Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 10 Rhagfyr 2013
Tuesday, 10 December 2013

Cynnwys
Contents

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are recorded in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Mohammad Asghar	Ceidwadwyr Cymreig Welsh Conservatives
Jocelyn Davies	Plaid Cymru The Party of Wales
Mike Hedges	Llafur Labour
Sandy Mewies	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Julie Morgan	Llafur Labour
Jenny Rathbone	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Y Farwnes Finlay o Landaf /Baroness Finlay of Llandaff	
Stephen Lisle	Swyddfa Archwilio Cymru Wales Audit Office
Dr Mark Poulden	Cadeirydd y Coleg Meddygaeth Frys yng Nghymru Welsh Chair of the College of Emergency Medicine
Veronica Snow	Arweinydd y Rhaglen Genedlaethol ar gyfer Gofal Diwedd Oes National Programme Lead for End of Life Care
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales
Margot Tierney	Cofnodwr electronig Electronic notetaker

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

Fay Buckle	Clerc Clerk
Claire Griffiths	Dirprwy Glerc Deputy Clerk
Joanest Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser

Dechreuodd y cyfarfod am 09:00.
The meeting began at 09:00.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Darren Millar:** Good morning, everyone, and welcome to today's meeting of the Public Accounts Committee. I will just deal with a few housekeeping notices. Could you all ensure that mobile phones, BlackBerrys and pagers are switched off, as they can interfere with the broadcasting and other electronic equipment? I remind everyone that the National

Assembly is a bilingual institution and welcomes everyone who participates in this meeting to contribute in either English or Welsh, as they see fit. Translation is available through the headsets that have been provided. The headsets can also be used for sound amplification. In the event of a fire alarm sounding we should all follow the instructions of the ushers, who will guide us to the nearest appropriate exit. We have not received any apologies for absence this morning.

09:01

Gofal Heb ei Drefnu: Sesiwn Dystiolaeth
Unscheduled Care: Evidence Session

[2] **Darren Millar:** We continue with our inquiry into unscheduled care. We are taking evidence this morning from Dr Mark Poulden, the Welsh chair of the College of Emergency Medicine. Welcome to the meeting, Mark. The College of Emergency Medicine represents consultants in accident and emergency departments, and published an open letter to the Minister earlier this year raising concerns about workload and safety levels in emergency departments. Mark, I understand that you are a consultant at the emergency department in Morriston Hospital. You will be aware that the committee has taken quite an interest in the role of general practitioners in providing emergency care, and I know that you have some novel arrangements in Morriston, which appear to be delivering some benefits, with the acute GP service in Singleton Hospital. So, we will want to hear more about that from you. Do you wish to make any opening remarks before the committee goes into questions? No.

[3] Looking at the coalface, as it were, for emergency medicine practitioners, why do you think that there has been such a deterioration in emergency department waiting times and in ambulance handovers of late? We saw a report just yesterday, for example, on the BBC, which seemed to suggest that Wales was lagging behind other parts of the UK when it came to ambulance handovers.

[4] **Dr Poulden:** If we could take one thing, it would be the issue of flow through the department. We are increasingly seeing more complex cases, which take us longer to deal with. Essentially, they need to pass through to the hospital. It is the long delays that mean that the departments are full of patients so that we just do not have the space to see new cases coming in. That is on the major side. That is balanced with the staffing problems that we have had—not enough senior people to make decisions, so being reliant on junior or locum staff who then have to seek another opinion from a senior to get the correct management for the patient.

[5] **Darren Millar:** So, when you say ‘patient flows’, is it about problems elsewhere in the hospital rather than in the emergency department, or is it a combination of the two?

[6] **Dr Poulden:** There is a combination, because it is the rate of influx. There are times, at peaks of demand, certainly, where if you have major cases and a number of ambulances turning up at once, it would be difficult for any system to cope. I think that the biggest problem for us at the moment is flow through the department and getting those patients who need longer, or those patients we cannot deal with in the department, through and out back into the hospital.

[7] **Darren Millar:** Is there capacity within the emergency departments to treat more people, perhaps, more quickly if you can get people out of the emergency departments at the other end? It is a bottleneck.

[8] **Dr Poulden:** Yes. If we drilled down into our data, we would find that the cases that

we have managed within the emergency department are often managed in a timely fashion. It is about those that wait, when you are looking at the data, for onward assessment. That is balanced with the space that we have, because patients spill from the trolley areas—the majors area—where they are waiting for a bed. Once that space is filled, we then have to put them somewhere; so, more majors patients then spill into the minors area. That then fills up with patients in inappropriate areas, and we even have patients sitting in waiting rooms. We change waiting areas into, essentially, areas where patients are stacked waiting for a trolley, waiting to be assessed, and waiting for a bed. The whole system then becomes completely clogged. The more that that happens, the longer it takes you to do any individual thing. The whole system becomes more inefficient.

[9] **Darren Millar:** The performance statistics seem to have improved in recent months. Do you know why that is? What has changed on the ground to deliver those improvements?

[10] **Dr Poulden:** I do not think that we recognise that in emergency departments. If I talk to my colleagues, I find that we feel that the pressure in the department is actually getting worse, if anything. That is part of the problem with the data that we collect. On the ground, it sometimes does not feel like the position being demonstrated by the statistics.

[11] **Darren Millar:** So, is it the way that the statistics are being measured? Is it an inappropriate way of measuring whether there are pressures or not in departments?

[12] **Dr Poulden:** I think that there are. Some of the—

[13] **Darren Millar:** You say that there have been no improvements. The ambulance waiting figures show that handover times are improving, and the waiting within emergency departments appears to be shorter for patients than it was, which is the case if we look at that the bare figures, but your members are telling us that their experience is very different. Why would that be?

[14] **Dr Poulden:** I think that it is the way in which the figures are then used. There are certain criteria of what constitutes certain periods, as the measurements are made. Certainly, we have looked at groups of data, where clinicians would consider a certain period to be a long wait in an emergency department. However, because of the criteria set down by the Government they actually do not appear as a long wait.

