Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Archwilio
The Audit Committee

Dydd Iau, 13 Tachwedd 2008
Thursday, 13 November 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
Huw Lewis	Llafur Labour
David Melding	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives

Eraill yn bresennol
Others in attendance

Gillian Body	Swyddfa Archwilio Cymru Wales Audit Office
Jeremy Colman	Archwilydd Cyffredinol Cymru Auditor General for Wales
Ian Gibson	Dirprwy Bennaeth, Uned Llywodraethu Corfforaethol, Llywodraeth Cynulliad Cymru Deputy Head, Corporate Governance Unit, Welsh Assembly Government
Phil Jones	Swyddfa Archwilio Cymru Wales Audit Office
Gill Lewis	Swyddfa Archwilio Cymru Wales Audit Office
Geoff Lang	Prif Weithredwr, Bwrdd Iechyd Lleol Wrecsam Chief Executive, Wrexham Local Health Board
Ann Lloyd	Pennaeth, Adran Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cynulliad Cymru Head, Department of Health and Social Services, Welsh Assembly Government

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 1.29 p.m.
The meeting began at 1.29 p.m.

Ymddiheuriadau a Dirprwyon
Apologies and Substitutions

[1] **David Melding:** Good afternoon and welcome to this meeting of the Audit Committee.

[2] I will start with the usual housekeeping announcements. These proceedings can be conducted in Welsh and English; when Welsh is spoken, there is a translation on channel 1, and should you be hard of hearing, you can amplify our proceedings with the headphones on channel 0. Please ensure that all electronic equipment is switched off completely—not even left on silent mode—as it will interfere with our recording equipment. So, please switch everything off that is electronic.

[3] We do not anticipate a routine fire drill this afternoon, so if we hear the fire alarm, please follow the ushers' instructions and leave the building safely.

[4] There are no apologies or substitutions; we have full attendance this afternoon.

1.30 p.m.

Gwasanaethau Therapi Ocsigen yn y Cartref
Home Oxygen Therapy Services

[5] **David Melding:** We will now discuss the findings of the Auditor General for Wales's 'Home Oxygen Therapy Services' report. This report shows that the Welsh Assembly Government intended that the new contract for home oxygen therapy services in Wales should integrate and streamline services for patients. However, the report makes clear that the national health service in Wales was not sufficiently prepared for the introduction of the contract and that the intended clinical benefits from improved specialist assessment services for patients have been slow to be realised. The report concludes that there are a number of important lessons to be learned from the way in which the new arrangements for home oxygen therapy services were implemented in Wales.

[6] I welcome to the meeting Mrs Ann Lloyd, head of the Department of Health and Social Services, Welsh Assembly Government, and Mr Geoff Lang, chief executive of Wrexham Local Health Board. We will start by asking the general question of your initial response to the report and then we will drill down into much greater detail, so please be brief in your opening comments. Can you first say who you are for the record, so that the transcribers can recognise who you are?

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

[8] I concur absolutely with your opening statement. The whole point of the change in this contract was to ensure that people would be reassessed for their oxygen needs so that we could modernise their services; it was not about saving money, but about using our resources more effectively. Patient surveys state that the change in contract is being held in huge regard by the patients who access the service and that the contract is being monitored extremely well, even though the number of indicators that we are using has expanded considerably over the past few years. Assessment is improving, but no doubt we shall come back to that issue

because it has been extremely slow in some places.

[9] It is sad that such a good outcome was marred by this chaos at the beginning of the contract. We had excellent responses from the community pharmacists who stepped back into the breach. There is a great deal in this report that we must ponder upon, and we must ensure that no such chaos is ever again a part of the implementation of a contract.

[10] **Mr Lang:** Good afternoon. My name is Geoff Lang and I am the chief executive of Wrexham Local Health Board. I echo many of Mrs Lloyd's comments about the intent of the contract and the difficulties that we have experienced in the process. It is important to note that there was a significant amount of effort expended by Welsh Assembly Government and local health board colleagues in moving forward through what was a difficult implementation for a whole range of reasons that we will touch upon. At the end of the day, there are lessons to be learned, and we must honestly assess those and document them for future reference.

[11] **David Melding:** Thank you for those opening and candid remarks. I am sure that we will continue the investigation in that spirit.

[12] **Lorraine Barrett:** Paragraph 1.6 of the auditor general's report states that the department saw advantages in joining the new contract with England for the reasons set out. So, if your department identified those benefits, why did the NHS in Wales not recognise and manage more effectively the risks involved in such an approach?

[13] **Ms Lloyd:** We considered well whether we would join with England. England had the expertise and also the purchasing power, which was important in this instance as we knew that we could not afford a huge escalation in cost because we wanted to use any resources that were available to assist with assessment. We discussed it with the oxygen reference group that was established, whose job it was to act as almost project assurance for the management of this contract. The group considered with us whether we should have a pilot scheme, but it felt that it was quite difficult, and probably confusing for everyone, if, as we were being regarded as a region under the Department of Health contract, we suddenly decided to run a pilot project. It could have been extremely confusing. Its recommendation was to run with the English contract as it stood.

[14] **Lorraine Barrett:** Hindsight is a wonderful thing, but was it a mistake to participate in a joint England-and-Wales contract?

[15] **Ms Lloyd:** I do not think so, because the advantages that we sought, we gained. The implementation of the contract in England ran into exactly the same problems, as I am sure the Auditor General for Wales will agree. We were lucky that we got out of those problems much faster in Wales, but the contracts had the same implementation problems. So, it was caused by the system, rather than by joining with England to access its expertise.

[16] **Eleanor Burnham:** I suppose that my mother must have been lucky, because she had it last year, and, by then, things had settled down and there were no problems. Looking at paragraph 1.11, I see that the department recognised that the framework for contract implementation was very tight, and apparently Air Products had concerns about the lack of contingency time, because the preparation was known to be slow. I assume that Mr Lang knows about the concerns of the local health board as to whether this would be ready for the start date on 1 February 2006. Patients' care depended on this service, and its introduction should have been seamless in theory and in practice. Given the ongoing concerns about whether it would be ready, why was a further postponement of the new contract staff not pursued?

[17] **Ms Lloyd:** We must remember that the guidance on this contract went out in March

2005 to prepare for its implementation by October 2005. A considerable amount of work had already been done on gathering patient details, although that was slow and Mr Lang will explain why the LHBs did, or did not, gather that information. It was sometimes difficult to obtain, because you had to seek consent, and all the rest of it, before patients' details could go to the new producer.

