pace

of change has matched your expectations within the ambulance service, or would you expect to be where we are in terms of the improvements that have been made?

[24] **Ms Lloyd:** Expectations in terms of performance have been at the pace that I would have expected, given the investment that has been put in. We will always be looking, as part of the business cases, to see what real, tangible outcome improvements will be available. We were not unclear about the challenge that the organisation would face in trying to meet the performance targets. It met the overall targets. In some places, it could not meet them for a variety of reasons, which we understand.

[25] That is why we continue to invest in its infrastructure for the next two to three years, to ensure that the problems that it faces, particularly in terms of logistics, can be addressed more satisfactorily. You will know that the performance targets that it faces this year are much harder than last year—in fact, they are very hard in some parts of the country. We are continuing to discuss that issue. It will also have a financial situation that is not enviable. However, it has met Government finance requirements so far, and we are continuing to discuss this—in fact, the finance director had a meeting two days ago to discuss progress so far. Progress has been good, but it is facing challenges, to which I am sure that we will come back later.

[26] Alan is right about the clinical governance issues, which were a major concern. My concern, and he has mentioned this, is about the failure to enthuse the staff to take up clinical leadership roles at a line-manager level, because they will be crucial for patient care for the future. In providing him with human resources advice and guidance from NLIAH—a lot of support from NLIAH—I feel that that can be taken forward.

[27] We are partly to blame, because I nicked the Gwent HR director to become my HR director, so there was a rebound effect. That is why we feel duty-bound to provide extra support to the ambulance service. My new HR director is also convinced that the leadership that is now available in HR will enable things to happen. It has been a real problem for the ambulance service that it has had no sustainable leadership in south-east Wales, because that is the area with the major problems, where there is discontent and where major HR problems continue to exist. Therefore, south-east Wales has not made the progress that we would have expected, but we know why that has been so. It is important to get good leadership into south-east Wales, and also to be able to spend more time engaging with the staff. I am sure that we will come to the staff survey later, too, but there are very clear pointers there about a lack of effective line management and whole leadership in the area. Good progress has been made, and we are clear about the problems that it is still facing.

[28] **Darren Millar:** Alan, the Minister made a statement in the Assembly in June on the significant improvements that she wanted to see in the next six months. What sort of goals and milestones have you set out for yourself over that period?

[29] **Mr Murray:** We are targeting higher, top-line performance across Wales and in the regions. This month, we are slightly above 64 per cent across Wales. We have had some very good days but we have also had some disappointing days. The relationship between our performance in south-east Wales and hospital delays is absolutely fundamental to that. Where we have a larger number of hospital delays, we have a bad day's performance, particularly in Gwent, Cardiff and the Vale of Glamorgan. So, we are keen to continue, and the auditor general has been kind in terms of saying how much work we have done with the hospital trusts to try to remove that issue. The advent of the Minister's 15-minute target for the handover and transfer of care to the accident and emergency department and the technology that we are due to put in in August to measure handover time, rather than ambulance turnaround time—which, as you will understand, are two different things—give us a better chance of clearing that issue out of the way. That will help us with our headline performance.

[30] In north Wales, we are already above 70 per cent. In central and west Wales, our variability is decreasing, and we have every expectation that they will be over 65 per cent soon. If we can resolve some issues in particular focal points in south-east Wales, I am certain that we can be well over 65 per cent in south-east Wales too. Coupled with that are some new measures that we are introducing, and the technology for which we have business cases currently in place, such as automatic vehicle location and mobile data, which will allow us to identify instantly the closest resource for every emergency, which will hone our deployment plans considerably.

9.50 a.m.

[31] As far as the equity issue is concerned, for this month, for example, we are already in excess of 60 per cent in Carmarthenshire, which has been a particularly difficult area in the past. Bridgend is currently over 60 per cent and we are approaching 60 per cent in the Vale of Glamorgan, so if we can relate that day-to-day variability to more than hospital delays—because there are other issues that we have to put our hands up to, such as ensuring that we have the right number of crews in place on every shift—we can certainly hit the 65th percentile that we have been mandated to hit and we can increase to perhaps 17 the number of local health board areas, out of the 22, that we will then be compliant in.

[32] **Darren Millar:** Given that the auditor general referred specifically to people's expectations, what are you doing to communicate to the public what you expect to see so that they can be aware of the improvements that they are likely to see for the next six months and for the reminder of the modernisation plan, recognising that we are only 18 months into it?

[33] **Mr Murray:** Recently we have set up what we initially described as public and patient involvement groups—we are now calling those partnership groups—so that we can engage the local public with what we are doing and so that we can get its views on how we should be moving forward. Public and patient involvement has not been one of the trust's strong points in the past. Bringing NHS Direct on board brought with it a certain expertise in PPI, which we are now using to set up these groups. We have not been doing as much work with the press and the media as we have hitherto. An issue there is not so much what you say, but how you report it and we have always been careful to say that we are making good progress, but it is just a start. Frequently that is not how it has appeared, so we have been a little more cautious in the last year or so in our use of the press and the media.

[34] **Darren Millar:** You do not want to raise expectations too high.

[35] **Mr Murray:** Yes. For example, what we said is different from what was reported. We said that we have made good initial progress, but that there was a lot more to do. However, what was reported was, 'Mr Fix-It fixes the Welsh Ambulance Service', so we have learned to be much more cautious about that, because that can create false expectations.

[36] **Darren Millar:** There have been some significant performance improvements, particularly in terms of GP urgent calls and life-threatening emergency calls or category A calls. You mentioned the HR appointment difficulty that you have. When you last appeared before the committee, you seemed to indicate that there were enough 'people in green suits' to deliver the 75 per cent standard achieved in England. Is that still your view? How far is the trust from hitting that target of 75 per cent of patients being reached in eight minutes?

[37] **Mr Murray:** We have been moving in a linear way from 60 to 65 per cent to 70 to 75 per cent. We have bid for automatic vehicle location and mobile data technology. We do not officially have a category C in Wales, that is, 'neither life-threatening nor serious'; we only have categories A and B, that is, life-threatening, and then everything else. That gives us

around 57,000 additional emergencies that we have to respond to within 14, 18 or 21 minutes. We have not asked for the reinstatement of category C in Wales. Instead, we informally categorise our patients as A, B or C and we are starting to take out of the workload the calls that come under category C via nurse triage, for example. So, we are reducing that workload and improving specificity on category A so that we are not sending people out pell-mell through the crowded streets of Wales to respond to patients who do not need that level of response. All those things will take us on a trajectory towards the 75 per cent target.

[38] However, a different choice has been made by the Welsh Assembly Government, and, frankly, it is one that the trust supports, namely that there should be much more focus on equity. In England, the focus has been on getting faster and faster at headline level, but, in England, trusts measure but do not report their performance below aggregate level. Therefore, a large regional ambulance trust in England would be reporting on its performance across the whole footprint of the service. We would tend to agree with the view here that the focus on equity is more important. However, it takes resources, and I do not believe that we could have predicted that when I made that statement. Therefore, had we been going in that linear progression, the answer would still be probably 'yes', but, as we are not, the answer has changed.

[39] **Darren Millar:** You have outlined several systematic and technological changes that you intend to introduce to speed up the service. I wish to drill down into this issue. Do you feel that there are sufficient numbers of ambulance personnel on the ground to deliver this 75 per cent target?

[40] **Mr Murray:** No, what I am saying is that the answer has changed, because it will require a significant resource to deliver the equity standard. To give you an example, in Ceredigion, which is our lowest activity area, on the lowest activity month of the year, we can only afford to miss two category A calls a day on average if we are to meet the equity standard. Therefore, I cannot over-emphasise how difficult, and potentially expensive in resources, meeting those equity standards is. Having said that, we support them, and we feel that they are the right way to go. However, they have taken us in a different direction than that linear progression from well under 60 per cent to 75 per cent. Therefore, for that reason mainly, the answer has changed.

[41] **David Melding:** Do you need more men in green suits, or is it about other resources? I could not quite follow that.

[42] **Mr Murray:** It is going to divert the people in green suits from that linear progression to 75 per cent. However, the view that we have taken is that, in order to meet those standards, we still do not need more emergency medical services crews. What we need is investment in control staffing and technology. We need investment to ensure that our nurse triage can continue substantively 16 hours a day, seven days a week, in three centres. We need investment in high-dependency crews, to take the work off the EMS crews, and, particularly, in the rural areas, the long-distance transfers, and we also need some investment in advanced practitioners on the ground, to resolve conditions at home, and to avoid admission to hospital.

[43] **David Melding:** That is fine; we will follow some of those points up—I just wanted to clarify that specific point. Thank you for that. Eleanor Burnham has the next questions.

[44] **Eleanor Burnham:** I am glad that I am not running the ambulance service. [*Laughter*.] I am sure that the expectation has been high, because of the history. Notwithstanding what you have just tried to explain, which was interesting, it ties into this nasty targeting question. Figure 4 on page 12 shows that a minority of patients wait over 50 minutes for an ambulance to back up an initial response. My question is about the effective use of rapid-response vehicles, but feel free to illuminate further. Do you believe that these are simply a mechanism

to stop the clock, rather than treating the patient?

[45] **Mr Murray:** I am grateful for that question. I have been in and around the ambulance service since 1974. I left the NHS for nine years to run my own business, and I did not come back to hit clock targets. I came back because I believed that there was an opportunity in Wales, because of a particularly friendly policy framework, including the delivering emergency care services strategy, to do something different and much more worthwhile. However, there are two things that we have to do, in broad terms. First, we have to provide a clinically effective response when people are having life-threatening and serious emergencies. Secondly, we have to provide more appropriate options for people who dial 999 or 08454647 and do not require an emergency ambulance. These people are not abusing the ambulance service—they are just confused about how to access the care that they need.

10 a.m.

[46] On clinically effective responses, back in the 1980s and 1990s, Eisenberg and his colleagues in Seattle did some studies that demonstrated that the optimum response time to a cardiac arrest was four minutes to cardiopulmonary resuscitation, and 10 minutes to advanced life support. The eight minute standard was a response to the latter, because there are a couple of minutes in the pipeline before you start the clock. Subsequent work from Heartstart Scotland, which I mentioned at the last Audit Committee meeting that I attended, also demonstrated a four-minute relationship to defibrillation when someone is in cardiac arrest.