[15] **Jocelyn Davies:** May I just ask—

[16] **Darren Millar:** I will bring you in in a second, Jocelyn. I will just ask this: have the criteria for measuring changed?

[17] **Dr Poulden:** I am not sure of the exact date—it was a year or two ago, I believe. I am not sure of the exact date when that was—.

[18] **Darren Millar:** Okay. However, you think—

[19] **Dr Poulden:** As clinicians, there are certain criteria that apply as a patient sits in an emergency department. That is sometimes different to how that is viewed externally, I suppose.

[20] **Darren Millar:** Okay. I now turn to Jocelyn.

[21] **Jocelyn Davies:** You mentioned patients waiting. Quite recently, my sister-in-law was rushed in in the middle of the night, in her nightclothes, and was put in the waiting room with family members all night. Where would she have counted in the statistics? She was off a

trolley and she was told, ‘We will get you a bed’; she was put in a waiting room and left there all night in her nightclothes. In fact, she said that that was worse than the pain that she was experiencing in her chest. So, where in the statistics would she have counted? I guess that she would have been counted as being admitted.

[22] **Dr Poulden:** This is the thing. It depends on how she has been recorded. In some cases, for instance, if patients are suitable for a clinical decision unit, essentially, their care in the department has completed. I suppose that there are nuances in the system where she would not appear as a long wait.

[23] **Jocelyn Davies:** It is a long wait even though that is where she is; that is where she is sitting, and she is not receiving any treatment. She is waiting a length of time to have a blood test 12 hours later, or something. So, she would not count as someone who is waiting although she is physically there, sitting and waiting.

[24] **Dr Poulden:** There are nuances, as I say. I cannot think of specific examples off the top of my head, but we have looked at this. As I say, when you look at the raw data, and when we as clinicians look at what we would consider to be a long wait or not, there is often a discrepancy because of the way in which the data are recorded.

[25] **Jocelyn Davies:** Yes. Okay.

[26] **Darren Millar:** I will now call on Sandy, and then Julie.

[27] **Sandy Mewies:** Good morning. That is quite disconcerting, really, because there are, allegedly, improvements in the way that data are collected. If that is showing an upward trend that clinicians themselves do not feel is happening, something should be done about it. Is there any way that your college has reflected the views of clinicians to the people who are collecting the data? Do you have an input, for you to say, ‘Hang on a moment; what we are experiencing and what we feel is happening is not accurately reflected’? Is there a way for you to do that, and have you done it?

[28] **Dr Poulden:** We have mentioned previously at the unscheduled care board meetings concerns about the way data—

[29] **Sandy Mewies:** What has happened?

[30] **Dr Poulden:** Nothing, as far as I am aware.

[31] **Sandy Mewies:** Is there any way that we can find that out? How would we find that out?

[32] **Darren Millar:** We have Andrew Goodall, who takes a lead on unscheduled care, coming to see us. We will have the opportunity to question him on that.

[33] **Sandy Mewies:** Thank you. I would like that raised.

[34] **Darren Millar:** I will bring you in in a second, Mike. Julie is first.

[35] **Julie Morgan:** I do not know if it is appropriate at this point, but what about people who are waiting in the ambulances outside? How does that length of wait interface with the data that you have produced?

[36] **Dr Poulden:** I am not sure of a technicality—I am trying to think of when the clock-on time in department actually starts. I must admit that I am not sure whether that is the time

when they are actually registered, or when they arrive initially in the ambulance.

[37] **Julie Morgan:** In the ambulance.

[38] **Dr Poulden:** In the ambulance, yes.

[39] **Darren Millar:** It is from the time of transfer, is it not?

[40] **Julie Morgan:** Yes, I think it is. I think that they are probably not registered until they actually come into the department.

[41] **Dr Poulden:** I am not sure about that, sorry.

[42] **Julie Morgan:** So, there is nowhere where you see the interface of those two figures.

[43] **Dr Poulden:** I am trying to think. I cannot think of when the initial time starts, sorry.

[44] **Julie Morgan:** There is one hospital that says, 'We do not leave anyone waiting outside in an ambulance. We bring them in'. There was publicity about that over the weekend. So, their figures would include the ambulance waiting times.

[45] **Dr Poulden:** Again, from a clinician's point of view, it is very difficult with the ambulance arrivals because it is about the individual safety at that time of an individual patient. Unfortunately, sometimes you get to a situation where actually keeping them in an ambulance outside is safer for that individual patient, but obviously not for your figures. As I say, with all the numbers and all the figures, at the end of every figure is an individual patient that has an individual experience, and that is the thing that we see from day to day.

[46] **Mike Hedges:** May I return to Morriston Hospital, which I live very close to? Is not one of the problems with Morriston Hospital that it is not just A&E that people are coming in through, but it is the inter-hospital movement, especially from the Hywel Dda area, which is taking up beds that you thought were available at the start of the evening but are taken by people who move in during the evening, or during the day?

[47] **Dr Poulden:** Do you mean in the emergency department? I am not aware of the numbers that come in directly to the hospital beds. I am aware only of those that come through the emergency department, but we do have a number of patients that come from neighbouring health board areas into the emergency department. For instance, they are under a physician in Morriston, and so they seek to come directly to the hospital as opposed to seeking their care locally.

[48] **Aled Roberts:** Rwyf eisiau gofyn fy nghwestiwn yn Gymraeg.

Aled Roberts: I would like to ask my question in Welsh.

[49] Mae'r adroddiad yn sôn bod yr adrannau brys hyn yn gweithio dan gymaint o bwysau fel bod rhai o'r effeithiau ar ansawdd y gofal yn dod yn norm yn hytrach nag yn achlysuron prin, felly.

The report talks about these A&E departments working under so much pressure that some of the impacts on the quality of care become the norm rather than the exception.

[50] **Darren Millar:** Just a second. Are you getting the translation, or is it amplification you are getting? It is channel 1, usually, for translation.