[18] We were beset by delays on this contract, as you can see from the helpful annotation in appendix 1 to this report. Nevertheless, the view was that we would stick to the February 2006 start date. The Welsh Assembly Government and Community Pharmacy Wales had written to the service in September to outline that the start date would be February 2006, and nothing came back to me to indicate that there would be considerable difficulties and gaps in the information required. With hindsight, I should have been far more rigorous about the risk analysis of this particular contract, given what happened subsequently. Indeed, we have been extremely rigorous about the contracts that we have had to implement since then, because we learned straight away that there were some local health boards and general practitioners who were not clear about the service that they would have to provide and oversee.

[19] **Mr Lang:** One of the points that Mrs Lloyd referred to was about the gathering of patient information and communication with patients. It was a very complex exercise, because no single source of information was collated that enabled us to prepare, to write to patients, to seek their consent, and to hand it all over to the provider. Local health boards had to undertake a task involving referencing a series of data sources. One aspect of the previous arrangements on which we had very good information was where concentrators had been supplied. We knew all the patients, and everything was registered. However, where patients were receiving a cylinder supply prescribed by their general practitioner, there was no database, so we sought that information from previous prescriptions, from community pharmacists, and from general practitioners. Then local health board staff had to undertake a significant triangulation exercise, which consumed quite a lot of time. So, that was a practical task, and, on reflection, there is an issue as to whether that progressed at the speed with which it should have progressed during the time when there was uncertainty about the contract. I am sure that we will return to that, because, potentially, an opportunity was lost there to carry out preparation work.

1.40 p.m.

[20] It also took a while to write to every single patient to seek their authorisation to send their information to the supplier. Some responded very promptly, but others did not and we had to chase them. So, it took a little time to get that work done; it was not an automatic transfer.

[21] **Eleanor Burnham:** If you were aware of all this, could you not have communicated with Mrs Lloyd, who is a very powerful person in this scenario? Should Mrs Lloyd not have put a stop to the process? If things were in such a chaotic state, surely anybody could have seen that; you did not need hindsight to see that. However, why did the contractors' warnings of the lack of contingency time not set alarm bells ringing?

[22] **Ms Lloyd:** That has to be set against what contractors always say, because they will always want more time for preparation. We had to make a judgment about whether to run it at the same time as in England and about the risk assessment that had been built up between us. The judgment at that time was that there had been sufficient time to prepare, and that the information and communication to the services that would have to operate this new contract was sufficient to allow for a reasonable transfer of responsibility at that date.

[23] **Eleanor Burnham:** A 'reasonable' transfer.

[24] **Ms Lloyd:** Yes. We always have to work on the basis reasonableness.

[25] **David Melding:** Bethan will follow up some of these points on the patient issue. There is still a question to be asked.

[26] **Eleanor Burnham:** I am only asking—

[27] **David Melding:** I was talking to the witnesses, not you, Eleanor Burnham. It was not a gentle rebuke.

[28] **Bethan Jenkins:** Geoff Lang has clarified some of the points that I was going to raise under paragraphs 1.13 to 1.15 on the local health boards being able to supply details of all patients. However, could you tell us why you could not work out the system earlier? How could you tender for a contract if you did not have that information from the LHBs?

[29] **Mr Lang:** I will explain the process that we went through. Could we have gathered those data earlier? We could have started the process earlier to get those data. One concern was about having a list of patients that was current, valid and up to date. By the very nature of oxygen services, people are constantly joining or leaving the list, whether because of improvements in their condition, or, sadly, because they die. That is the nature of the condition. So, we had to have a validated and current list if we were to write to every patient. Had we done it six months in advance and sealed the list, we might have been in the position of sending letters to the relatives of deceased patients. We did not want that, so there was an ongoing review of its validation, and there was a judgment call to be made about how long to leave it so that the list would be current. Had we started the work very early, we would have run the risk of the list being out of date. Not only were there logistical issues with the supplier in that regard, but also very real, personal issues for the families of the patients who had died while still receiving oxygen therapy. So, there was a balance to be struck.

[30] On reflection, given the effort that it took to sign off those lists and the pace at which they were delivered, I see that it took longer than we thought that it would. It was a more complex task to get to the answers, and it involved far more hands-on time than we had hoped it would, because we hoped that the data sources would help more than they did. So, timing became a problem.

[31] **Bethan Jenkins:** Have those systems now been refined?

[32] **Ms Lloyd:** The systems are working very well.

[33] **Mr Lang:** We have very full details of every patient.

[34] **Ms Lloyd:** To answer the second point of your question on how you can go out to tender if you do not know who you are tendering for, there is a difference between individuals receiving care and the overall volume of service that needs to be delivered. We knew what the overall volume was. The complicating factor was pinpointing exactly who those patients were and what type of therapy they were receiving, because there are lots of different types of therapy. That was what was so complicated for the local health boards.

[35] **Bethan Jenkins:** The second part of my question is on the delay caused by the legal challenge by the failed bidder. I found it unusual that there would be a legal challenge. Could you expand a little on that, and explain why you did not take the time to get the necessary patient information while that process was taking place?

[36] **Ms Lloyd:** The legal challenge came when the implementation date was October 2005. The legal challenge caused a delay and therefore the tender contract could not be signed

until later. That is why we extended, with England, the implementation date to February 2006. On the question of why we did not know the real nitty-gritty detail, I endorse what Mr Lang said: you have to get it absolutely right for the patient, so you have to go as near as possible to the transfer of a contract. You also have to be sensitive about gathering this information, and you have to make sure that it is accurate and not out of date. So, they could have gathered it nine months before hand, but it might have been seriously out of date by then. As he said, the local health boards had to judge when to do it. Having been given guidance in August 2005 about when we could sign the contract, and we wrote in September to say that it would be delayed until February 2006, LHBS, knowing that, had to start to refine these lists so that they would be really accurate.

[37] **Janice Gregory:** This was clearly an incredibly stressful, distressing time for those who were in receipt of the product. I am sure that all Assembly Members will have had contact with some of those people. Taking into account everything that you have said so far about why everything was on such a short timescale, why did you think that it was more important to start on time than to ensure that patients were fully aware of what was going on and to allay their fears?

[38] **Ms Lloyd:** Quite honestly, no-one was aware of the scale of the problems facing us at that time, because the communication was not coming back in that way. A lot of effort had been put in by us and by the local health boards to keep people up to date. In other words, good guidance was sent out to GPs by GPC Wales and by Air Products to inform them of the changes that would take place and what they had to do about that. That was issued by local health boards in January, I think. Prior to that, in November, we set up a website containing all the information. LHBs held professional development days for general practitioners and their staff, which concentrated on the different way of accessing oxygen following the transfer of the contract. After consent was received from patients, Air Products sent them a detailed leaflet on what to expect.