[47] Rapid response vehicles are the best way of getting that early 10-minute advanced life support response to the patient. We even measure our four-minute response to cardiac arrest and chest pain, and it has increased from 21 per cent to nearly 26 per cent, mainly as a result of rapid response vehicles. A rapid response paramedic can do almost everything that a paramedic on a double-crewed ambulance can do. They cannot lift the patient, and there are some minor contraindications with thrombolysis. If there is rough ground to carry the patient over, it is better to wait until they are in the ambulance. However, apart from that, they can pretty much do everything. There are two reasons why they are faster than an ambulance. First, their job cycle is shorter because they do not tend to admit people to hospital, so the cycle is typically half of that of an emergency ambulance, which means that they rotate back into the deployment plan twice as fast. Secondly, they are smaller and more manoeuvrable than the ambulance, so therefore they can travel faster through traffic. About a third of our category A hits are currently made by rapid response vehicles; this is not to do with stopping the clock.

[48] If there is one message that I would want to get across to my clinical colleagues, it is that there is a deep mythology in the health service that targets are bad things, and that you can become target-focused and not patient-focused. Focusing on this target is a patient-focused issue, because brain cells die at a known rate. If we can find a way of keeping them alive for an hour, we can take our time about getting there—we can get rid of the Mercedes and buy some milk floats, perhaps. However, until then, it will be vital that we get there fast. In non-life-threatening emergencies where the patient is seriously injured, seriously ill or in a public place, there is a reasonable expectation that we will get there fast, as my postbag tells me, as if I did not already know.

[49] As for follow-up ambulance response times, one of the things that we have been targeting stringently over the past year and a half is the 14, 18 and 21-minute targets, which can only be met by a double-crewed emergency ambulance. You will see from the auditor general's report the types of improvements that we have made against that standard as a result. In 2006-07, 11.2 per cent of ambulances took more than 21 minutes to arrive, and the figure is now 7.6 per cent; 4.2 per cent took over 30 minutes, and the figure is now 2.7 per cent, but it has been as low as 2 per cent. The figure for ambulances that took over 60 minutes

to arrive is 0.4 per cent, and during the period before the hospital delays started to really affect us, that figure went down from 0.4 per cent to 0.2 per cent.

[50] Why is there currently a lot of publicity about the length of time that paramedics and rapid response vehicles have to wait for follow-up ambulances in that small but important number of cases? It is because they are there. Before we started, we did not know, because there was no-one with the patient, but now you get a rapid response paramedic with the patient. It is because they are there and because they sometimes wait for an inordinate length of time because the ambulances are not available on the street, we hear a lot more about it. It is a problem, and I am not minimising it, but it is something that we have focused upon and which we have improved.

[51] **Eleanor Burnham:** I think that you have answered the second bit of the question.

[52] Ann, do you see the rapid response vehicles as an important part of delivering unscheduled care services?

[53] **Ms Lloyd:** Yes, I do. There has been a definite improvement. Alan has explained very well the role that is played by rapid response vehicles. However, it is a far more complicated problem. Alan has referred to the elements that are causing delays within the system. It takes more than just the ambulance service to get appropriate emergency response to care on the street when it is required. Every bit of our system has to play its part. That is why the implementation of the delivering emergency care services system is so vitally important. Addressing the problems that are causing delays for other services, like the ambulance service, such as turnaround times in hospitals, must be addressed. Hence, the additional targets to try to put pressure where there is a major blockage within the system. The Minister announced in June the early implementers for DECS. The rolling out of that system and the collection of managerial and clinical effort around delivering really good emergency care services effectively is one of her key priorities over the next 12 to 18 months.

[54] **Eleanor Burnham:** There are regional variations, as shown in paragraph 1.17 to 1.25, which talk about Monmouthshire and Powys. In your view, how can the new locality targets achieve equity, given the rurality of some of these areas? Do you believe that the locality targets can be met within the current configuration? Could it result in resources being taken from high performing or busy areas just to meet these other targets? Perhaps you would both like to answer.

[55] **Ms Lloyd:** I do not think that it is as simple as that. If we expect the ambulance service, on its own, to deliver these, then we will not succeed as well as we might. We have to look at the plethora of alternatives, particularly clinical alternatives that might cream off and provide effective intervention for people who might normally have called an ambulance. That means that we have to look at the way in which we are using our co-responders and our first responders. One of the key themes within the Minister's rural strategy is ensuring that more advanced care is available within very sparsely populated areas than has been available in the past and the sort of practitioner that needs to be trained and developed to deliver advanced care within rural communities.

[56] **Eleanor Burnham:** Who do you suggest should deliver that?

[57] **Ms Lloyd:** It could be GPs trained to a higher standard. The postgraduate dean is looking at that for me at the moment. It could be advanced nurse practitioners or other practitioners who are trained and accredited to undertake different roles for the future. When the Minister's rural strategy is published in the next six or seven months, those are the sort of things that it will have been looking at.

[58] It is interesting to see that Monmouthshire is so fragile, with only 50 per cent of category As. Arrangements have to be made, because a lot of Monmouthshire is on the border, and, half the time, it is the Gloucestershire Ambulance Service NHS Trust that provides a back-up service. So, we have to have a whole picture of the alternatives to help to do it. Powys is the greatest problem of all, and it is there that we are trying to address what the local health board is doing in terms of improving care to provide adequate care for people, and what additional care pathways can be developed through the rural strategy. We cannot achieve those equity targets by looking at what the ambulance service alone can achieve. We expect really good performance from the service, and it will not be left off the hook—it will have to achieve the absolute maximum—but the other partners have to assist.

[59] **Eleanor Burnham:** I will now turn to Alan. How are you seeking to address this in the meantime, particularly in Powys?

10.10 a.m.

[60] **Mr Murray:** I welcome that question and I will specifically mention Powys. In general terms, however, we are now resourced in our unscheduled care directorate, which is part of the clinical directorate, to participate actively in every community's DECS effort and we are now doing that. We are now part of every community's DECS delivery team. We have gone at risk—we cannot sustain it at the moment, but we will be doing it for as long as we can possibly afford it—to put nurses into two of our control centres. They are triaging both category C and some category B calls. We are not in a position to report on the effect that that has had on actual numbers at the moment, because we have just started, last month, putting in stop codes for category C calls. Before we started doing that, something like 194 or more category C calls a month had the ambulance at the door before the nurse had finished the triage, and that is only working a small number of hours per day. Putting the stop codes in will allow us to do a proper evaluation of that, but we are managing a number of patients into different pathways, including primary care.

[61] We are active participants in the development of the north Wales falls pathway. We are looking forward to implementing that in the coming weeks. A very large percentage of our 999 calls are for falls and most of our over-60s emergencies—I am 56 next week, so I have to be very careful what I say—are as a result of falls. I will just have to be careful around the house.

[62] We have a paramedic development framework to train every paramedic in the service. It is a short two-day course to improve their assessment skills, so that they are more proficient and confident about deciding when not to take people to hospital. We are focusing on two particular areas: the resolution of hypoglycaemia and the resolution of epileptic convulsions. I was with one of my rapid-response paramedics in Cardiff the other week and I watched him do a resolution of hypoglycaemia for a lady who was very unwell. He turned the ambulance crew back at the top of the stairs. She agreed with him that she did not need to go to hospital and he left the patient care record written out in the medical model, in a way that would be easily readable by a GP. He left a copy of it and said, 'If you are unwell again, later on, please ring us and give this to the paramedic. But when'—not if—'you see your GP in the morning, take this with you, along with this 12-lead ECG, and the GP will see right away what I found and what I did'. That is an example of the kinds of things that rapid-response paramedics with that additional training can do.

[63] The development framework also includes a 14-week foundation programme to get some foundation-level practitioners on the street. We do not believe that we need 14 weeks for all of them, because we have graduate paramedics who have done clinical degrees and they only need a four or five-week conversion course. We also plan to implement a bachelor of sciences degree for fully fledged practitioners, so that we will be playing our part in the

rural strategy.

[64] As far as Powys is concerned, Judith Paget had not even taken up post when she and I were in discussion, because her predecessor and I had agreed that we would set up an unscheduled care partnership board in Powys. We agreed that the only way in which we could both meet our patient care targets would be if we worked in partnership. That board was set up and it has met several times now. The medical director of Powys is taking a paper to the next local health board meeting about supporting the local health board providing funding for the initial training of some practitioners, so that we can get those people on the ground. We have already had very encouraging discussions with the out-of-hours provider in Powys. All of the provider's GPs carry defibrillators in their cars and, basically, all they lack is communication with us. Even army medics are keen to get involved in the partnership. This will not happen overnight and, again, we have to be very careful to manage expectations. With 129,000 people spread over 25 per cent of the surface area of Wales, and spread particularly evenly, it is going to take a lot of very concentrated effort, but the people of Powys need to know that we are not ignoring them because they are simply too difficult. That is far from the case.

[65] **Eleanor Burnham:** That is reassuring, because the rest of my question is about the targets acting as a disincentive to developing new models of service in rural areas. Are these unaffordable? Are we talking about vast amounts of money, or are you just talking about working a bit smarter? You have already talked about using people who have better skills, perhaps, and about managing and training.

[66] **Mr Murray:** Are we talking about the equity targets?

[67] **Eleanor Burnham:** Yes. I am talking generally about rural areas, and how you will achieve this.

[68] **Mr Murray:** The trust has estimated the need for a degree of investment to get where we need to be. We are treating Powys as a separate issue, because it requires this kind of sustained systemic effort. That will also be necessary, to a degree, in other parts of west Wales, such as Ceredigion, which is also reasonably sparsely populated.

[69] **Eleanor Burnham:** That may also be the case in south-west Gwynedd, which is in a difficult position, is it not?

[70] **Mr Murray:** That is right. Although it is part of the Gwynedd locality, we tend to think of it as something separate. As one of my supervisors said at one of the public meetings that the auditor general held in Bangor, people tend to forget that there is a large lump of granite in the middle, which makes things rather more difficult. Therefore, we believe that a degree of investment is needed to do this, and we are currently in discussion with our commissioners about that.

[71] **David Melding:** Darren Millar has a short supplementary question.

[72] **Darren Millar:** One thing that I found interesting is that you are obviously actively engaged in the rural development strategy, because of the complex issues around rurality and access to patients. However, rurality is an issue in north Wales, although the transport infrastructure is relatively good along the coast, which I assume is why the performance is significantly better. Therefore, what sort of engagement are you having with the transport strategy currently being developed? Is that something that you are actively engaged in? That seems to be a crucial part of the improvement programme for you.

[73] **Mr Murray:** Are we talking about this as part of the spatial plan, or is it the patient

transport strategy?

[74] **David Melding:** I believe that it was more about the spatial plan. That question may be more for Ann, but I will leave it to the witnesses to decide.

[75] **Ms Lloyd:** Are you engaged with the spatial plan?

[76] **Mr Murray:** Frankly, no, we are not.

[77] **David Melding:** That is an exemplary answer. [*Laughter*.] Please do not spoil it by saying any more. I had not anticipated this question either.