[51] **Dr Poulden:** I have just done it. I am sorry, I did not hear the start of the question.

[52] **Aled Roberts:** Mae rhannau o'r adroddiad yn sôn am yr adrannau brys hyn dan bwysau, a bod hynny yn dod yn norm yn hytrach nag yn rhywbeth achlysurol. A allwch chi ddisgrifio'r effaith y mae hyn yn ei chael ar ansawdd y gofal, ac a yw'r problemau o ran ansawdd gofal yn yr adrannau wedi mynd yn waeth yn ystod y blynyddoedd diweddar?

Aled Roberts: There are parts of the report that talk about A&E departments which are under elevated pressures, and that that becomes the norm rather than something that happens occasionally. Could you describe the effect that that has on the quality of care, and have the problems in terms of quality of care within those departments become worse over recent years?

[53] **Dr Poulden:** I think that that is an issue in that, essentially, when you work in that pressured environment, you become desensitised to that pressure, and over a period of time quality does slip because, when you are running a whole department, you are running it for all the patients who are there, and one has to balance that with the care that individual patients receive. Unfortunately, sometimes, the care that an individual patient receives suffers because you are trying to manage care for the collective group. Unfortunately, we see that care for individuals does deteriorate because we are trying to manage the safety of the overall department.

09:15

[54] **Aled Roberts:** Bu i Mike Hedges sôn am achosion lle mae cleifion yn cael eu trosglwyddo o'r naill ysbyty i'r llall. Yn y gogledd, yn Ysbyty Cyffredinol Llandudno, nid oes gofal meddygol ar y safle ar rai nosweithiau a dros y penwythnos. Rwy'n ymwybodol o un achos bythefnos yn ôl, pan gafodd claf ei drosglwyddo i Ysbyty Gwynedd gan aros rhyw dair awr mewn ambiwlans y tu allan i'r adran gofal dwys. Cyfrifoldeb pwy yw'r person hwnnw yn ystod y tair awr hynny? Ai dim ond y nyrs a chriw'r ambiwlans sy'n gyfrifol am y gofal, neu a yw'r doctoriaid o fewn yr adran brys yn gyfrifol unwaith y bydd yr ambiwlans yn cyrraedd yr ysbyty?

Aled Roberts: Mike Hedges talked about cases where patients are transferred from one hospital to another. In north Wales, in Llandudno General Hospital, there is no medical care on the site some nights and over the weekend. I am aware of one case a fortnight ago, when a patient was transferred to Ysbyty Gwynedd and waited some three hours in an ambulance outside the intensive care unit. Whose responsibility is the patient during those three hours? Is it only the nurse and the ambulance crew who are responsible for delivering care, or are doctors within the accident and emergency department responsible from the time that the ambulance reaches the hospital?

[55] **Dr Poulden:** That is very difficult, because it is not clear. As an individual doctor, if there was a patient outside the department, we would try to assess the needs of that patient compared with what we have in the department, because it may well be that we would have to displace someone from one of our trolleys—even though that is inappropriate—to a waiting area to get a sicker patient in. That is a balance of risks.

[56] It is not clear, because, essentially, as doctors—especially for some of the junior doctors—it is not an appropriate environment and they are not trained to deliver care in the back of ambulances. So, we are working in an alien environment, essentially. However, certainly as a senior doctor, for me, personally, part of my role involves helping to manage the system that we find ourselves in. Only yesterday, I spent pretty much most of my eight-hour shift in Morriston working in the car park in the back of ambulances, which is inappropriate, really. However, it was needed in order to maintain the safety overall as much as possible.

[57] **Aled Roberts:** Mae cwestiynau yn codi lle mae nyrs sy'n gofalu am glaf mewn

Aled Roberts: Questions arise when a nurse caring for a patient in an ambulance has to

ambiwlans yn gorfod mynnu bod claf yn cael ei roi yn yr adran frys, oherwydd bod y nyrs yn mynegi pryder ynglŷn â'r tymheredd yn yr ambiwlans—ac roedd y ddynes hon yn ei 80au hwyr.

insist that that patient is placed within the accident and emergency department because of concern regarding the temperature within the ambulance—and this woman was in her late 80s.

[58] **Dr Poulden:** Once again, it is a balance. On the whole, within the ambulance, patients are usually warmer and they have equipment around them to monitor them, versus sometimes being in an inappropriate environment, for example in a corridor in an emergency department. Probably, I would prefer to be in the back of an ambulance rather than a corridor in the emergency department. None of it is ideal, but we all do it as a balance of risks. It is very difficult for the individual staff making those decisions, because it is essentially not part of their role, to a certain extent.

[59] We use paramedics, essentially, to continue the care—to continue monitoring the patient, to continue giving the treatments that they can give until we can bring them into the hospital. Sometimes, we do that in conjunction with them. We have what is, I suppose, a ridiculous situation daily in Morriston where paramedics are coming in and we do not have anywhere to put the patients; the paramedics take the patients around to the x-ray department, have the patients x-rayed, bring them back and put them in an ambulance because there is nowhere else for the patient to go. You can look at that in two ways: we are trying to continue the care of the patient while they are in the care of the paramedics, but obviously that is tying up our paramedics for long lengths of time.

[60] **Aled Roberts:** Fe wnaethoch chi sôn am eich profiad ddoe am yr wyth awr; pa fath o brofiad buasech chi yn ei ddisgrifio o ran pwysau gwaith o fewn yr adran frys o gymharu â rhai blynyddoedd yn ôl?

Aled Roberts: You talked about your experience yesterday for the eight hours; what sort of experience would you describe in terms of work pressures within the emergency department compared with some years ago?

[61] **Dr Poulden:** It is a different pressure. The A&E departments are pressured environments by their nature. I am old enough to remember when waits in emergency departments were prolonged. When the four-hour target came in, we saw an improvement in that, which was a good thing. We now seem to be seeing more of a prolonged wait for beds among the sick and often the elderly. If we look at the data, we will see that it is often purely due to the numbers and their needs. It is almost the case that the older you are when you present to an emergency department, the higher chance you have of waiting for a prolonged period. That is even more detrimental for these patients' outcome.