[39] I have talked to Mr Lang about this. For some general practitioners, the new forms were complex and we needed to back up the training that we gave to them. However, that has been overcome in time. Everyone made an effort to ensure that the communication to those who would have to access or use the service was thorough, but there was still a nervy period when people were running out of oxygen and they did not know how to access the new service. As you would expect, because Air Products was going for new, urgent, and emergency patients first, it was a natural reaction for the longer-term patients to try to access it, namely those who had six-month contracts and were still being supplied by pharmacists. If someone rang up to say that they would run out in three days, they might then be accessed as an emergency. That is why the situation escalated in the way that it did.

[40] **Janice Gregory:** You were very frank at the beginning, Ann, and said that you accepted that this was chaotic. I am sure that lessons will have been learned. However, I am keen for you to tell us how you will ensure that you secure effective and timely communications with patients in any future service changes?

1.50 p.m.

[41] **Ms Lloyd:** First, we would have a clear process that would enable GPs, or community pharmacists, or whatever professional group we were dealing with, acting on behalf of the patient, to know precisely when we needed information. I think that we might have had an easier way around the seeking of consent, which is always time-consuming. We might also have sought a better agreement with individual patients receiving treatment, so that we did not have to go through quite such a rigmarole, although of course their confidentiality must be respected. We would make jolly sure that everyone who was going to access the service knew exactly what the rules were, so as to batten down the panic, giving them a

greater assurance. I think that we would have risk-assessed it more highly—having seen this, and we have done so subsequently—given people's natural reactions when something that they depend on is might not be available. What do we all do in that situation? We have seen the runs on supermarkets for water, for example. Therefore, we have to increase the scale of risk assessment, and ensure that people are well-equipped to cope with that.

[42] It is about information, streamlining the system, and almost re-risk-assessing it daily, given the intelligence that is coming backwards and forwards. The intelligence streams were just not good enough on this, because we would have sought to avoid it, as we did when it happened—we acted extremely quickly when it was escalated up to me. However, we must ensure that we are completely confident that our communication backwards and forwards, and our learning and education, is absolutely right, to try to make it as easy as possible for the professionals and individual patients to be reassured that everything will be smooth. This will not be the last contract that goes over, and we have done more since.

[43] **Darren Millar:** The auditor general's report notes, in paragraphs 1.17 and 1.18, that it was always envisaged that there would be a six-month transition period in the contract. The contractor suggested that there should be a phasing of the introduction of the contract—by the nature of someone's particular needs, for example—and yet, for some reason, you decided not to take its advice. We heard in your reply to an earlier question from Bethan Jenkins that you did not take its advice regarding the contingency time either. Why were you ignoring the call from the contractor, on this front, to have a phased introduction in this way?

[44] **Ms Lloyd:** We did not ignore its advice—it was phased. The whole purpose of this was that the new contractor would take over new and urgent patients; it already managed half of Wales in terms of concentrators. The intention was that people who were on six-monthly prescriptions would continue with those, and that, when those were coming to an end, they would be passed on to the new contractor. We did not expect that, from day one—and that was not the agreement that we had reached with the contractor—it would provide a service to everyone who was on oxygen, wherever they were.

[45] So, it was phased, but the concern was so high once we were in the new contract that we were finding—LHBs will tell you what they found—all sorts of people coming in as urgent patients, or new patients on occasions, who had long-term contracts, namely six-monthly prescriptions. However, because there was a concern that there would be real adverse delays in receiving their oxygen, people were putting in requests for 'urgent' cases, whereas that was not necessary at the time.

[46] **Darren Millar:** However, you did not take on board the recommendations to phase by the type of illness or therapy.

[47] **Ms Lloyd:** That is exactly what we did.

[48] **Darren Millar:** That is not what the report states. Paragraph 1.18 suggests that:

[49] 'Air Products told us that they had strongly recommended phasing the transfer of patients in need of home oxygen services across to Air Products, for instance by type of therapy required. However, the Department took the view that it had limited flexibility to differ the implementation arrangements'.

[50] **Ms Lloyd:** The type of therapy applied to, or required by, patients was split into two: the cylinder services and the concentrated services. The concentrated services are used by people who have a high need for oxygen. That was our differentiation between therapies, rather than splitting it into six or seven types—whether you have oxygen on one day for two hours and so on. We differentiated, as I think was recognised, between those two basic

types—

[51] **Darren Millar:** Were they on a much broader base?

[52] **Ms Lloyd:** I do not recall the contractor advising me on how we should do it—phasing it on people who only need a small amount of oxygen on a daily basis or intermittent oxygen. I do not recall that; I have not seen the correspondence or the evidence on that.

[53] **Darren Millar:** Just for the sake of clarity, can we have some help on this?

[54] **David Melding:** Jeremy, do you accept that Ann's account is accurate?

[55] **Mr Colman:** She says that she has not seen the evidence. The report has been discussed in some detail with staff in the Assembly Government and, on that basis, we are assured that it is accurate. You have signed up to it.

[56] **Ms Lloyd:** I understand that. I am happy to go back to see if there is any correspondence. Certainly, when I asked, I could not find any. Of course, no-one who had anything to do with this is now in this division. So, I am happy to go back to look at the contractor's precise definition of therapy, so that we can all be clear.

[57] **David Melding:** Jeremy, does any of your staff want to come in on this?

[58] **Ms Body:** My understanding is that the contractor said that it raised this issue with the Department of Health, so while there would have been some Welsh involvement in that, it would not have been raised with Mrs Lloyd personally.

[59] **Ms Lloyd:** Thank you, Gillian.

[60] **David Melding:** Your honour is restored. [*Laughter.*]

[61] **Darren Millar:** I know that Geoff wants to come back on this issue, and I look forward to his answer, but why did the department take the view that it had this limited flexibility when it seemed to be referring to the Department of Health. That is obviously not a question for you, so perhaps Geoff could respond to my earlier question.

[62] **Mr Lang:** [*Inaudible.*]

[63] **Darren Millar:** Okay. Why did you take the view—[*Inaudible.*]—this is in relation to these different therapies, so there is no point in asking that question, because clearly there is a question around accuracy and what this refers to.

[64] **Ms Lloyd:** On the question of piloting, we asked for the advice of our own oxygen therapy reference group, which, as you know, included the great and the good who knew all about oxygen therapy along with the consultants who would provide the assessments. On its advice, we did not think that we would gain much from exercising a pilot roll-out, because it felt that it would be confusing and that the system needed to start to run, as it had been delayed for so many months. So, we sought advice from our own reference group, which is what it was there to do. We were only one of 10 regions—they called us a region—under the Department of Health's contract. It considered that we should go with the arrangements in England.

[65] **Darren Millar:** But is not the contractor in a better place to say whether it has the capacity to deliver a contract? Given that it had flagged up the need to phase the introduction across a range of different therapy types, that it had said that it needed more time to

implement the new contract, that it had suggested that there needed to be a pilot scheme and that you ignored all of those suggestions, were you not setting this up to fail?