[78] **Darren Millar:** But it is an issue though, is it not?

[79] **Ms Lloyd:** Yes it is.

[80] **David Melding:** It is perhaps something to take away and think about. Do you want to add anything to that, Ann?

[81] **Ms Lloyd:** Yes. Officials in my department are engaged with that, and will be liaising with the ambulance service when conclusions are reached on that and on the Heads of the Valleys.

[82] **Darren Millar:** It seems to me that, in the spatial plans that—

[83] **David Melding:** I do not want to open up a whole new area here.

[84] **Darren Millar:** I appreciate that, but it seems to me that, in the spatial plans that are currently being developed, there is very little reference to access to health services.

[85] **Ms Lloyd:** Yes, I know that. That is why we have put someone from the health service on each of the spatial planning teams—from an official level and from the service level.

[86] **Darren Millar:** So you recognise that there is a weakness?

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

[88] **Eleanor Burnham:** I presume, Ann, that you are discussing the road system earnestly with the Deputy First Minister and Minister for the Economy and Transport? In north Wales, in particular, ongoing work on the A55 has huge implications for the delivery of ambulance services, let alone all of us trying to get around.

[89] **Ms Lloyd:** Yes, I know—I got stuck in them last week.

[90] **David Melding:** That can happen anywhere.

[91] **Eleanor Burnham:** The A55 is arterial, and is therefore of real consequence, particularly if you are going to Walton and other places in an emergency.

[92] **David Melding:** We could all raise local examples. Janice Gregory has the next questions.

[93] **Janice Gregory:** I wish to move on to excessive turnaround times at hospitals. I refer you to pages 22 to 26, and 50 to 51. In paragraphs 1.27 onwards, concerns are raised about the sustainability of improved performance in your trust; I believe that we all welcome the

improved performance to date. The most adverse publicity is centred around television shots of ambulances lined up outside hospitals—we can all refer back to the example of the Heath hospital last autumn—rather than being on the road, bringing people in. We all know that there are factors that cause that to happen.

10.20 a.m.

[94] My first question is to Alan: what more can you do as an organisation to minimise that? What support would you need? My second question is for Ann: what more can the Welsh Assembly Government do, throughout all aspects of the NHS, to address the issue? It is clear that this is not a single issue, and a joint response is required. Ann, how has the new target for 15-minute patient handovers worked? Perhaps Alan could answer that too.

[95] **Mr Murray:** To start with the second part of the question, the 15-minute handover targets are helpful in themselves. Screens will be going into every accident and emergency department in Wales, so that the paramedics and the nurses can record the registration and arrival of a patient as the starting point, and the handover of the patient as the finishing point.

[96] What can we do to help? Last year, we took nearly 3,000 more emergency calls than the previous year, but we transported 6,000 fewer to hospital. We are still improving that by dint of three things. The first thing is improved specificity in our call categorisation. Second is triage by the nurses in our control centres. We want to see some investment in that, and we want to see them in our three regional control centres—there will only be three from October, when Vantage Point House opens—with perhaps some paramedics working alongside them, because they have a much clearer understanding than the nurses of the operational aspect of cases. Thirdly—and I think that I mentioned this the last time I spoke to this committee—our two opportunities to get it right are when we take a call, and when we are face to face with a patient, so we consider the face-to-face aspect also to be important, and the paramedic development framework will certainly help with that. We are already seeing the fruits of that, as I described to you earlier, when relating my experience in Cardiff. We negotiated with the Royal Gwent Hospital, for example, that when paramedics receive patients who meet certain criteria, they can speak to the consultant in the admissions unit at Nevill Hall Hospital and agree to take the patient there rather than to the Royal Gwent Hospital. The problem with that, at the moment, is that only the consultant can authorise that decision; we are looking forward to the point when all of the nurse practitioners in the unit can deliver the same authorisation. We can then extend the operating hours of that arrangement and start taking people, as appropriate, and when safe, away from the accident and emergency department.

[97] The Royal Gwent Hospital improved significantly over the late part of the winter, but it then began to drift again. One of the most successful changes that it made was to put in a rapid assessment team, which was able to take someone from a spinal board, do some quick tests on them to exclude spinal injuries, and sit them up in the minors unit, so that we can take the board and stretcher and get back out again.

[98] At the moment, one of the biggest drains on our resources, apart from the crews themselves, are the operations managers. They often spend entire shifts in accident and emergency departments, either nursing patients to let crews go, or ensuring that the processes are working and alerting the operations managers at the hospital to the need to accelerate certain processes. If there is one message that I could give today, it is this: managers have received a lot of criticism in the process of this report being produced, but I have managers who do a full day’s work and then do almost a full evening’s work on the forecourts of hospitals. I have managers who do a full week’s work and then work over the weekend, on the forecourts and in accident and emergency departments at hospitals. Clearly, that is a big drain on our resources, but it speaks volumes about the level of commitment of those managers. That is a message that I want to convey very strongly today.

[99] **Ms Lloyd:** As Alan has said, one of the ways in which we can help that problem is to make it a target, but we must insist that the trusts become responsible for the target and that it is not just seen as an ambulance target. When you look at the causes of delay—Alan has explained some of them—you see that the whole system in a hospital contributes to these sorts of delays. So, I asked our delivery and support unit, which will help Gwent and Cardiff, in particular—and it is in Gwent and Cardiff at the moment—to look at the management of a 15-minute target, for its latest position and what it thinks it is going to have to address with these organisations. The first things is that ambulance liaison in accident and emergency departments has been quite helpful because it at least addresses the questions of what is coming towards the door, whether it has been effectively triaged, how the patient is being managed, and what the likely care pathway for that patient is. We need to get smarter at that.

[100] There must be co-ordination between clinical teams within the hospitals, between accident and emergency and medical specialists, in particular. I did a study years ago for the Department of Health into Ealing Hospital, which was a complete disaster zone, because the medical specialties did not own the accident and emergency department and did not own the patients who were in the department. You had this massive hiatus, and the criticism was directed at the accident and emergency department, but it was not the accident and emergency department that was failing the patient, but the remainder of the system and the remainder of the hospital. So, we must ensure that there is much greater liaison between the accident and emergency department and the rest of that unit, and we must also ensure that we can use general practitioner urgent admissions effectively, because there should be good relationships between GPs, surgical assessment units, clinical decision units and medical assessment units. All of these things must be in place so that patients are not channelled through accident and emergency departments, counted twice and then admitted, when they could have gone straight into a clinical decision unit. So, we are testing that those processes are in place.

[101] We must also ensure that bed management in the trusts is effective and that patients are not just being batched up—which is a dreadful term to apply to patients—to be discharged later in the day when the consultants or the juniors come around. That is about the issue of who can discharge the patient and the need for a greater relationship and liaison between the clinical teams. My delivery and support unit thinks that it is getting better during the day and during the week but that the performance starts to slide after 5 p.m. and at the weekend, and it is in those areas that we will be offering help and support to the trusts that have particular problems, so that we can help them to overcome this issue. It is a clinical governance issue. Being nursed and managed in an ambulance or in a hospital corridor is not good. So, it is a considerable clinical governance problem, and the whole system must work together to solve it, but we are providing that support to them.

[102] **Janice Gregory:** There is a very simple example in Nevill Hall Hospital. For anyone who may be looking at the ambulance service, there seems to be such a logical and easy answer to what is quite a significant problem in the south-east. Why has—this may sound simple and naive, but I am thinking of my constituents who would want me to ask this question—the Welsh Assembly Government not given trusts the following instruction, ‘The nurse practitioners will deal with admission, and the consultants can also be included, but there will be another tier of staff who will be able to ensure that a patient can be admitted’? I apologise if I have misunderstood what was said, but why are we waiting for the decision with regard to nurse practitioners being able to undertake this task? If you can see that that would be advantageous to patients who do not know whether they are going to one hospital or another. I would imagine that most patients would not give a damn where they were taken, as long as they were treated appropriately. So, why do we have a hiatus in this area?

10.30 a.m.

[103] **Ms Lloyd:** That is one of the frustrations of Government, as I am sure that the Minister would tell you. This is good practice, and that is why the DSU is rolling it out, namely to challenge organisations. The challenge to the system is: 'If we have an outcome that must be achieved, and there are examples of good practice on the ground that are working and have been audited, unless you can come up with something better, why are you not doing this?'.

[104] **Janice Gregory:** You are dealing with this as a matter of urgency.

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

[106] **Janice Gregory:** That is what people will want to know.

[107] I will go on to my next question, relating to pages 32 to 33, which describe the extensive changes that there have been to the trust's governance, and, as we know and have heard, an almost entirely new executive team is now in place and improvements have been recognised. Ann, are you satisfied with and confident in the trust's leadership and governance? What can the Welsh Assembly Government do to assist the trust in driving through the difficult changes?

[108] **Ms Lloyd:** As the auditor general has pointed out, a practically brand-new team is in place. The chairman had shown leadership in his report, where there is a clear analysis of the strengths and weaknesses of the organisation. As Alan and I have both said, there are gaps in the executive, and efforts are being made to fill them, because they are hugely important. So, it is an incomplete team at the moment, but from reading this report and the chairman's report, I can say that it has achieved a great deal. However, it is an incomplete team in terms of human resources, which is fundamental to resolving and helping with some of the communication and staff morale problems and some of the engagement issues that are mentioned in the report. There is still a gap in terms of strategic and logistical development, and, in part, in workforce planning too. Given the new style of service that is being developed, we must ensure that the workforce plan now fits that new style of development. I will be looking to the new HR director and Alan to produce a workforce plan with the engagement of staff that underpins the modernisation agenda that he has outlined.

[109] So, it has done well. I think that there will be improved leadership at the top level once we get these holes filled. With many organisations, the main problem is confidence in middle and line management, and Alan and I have discussed that at length. In terms of the new HR director, we agree that there must be consolidation and that we must get clinical team leaders in place, and we must ensure that line management is well developed, properly assessed and properly trained, so that it can have the confidence of the staff on the ground that they will be assessed and appraised and that their performance will be organised effectively.

[110] From talking to the chairman, I also think that the board will need some strengthening in terms of non-executives in this next phase. The Minister has already appointed an additional non-executive director to enhance the skills of the board. The board has done well in stepping up to this challenge, but now whole-board development needs to take place, and there needs to be a leadership development strategy too. So, there are things to do, but really good strides have been taken under difficult circumstances. However, there are holes, and we all know what they are, and we are joined in trying to ensure that they are filled.

[111] **Janice Gregory:** The focus groups had some serious concerns about the quality of the leadership. Alan, do you have anything that you would like to add in terms of how you get everyone on board with the modernisation plan? Change is never easy for staff, is it?