[62] **Darren Millar:** Aled, very briefly, as I am conscious of the time.

[63] **Aled Roberts:** A ydych wedi trafod eich profiad ag uwch-reolwyr, a beth yw eu hymateb i'r math o broblemau rydych yn eu hwynebu o ddydd i ddydd?

Aled Roberts: Have you discussed your experience with senior managers, and what is their response to the kind of problems that you face on a daily basis?

[64] **Dr Poulden:** We do that, almost on a daily basis, and it is about managing the flow. They have a certain bed stock to deal with. To use a case in point, yesterday all non-cancer operations were cancelled in Swansea. We were opening beds at risk—beds that had been closed due to infection control. Across the system, it is a balance of risk, and that is what essentially our managers have to deal with.

[65] **Darren Millar:** Sandy, you may ask a very brief supplementary question.

[66] **Sandy Mewies:** It is very brief. You were talking about the great increase that there has been in numbers. Are any of those patients there inappropriately? Should they be somewhere else? If they are, are they sent away or do they become part of the process because they are there?

[67] **Dr Poulden:** Are you talking about the increase in the number of elderly patients?

[68] **Sandy Mewies:** All patients; the patients coming through your doors.

[69] **Dr Poulden:** I do not think that we have seen a huge increase in the number of inappropriate cases. I see three broad groups. There are those that can only be dealt with in an emergency department; those that could be dealt with equally as well in an emergency department or in a primary care environment; and those that should definitely be dealt with in a primary care environment.

[70] **Sandy Mewies:** How large is that third group?

[71] **Dr Poulden:** I do not think that it is large. It is something like 10%. It is difficult, because if you put those cases in front of a group of clinicians and ask, 'Where else should this patient be?', you will get some variance between the responses. On the whole, these groups are not a huge problem, because they are often quick to turn around. They do clog up the system and, ideally, they should not be there. Some have more complex need so they take a bit of time, because although it is a primary care issue, you only know that after you have done a full assessment of the patient. So, in an ideal system there should be ways of directing those patients, but you need an easy system of direction because if it is not, by the time you have assessed them and taken the time to advise the patient and make the arrangements, you may as well have just seen and dealt with them in the first place.

[72] **Darren Millar:** However, you are telling us that the sheer numbers of inappropriate referrals have not increased significantly?

[73] **Dr Poulden:** No, I do not think so.

[74] **Darren Millar:** Okay, that is an important point.

[75] **Jenny Rathbone:** Given that there are people being sent to hospital who could be cared for in their own home, what strategies can your colleagues use for coping with the situation when all your cubicles are full and elderly people are in ambulances? You mentioned that yesterday you were treating people in the car park of your hospital. How common is that, and are other physicians and specialists prepared to go into the ambulance?

[76] **Dr Poulden:** That is the difficulty. I suppose that we are used to it in the emergency department. The strategies that we have for maintaining safety are often around staffing and trying to get additional staff, and bringing people into the clinical environment who are doing other roles at that time. It is about how we allocate staff. We had me essentially walking the car park and another person walking the department, trying to deal with those patients and getting them out of the back of the department. We have systems in place where all the patients are assessed and given national early-warning scores, so that we know how sick the totality of the cases are. We then try to bring in making the rest of the hospital aware of how it can support us, both in doing what it can in an elevated fashion to discharge and to create beds, and to pull patients through the system.

[77] **Jenny Rathbone:** Have you ever met a situation where you have assessed somebody in the ambulance and said, 'This lady doesn't need to be in hospital. Please take her home or back to the nursing home'?

[78] **Dr Poulden:** Yes. I have been at both ends, in a way. I have assessed someone and deemed them suitable to be discharged and the ambulance has then taken them back home, and, on the other end of the spectrum, only yesterday, I completed the care of a patient in the back of an ambulance, where he was waiting, and referred him on to an in-patient specialty and he continued to wait for his assessment and bed, while still in the back of an ambulance. So, I had completed the emergency department episode, essentially, in the back of the ambulance prior to admission.

[79] **Jenny Rathbone:** How problematic is it for people who are more junior than you, who may be less experienced and want to get second opinions?

[80] **Dr Poulden:** It is problematic, because it is an alien environment. It is uncomfortable for me, with a number of years of experience, but for juniors it is worse. It is difficult; it is essentially a balance of risks whether or not you send a junior doctor into the back of an ambulance to assess a patient.

[81] **Jenny Rathbone:** Okay, so until we have changed the culture and the ways of working, is there anything else that we could immediately do so that you as emergency doctors and nurses could make the stay of older people less fraught?

[82] **Dr Poulden:** Even in an ideal situation, in a well-functioning emergency department, when you are bringing in anyone, dragging them into the hospital, it is a bright, noisy environment—although it seems to be more acute for an elderly person—and I think that it is about getting the assessments right. Certainly for patients with ongoing conditions and patients from nursing homes and residential homes, it is almost about preplanning their care and trying to anticipate what may go wrong so that they do not get dragged out of their beds, kicking and screaming, in the night, but that the assessments are done in the home and that as much as can be done in those environments as possible is done.

[83] **Jenny Rathbone:** So, it is planning for people's inevitable deterioration when they are reaching the end of their life.

[84] **Dr Poulden:** Absolutely.

[85] **Jenny Rathbone:** Thank you.

[86] **Darren Millar:** Okay. Jocelyn?

[87] **Jocelyn Davies:** When I attended an emergency department earlier this year with my mother—it was not my sister-in-law, but my mother—who is well in her 80s, when we got there, the ambulance crew punched into a pad on the wall. What is that?

[88] **Dr Poulden:** That is the hospital arrival system. That is the system that monitors when they arrive and then records the time until the 15-minute handover target.

[89] **Jocelyn Davies:** Right. So, that is when it is being counted in terms of—

[90] **Dr Poulden:** Yes, they notify and then there is a handover.