[66] **Ms Lloyd:** We have to remember that the contractor signed up to the contract, which was to guarantee a full service from 1 February.

[67] **Darren Millar:** [*Inaudible*.]—ending these things.

2.00 p.m.

[68] **Ms Lloyd:** Yes, but it signed up to a contract. If it really seriously believed that it would not be able to deliver the contract, it should not have signed it.

[69] **Darren Millar:** However, you did not think that they were three flags that suggested that this was a high-risk strategy for you to be following.

[70] **Ms Lloyd:** We knew that there was a risk attached to any transfer of a contract, but the contractor had signed up to it.

[71] **Darren Millar:** However, the company also said that it needed more time; it suggested a pilot scheme and phasing in the contract.

[72] **Ms Lloyd:** Yes, we know that.

[73] **David Melding:** I think that that has been acknowledged, Darren. We have had a very clear answer.

[74] You were constrained by the fact that you wanted to maintain an England-and-Wales approach. Is that satisfactory in terms of devolution? While we need England-and-Wales contracts or approaches, there does not seem to have been much room for manoeuvre built in to accommodate a particular situation in Wales.

[75] **Ms Lloyd:** No, and that is another learning point. We had to balance whether we had the money and the expertise to manage a very significant contract like this one on our own. We were concerned, as we were only regarded as a tenth of the contract, whether or not we would have been adversely affected by our limited purchasing power. While Welsh Health Supplies does very well for us in Wales, it still ties in to the Department of Health's contracts when we deem it appropriate. It was because of that and because we knew that we did not have the specific expertise in Wales that we could gather together at the time—this was in 2004-05—that we decided to run with the larger contract. Obviously, for every contract that we have subsequently run, we have decided whether or not we should go with England. As you know, on some of the contracts, like the consultants' contract, we have not gone with England and we have done our own, because we believed that we had the expertise and the will here to be able to do that.

[76] **Lesley Griffiths:** If we look at paragraphs 1.19 and 1.20, which focus on the unanticipated demand that was evident at the beginning of the contract, we see that even the number of telephone calls was hugely underestimated. Why do you think that there was that unforeseen level of demand?

[77] **Ms Lloyd:** I think that there was a lack of clarity in the communication to GPs and patients and people naturally started to get extremely anxious about their supply. They rely on that supply—to state the obvious—and extra requests were going through to GPs from people whose supplies might have been running out in the near future; GPs were obviously responding to that, quite naturally, and putting forward the requests. So, although you can

expect an increase in demand or inquiries in the transition period, this was absolutely enormous in terms of the escalation in demand that was experienced by the contractor.

[78] **Mr Lang:** Just to add to that, if I may, there was an agreed transition process for new patients and concentrated patients and the expectation regarding the volume of contact was built around that. Due to the anxiety and the concern, I think that the distinctions got blurred regarding which patients should have been accessing the Air Products contract at which point in time and, therefore, the body of patients seeking to access Air Products and its services was bigger than expected. The distinction got blurred and people on longer-term therapy, who were unsure about how to get their oxygen therapy, rang their GPs, who said, 'The only thing that I can do is send you more of these prescription forms or you can try ringing Air Products'. There was a general sense of anxiety and concern among patients and GPs were unable to do anything, in an urgent situation, other than fill in a prescription and send it to Air Products, because there was not enough time to arrange other things. I think that these things were compounded. I could not explain why the numbers were quite as large as they were, but there were a range of factors and, as Mrs Lloyd said, a lot of it relates to the nature of the condition and the therapy; when you get anxious about it, you really want it sorted.

[79] **Lorraine Barrett:** I felt that there is a similarity here with the out-of-hours GP contract, when the number of calls in the Cardiff area, which is the area that I am most aware of, far outstripped what they could cope with. That was because of the build up of publicity and people were unsure, so they were phoning up to check. I suppose that you would agree that if this had all been done properly, with everyone informed well in advance of what changes were to take place, there would not have been this panic. The number of calls was phenomenal. I think that the same thing happened to some extent with the out-of-hours provision.

[80] **David Melding:** You needed a better risk assessment, as you said earlier.

[81] **Mr Lang:** Returning to the earlier point about engagement, and how we would communicate better with patients next time, in an ideal situation, we would have wanted the opportunity to have two or three sets of correspondence to patients: the first to ask about information, the second to remind them of what was going on, and the third from the supplier to reinforce that. With the timescales concertinaed, we were unable to do that, and the level of uncertainty was higher than it would have been had we been able to manage the engagement in a more structured manner.

[82] **Chris Franks:** Page 14 refers to the order forms. I notice that there is reference to faxes and phone calls, but not e-mails. I take it that we are only talking about phone calls and faxes. I am intrigued by the fact that e-mails do not figure in this, but perhaps that is an aside.

[83] I have listened with interest to the discussions about problems with patient privacy and the need for accurate lists, and all of this caused concertinaed timescales. However, I am very disappointed that the order forms seemed to cause such a problem. Whose fault was it? If a huge number of GPs were struggling, then I suspect that the problem was not in the surgery, but in the design of the forms or in the instructions that related to them. I can only suggest that it was the department's responsibility to have workable forms. Is that a fair comment?

[84] **Ms Lloyd:** In discussing with Mr Lang the problems that his general practitioners may or may not have faced in filling the forms in, the view that he has—he can tell you himself—is that these forms were designed to get a much more accurate assessment of the needs of patients. Some of his colleagues were having some difficulties in filling those in.

[85] **Mr Lang:** When the reference group looked at the design of that forms—the group undertook work to look at that—it did so in the context of a specialist assessment service, that

is, that these assessments would be by specialists, who would undertake thorough examinations and be able to identify the flow rate of oxygen that patients required, how many hours they required every day, the nature of delivery and so on. We were left with a situation in which GPs could do some of the early assessment, which asks whether these patients, on face value, look as though they need oxygen, yes or no. However, trying to quantify flow rate and hours of delivery is beyond what you would expect of general practitioners. They would normally arrange an emergency supply, with a specialist assessment to follow. The forms could deal with the emergency supply of oxygen but, other than that, they required a lot more detail, because they were designed for specialists. There was an issue about thinking through who would use the forms. The scenario that we found ourselves in was that GPs were generating a lot of forms, because of contact from patients, whereas the assumption under the contract was that GPs would not be generating so many forms, because we would have specialist assessment services, and they would be post-discharge prescriptions from hospital and so on. So, there is an issue about the design of the documentation, and whether it catered for all needs.

[86] **Chris Franks:** So, forms that were not necessarily designed for GPs were being used by them, and the result was chaos.