[112] **Mr Murray:** The auditor general's report made it clear that there is a block there, and it is about switching people on again. In a previous organisation that I turned around

relatively quickly, the problems were of recent origin, and people were still angry about them; you can use anger creatively. In Wales, because of the long-standing nature of the problems, the anger had gone, and resignation had set in. In that previous organisation, with a lot of cajoling, and a lot of effort, we got 70 per cent of the staff to undertake the e-learning package that underpinned the understanding of the modernisation plan; the rest of them picked it up almost by osmosis—it became part of the organisation's common currency. In the Welsh Ambulance Services NHS Trust, we could not get beyond 30 per cent.

[113] Therefore, there are two issues here—transmit and receive. I have set up an 'ask the CEO' database on our intranet, where I have been answering staff's questions honestly. I get a sense, from some of the positive feedback that I have had on that, that we have crossed the bridge, and that people are beginning to warm up. However, if you speak to other people in the organisation, they will tell you the opposite. The question is, is either sample truly representative of the workforce? I do not know that my sample is wholly representative, but it is certainly a significant warming up from where we were.

[114] On practical steps, we have started a management development programme that is focused on human resource issues, communication and staff engagement. We are clearing the decks for the locality ambulance officers, so that they can spend more time with their staff. We are also encouraging them to work from different stations in their area, so that they see their staff face to face. We are giving them key performance indicators that require them to have a face to face with each member of staff on their team each month. Every member of staff will have a named line manager. I believe that those are all steps in the right direction.

[115] I invented the concept of clinical team leaders, which is now common currency in the UK ambulance service, in Northern Ireland in the 1980s, and it has worked for me wherever I have been. It has been a source of huge frustration to me that there has been a delay in getting those team leaders in place. I am now looking forward to our new arrangement with NLIAH facilitating that quickly.

[116] Other reasons why the existing supervisors did not apply in greater numbers—I have spoken to them personally, and have run out with some of them from time to time to get the opportunity to find out why they were not applying—was that, effectively, they were given misleading information about what the job would entail. Frankly, there were also other considerations about what they were going to do without operational supervisors, when they needed them in hospitals to turn patients around. We have been trying to convince them that that is a transitional problem, and that it should not stop the modernisation process.

[117] In relation to the allegations of bullying and harassment, we have also invited the NHS Wales equality and human rights—I am sorry, I cannot remember the correct title—

[118] **Ms Lloyd:** It is the NHS Centre for Equality and Human Rights.

[119] **Mr Murray:** There are so many initials—it is like Northern Ireland politics. We have invited the NHS Centre for Equality and Human Rights to come in and drill down below the staff survey to look at exactly what behaviours are being described as bullying and harassment. I am sure that, when we do that, we will find that there are some that you and I would agree are bullying, and I am equally sure that we will find that some are the first performance management efforts in a service that has not been performance-managed before, and some will be somewhere in between—ill-thought-out performance management efforts. So, those are the kinds of areas that we are looking at. Having named line managers, and seeing them at least monthly with a problem-solving focus, will be a big step forward.

[120] **David Melding:** We now have an opportunity to pursue some of those points in greater detail.

10.40 a.m.

[121] **Bethan Jenkins:** I will move on to the performance management systems, which are mentioned in paragraphs 1.64 to 1.76. This question is to Alan. How much of a priority has it been to improve your performance management systems and what more needs to be done? How do you intend to use this improved information to ensure that supply and demand are adequately matched?

[122] **Mr Murray:** To follow the continuum through, the first thing that you have to do is match your demand and your supply before you start the performance management process. We do that using a methodology called 'average peak', which, as you can see, has been reviewed by the Wales Audit Office and by the independent academic that supported Stuart in his review. Their comments were that the methodology was fine, and that it was about selling that methodology more effectively to staff so that they understand how and why it works.

[123] The next thing that we needed to do was get our shifts in place and we had some hiccups with that. I believe that the only shift rota not currently in place in south-east Wales is in Aberbeeg, and we are now undertaking a sensitivity review of all of those rotas with the staff, and with the staff side, to ensure that they are absolutely right. The new regional director, Grant Gordon, is leading that. This is mainly, but not exclusively, a south-east Wales issue.

[124] There are a few other things that we have to do in terms of ensuring that we put those people on duty when they should be. We installed a system called ProMis, which is widely used in ambulance trusts. It links in with the electronic staff record and, in our case, has become the front end of the ESR—a much more user-friendly front end than the main ESR front end. It provides powerful support for our three regional resource centres, which are all now in place and functioning, to ensure that they know exactly who is available within the rules and the European working time directive and so on. For example, when a shift is vacant, it will do a hunt to see who was on rest day yesterday, today and tomorrow and prioritise the list to ensure that we can get those people and put them in place. Staff can look at that on the web and hunt shifts that they want to work and make an offer on the web without having to talk to the resource centre.

[125] After that, we have to distribute our workforce across the map to ensure that they are where they most need to be when an emergency arises. One problem is that, in most of Wales, we do not know precisely where they are, because we do not have automatic vehicle location. Having AVL will make a huge difference to our ability to deploy our staff effectively. After that, it is about the 999 call and what we do in terms of how quickly we can take the call and verify the incident location; how quickly we can allocate the nearest resource and how quickly that resource gets out of shoot, as it were; how long it takes them to get to the scene and how long they spend at the scene and so on right through to when they are available at the other end.

[126] When I was being interviewed for this job, I made it clear that there was one thing that you get if you get me and that is a formal performance management framework based on statistical process control and benchmarking. I have used it successfully before; we introduced it here and put it in place. We bought some consultancy support to teach us how to use it and we set up a four-level performance management framework. Level 1 is the operational level—it is not fully in place yet, because it is always the most difficult; not having team leaders in place has made it even more difficult—level 2 is the locality, level 3 is the region and level 4 is national. With each of those, someone sweats for hours over a storyboard to identify two or three major issues affecting performance this week. They bring it into the meeting, present it and the people in the meeting decide what they are going to do

about it and then they leave and get on with doing it. We call that the IDA process—issue, decision, action. That is operating pretty well at the national, regional and locality levels after some initial problems because of the reach and the fact that we did not have regional leadership in south-east Wales, for example. However, it has not yet been rolled out below those levels.

[127] That is how the performance management framework operates—it relies on good information. Our information and communications technology director, David Jackland, has been responsible for putting in the technology and the information management support. When the auditor general's team came to look at our information department this time, it was absolutely delighted with the changes that had taken place, but I am sure that the auditor general can speak for his team. There was such a huge difference with where we were before. Before, we had Nicky and Michelle, and now we have Nicky heading a proper professional informatics team, and we are using the information that she and her team provides on a planned and ad-hoc basis—do not talk to her about the ad-hoc requests that she gets, because they are all from me—to drive the performance of the service.

[128] **Bethan Jenkins:** To follow up on that, where do you see it going from here? How can you use this information? Obviously, it is more accurate now, but how can you use it more creatively in the future and how do you see it progressing?

[129] **Mr Murray:** The systems are in place. The biggest priority is getting level 1 in place. Level 1 is about the locality managers and the team leaders, and it gives the team leaders the power to influence performance in their areas. So, getting level 1 in place, and refining the process so that we do not overcomplicate things by presenting too much information at each meeting, is important. However, the basic process is already there—it is a standard continuous quality improvement process, which is working well.

[130] The next big step for us would be automatic vehicle location and mobile data, because that will provide much more live information to the performance management process. It will also enable us to manage our performance live. With modern automatic vehicle location systems, you do not look at the map. We have an old AVL system in south-east Wales, which measures distance as the crow flies rather than road distance, so it does not give meaningful information to the control staff. I was talking to them yesterday, and they said that they do not even look at it. The key with the modern systems is that you do not even have to look at the map, because when a call comes in, once the call-taker has verified the location, the AVL system will automatically throw up the nearest unit and the call-taker will be able to drag and drop the call onto the unit, and send it immediately.

[131] It also gives us a powerful tool for managing our deployment plans. I am a little ambivalent about this, because excessive reliance on technology for deployment planning disengages the staff, and I have found in the past that the best way of doing deployment plans is to use those systems to provide the information and bring experienced road staff and experienced control staff to bear on it. That way, you get much more ownership of the plans. We are already doing that in north Wales without the technology, and we are rolling it out to south-east Wales and central and west Wales, but once we get the technology, it will boost that considerably.

[132] **Bethan Jenkins:** With regard to the fire service and prioritising where your ambulances are going, I know that there are different regional areas; you mention in paragraph 1.72 that Bridgend has come under the control of another area, and its ambulances are perhaps not now being sent to other parts of Wales. Is that something on which you have worked with other health areas or not?

[133] **Mr Murray:** Our work with the fire service centres particularly on two areas. First, we

use a significant number of its premises, and we see that growing. I am grateful to my colleagues in the fire service, because they are not doing this as an income-generation scheme—they are doing it out of true partnership. So, we are increasingly using fire stations. If you drive past Cardiff central fire station, you will probably see a large yellow vehicle parked in front of it, although they will probably be out working now. We use fire stations in Cardiff and in rural areas throughout Wales. The other area where we partner with the fire services is in mid and west Wales, where we use fire service co-responders to respond to life-threatening emergencies. Those are our key areas of partnership with the fire service. The police in north Wales also provide us with facilities for first response, and, at times, we use their helicopter to give us a bit of an edge on the air ambulance side of things. So, that is where the main partnerships are.

10.50 a.m.

[134] In terms of logistics, we are very different services. The fire service operates from fixed locations and, in fact, because of the work that it is doing on prevention, its response caseload is going down and down. I know that Rob is involved with the fire service as well—he can confirm that, but I think that it is widely known anyway. We are a mobile service, and we have to deploy our resources—we cannot keep them in the stations. We have 93 stations, and we need well over 120 deployment points to serve Wales.

[135] **David Melding:** Do you have a supplementary question, Eleanor?

[136] **Eleanor Burnham:** Yes. Following on from what you just said, I understood that, in north Wales, there was to be a first-response administrative call centre. Is this not the right time to merge NHS Direct into all of this?

[137] **Mr Murray:** NHS Direct is part of this, and Vantage Point House will be the model for the future. At Vantage Point House, we will house NHS Direct for the whole of south-east Wales, ambulance control for the whole of south-east Wales, both emergency and non-emergency, and the out-of-hours service for Gwent—they will all be under the same roof. That is the first step, and being colleagues will be a big psychological step for everyone. The next step will be to realign the processes, and following that we have identified at least one option for a common technology platform that will allow us to move towards a single call-taking workforce. In that way, an NHS Direct call-taker could pass calls to the GP out-of-hours service, and, similarly, a GP out-of-hours call-taker could pass a call to the 999 dispatcher, rather than the 999 call-taker. Then we start to join together those services, very much in the spirit of DECS.