[91] **Jocelyn Davies:** I see, right, okay.

[92] The auditor general's report talks about the lack of good-quality data in unscheduled care and problems with the emergency department datasets. Why do you think that there has not been more progress in developing outcome measures and measures of patients'

experience, so that you have data and that you can do something with the information?

09:30

[93] **Dr Poulden:** I think that the trouble with data systems is that people come at them from different angles. As a clinician, working on the floor, what I want out of the system is for it to allow me to manage the patients in the department, to have some clinical input so that I can seamlessly order investigations, for instance, and that those investigations come back to that system of the patient record, but then to get some meaningful clinical data as well as time-based data out of it. Some of the system is, essentially, designed to deliver the outcomes that are put upon us. I am referring to the sort of hard, raw statistical data that, often, for me as a clinician, are not much use. Like with any data system, you get out what you put in, and it is encouraging people to put in data. Personally, I think that if you have a system that clinicians will get an immediate benefit out of when they are using it, it encourages them to use it more and then you get some good-quality data. There is a project ongoing at the moment across a number of the health boards in Wales and on which we are working collectively.

[94] **Jocelyn Davies:** Is this the all-Wales information system?

[95] **Dr Poulden:** Yes, there is a group of emergency physicians looking at the front-end part. That group has been looking at a number of computer systems.

[96] **Jocelyn Davies:** Do you think that that is going to resolve the problems that you have just outlined for us in relation to the current system? Do you think that this new system is going to be—

[97] **Dr Poulden:** I would hope that it would be significantly better and resolve some of the issues, yes.

[98] **Jocelyn Davies:** In relation to the experience of the patients though, how is that being measured? I can assure you that my sister-in-law thought, from her experience, that it was awful to be left all night in her night things in a waiting area with complete strangers. Nobody spoke to her. Nobody had eye contact with her. They just said to her, 'You're waiting for a bed'. She never had a bed. She was sent home the following day, but that patient experience—

[99] **Dr Poulden:** Those things are more difficult to measure, because you cannot get a number as such. You have to measure some form of patient experience, and that is qualitative, with questionnaires, follow-up and things like that. That can be done. It is difficult to do that at the time and get a number, for instance.

[100] **Jocelyn Davies:** Is that work routinely carried out?

[101] **Dr Poulden:** It is not routinely collected. The College of Emergency Medicine put out quality indicators in England that try to measure patients' experience of the service.

[102] **Jocelyn Davies:** You mentioned earlier a sort of assessment of risk. How are you managing the safety within emergency departments if you have all this stuff going on—treating people in the back of ambulances and swanning about in corridors? How is safety assessed?

[103] **Dr Poulden:** On an individual basis, it is often assessed by having the consultant who is aware and, essentially, taking the helicopter view of the whole department. You also assess safety by having individual contact with your patients, the rest of your team seeing individual

patients and, potentially, reporting back to you and by working with our nursing colleagues. So, it is looking at that as a whole. There are, obviously, individual ways of dealing with individual situations, but on a day-to-day basis it is about someone taking that overall and overarching view, essentially.

[104] **Jocelyn Davies:** Listening to you, it has just occurred to me, and probably anybody who has been in an emergency department, that it looks and feels a bit chaotic and unpleasant. Making decisions about which patient I would put in the waiting area while I bring someone in from the corridor and assessing people in corridors, sounds as if it could be chaotic. Perhaps, it is organised chaos. Do you feel that—

[105] **Dr Poulden:** There are a number of issues. The patients are triaged, so there is an initial assessment where they will get a triage category and the national early-warning score, which gives us an idea of their physiological condition and how sick they are. We can have display boards, so, for instance, where you have eight trolleys with eight patients, you can use scores that are colour-coded. That means that, at a glance, you can see that you have two relatively sick patients and six not-so-sick patients. So, there are various things that you can do to have a visual idea of what is going on.

[106] **Jocelyn Davies:** So, the circumstances are not ideal; you have already said that. I mean, I guess that you would prefer not to be in the car park for eight hours of your shift. So, it is not ideal, but, as far as you are concerned, on the whole, safety is one of the priorities.

[107] **Dr Poulden:** Safety is the priority on a day-to-day basis.

[108] **Darren Millar:** Oscar has the next questions.

[109] **Mohammad Asghar:** Thank you, Mark, for giving us all the details about this emergency case. I have heard of a very different experience, from one of my constituents. She spent two days in hospital on a trolley, she was treated on a trolley, and she was sent back on a trolley. She had a heart problem, but she had three days' rest, and an aching body, and did not have complete rest, even in hospital. That is probably due to the shortage of beds. To what extent is the reduction in bed numbers directly causing additional pressure on emergency departments, and to what extent are health boards ensuring that there is sufficient alternative capacity in place before they take beds out of the system?

[110] **Dr Poulden:** That is a difficult question. Again, anecdotally, and from my own experience, I think that the pressures on health boards to manage the number of beds, financially, are one issue. I think that another issue is that, often, systems are put in place to try to manage more patients in the community. Therefore, a small project is done and people say, 'Okay, if we do this in the community, we think that we can manage with 10 fewer beds', for instance. What I think that we would find happening is that the beds are taken out before the system is actually up and running, and that the true effect of that system and the natural consequences have not been fully considered. It may well be that, in the little trial, that is what happened, but, in real life, although you can manage with a few beds less, the impact is that the patient then ends up back in the emergency department. Therefore, it is looking at the system as a whole, and making sure that those things are fully tried, and are operational, before the bed stock is reduced. It is difficult, because, if you look at all the patients in hospital beds—a snapshot at any one time—I am sure that you could find a large proportion who do not need to be in those beds. Therefore, there is an argument for reducing beds, but it is about making sure that there are robust systems in place to manage those patients before you take the bed stock out, essentially.

[111] **Mohammad Asghar:** You must be a very good doctor to help a patient in the car park. I would like to see anyone in the Royal Gwent Hospital doing it. The thing is that you

must be a very good doctor. How well do you think that health and social services—and you have just said yourself that there are some financial constraints on the beds, and all the rest of it—are working together to provide alternatives to hospital admissions, and to support timely discharge from hospital beds?