[87] **Mr Lang:** The result was the supply of oxygen. It was not as specific as it should have been. Patients got an oxygen supply, but it was not as specific in its modality and its delivery as a specialist assessment would have given them. I would not agree that it was chaos. The patients who had a form submitted for a supply of oxygen got their oxygen; what they did not get was as specific a prescription as might have been given by a specialist.

2.10 p.m.

[88] **Chris Franks:** I appreciate that you need specialist information, but what I cannot quite grasp is why these more complex forms were being given to GPs. Why did they have them, if the forms were not designed for them?

[89] **Mr Lang:** There was only one order form for the contract, which, as I said earlier, was designed in relation to a specialist and detailed assessment that, before commencing oxygen, would give the appropriate therapy. The reality was that we had people who needed replacement prescriptions and new prescriptions that GPs were generating for emergency supply. The form was appropriate enough to get a supply delivered, but it was not one that a GP could follow through to the nth degree of detail.

[90] **Chris Franks:** From the evidence, the message that I am getting is that we were causing busy GP surgeries unnecessary work and stress, and causing difficulties for the patients, because there was just one form to work from. Was this trialled at all with GP surgeries?

[91] **Ms Lloyd:** I do not know that I necessarily agree with that. Guidance had been given to the general practitioners from their own society. It had not been flagged to us that all of them would not be able to use this form. It was supposed to be underpinned by a detailed assessment, but they could use the form for a simple requirement for oxygen—they did not have to fill in everything. The problem that Air Products faced was that these were wholly incomplete in some instances, and because no response came back from Air Products, because it had been flooded with forms, yet another form would go in from the GP. That was the issue that we faced. Have the GPs been better equipped to fill in these forms, Geoff?

[92] **Mr Lang:** Training and briefing sessions were given at the time for GPs on the form. GPC Wales provided information about how to use the forms, but it would be fair to say that there was not comprehensive cover, so not every GP was wholly familiar with the form on the

day. That is probably true of most systems that change for general practitioners. On whether or not they were trained, there was awareness, which was consolidated as we went through. In my patch, we have a number of practice pharmacists who go out to work with the practice team, and they spent a lot of time with practice nurses, GPs, and practice managers in the early days taking them through how to use the forms, and making sure that they were able to use them, and it settled down over time. So, there has been an improvement and I am not aware of comments now, or for some time, that there are problems with the documentation. It was a very comprehensive document and, in the early days, with lots of pressure, people found it difficult to adjust to using it. It was not designed for simple use—it was designed for everything, which caused some problems.

[93] **Eleanor Burnham:** Could that problem not have been solved by asking the GPs to design the form, so that they could use it? You could perhaps have an additional part for the specialists. It is fundamental. If you do not ask these people, who are busy people and under stress, what they want on these forms that they have to use, they will not be able to use them, surely?

[94] **Mr Lang:** They were involved. GPC Wales was involved alongside the Welsh Thoracic Society, the consultants' organisation and specialist nurses, physiotherapists and others who discussed the form, but created a single comprehensive form. That is what the supplier wanted, a single document that could be used for everything, in order to streamline the system. The issue then was whether individual GPs knew which parts of the form to fill in, and how, in order to get what they wanted. That was where the problem arose.

[95] **David Melding:** Is the same form still in use?

[96] **Ms Lloyd:** Yes, it is still in use.

[97] **David Melding:** So, is compliance now at a rate that you would regard as proper?

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

[99] **David Melding:** So, that indicates that it was temporary problem.

[100] **Irene James:** Paragraphs 2.4 and 2.5 on page 15 indicate that the pharmacists who were going to lose the oxygen business after February 2006 had run down their services and needed to negotiate a new contract to put those services back into place**.** Those arrangements, while essential to secure the provision of home oxygen, came at a huge cost.

[101] **Ms Lloyd:** To whom?

[102] **Irene James:** The pharmacists.

[103] **Ms Lloyd:** The pharmacists were charging. As soon as it was flagged up that there was a major problem on the first day, we authorised that FP10s, the normal prescription forms, could be used and taken to a community pharmacist. We asked the local health boards to negotiate with the local community pharmacists, because they are on the ground, to resume their service. If costs were incurred by the community pharmacists, that would be part of their responsibility. The community pharmacists were absolutely great.

[104] **Irene James:** Do think that it was reasonable to tell the LHBs that they would have to meet the cost of any increase in charges?

[105] **Ms Lloyd:** They had the money. They had the resource.

[106] **David Melding:** Mr Lang, are you brave enough to respond? [*Laughter.*]

[107] **Mr Lang:** It was not a wholly unreasonable position. It was fair to say to LHBs, 'You resolve the situation', because we had the relationship with contractors on the ground, and, as you can see from the report, different positions were reached in different parts of Wales. That depended on the position that the local health boards took, and also on the position that community pharmacists took, because they took different approaches in different areas.

[108] In north Wales, we had early discussions with our community pharmacists. We acknowledged that they had started to run down their services, so there were costs involved in getting them together, and the fee structure did not necessarily reflect that: it was a traditional fee structure for a traditional contract. We found ourselves in a situation where we were trying to use a traditional structure to reflect the fact that, as well as the traditional delivery, there were issues about gearing up, and that, ultimately, community pharmacists were not obliged to help us. We had terminated their contract and set up a new national contract. I was mindful, in my discussions with community pharmacists, that they were the only supplier that we had to work with. We were able to agree in north Wales that those fees had not been updated for a while, and did not necessarily reflect the time spent by pharmacists doing things. We agreed that a reasonable reflection of that was a 10 per cent change. I still think that that was a reasonable position to reach.

[109] Community pharmacists and LHBs in other areas had different discussions, partly because of the stance that community pharmacists took in certain parts of Wales, which was different from the stance taken in other areas.

[110] **Huw Lewis:** I want to talk about the story of the plans for specialist clinical assessment services and how that developed. It was decided to go into a bidding process, with the LHBs submitting bids for the clinical assessment that they had assessed that they needed. They put a bid in for around £5 million plus, which was immediately rejected. Revised bids were asked for and came in, and were immediately rejected. We ended up in a situation where £36,000 was allocated on a per-LHB basis; it was put out the door to them.

[111] This story strikes me as worrying on several levels. First, is it routine that bidding processes are this dysfunctional in the Welsh NHS? There is a vast discrepancy between the £5 million plus that the LHBs asked for and the £700,000-odd that they ended up with. Were they trying it on? Are they not very good at putting figures together? Is there a vast discrepancy between what is required at LHB level and the resources that are available for you to commit? The mismatch seems enormous.

2.20 p.m.