[138] We talk about a single point of access, and this is probably the closest that we have to that in Wales at the moment. We have to be careful about it, because 90 per cent of first contacts with the NHS are still through general practice, so we have to be careful that we do not get what we wish for; we could be like a dog that chases a car and catches it, and then does not know what to do with it, because it is too big to eat. Those are our first steps down that road. The merger with NHS Direct has been one of our major successes, and this is our first systemic effort to capitalise on that.

[139] **Eleanor Burnham:** However, in north Wales, I understood that there was to be one call centre for taking first-response 999 calls, and so on.

[140] **Mr Murray:** For 999 calls, yes. A process is in place working towards a single centre for fire, police and not just ambulance, but health. This is a broader health communications agenda. However, that is still in its infancy, and I think that we may hear more about that later.

[141] **David Melding:** Do you want to pursue question 9, Bethan?

[142] **Bethan Jenkins:** Yes. This moves on to part 2 of the report. Looking at the first few paragraphs, the auditor general has concluded that the problems facing the trust are only to be expected at this stage, because it is going through this transformational period. Do you both agree with that conclusion? How can you address these problems for the future?

[143] **Mr Murray:** Not only do I agree with the conclusion, but I am grateful for it, because it is important that people understand the scope of the change process that we are going through. Professor Morton Warner said that, initially, we might do better but feel worse, although that was only to be expected at this stage; that is also very accurate. There are things that we could have done differently, that would have mitigated that problem, and I if could go back, I would have started the management development process earlier. However, I suppose I have to look at things in the context of that time. We had a clinically unsafe service, because we were not responding quickly enough. There was huge public expectation that we would improve that, so we had to get on with that at the time. However, I do not think that I would exonerate us completely—we should and could have started the management development process earlier. However, we did not.

[144] Some of the measures that I mentioned earlier, such as having named managers, regular monthly meetings with each member of staff, training and development for managers, and I would also add having local champions of change who do not necessarily have to be mangers, are all steps in the direction of resolving that and making people feel better. We have also introduced a range of communications media over the last year. Every month, a number of executive and non-executive directors go out on pre-arranged visits to ambulance stations, control centres, training centres and hospitals. We notify the staff that we are going to be there and quite a few members of staff come in, off duty, simply to see us. We have some talking points that we want to get across about the modernisation plan, but there is also an open agenda so that people can address the issues that are exercising them. All of that is compiled by our national corporate communications lead, who brings it to our executive management group, so that we are all aware of the issues that are being raised and get an opportunity to respond to them. The chairman, the vice chair and I divide the workload of having monthly listening lunches, where we give the staff some sandwiches, a cup of tea and some sticky buns and we have a completely open agenda. I know that there can be a great deal of cynicism about what staff are likely to say to the chairman and the chief executive. I can assure you that they do open up; they are beginning very much to open up and we are having some very trenchant discussions.

[145] **Bethan Jenkins:** I know that you say that, and I acknowledge that you would say that, because you are in your position, but I happen to know a few people who work in the service and they would not dream of saying what they really felt in those types of situations. I know that you say that they are informal lunches and that people are opening up, but are there other mechanisms in place that mean that staff do not have to talk to senior managers, but can perhaps tell somebody who is on their level?

[146] **Mr Murray:** Yes, there are. I will certainly come to that, but can I tell you that my last listening lunch—

[147] **David Melding:** We will come to that in a subsequent question, so you will have a chance to explore staff morale in general.

[148] **Mr Murray:** My last listening lunch was in St Asaph and if the person who was talking to me about patient care services in north Wales was holding back, I really would not like to have seen him when he was being honest. [*Laughter.*]

[149] **Bethan Jenkins:** Okay.

[150] **Mr Murray:** People may be cynical about that, and I understand their cynicism about who is going to tell the chief, but I have done everything in my power to be both accessible to the staff and not to be intimidating to them. As far as I am concerned, I want us all to be on first-name terms and I want to get rid of some of the hierarchy in the service. That is beginning to work very well. There is also the 'ask the CEO' database, where they can post questions anonymously, if they choose to do so, although some people put their names to them. We have had a lot of very interesting posts that have caused me to furrow my brow when writing the responses. We always do the research and we answer them, except if they are disrespectful. If they are frankly disrespectful, I have made it very clear to staff that I will not post them. If they want an answer, they need to ask a straightforward question and not ask, 'Would you agree, Mr Murray, that all managers are idiots?', because they will not get an answer to a question like that. We have had a few of those, but we do not get them any more. People have seen that they are getting answers and they are using that very well.

[151] It is not just 'ask the CEO', by the way; everybody is engaged in the answers. That has been a particular success story. We have also done roadshows about the modernisation plan. We use our *Siren* publication, which our survey shows that people actually do read, to disseminate information about things that the staff have done, such as success stories and good news stories. They are not good news stories about us; they are good news stories about the folks in the green suits and what they have done that is praiseworthy. We put in information about the progress of the plan and we have specific bulletins on things like Vantage Point House. Each of the three regions now has a regional bulletin that they put out. We are using those to make sure that people are fully aware of what we are doing.

[152] **Bethan Jenkins:** Thank you. There will be questions to follow this initial question, but I just wondered whether you, Ann, wanted to come in on that and on how you will be supporting the trust in this period, moving forward.

11 a.m.

[153] **Ms Lloyd:** As you know from the Minister's statement following the publication of the chairman's report, she has acknowledged, as has the auditor general, that significant improvements have been made, but that she was still disappointed about some aspects of the performance that we discussed previously. Therefore, we will be working with the trust over the next six months to ensure that there is an effective improvement in those areas, and that its business cases for equipment are progressed as fast as humanly possible. We expect that some of the equipment, and the provision for the control rooms, will help the trust to improve its performance.

[154] As is clear in these reports, the south-east is our major problem, and our major concern—particularly as regards staff morale, and the air of general despondency that seems to emerge from that region. We have to work closely with the trust to ensure that those problems can be overcome. Having a full-time leader will make a difference, but we will also turn our attention to the lower levels of the organisation, to ensure that staff feel that they are listened to, and that their ideas are taken on board. We must proactively engage with them in a way that we have not been able to previously. The trust itself has tried extremely hard to take forward this massive agenda as fast as it could, but, possibly because of the level of urgency, it has not been able to take all of its staff with it, in all parts of Wales. That is basically what Alan has said. So, staff relationships and staff involvement have to improve, which we all acknowledge.

[155] **Irene James:** That has covered quite a few of the points that I wanted to mention. I wanted to look at page 39, and paragraphs 2.1 to 2.14, which highlight the acute problems

that the trust is specifically facing in the south-east region. It is worth noting that there was a month's unofficial ban on overtime during that period, which tells us an awful lot about staff morale at that time. When you last appeared before the committee, Alan, you said that there was not an obvious reason why the south-east region should have lower levels of performance. Dare I ask why it took so long to put the new management process into place in that region?

[156] **Mr Murray:** We appointed a regional director very early in the process, but we had to withdraw our offer of appointment from that individual, and that set us back greatly. When we re-advertised the post, we re-drew the specification, because we knew that there was a limited pool of senior talent within the ambulance service in the UK. We re-drew it specifically to allow people from outside the ambulance service to apply as well. We did not actually get any applicants from outside the ambulance service, but we ended up with one eminently appointable candidate from inside the service. He is now in post, and he is already making a huge difference. The wait was so long that I cannot entirely say that it was worth the wait, but I am delighted with the quality of the individual concerned. Grant Gordon is already making a huge difference.

[157] **Irene James:** You have pre-empted my next question, which was whether any impact had been made on the problem, and what the difficulties were. I thank you for your response on that.

[158] I would like to ask Mrs Lloyd about some of the problems in south-east Wales. They are very wide problems, are they not? Specifically, if we look at turnaround times in Cardiff and the Vale of Glamorgan, and in Gwent, what are we doing to address these systems' problems?

[159] **Ms Lloyd:** I explained what we were doing with the delivery and support unit, looking at the turnaround times and making sure that good practice was put into that. As a manager looking from a distance, my analysis of the problems in south-east Wales is this: to what extent do staff feel that they are being led at direct management level, and do they respect the decisions that are taken? The problems are symptomatic of the fact that we must improve the way in which staff are engaged and involved.

[160] That is not to say that you have to be soft, because hard decisions have to be taken, but there is a way to do that. Grant has an uphill task, and we must all help him to succeed. However, I believe that we have to work actively with the National Leadership and Innovation Agency for Healthcare to ensure that staff leadership is effective from line management upwards, and is based on an understanding of how modern management should work and how staff engagement must be developed. We will also have to look at the logistics of service delivery. The Minister has discussed that with Alan and me, and she will be writing to you tomorrow about the next steps of the logistics survey, which she promised in her statement.

[161] We need to ensure that the staff and the senior executive team in the south east are well supported, because that is the area with the greatest problems, which are ongoing. We must ensure that the leadership and that line managers are well supported to deliver with their staff, who are good, but who obviously feel disenfranchised, given the results. They are able to deliver good services, but, without clinical team leaders, we will not be able to make the necessary progress on delivering excellent patient care. Similarly, without the active involvement of those partners who can help the ambulance service to deliver some of its targets and governance improvements, and unless they are actively involved, the ambulance service will not be able to manage on its own. It is my job to ensure that the partners are engaged and take this seriously.

[162] **David Melding:** These are big hospitals, so there are big problems if turnaround times are consistently poor. I will not press you for a simplistic percentage answer as to where the fault lies, but it seems to me that the NHS trusts have a lot of responsibility for the situation that has been allowed to develop. In fact, the problems have continued for so long that this now almost seems to be the culture. That has not been turned around as quickly as one would have hoped, looking at progress since 2006.

[163] **Ms Lloyd:** I think that problems have been exposed, actually. There have been improvements in how trusts lead their clinical teams and develop care pathways throughout the service. However, the increasing scrutiny of the ambulance service's clinically led targets, as Alan said, has led to deficiencies or problems in big hospital trusts being exposed, and the ability of managers to tackle these problems is variable, given all the other things that they are trying to tackle at the same time. As the Minister said yesterday in her statement on NHS reorganisation, clinical leadership is paramount for success. The success or otherwise of the trust management in engaging effectively with, and developing, their clinical leaders will be fundamental to changing some of these problems, as is the case in the ambulance service.