[112] **Dr Poulden:** I think that there is no doubt that we have seen an improvement in that joined-up working since local health boards have been working much closer with social services, and I think that that joined-up working is increasing. I think that it is important for everyone to understand each other's problems; sometimes, I think that until you actually sit down with someone from the other side, or from a different part of the system, they do not truly understand the pressures that you are under. It is interesting sometimes that, when you do sit down, and you understand each other's issues, you can then work together to create a better system.

[113] I think that some of the issues have been that we are all used to working at the front; I work in seconds and minutes, and then, as you go through the system, those times increase to minutes and hours, and then to days and weeks. Until we get all of those aligned, there will always be hand-offs and issues through the system. Therefore, it is about bringing people together, and making them understand the system and their responsibility. It may be that, at the back of the system, you do not understand that those decisions have a knock-on effect, and that that knock-on flows all the way through to someone who is unwell waiting to be picked up in an ambulance. Therefore, it is about understanding the whole system and getting everyone on board to understand the whole system.

[114] **Julie Morgan:** I want to ask you about the 111 helpline. What is your view, representing your college, about the development of the 111?

[115] **Dr Poulden:** The most important thing with 111 is what is behind it. It is about having a good initial assessment over the phone and then a comprehensive directory of services to direct the patient—a directory that is up and running and functional, rather than just virtual. The concept is good; to have a system that patients, relatives, carers, and even medical staff and healthcare staff can phone to be able to navigate through the system in a single point is good, and it is not 999. The experience from the pilots around England shows that it is really dependent on the comprehensive directory of services that sits behind it.

[116] **Julie Morgan:** There have been a lot of problems in England.

[117] **Dr Poulden:** Yes.

[118] **Julie Morgan:** Do you think that it is possible to avoid those in Wales?

[119] **Dr Poulden:** I think that one of the good things is that we can look across and see what the issues are. I think that, yes, we could avoid some of the issues. The benefit of Wales is that it is quite a small, tight-knit and defined area.

[120] **Julie Morgan:** So, what about NHS Direct? How do you feel that works?

[121] **Dr Poulden:** Again, I think that, personally, it serves a purpose, and for a lot of patients, it delivers what they require. The difficulty is that a large proportion of its work is, I suppose, delivering something in relation to conditions that, had it not been there, the patients would have dealt with themselves. I think that the difficulty with any telephone system—again, this is anecdotal, because I am on the end of it—is that I see a number of patients who have been asked to come to the emergency department because they have phoned NHS Direct, and after that face-to-face assessment, it was obvious that they did not need to come. So, I think that it did not reduce the workload for emergency departments, which I think some

people thought it would.

[122] **Julie Morgan:** Right. So, it does not, in your experience, have any impact on the numbers coming in.

[123] **Dr Poulden:** It does not have an impact on reducing demand on emergency departments, no.

[124] **Julie Morgan:** How would you see 111 and NHS Direct working together? Are you clear on that?

[125] **Dr Poulden:** No.

[126] **Julie Morgan:** I think that we probably share that—well, it is not confusion; we do not know yet.

[127] **Dr Poulden:** No.

[128] **Mike Hedges:** You said earlier that some patients would be better off going to primary care, and that it would be equally beneficial for some to go to primary care or to A&E. Do you have any idea of the extent to which those who are turning up at A&E are doing so because they cannot get an appointment in primary care?

[129] **Dr Poulden:** It is something that is not gathered in. We do not record the reason they have come as being because they cannot get an appointment. Anecdotally again, you will hear patients who will say, 'I've tried and I can't'. Now, you have to take that with a little pinch of salt because, on occasions, I have then phoned the practice and it has fitted the patient in. So, I think that the perceptions of patients sometimes vary, but there is no doubt that there is a group of patients who cannot get in to see their GPs. I think that, some of the time, it is because we are in this sort of 24-hour economy, and patients want what they want there and then. So, whereas it would be appropriate for them to wait until tomorrow for an appointment, they would like to see somebody today. So, there is that balance as well.

[130] **Mike Hedges:** I think that, in some cases, and certainly in the Morriston area, you phone at 8 a.m. and are told that all the appointments have gone for the day and that you should phone again tomorrow, and you phone the following day at 8 a.m. and the only place to which you can go where a doctor will see you is A&E. That is why people are turning up in Morriston Hospital A&E. There is another question that I was going to ask you. The out-of-hours GP service in Morriston runs alongside the A&E and I have been told by people who live in Morriston how well that works; do you concur with their views?

09:45

[131] **Dr Poulden:** It is that we work quite closely together. There is always room for improvement, but we will often direct patients who arrive in the emergency department to the out-of-hours service, and the out-of-hours staff will come around to the emergency department for help with individual patients. So, I think that, on the whole, co-location is a good thing and closer working relationships are—

[132] **Mike Hedges:** Should co-location happen in more places in Wales than it currently does?

[133] **Dr Poulden:** I think that the answer to that is that it depends on where your services are, how easily accessible they are and what area they are covering. Obviously, potentially in some rural areas, it would be inappropriate to ask patients to go for their local out-of-hours

care all the way to the emergency department and its co-located GP services. I think that it depends on numbers and geography, but, on the whole, co-location works very well.

[134] **Mike Hedges:** As opposed to in west Wales where they seem to make their way to Morriston Hospital in large numbers.

[135] **Dr Poulden:** Sorry?

[136] **Mike Hedges:** As opposed to west Wales where they tend to make their way to Morriston Hospital in large numbers.

[137] **Dr Poulden:** I do not see a huge amount of primary care coming from west Wales to Morriston Hospital, to be honest.

[138] **Mike Hedges:** But, you do see some.

[139] **Dr Poulden:** Some.

[140] **Mike Hedges:** Okay, thanks.

[141] **Darren Millar:** Thanks, Mike. Sandy Mewies has the final question.