[112] The second part of my question is: how did we get to a point where local health boards of enormously different character, size, population area and, obviously, need in terms of levels of respiratory illness, for instance, which vary greatly from one part of Wales to the other, all ended up with an equal amount of cash? Regardless of how much cash that is, why is it considered to be a situation where you can allocate the cash equally to each area? Was it a case of someone saying, 'Let us close our eyes, cross our fingers, throw some money at this and hope that it sorts itself out.'? How did we get from £5.3 million to £36,000 per local health board?

[113] **Ms Lloyd:** The process was that, as part of this contract, it was really essential that the assessment service should be set up. In Wales, when we first advised the Minister back in 2003, we took the decision that additional resource should be bid for under the budget planning round to allow this service to be set up. That did not happen in England. England did

not give them a penny; they had to do it from within their own resources. You still have to question whether additional resources actually would have been required in the end when you see what Blaenau Gwent did, not using any additional resources, to establish its own assessment service from within its own resources. The Minister had been successful in acquiring a small additional resource for assessment services. The reason why bids were requested was exactly your point—that there would be variability, as one would expect to be the case throughout Wales, and we wanted to be fair and reasonable and to reflect that variability. However, the bids came back at an enormous price, far in excess of any money that we had, and also reflected this super gold standard of the UK's British Thoracic Society.

[114] **Huw Lewis:** They were trying it on.

[115] **Ms Lloyd:** No; they were reflecting the super gold standard.

[116] **Huw Lewis:** They must have known that they were wasting everyone's time.

[117] **Ms Lloyd:** No; I do not think so. They would not necessarily have known what resource was available. Nevertheless, we told them that we could not afford the super gold standard and asked whether they would please start on the journey of the assessment to set the assessment up. We also asked for extra bids, which still came in fantastically above anything that we were able to do.

[118] The year was progressing and we still wanted to encourage them to establish their assessment services. We had received only a partial year cost in any case. We decided to get the money out through the door to make sure that there was an incentive behind the assessment. We could not waste any more time and we decided that we would have to do something that we did not particularly want to do, because we wanted to reflect variability. However, we just had to give them all the same small amount of money to pump-prime their development of this assessment service.

[119] We were also of the view that, if one organisation could do this highly successfully by absorbing and recycling its own resources, particularly in a part of Wales where you would expect there to be an enormous demand, the others could probably do it. We had bid for the money; we had acquired more, and we wished to see what would happen during the next 12 months to see how they would get on with establishing effective assessment services, and then what the quality of those services was like and how we could step forward in terms of reaching this ultimate goal, if that was where we wanted to go.

[120] We reviewed that in 2006-07, and we decided in 2007-08 that we should again provide a pump prime, because the assessment services had not been taking off as we had had expected. We understood that it was complicated to negotiate with the trusts and other organisations to provide the necessary staff and that staff were in fairly scarce supply. However, we wanted to give an incentive to them and so we sent out the money and it is still out there; it is a constant uplift to them.

[121] **Huw Lewis:** Thank you for that—

[122] **David Melding:** I think that Mr Lang wants to add something.

[123] **Mr Lang:** On the submissions, regardless of whether local health boards were trying it on or exaggerating the figures, I think that it is important to note that, as Mrs Lloyd said with regard to the standards, at the beginning of the journey of implementing the contract, it was agreed that the British Thoracic Society guidelines were the basis on which we would look to develop. We should remember that there were consultant physicians, respiratory nurses, general practitioners, pharmacists and others on the steering group that looked at the

contract, so there was a fairly clear understanding in the service in Wales that that was the standard that we were aiming for, and the bids were developed on that basis. I also know, from discussions with one of our consultants who was involved quite heavily in some of the process, that that was the standard they were looking to deliver.

[124] The British Thoracic Society guidelines do cover oxygen assessment, but they also cover a whole range of appropriate interventions and support that you might give a patient if they do not have oxygen. The answer is often not as simple as saying, 'We can get this person off oxygen.', because that patient needs to be confident that they can cope without it, so there are pulmonary rehabilitation services and a whole range of other things available. So, the models that came in were to establish a full assessment service with the appropriate support. However, that exceeded the resource available.

[125] One of the issues that we missed was a mature discussion about which bits of the resource we should progress if we had only a certain amount of resource. What happened is that we went into another cycle of bidding, with immense frustration on both sides, and, at the end of the day, the money was allocated. We should have had a discussion with our clinical colleagues to say, 'We are going to have to do this in stages, folks, so which step are we going to take first and what do we need to get on the ground?', but that was not resolved. We have ended up in a position where, now, locally, each local health board has looked at what it can afford by using some local resource, by using just the Welsh Assembly Government resource, and by thinking about its prescribing position. We are now moving forward with the assessment services, but the journey there varied, depending on where people started, the services that they had on the ground, and the expectations of the clinicians that they were working with.

[126] **Huw Lewis:** I take those answers on board, Chair, but it strikes me that there is an obvious lesson and worry here. Are we continuing to allocate resources in other parts of the NHS's operation in Wales through this bidding process? It seems to me that this is an example of a bidding process being so dysfunctional in its communication between the centre and the LHBs that it was worthless; in fact, it was worse than worthless—it was an enormous waste of time. If there was around £0.75 million in the Welsh NHS's back pocket to allocate to this, why not tell the LHBs at the beginning of the process and say to them, 'Look, we have about £0.75 million here and there are 22 of you—we want to be as sensitive as we can with this, so what would your realistic slice of that money be? Have a think and let us know.'? On the other hand, why not just allocate it according to the well known map of the incidence of respiratory disease across the country, because you know roughly how many people are using oxygen in each LHB area?

[127] I suppose my question is whether we have learned from this situation. For heaven's sake, I hope that we are not doing it this way any more. Secondly, this is an ongoing problem, so why do we not now, after three years, have 22 Blaenau Gwents, instead of one Blaenau Gwent and 21 dysfunctional operations?

[128] **Ms Lloyd:** I will answer the first question. I found this situation deeply frustrating; it was ridiculous. We do not ask for bids very frequently at present, but you will have seen that any time we ask for bids, looking at the latest in continuing healthcare, the service knows precisely how much there is to allocate and that it has to do it with its partners, be clear of the outcome and know what the scale of the problem within its area is. We know approximately what the allocation to each area should be, based on those needs, and that is the basis on which the bids that have come in recently are being judged. The allocation and the rationale behind it will be very transparent. So, we cannot allow this sort of nonsense to go on again.

[129] I cannot remember what the second question was, I am sorry.

[130] **Huw Lewis:** Why are we still in a problematic situation, given that one area seems to have, from the beginning, cracked the problem? Why is everyone not following that example, and why have they not been doing it for a couple of years?

2.30 p.m.