[164] They have made great strides, but life is becoming harder, and there are several issues to be tackled. This is not just about the trust; the LHBs have a responsibility to commission effectively, to manage demand, and not to allow patients to be immediately jettisoned into the emergency care service when there are alternatives available. So, this is about the whole system, and we will be looking at that as we develop the principles of NHS reorganisation. I now have to design an NHS structure based on the principles of service, so that those principles can be effective.

11.10 a.m.

[165] **Mr Murray:** I want to come back on the last question, if I may. Grant Gordon is already consulting on plans to restructure the management of the south-east region, and, instead of having locality managers, he is looking at having three area heads of the ambulance service in what would have been described in the old days as Gwent, South Glamorgan and Mid Glamorgan, and at supporting those people through operational support managers, who can deal with the non-clinical leadership issues, like return-to-work interviews, disciplinary investigations and that type of thing.

[166] A couple of issues have frustrated the local management and have made it difficult for them to manage, one of which is that they have been spending a lot of time in the hospitals rather than working with their teams. We have some good managers at locality manager level in south-east Wales, and I could cite Irene Whitnall in Merthyr and Blaenau Gwent. She is an exceptional operations manager, and, as I described to an MP whom I was responding to the other day, when you see her with her team members, you understand the reason for her success: they would jump off a bridge onto the M4 before they would let Irene down. So, we have some exceptional leaders who have not been given the opportunity to lead, and they have not been given the development that they need. I reiterate that it would be wrong to say—though I know that no-one here is saying this—or to leave the impression that this is somehow the fault of the line managers.

[167] On the morale issue because of the overtime ban from mid December to mid January, immediately after I heard that that was happening—and, by the way, it was unofficial, and the unions discouraged it and tried to stop it—I asked whether I could speak to the main opinion-formers, and I do not know who those people were, but I was told that my mobile phone number had been given to them. It was about a week and a half before the end of the dispute that I finally got to speak to two of the people who were most involved in leading it. When I asked them what their reasons were, they said things like not getting meal breaks or leave and so on. A lot of issues like meal breaks and inadequate staffing on the road were directly

related to ambulances queuing at the front doors of hospitals.

[168] **Irene James:** Following on from that, my next set of questions was going to be on paragraphs 2.15 to 2.18, which discuss the fundamental challenge that the trust faces in addressing staff morale. A staff survey and focus group revealed negative views and highlighted morale as a serious problem, and we have all agreed with that. There were also perceptions of workload pressure, a blame culture and bullying. What do you think could have been done to avoid the serious drop in morale that has obviously occurred in the trust, Mr Murray? You have mentioned some things that some line managers have done, and perhaps you could continue on that theme.

[169] **Mr Murray:** As I have said, we could have brought forward the management development programme that we are currently engaged in. We could have brought forward the work that we are doing to examine what our locality ambulance officers do, and stripped out as much as possible of the non-staff-related work to give them an opportunity to focus on staff. We could have given everyone a named line manager, and we could have put in key performance indicators about seeing staff each month, which we are currently doing. In other words, we could have brought forward those things that we are currently doing.

[170] I am concerned about the perceptions of a bullying culture in the service. As I have said, when the NHS Centre for Equality and Human Rights completes its work, we will find that there are things that you and I would agree with verbally, but we will probably also find other things to do with performance management, namely that people had never been performance-managed before. I will not pre-empt that; I am just saying what my instinct is. Some of it will be fully justified; some of it may not be. However, I am keen to find out what those specific behaviours are so that we can address them.

[171] As for whether we could have completely prevented the drop in morale, the answer is definitely ‘no’, because we took an organisation that was already severely disaffected, as evidenced by the fact that only 30 per cent of them would even pick up the CD-ROM and put it into the drive, and then we piled significant change on top of that. A certain degree of adverse impact on morale was inevitable, although I am not saying that there was nothing that we could do to mitigate that to a greater degree.

[172] **Irene James:** We heard last time about the changing of meal breaks, and you have mentioned it today. Do you think that those changes are still barriers to achieving what we need to see?

[173] **Mr Murray:** The change to the meal break arrangements went far better than we had any right to expect. Had I been designing ‘Agenda for Change’, I would not have included unpaid meal breaks for emergency staff. I am quite frank about that, and I have been frank about that with staff. However, we have what we have. There is only one way to change that, namely to require staff to be available during their breaks, which would mean that we could pay them for those breaks. That would run entirely counter to the intentions of ‘Agenda for Change’, and would be difficult to justify and explain. However, even if we did that, we could not afford it, because it would cost us £3.3 million to reinstate paid meal breaks, and Tim will correct me if I am wrong about that. To be frank, if we had £3.3 million, we would be doing something else with it.

[174] It could have been worse. Why was it not worse? It was not worse, because we got partnership from the unions on the issue. We nearly ran into a crisis when we introduced unpaid meal breaks. I suppose that one of the frustrations of a national pay mechanism is that we have nothing to do with designing it, but we get the blame when we implement it. Therefore, on the ‘ask the CEO’ database, there are questions from staff such as, ‘If you really value us, why are you doing x, y, or z?’, which are all entirely related to ‘Agenda for

Change'. I have to say to them again and again, 'Sorry, I understand your frustration, but I did not design 'Agenda for Change''.

[175] **Ms Lloyd:** Nor did we, by the way.

[176] **Mr Murray:** When things came close to crisis point, the staff side quickly got into partnership with us. We agreed formal local agreements for availability payments of £5, where we ask people to be available and they agree. We do not always ask, but, when we ask and they agree, we pay them £5. Where we disturb them before a certain point in their meal break, we pay them a further £20. Some staff will make themselves available; some staff will never make themselves available. That is a cross that we have to bear.

[177] **Irene James:** That is true throughout life, is it not?

[178] **Mr Murray:** Yes, it is.

[179] **David Melding:** Let us move on. Irene James has the next questions. No, sorry, it is Lesley Griffiths. I said that with such confidence that everyone thought I was right.

[180] **Lesley Griffiths:** Turning to page 44, I want to look at the 'Time to Make a Difference' programme. The auditor general states that there is a need for greater clarity, particularly when looking at the timescales for delivery. How confident are you that you can deliver the programme within the five-year timescale? Balancing that, the report states that you may need to reschedule your projects to ensure that your staff do not get burned out.

[181] **Mr Murray:** I am more confident now than I would have been had you asked this question six months ago. As the executive team, we have given ourselves some protected time to go away and do development work related to the delivery of the programme. We have had some training from experts in programme management, because having expert programme managers in the trust is only part of the point. Everyone in the organisation who is concerned with delivering programmes needs to have development in programme management. For us, it was about programme sponsorship, because each of the executive directors is a sponsor of a sub-programme. During one of our protected two-day sessions, we agreed that we needed to do several things.

11.20 a.m.

[182] First, we had missed out a step in the process. We made the mistake of thinking that the 'Time to Make a Difference' modernisation plan was a blueprint for the future, but in programme management, a blueprint is something specific; it is a picture of where we are and where we propose to be. We agreed that we would take a step back and develop that blueprint and reorganise the programme around four sub-programmes, namely those of staff, control, regulatory, and fleet and estates. We have moved some of the projects back into later tranches—further back into the five-year programme. So, we have stripped the programme down considerably.

[183] The particular areas that we are looking at under staff are the knowledge and skills framework, communications and staff action planning and professional education. I am happy to say that we have appointed a consultant paramedic, Andrew Jenkins, to the trust, and he is leading our clinical effectiveness team. He is only the fourth consultant paramedic in the UK. He has been fully accredited by Health Inspectorate Wales through a fairly difficult process. We are proud to have him and of the fact that he is home grown.

[184] Under control, we are looking at a number of areas like standardisation and modernisation in our emergency and patient care services. For example, the development of

the clinical desks, which we have talked about, staffed by NHS Direct nurses, upgrading our computer-aided dispatch systems for emergency medical services and PCS and a number of other issues, including how we get the best out of our community first responders.

[185] The heading of regulatory covers three main areas, namely business continuity, clinical governance and civil protection. Under the heading of fleet and estates are logistics, the fleet, our estate strategy, our high-dependency service, Airwave—major digital radio replacement—and mobile data, including satellite navigation and automatic vehicle location. Those are the areas that we have restructured the programme into.

[186] So, we have made it more manageable; we have made significant progress in it. I would like some of you to come up and visit our programme management department to take a look at the work that is being done. I issue that invitation. If you did so at the moment, you might think that some of that work belongs in the Tate Modern rather than in St Asaph, because a huge benefits map is being created at the moment, looking at the contribution of each of the different parts of the programme towards the delivery of the desired benefits at the end. That will be fundamental in enabling us to improve our business case development, because we will be able to say, 'This is the investment that we need and this is what we expect it to deliver' and relate that back to the overall programme. Before the review started, we had already decided that we might be biting off more than we could chew, and we are doing better now.

[187] **Lesley Griffiths:** This question is for Ann. How will the Welsh Assembly Government support the trust? Obviously the trust will have to meet the short-term improvements that the Minister has demanded, but there also needs to be a long-term strategic approach.

[188] **Ms Lloyd:** As Alan has pointed out, the trust has refined its approach to 'Time to Make a Difference', and we will agree the action plan with the trust when we do its next review, and we will monitor with it the improvements that are being made and any areas where additional help and support is required. So, that is how we will do it: through our normal performance management arrangements with the trust.

[189] **Lesley Griffiths:** You have both mentioned that there is a lack of line management and leadership. Can you tell me, Alan, why progress has been so limited in developing the quality of immediate line management?

[190] **Mr Murray:** I think that I have already said that when we started, there was huge expectation that we would improve a service that was not clinically effective at the time. In a meeting with the staff side before my interview for the job, one of the staff-side representatives said, 'Well at least service is clinically effective', and I said, 'Forgive me if I differ with you on that', because no matter how good you are when you get there, if you get there late, you will not be clinically effective. So, we had a huge focus on delivering improvements to make the service clinically effective. As I have said, if I could go back a year and a half to the start of the modernisation programme, I would have done the things that we have set out today much earlier in the process. However, that is second-guessing the context. There was a huge expectation on us that we would deliver the improvements and we put our focus in those areas. So, we were far too goal-orientated and not sufficiently process-orientated, if you want to put it into horrible management-speak. We could have done better, and we could have done it earlier.

[191] **Lesley Griffiths:** How much of a priority is it for you to implement a management development programme?

[192] **Mr Murray:** It is a huge priority, and we are well into it already. We have appointed a workforce modernisation manager in our HR department, and he is leading on that process.

He is also leading on the staff survey action plan, because as soon as we saw the adverse staff survey, we developed an action plan jointly with staff, and we are well into the implementation of that plan. The development of the managers was hugely informed by the staff survey, even before we saw the outputs of the focus groups, because the staff survey outputs and the focus group outputs are similar in many respects. It caused us to push the issue of management development to the top of our priority list.