[142] **Sandy Mewies:** Thank you, Chair. The Welsh Government has told us that it is working very closely with colleges like your own on the national programme for unscheduled care. If we look ahead to that programme, what would your main priorities be, based on your own experiences, and do you think that the national unscheduled care programme has those priorities in mind in the work that it is doing?

[143] **Dr Poulden:** I think that if you asked all of my colleagues in emergency departments, 'If you were allowed one thing, what would that one thing be?', that one thing would be to get the patients who have to wait for long periods of time in the departments into the hospital beds. That would be what they would want if they were allowed one thing. I think that the next thing to look at is having appropriate levels of suitably qualified staff in the departments to deal with those patients who arrive. Certainly, I think that those things are in mind. On moving patients through, I think that a lot of work is going on and that it is about how we share good practice, because we hear of individual pockets of good practice. I think that the difficulty with good practice is that it is often based around an individual person or an individual team and that process cannot just be dropped somewhere else—you have to work with your local teams. It is how we share that. I think that the programme has that in mind, but whether I have confidence that it is going to deliver, based on the extent of the problem that we are faced with, is another matter. On the individual staffing, the UK college is working with the UK Government and we are looking at a number of things. On trying to recruit into emergency medicine, it is now viewed by junior doctors as an unattractive speciality, due to the pressures and the amount of out-of-hours working. We are unfortunately in a vicious spiral at the moment, in that the fewer staff you have, the greater the pressure on the existing staff and that is what they see as the future, and until we turn that corner, from a staffing perspective, that is very difficult.

[144] **Sandy Mewies:** So, is that a sort of maybe/probably with quite a lot of caveats? [*Laughter*.]

[145] **Dr Poulden:** Probably, yes.

[146] **Sandy Mewies:** Thank you.

[147] **Darren Millar:** On that note, that brings us to the end of this particular part of our evidence session. We are very grateful for your attendance today, Mark. If there are any points that you want to provide further information on, please do not hesitate to get in touch with the clerks and we will circulate those to the committee. You will also get a copy of the transcript of today's proceedings, so that you can correct any factual inaccuracies in it, but thank you very much indeed for your help.

09:50

Gofal Heb ei Drefnu: Sesiwn Dystiolaeth
Unscheduled Care: Evidence Session

[148] **Darren Millar:** We will move on to item 3 on our agenda, continuing with our unscheduled care inquiry. I am very pleased to be able to welcome Baroness Ilora Finlay and Veronica Snow, who is the national programme lead for end-of-life care, to the committee. Welcome to you both. Baroness Finlay, the Minister for Health and Social Services asked you to do a piece of work, back in April, on older people and unscheduled care, and, as you know, this committee is looking at unscheduled care following the publication of a report by the Wales Audit Office. We are particularly interested in those people who are intensive users, shall we say, of some of our unscheduled care in our emergency departments, the role of GPs and the potential of the 111 service. Do you want to tell us a little about the work that you both are doing and how that might be able to have an impact on and feed into some of the work that we are doing us a committee?

[149] **Baroness Finlay:** Certainly, and thank you for asking us to come today. We were asked by the Minister to lead a national conversation about the whole problem of unscheduled care for the elderly in particular. So, we felt that we needed to go around and listen to as many people as we could at every level. We have tried, therefore, to meet with boards or representatives of boards, we have met with people in accident and emergency departments, and we have tried to meet with people right down on the ground and also we have met with patient groups to get their feedback.

[150] I think that it is fair to say that what we have come up against the whole time is that this is a complete system problem. What we are seeing, because it hits the headlines, is the bottleneck at A&E, but it goes completely across the system from beginning to end. There are also implications for the way that different parts of the system are inspected, particularly nursing homes. The pressure that that then puts on nursing homes to manage patients who have had a fall precipitates them towards pushing those patients to A&E, who, of course, mount up at A&E, meaning that that is another group of patients going in who could possibly be managed differently if the way that the nursing homes were looked at and if the way that the contracts were managed were different. At the other end, as you have already heard this morning, there is the failure to rapidly transfer patients from hospital back out into the community and to get community support in place. I think that it is fair to say that we have felt that, in many parts of the system, there is a risk aversion that works against anybody other than the patient in front of whoever is doing the assessment and, sometimes, works against the patient as well, because there is no such thing as zero risk. Sometimes, not doing something or not taking an action is as harmful as doing it, and one of the classic examples is in relation to people who are frail and, if you like, teetering on the edge. They want to be in their own home, and they are just about managing in their own home, but take them out of that environment and it is as if you have pulled the props out from underneath them and they deteriorate and they never quite get back to where they were before. So, I think that the whole system that we are operating in needs to be looked at very carefully, and our conclusion overall is that we need to be pretty radical if we are actually going to make a difference in the long term.

[151] **Darren Millar:** You mentioned the nursing home sector perhaps being risk averse in transferring patients to A&E departments when they could be cared for within what is a patient's home, very often, in the nursing home setting. Is there an opportunity for nursing homes to provide services to patients other than their existing service users, shall we say, and to receive people from hospital rather than those people being admitted into hospital beds?

[152] **Baroness Finlay:** I think that we have to ask, 'What is the purpose of the bed that you are putting someone in?' If it is simply as a place of safety for them to be warm, fed and observed to a certain extent, that is one thing, but, if you are saying that people who are in hospital are there because they are sick and need diagnosis, treatment, and review of that diagnosis, then that is not going to happen in a place when you do not have those professional skills and input on site routinely. So, you would not want to put someone who is clinically unstable in a place where they would just be tucked up in bed and it might be warm and they may get some feeding, when, if they are sick, they are going to need more than that.

[153] **Darren Millar:** In your experience, are there many people who need feeding and warmth—who are in that first category—in our hospitals?

[154] **Baroness Finlay:** I think the delay in discharging patients is a real problem, and some areas are worse than others. If you do not have patients transferred out, however, you do not free-up the beds for the sicker patients to come into.

[155] **Darren Millar:** Veronica, how does your work on end-of-life care feed into the national conversation and the work that Baroness Finlay is doing?