[131] **Ms Lloyd:** Some areas have had considerable difficulty in negotiating the level of skills required to undertake this. It is extremely variable throughout Wales; some people have done an excellent job and picked up those elements of the Blaenau Gwent system that suit their local population. There are three areas where they still have not made any improvement, and I have taken back the money until they can prove that they will deliver it. Otherwise, we will have to intervene and take a lead ourselves on establishing services, particularly in one area—your own, Huw—which has distinct needs. There is an evaluation going on now and the updates will come in in December. The oxygen therapy reference group has devised for us an audit tool that we will receive in about a week. So, we will be able to see exactly how effectively the new services have been established and take a view for the Minister on what more needs to be done.

[132] However, it is extremely disappointing that, in some parts of the country, the services have been extraordinarily slow to develop, particularly as the whole point of ensuring that people were well assessed was to ensure that their service was modernised and honed to their individual needs. However, our audit, which will be looked at by the oxygen therapy group, will give us the next steps forward with this problem.

[133] **Darren Millar:** I turn to the costs of the contract. Putting the dispute aside, was it not forecast that the annual cost of the contract would be around £2 million? However, invoices received from Air Products Healthcare in the first year were in excess of £6 million, and around the same cost as the previous service that was delivered. Why was the estimate for the cost of the contract so wildly different to the actual cost?

[134] **Ms Lloyd:** I will go back a step and describe what the cost consisted of. In 2003-04, when we put the submission to the Minister arguing that we should modernise our oxygen services and consider the advantages of going in with England, the cost was estimated at £6 million. That was made up of a prescribing cost, held by local health boards, of £2 million, which is the cost of the gas; a centrally held non-cash budget of £2 million for the concentrator services, the more specialised stuff; and £2 million for the services provided by the pharmacist. The submission did not envisage that those costs would be reduced in any way, and we suggested to the Minister that, in addition to the existing costs, we would need additional resources for the assessment service—indeed, that was agreed.

[135] However, when we got the tenders back in March 2005, they came in at £2 million plus VAT for a fully integrated service. All the tenders reflected that; there was a differential, but many of the tenders were in and around that area. On the basis of the tenders, you budget. There was already £2 million out with the LHBs, bearing in mind that the costs of this contract were rising by £300,000 a year. So, we thought that that meant that the 2006-07 central budget would not be needed. We kept a reserve, as we did for the assessment service, but if that is the cost of the contract, then that is the cost of the contract.

[136] The Welsh health services manage this contract on behalf of Wales. The invoices started coming in following the delivery of the contract. They made it clear that some large utilisations were not included in that tender documentation—not in any of the documentation for any of the bids.

[137] We have looked at this very carefully right across the board. Do not ask me how this happened; it is to do with the Department of Health. So, the cost for the first year rose to the

cost that it had always been: around £5.8 million plus VAT. We considered how we would manage that. At that time and subsequently, LHBs were making large savings on category M—and I mean large savings. We clawed some of those back but, latterly, in 2007-08 and 2008-09, we have let them keep those to manage their cost pressures. I am talking about an additional £24 million a year, so it is quite a lot of money. Instead of having to reduce some of the Minister's other priority budget lines, we believed that there would be enough resource within the prescribing budget for LHBs to cope with even this apparent threefold increase in costs. I cannot tell you why elements were left out of the contract. We have investigated it, and we cannot tell you why it is, although I have asked for explanations. So, that is the picture.

[138] **Darren Millar:** Presumably, it was quite easy to predict the volumes, as you indicated earlier.

[139] **Ms Lloyd:** The volumes are all quite clear in the returns of the tender documents, which were evaluated by the Department of Health.

[140] **Darren Millar:** But huge areas were missed.

[141] **Ms Lloyd:** Nobody picked up that these elements were missing.

[142] **Darren Millar:** It is absolutely incredible.

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

[144] **Darren Millar:** Given that the total supplies were far greater than Air Products had originally anticipated, do you think that you got three times as good a service from Air Products, given that it tendered at the price of £2 million?

[145] **Ms Lloyd:** I do not think that that is an answerable question, actually. It did not diminish its service because of this cost dispute; it maintained its services as it was expected to. So, the patients still got the very refined service. The dispute about the moneys was taken out of the sphere of delivery to patients, so patients were not affected by any of this. The Department of Health had to negotiate throughout the country on the consequences of the dispute.

[146] **Darren Millar:** Given the additional supplies that were required over and above what was anticipated in the contract, do you think that there is scope to reduce the price overall in future years, because of economies of scale?

[147] **Mr Lang:** I think that there is scope, because, as the contract has progressed, the amount of information that we have had from Air Products has grown. It started with information about its basic compliance with the contract standard, so if oxygen was urgently required within four hours, did it deliver it within four hours? That has been there, and the performance is very strong on that. A patient survey was undertaken to assess the impact, and the percentage of patients saying that they were very satisfied with the rate of service was in the high 80s and 90s. There was a slight variation on modality, but, by and large, it was a very positive patient return.

[148] We have now started to get information through from the supplier about concordance and the degree to which patients' consumption of oxygen is aligned to the modality of the prescription, which drives the tariff in the contract. The contract is a per-day contract, depending on the modality of the delivery of the oxygen, the flow, and the number of hours for which a patient should be taking oxygen. We are now getting information that tells us patients' usage compared with their prescription, in effect. That information will be very

useful for us to target our assessment and support services, to review our prescriptions, and to ensure that the prescription in the contract is aligned with patient needs. So, I believe that there is scope, but I could not say how much scope there is. Without undertaking a detailed analysis, it is very difficult to assess, and that links to some of the returns in relation to the assessment service. At one level, you could do an investment return analysis and say, 'If you invested in a team, what would your return be?' and the difficulty to date has been quantifying the return. We are now at the point of being able to do that and target areas of reduction. So, I hope that we will get better value out of the contract as time moves on, and we should be targeting our energies to achieve that.

2.40 p.m.

[149] **Ms Lloyd:** Along with a better service for patients who will get the service that they require. That is quite sensitive.

[150] **Bethan Jenkins:** Paragraphs 2.20 to 2.22 show that, by early 2007, LHBs were disputing between £1.3 million and £1.5 million of invoices from the contractor, for example in instances where charges may have been made for services not received, or the continuation of charges for emergency oxygen made after the first three days of service. What action did your department take once the LHBs disputed these invoices?

[151] **Ms Lloyd:** We agreed with the Department of Health that its contracts resolution department should undertake the negotiations for us. We appointed our own lawyer to work with them so that our rights and responsibilities would be protected. We left that lawyer to liaise with us on the success or otherwise of the negotiation, to feed in the detailed information from Wales, and to present our justification for some of the disputed invoices that we had received. The lawyer maintained good contact with each of the local health boards about the progress of those negotiations and saved us a great deal of money.

[152] **Bethan Jenkins:** Do you think that there were problems arising from the nature of the contract itself?