[193] **Mr Woodhead:** To add a couple of things in support of that, the fact that we have identified the HR and staff strand as one of the four key priorities is telling in itself. As well as that, even within some of the difficult regimes, which I am sure we will talk about in more detail, we have put aside moneys in this financial year for staff and management development in particular. So, those are two things that show the importance that we are placing on that particular area.

[194] **Lesley Griffiths:** Moving on to staff appraisals, I think that it was Ann who said that staff should have the knowledge that they would be appraised and move on. However, there seems to be a lack of progress within the trust. What progress has been made in implementing staff appraisals?

[195] **Mr Murray:** The biggest barrier to staff appraisals and the knowledge and skills framework has been the lack of clinical managers. Frankly, we are not going to make a lot of progress on that until we get the clinical managers in place, because they are the people who will do the appraisals on the clinical, front-line staff. We are also putting operational supervisors into our non-emergency service, and they will fulfil the same function in that area. We have established the knowledge and skills framework profiles for over 70 per cent of our staff, which is a huge step forward. It was something that Julie Rowles established when she was there, and it has laid some foundations because the KASF will be the vehicle for staff appraisal and staff development. However, until we get those clinical team leaders in place, we will not make the substantial progress that we need. There will be a formal development programme for the clinical team leaders, and some of them will become practice placement educators for the delivery of the new higher education paramedic programme but, until we get them in place, we will not be able to make substantial progress. However, we plan to have them in place by October, and then we will see the progress begin.

[196] **Lesley Griffiths:** That is concerning, because it will have an impact on staff morale and motivation. Is there anything that the Welsh Assembly Government can do to assist?

[197] **Ms Lloyd:** We have sent out the guidance. Tracy, my HR director, is liaising closely with the trust to ensure that this is taken forward expeditiously, and that the new organisation development and human resources director is helped to ensure that this is taken forward. We have an enormous number of successful and talented people within the service, and they need to be acknowledged and they need to understand where they are going to fit into the system for the future, because they are necessary to deliver the improvements that we have been talking about. So, it is a fundamental piece of work that needs to be done.

[198] **Mr Murray:** Whatever help we get, until we get the clinical team leaders in place, there will not be anyone there to do it. So, it is key that we get those people in place, and we are targeting the end of October for that to happen. The help from the National Leadership and Innovation Agency for Healthcare will be hugely powerful in getting that done.

11.30 a.m.

[199] **Chris Franks:** Looking at the sorry history of the estate management for the trust, I note that there has been progress regarding the Health and Safety Executive notices. However, you have a huge backlog of around £13 million, and you do not yet have a detailed

estates strategy in place. I would have thought that this is a specialist task. You do not necessarily need ambulance people to—

[200] **Mr Murray:** As an ambulance person, I would be the last person that I would ask to draw up an estates strategy.

[201] **Chris Franks:** Why do you not have a plan yet? Is the task just so huge that you cannot cope?

[202] **Mr Murray:** No. I think that this comes under the heading of meeting expectations that may be too great. The estate is one of the longest-term issues in this modernisation plan. In the short term, we have discharged two health and safety notices, and that has taken a huge effort. The one referred to in the report is now discharged. So, we now have no outstanding health and safety notices. The first one was inherited and dates from three years before I started. There had been delay upon delay in discharging it. When we took up our posts, Tim led the charge on that. We got that discharged within a matter of months of our arrival. The second related to asbestos-containing materials. It was a matter of process rather than estates development. We did that.

[203] Developing the estate strategy is one of the longest-term aspects of this. This is the bit that will take us five years. We have a strategic outline case currently with the Welsh Assembly Government. We have had very positive feedback on that strategic outline case, and we are waiting for it to be approved. This is the gateway to developing an estate strategy, because the strategic outline case is about getting the commitment to the capital investment. Until we get that commitment, there is absolutely no point in our wasting time developing an estate strategy; we need to know that we will get the money to do that.

[204] As far as the backlog maintenance on our current estate is concerned, it may not be such an issue, because we may be divesting ourselves of a lot of that estate. Operationally, we need two types of estate. First, we need big buildings within travel-to-work distances of where people live. They need to be reasonably close to major hospitals and we need to be able to start and finish our entire workforce from them. There are some exceptions to that; some places are so far flung that staff have to start and finish on their stations. That brings all of the vehicles and people together so that we can deal with infection control much more readily, we can do logistics management, and we can do the stocking and washing of the vehicles so that staff do not have to do that. They can leave them at the end of their shift with the keys in the ignition, take their personal kit, and go home.

[205] The other type of building that we need is a social deployment point, of which we need probably 120. Our goal will be not to own any of those if at all possible. We may end up owning some, and they will still be ambulance stations, but, in order to be suitable deployment points, they need to meet three criteria. They have to be where you would put an ambulance if you did not have that investment in bricks and mortar, and they need to be capable of supporting 30-second activation and mobilisation. Some of our estate will not do that and, with the best will in the world, even if you were Linford Christie and had a greasy pole at the top of the building, you could not get an ambulance out of some places in 30 seconds, because the estate gets in the way. The third thing is that they need to be able to access a good, useable road network that goes in at least three different directions almost immediately. We have not done the survey yet, so I cannot tell you how much of our existing estate will not meet those three criteria. Failing to meet one of them and being unable to put it right is enough to invalidate their use as deployment points. So, when we get to the estate strategy, we will look at how many of those buildings we intend to keep and how many we will share with people like the fire service.

[206] **David Melding:** Do you intend to move on, Chris, or may I bring someone else in on

the estate?

[207] **Chris Franks:** I was going to move on to Mrs Lloyd.

[208] **David Melding:** I will leave it with Chris and then bring others in.

[209] **Chris Franks:** Okay. We have heard that the strategic outline case has gone to you. When will you make a decision? What is the timescale?

[210] **Ms Lloyd:** The timescale is quite short because there has been considerable discussion about it, and we will be meeting, at the beginning of September, to discuss the outstanding cases. From the feedback that we have had internally, the current business case—and this is only one of many that the ambulance service has before it at the moment—will be in a reasonable state to be presented to the Minister for her to make the final decision. So, they should get the go-ahead in September, and they will receive thorough feedback from us on all the business cases.

[211] **Chris Franks:** That is good news. It has been indicated that there is a certain lack of clarity from the Government regarding the future of unscheduled care services. How does that impact on the estate plan?

[212] **Mr Murray:** We do not feel that there is any lack of clarity, I have to say. We are all pretty clear about what needs to be done to deliver DECS. There is a lot of local health community effort going in to delivering it, and we are involved, as key partners, in all of those communities.

[213] That could affect our estates strategy very significantly, because, in a traditional ambulance response model, you are talking about sharing facilities with other emergency services and we would certainly want to do that—and we already do, with the fire service, and I think that we also have some shared premises with the police. In very rural areas, I think that our clinical staff are likely to be working as part of multidisciplinary teams when they are not doing 999 work. So, they may well be supporting the delivery of minor injury services and there is certainly a suggestion that we should be helping Powys to keep three safe and clinically effective minor injury services open. We might actually be working as part of the primary care team in the community, helping to support people with long-term conditions. Clearly, to do that, we have to develop the knowledge and skills of our staff as I have referred to. It could have a very significant effect on our estates strategy as we might be working from primary care premises or minor injury units in very rural areas, rather than from fire stations or portakabins by the side of the road.

[214] **Janice Gregory:** I want to talk to you briefly about doing the evaluation of the estate and moving on to the strategy. I can refer to an incident that happened in my constituency where the ambulance station, which was a strategic site, was closed after a big fight—and I should say that it was before your time—but, next door, there was a perfectly good operational fire and rescue station. Huge frustration was felt not only by me, but people in the locality who could simply not understand why emergency services could not share facilities. We all understand the territorialism of it all over the bricks and mortar, but I have been listening and I was interested, Alan, in the three criteria. There is no doubt that the three criteria would have been met if the fire and rescue station could have been used. Most of the fire and rescue stations that I can think of in my constituency share the same site as the ambulance service, as I am sure is the case for all of us in our constituencies. Will you be factoring that in? I understand what you say that staff should have their own ambulance site, but if a joint site can house the vehicles and all that staff would want there, surely it would be a more cost-effective way of providing those strategic sites as well.

11.40 a.m.

[215] **Mr Murray:** Absolutely. I can understand your frustration, because we are moving more towards joint fire and ambulance stations. That does not mean a little room for the ambulance staff and a little room for the fire service staff; they are the same building. Dolgellau is a case in point. We had to close the ambulance station there because of asbestos, and so we moved the staff into the fire station at the back. We have done that in a number of other cases—for example, at Cymmer—and, as I say, we have been very grateful to our colleagues in the fire service for not treating this as an income-generation opportunity. Instead of saying 'Here is the bill', they have said 'Please come in', and they have been consistent in doing so. Sharing buildings will happen more and more. There is no need for ambulance staff to have their own premises. There are two kinds of buildings that they need: one where they pick up their kit and the ambulances; and one where they can go when they are on standby so that they have a roof over their heads, with tea-making facilities and a toilet.

[216] **Mr Woodhead:** May I add to that? Our strategic outline case has been shared with all three fire services, and we have had a letter of approval from them. They agree that this is the way forward. We will work with them on the detail for local areas, and with the relevant emergency services, local health boards, and anyone else who might usefully share the estate.

[217] **Mr Murray:** One of the early developments that we have in mind is two make-ready depots. One is in Wrexham, and the north Wales fire service is impatient to get started on that. So, we are actively planning a joint development with the fire service in Wrexham.

[218] **Janice Gregory:** That is good to hear. Thank you.

[219] **Chris Franks:** I will focus on paragraph 2.66, and ask Mrs Lloyd a question. How well do NHS organisations understand the demand for unscheduled care services? How will the Assembly Government address the wider issue of providing services that meet people's real needs, and in doing so, move away from a system that defaults to emergencies, where everything is a 999 call?

[220] **Ms Lloyd:** The health service collects sufficient information to analyse effectively the demands of unscheduled care. The DECS strategy looks at how effective self-care can be, and what kind of non-emergency care can be delivered in the home. It tests the boundaries on all the ways in which current services are delivered, to see how we can ensure that people are supported better in their own homes, so that we do not perpetuate the attitude of 'Oh my goodness, it is a crisis; I have to ring an ambulance'. The pilot schemes that the Minister has announced are looking at each level of care, and at what is appropriate for a community, so that we develop a number of styles of service with particular outcomes attached to them. We are engaging patient groups, local decision-informers, local authorities, and so on, to ensure that unscheduled care is handled much more effectively for the future. Rather than defaulting to the 999 service, people will know explicitly which model applies to them, where they should go for help, and how they can acquire it as soon as possible.

[221] This means that far more care will be delivered locally through primary care and other sources. It touches on some of the issues that Alan mentioned about extended care practitioners. For example, in the Monmouthshire and Gloucestershire region, and similar border areas, there is scope for joint-working. I know that the out-of-hours service in Gwent is working with one of the few consultant paramedics available, in England or Wales. If it gets a call from a continuing care patient, it makes an initial assessment, calls the extended care practitioner, and the practitioner will take over the care and wellbeing of that patient, particularly over the weekend. So, the doctor will defer the continuation of the treatment to an emergency care practitioner whose job, legitimately, is to manage the care of that patient over the weekend, rather than saying 'I need a high-dependency vehicle to take this person into

hospital, where they will be cared for over the weekend, and we will see what happens with them on Monday morning'. The whole service is geared to providing a much better local response, which obviates the need for an emergency care or high-dependency vehicle to be called out, and better uses the skills of our staff.

[222] That is what I mean by a workforce development plan. If we are looking at a different style of service for the future, individuals being cared for at home should understand explicitly where to go for care. One thing that we have been bad at in the health service is making things simple for people; we are really good at confusing them. So, in future, patients will know who is in charge of their care and who to go to for advice and guidance. Our information systems will be shared between ambulance service personnel, the out-of-hours service personnel, general practice primary care and the secondary care system. There will be a single record of care for individuals, and they will know who to ring if there is a sudden change in their treatment regime, or if they become unwell. In that way, we will stop the emergency care services from being immediately used to get people to secondary care locations, or for all sorts of other reasons that do not amount to emergency care. The pilot schemes will tell us a great deal, particularly about caring for those with chronic diseases, which is a major issue for us in Wales, which we have to crack, and we will also get some results over the next six to nine months. This is all geared towards ensuring that care services are appropriate, and that people understand how to use them, including an element of self-care. In future, the emergency care services will be used only for emergency care.

[223] **Mr Murray:** Could I just come in there to give you a brief idea of the potential here? We know from work done in England that about 60 per cent of patients brought to hospital following 999 calls are discharged without receiving in-patient care. We know from work done nationally across the UK and also from work that I did with a previous service that between 9 and 10 per cent of our emergency calls are life-threatening, although it is difficult to reach that level of specificity on the phone. In the north east of England, a system called NHS Pathways is being used, which is in beta-testing at the moment, and is awaiting a licence, but it seems likely to get one. That system allows call-takers to triage 999 calls rather than just to categorise them. They have reduced the proportion of category A calls to 25 per cent; we are currently at 41 per cent, and England generally is around 35 or 36 per cent. They believe that they can safely go even lower than 25 per cent, so there is a huge amount of potential there.

[224] We have already improved our 999 specificity, but we have also been doing a huge amount of work with NHS Direct. When they joined us, we agreed that they should have some outcome-based performance indicators, and that they would get from around 18 per cent homecare up to 40 per cent. They are currently just under 40 per cent, and have achieved that safely. If you take 999 dispositions and accident-and-emergency dispositions together, you see that there are now 10,000 fewer each year than there were when NHS Direct first joined us. So, we have already started laying some of those foundations, and initiatives like the falls pathway will help tremendously.

[225] **David Melding:** I have two supplementary questions.

[226] **Eleanor Burnham:** Could I make a point briefly?

[227] **David Melding:** This is an important evidence-taking session, and I remind members that we have a lot of business to deal with afterwards, so please do not repeat points that have been made earlier, and please do not make them at length.

[228] **Eleanor Burnham:** How do general practitioners fit into all this? Do you hope that they will extend their hours? It can be quite difficult for some people to get to their GPs. Thank you, Chair.

11.50 a.m.

[229] **Ms Lloyd:** GPs are crucial as they are the gatekeepers to most of the care that people in the community receive. Discussions are ongoing with general practitioners in Wales about their hours, but also about accessibility outside those hours. The success of the out-of-hours service for Gwent, which is provided by the trust, and engages with those local GPs, will be consolidated when the out-of-hours service is moved to Vantage Point House. So, all these emergency services will be together and we will get better triage systems and a better response, but the GPs are absolutely essential to this.

[230] **Darren Millar:** You mentioned the trial programme in the north-east with the new software in order to reduce the number of category A-banded calls. Is there a cost in terms of the time taken to get to the patient as a result of the extra triage that is required, because I assume that it takes a longer phone call to get to the right categorisation?

[231] **Mr Murray:** It takes roughly the same amount of time. It gives the call-taker a lot more discretion than our current system does. For example, in our current system, you ask whether the patient is alert, and if the answer is 'no', that is red—999. In the other system, there could be a supplementary question such as, 'If you shake them gently by the shoulder, do they respond?', and that might take you to an entirely different conclusion. It is not significantly longer. We dispatch the ambulance to the address while the triage is going on; there is a downside to that, because if we decide that the ambulance should be stopped, we have to stop it, but as long as we discuss that fully with the crew and they understand why we are doing it, and partly we are doing it for them to avoid the necessity for them to put themselves at heightened risk, we should have no problems with it.

[232] **Lorraine Barrett:** I am looking at Part 3 of the report, and the financial risks across all areas affecting the trust. Ann Lloyd, can you tell us whether it is realistic, given the remaining challenges to improving performance ,and the projected rise from £12 million in the current financial year to £23 million in 2009-10, do you think that all these aims and ambitions can be met?

[233] **Ms Lloyd:** It is extremely challenging—I can hear Mr Murray sniff at that—and we have decided that we must evaluate the capacity to achieve the required savings given the service change plan against the proposals for the full implementation of 'Time to Make a Difference'. We must ensure that the quality of care and service is not reduced at any time, and that it is able to fulfil the developments that have been discussed this morning well and properly, improve clinical team leadership and all the rest of it, and that we are able to provide the capital resource that will enable it to fully modernise its services. It is extremely challenging; it is not absolutely set in stone, because there must be some sensitivity around this in order to achieve the modernisation agenda and to achieve the part that it must play in DECS. To date, it has done extremely well in achieving the financial requirements that we have set it. On occasion, we have felt that what it has achieved was extremely challenging for it, given the changes that it was effecting. However, it has done it. We expect it to be able to achieve this, but we are sensitive to the fact that, at the same time, the service is being modernised, and work must be done to modernise that service, so there will be an ongoing discussion, as there has been this week, about the challenges that it is facing.

[234] This year, it has additional cost pressures, because we are mindful of the issue of fuel prices and we are discussing that with it, because that is very much outside its control, and there is the pay award and other such things, about which there are ongoing discussions. The situation throughout the whole of Wales, however, does not give the Minister and I any flexibility, so we will have to make considerable choices over the next month.

[235] **Lorraine Barrett:** Could you comment on the new technology to modernise and speed up the service such as satellite navigation—I do not know whether that would speed things up, I suspect it would depend on how it were used—and mobile data terminals. How much of a priority is it, Alan, to have this type of technology?

[236] **Mr Murray:** It is a top priority for us because we are currently using our resources relatively inefficiently. Our efficiency has increased over the last three years as a result of delivering the SCEP and Tim could probably give you some headline figures on that. Our cost per call has reduced slightly in absolute terms, but when you factor in 9 per cent NHS inflation, our cost per call in real terms has gone down very significantly indeed. However, we are still using our resources relatively inefficiently compared with our colleagues across the border, who have this technology. The technology throws up the location of the nearest unit immediately when the call taker verifies the location of the incident.

[237] We have satellite navigation in all our new ambulances, but the kind that we have requires numbers to be punched in. It is designed specifically to take its geographic information from the mobile data terminal. So, when you drag and drop the incident onto the particular responder, the incident details go to the screen and the location in eastings and northings. That is considerably more sensitive than having a map reference or a postcode as the information goes straight into the satnav system, so that they can start driving immediately. Also, as we know where our resources are, we can install more sophisticated technology to allow us to manage our deployment plans more effectively. So, this is a top priority. It is the best way that we have available to get more out of the same resource.

[238] **Lorraine Barrett:** I will leave it there because we have been sitting here for two and a half hours and I am liable to get deep-vein thrombosis and need to call an ambulance. [*Laughter.*]

[239] **David Melding:** I suspect that you will get an earlier set of questions at our next evidence-taking session, but I do not want to give too much away. That concludes the range of questions that we wish to put to you. I thank the witnesses for their clear and straightforward answers. This is an important matter for the general public and rightly we have had a long evidence session, but I realise that it is tiring for the witnesses as well as for Members. A transcript will be provided and if you feel anything has been incorrectly transcribed, you will have an opportunity to correct it.

[240] I suggest that we break for five minutes. We will be able to finish our agenda by 12.30 p.m. with a fair wind, but I appreciate the patience of Members this morning.

Gohiriwyd y cyfarfod rhwng 11.58 a.m. a 12.06 p.m.
The meeting adjourned between 11.58 a.m. and 12.06 p.m.

Ystyried Ymateb Llywodraeth Cynulliad Cymru i Adroddiad y Pwyllgor Archwilio ‘Mynd i’r Afael ag Oedi wrth Drosglwyddo Gofal’
Consideration of the Welsh Assembly Government’s Response to the Audit Committee Report ‘Tackling Delayed Transfers of Care’

[241] **David Melding:** You will have received a paper with the Government’s response as well as advice from our auditor general. Jeremy, do you want to amplify anything?

[242] **Mr Colman:** The only point that I would add, to clarify my letter, is that this is such an important subject and although the Assembly Government’s response accepts the committee’s recommendations, it is, perhaps for partly understandable reasons, a bit thin on how exactly it will implement them. Our work has shown that it is a whole systems problem, but one has to

plunge into the local detail.

[243] I decided some weeks ago to ask my staff to undertake some follow-through work, which is under way and will be reported back to committee reasonably soon. I did that because we were conscious that the Assembly Government's response would be unlikely to get into the detail of those. As far as it goes, it is a good response, but we wanted to see detailed implementation of the recommendations. Some of the things that we have seen have represented dramatic improvements in the situation in some localities. So, that is good. However, we need to do more work.

[244] **David Melding:** Are Members content with that? We need a fairly swift session and not at the length of our previous ones to tie up the follow-through. I see that Members are agreed.

12.07 p.m.

Cynnig Trefniadol
Procedural Motion

[245] **David Melding:** Subject to the committee's agreement, I wish to conduct the remainder of the meeting in private. I propose that

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

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

Derbyniwyd y cynnig.
Motion carried.

Daeth rhan gyhoeddus y cyfarfod i ben am 12.07 p.m.
The public part of the meeting ended at 12.07 p.m.