[153] **Ms Lloyd:** The contract was imprecise, as we have said, and that is being refined over time anyway. However, there were other things that were fairly easy to resolve. For example, March was counted as 33 days. The contractor had concerns about whether or not it had been paid sufficiently. The net result after the protracted negotiation was that we made a saving, which the LHBs got.

[154] **Bethan Jenkins:** I want to pick up on the counter claim made by the company, because I have spoken to people in my constituency who have ongoing problems with the last point in paragraph 2.21, entitlement for patients on holiday using different suppliers. What is the situation in that regard under the current contract? Many people are also buying their own cylinders, because the lightweight cylinders are not lightweight. Are you taking patients' views into consideration when these counter claims are made? What changes will you make to the contract in relation to that?

[155] **Ms Lloyd:** The Department of Health is managing the charges for services from other regions as a block, because it will see the ins and outs of what this particular company has to bear on behalf of others and it will sort that. So, that is that.

[156] The patient survey has been helpful in refining those areas of this contract that need to be improved, and one such area was what happens when someone is on holiday. Of all of the areas of satisfaction or dissatisfaction, that was the area with the lowest score of satisfaction, and even then it was around 70 per cent. Some patients did not know about it, some felt that they could not access it, and others felt that they were not getting the equipment

and the product that they needed. That has gone back into the discussions with the variety of contractors as to what more suitable service could be provided.

[157] **Bethan Jenkins:** Are you talking to the charities involved as well as the patients, including the British Lung Foundation? I am not sure whether the people to whom I have spoken were even aware of the existence of a patient survey.

[158] **Ms Lloyd:** Were they not? It was done for the Department of Health by an independent social research firm. Its findings came out in 2008, in around June or July, and was very detailed.

[159] **Bethan Jenkins:** Could we have a copy?

[160] **Ms Lloyd:** Certainly. Here it is. It is very detailed and very helpful.

[161] **David Melding:** Perhaps you could arrange to have a copy sent to Bethan.

[162] **Ms Lloyd:** Yes, I shall.

[163] **Bethan Jenkins:** Thank you.

[164] **Ms Lloyd:** We can ensure that our oxygen reference group gives charities connected with this sort of problem a copy of this report.

[165] **Lorraine Barrett:** Can we all have that?

[166] **David Melding:** Yes.

[167] **Ms Lloyd:** Yes, we have the e-mail link.

[168] **David Melding:** It is even better if you can e-mail it.

[169] **Lorraine Barrett:** Figure 4 forecasts the increasing costs of the new contract until 2011. Is it likely that the development of effective specialist clinical assessment processes could help to reduce future costs, as well as improve clinical quality?

[170] **Ms Lloyd:** That is what we anticipate; the whole point of it is to use the resources more effectively. If you look at the first two years in figure 4, given the cost increases of the old contract, those are the figures that you would expect to have seen anyway. However, we expect that, when we get to 2010-11—the last two years of the contract, when 100 per cent of LHBs will have a 100 per cent assessment—we should see a much more sophisticated set of data and an audited assessment, and we will be able to see those costs coming down. However, this was not about saving money; it was about improving the service.

[171] **Mr Lang:** It also bodes well for the renegotiation of the contract at the end of its initial life. I believe that we will have very robust data—it will be up to date and clinically accurate—and we will then be able to give a clear picture to potential suppliers of exactly what oxygen service we require, and where, if we have a future direction, we expect that to go. Again, I would expect that to bring benefits, and the information that we will have will greatly help.

[172] **Eleanor Burnham:** I wish to clarify one point. What does category M refer to?

[173] **Ms Lloyd:** These are the drugs that come off licence.

[174] **Eleanor Burnham:** Thank you. Appendix 1, on page 21 of the auditor general's report, lists the chronology of events surrounding the decision to modernise domiciliary oxygen services, which is fascinating to read. Do you agree with the aspiration for July 2002 that the existing services are complex and need updating, and have you improved the services? You have never used the word 'improve'; you have used the word 'modernise'. Does 'modernise' mean 'improve'? The next sentence notes that,

[175] 'Lord Hunt indicates that in principle he supports the option of an integrated Domiciliary Oxygen Service, largely ordered by hospitals'.

[176] I am not sure that I understand what 'largely ordered by hospitals' means, because we have been talking about domiciliary oxygen services.

[177] **Ms Lloyd:** What Lord Hunt will mean by that is having specialist assessment centres, so that they are ordered, as he has put it in this simple way, by hospitals. When we consulted on the various options for improving, or modernising, the service, we received several comments about whether or not assessment centres per se could be in primary care. In Wales, we agreed that there should be a facility to provide these—not solely by secondary care in hospitals, but in the community, by primary care.

[178] Therefore, we slightly modified the intentions of England, by retaining an ability to always have a primary care focus for assessment, especially using specialist GPs. The intention was to improve the service. The core of the changes were very much about ensuring that people had the right service, that it was timely, that there was a constant assessment of their needs—which, as you know, change constantly—and to make it a secure service for the future.

[179] **David Melding:** That concludes our evidence gathering. I thank Ann Lloyd and Geoff Lang for the help that they have given us this afternoon; I think that we have successfully gathered the evidence that we need for our report. You will be sent a transcript of these proceedings, in case there are any errors in the transcription, not for you to alter anything that you wish that you had not said. You will have that opportunity of correcting the Record if there has been any misattribution in what you have said. Thank you for your attendance this afternoon.

2.50 p.m.

Ystyried Ymateb Llywodraeth Cynulliad Cymru i Adroddiad y Pwyllgor Archwilio 'Cyflawni'r Ddeddf Arbed Ynni yn y Cartref yng Nghymru'
Consideration of the Welsh Assembly Government's Response to the Audit Committee Report 'Delivering the Home Energy Conservation Act in Wales'

[180] **David Melding:** You will see the correspondence with regard to this matter. Jeremy, do you wish to say anything in particular or in addition to the letter that you have sent us?

[181] **Mr Colman:** I have one simple point to make. This committee recommended that the Assembly Government's response to the issue of home energy conservation should be considered in the context of the national energy efficiency and savings plan; the Assembly Government's response is that it will do that. However, the plan has not yet been produced, so we must all wait until it is, which seems perfectly sensible to me. Therefore, I recommend no action at present for the committee; there will be action for us when the plan is produced.

[182] **David Melding:** Therefore, Jeremy and his team will advise us once we have that plan. I think that we are all satisfied with that.

2.51 p.m.

Cynnig Trefniadol
Procedural Motion

[183] **David Melding:** 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).

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

Derbyniwyd y cynnig.
Motion carried.

Daeth rhan gyhoeddus y cyfarfod i ben 2.51 p.m.
The public part of the meeting ended at 2.51p.m.