[156] **Ms Snow:** The end-of-life care programme looks at the totality of end-of-life care, and, obviously, as people get older and older, they begin to have comorbidities. Generally, the elderly population that finds itself in A&E will have end-of-life care needs. From the point of view of the nursing homes, if I could just pick that up, there will be a capacity issue in some areas, but there are other nursing homes that would be equipped and ready to develop that type of service. As Baroness Finlay said, however, it is a whole-systems change, and that would have to be included in a strategy.

[157] **Darren Millar:** Thank you for that. I am going to come now to Sandy.

[158] **Sandy Mewies:** Thank you, Chair. Baroness Finlay, you have said in the past, and it is something that we have heard in this committee, that emergency departments are full of elderly people who are there often because other services do not operate around the clock. Can you outline how Wales compares with England and any other countries that you may know about in relation to ensuring that unscheduled care services for older people work around the clock, seven days a week? What changes are needed to ensure that we have these services here so that they are appropriate services? I will go on later to another question.

[159] **Baroness Finlay:** I think that you have hit on something really important, which is seven-day services. English NHS services are in a time of major upheaval, I think it is fair to say, and are known to be, but one of the things happening in that is that there is a really serious look at seven-day services. The mortality and morbidity figures for patients admitted under surgical services, and who have operations just prior to a weekend, are worse. I cannot give you the exact figures off the top of my head; there was a piece in a recent edition of the *British Medical Journal* looking at that. You see this seesaw pattern. We have looked back at Welsh data, and there is a seesaw pattern with discharges that goes on week after week. Illness does not respect the clock or calendar, and therefore the services have to be there for those who really are sick.

[160] Something else happens with the elderly, particularly in Wales, and that is that a lot

of them have family living away. The family will arrive to see often mum and sometimes dad at the weekend and will find that they are less well and that something has happened that they have not had seen to for a few weeks, and they feel, understandably, that they cannot go back to wherever they normally live without seeing mum or dad sorted. So, there is a pressure as well for them to get an elderly person to be seen. The other thing, of course, is that, if you have fewer staff around just generally, then some of the things that used to be in place are not. Therefore, because GP surgeries do not open on a Saturday, the local chemist finds that it does not have enough footfall to make it profitable to be open, often, in the afternoons. That means that a place to which someone might have gone to seek advice, or to ask, 'Do you have something that would tide me over until Monday, when I will try to get to see the GP?', is closed, so the time gap is longer, and, again, that puts pressure on people.

10:00

[161] I was listening to the previous session, and I think that Mike Hedges—if I remember rightly, from what I saw on the television that we were watching—was talking about phoning at 8 a.m., and trying again to phone at 8 a.m. Now, I think that the elderly are more easily put off, and do not persevere, and do not push so hard. I think that there is also another problem, actually, which comes through the media, where there is a message that the elderly are somehow a burden in our society—we hear about the demographic time bomb—so that they are made to feel that they are being a bit of a nuisance, and are therefore more reluctant to call for services, and to ask for what they need. They are worried about upsetting people, and they are really worried that, if they make a complaint of any sort, it will somehow rebound against them, and so they become less reluctant as well, which, of course, puts the pressure up when the family come to visit from away. So, I think that all these things are very much multi-factorial throughout the system.

[162] Going back to your question, which was about how Wales compares with England, I think that it is really difficult to compare the data directly, because we are actually now collecting data in slightly different ways, and one can get hung up on collecting the data. The bit of data that I think that we are not collecting that we really should be collecting is what the patients are experiencing, and what they say. Until we really routinely find out, very simply, from patients what their experience is of the system, we are not going to get the change coming through. We introduced it in palliative care some years ago, and, although the return rate is low from the number of patients that are seen, and although some services are much better at going and seeking the patient opinion than others, the feedback that we have had has been invaluable.

[163] **Sandy Mewies:** Thank you—that is very interesting. I think that it chimes with what we know, because what you are saying is that there has to be a smoothing of all the services, so that there is not this sudden break on Saturday and Sunday. You are absolutely right; in my experience, the weekend and holidays is the time when people fall ill, and it is often when their families are able to see them. You talked about things such as pharmacies, and you are absolutely right that they open on a Saturday morning, very often, but not in the afternoon. I entirely agree with you when you say that older people, in the main, are very reluctant to kick up a fuss or to stand for their rights, are they not?

[164] **Baroness Finlay:** Yes.

[165] **Sandy Mewies:** All those things lead me on to my next questions. What is your view on how good NHS Direct Wales is at meeting the needs of older people, and do you think that the upcoming NHS 111 service will have an impact on reducing the number of older people who attend emergency departments? I do not know whether you are able to reflect at all on any experience that you have of whether older people already use NHS Direct. I find that, when I talk to older people, that is not a port of call, and that it tends to be younger people

who use it, but I wonder whether you have any experience of that.

[166] **Baroness Finlay:** Veronica and I were concerned about the whole question of the telephone, so we went in to NHS Direct, and sat and listened in to the next call that came in—just randomly. It was not an older person. However, the thing that we became very aware of is that it has to operate a risk-averse system because, if it does not, inevitably, something will go wrong and the sky will fall in on it. It is also because they are not connected. So, they cannot say, 'We will phone through to your GP and get you seen within the next half hour'. There was no route whereby they can say, 'Hold on, we will hold this call for a moment and we will direct dial through to the GP surgery, and not on the ordinary receptionist number', but that is the only one they have access to. They do not have the back office number for the GPs to direct dial and say, 'Right, we will get you an appointment now'. All they can do is advise them to try to get an appointment and, if not, that they ought to be seen. Inevitably, they got their nickname of NHS redirect because of the patients who come to A&E.

[167] Also, they have these algorithms that they work through, which are there for good reason. You can see why; you could not just be randomly giving advice. I have a concern as a clinician with the whole question of telephone advice and always have done. I think that it is extremely difficult to give advice over the phone to somebody who you do not know and you have not seen. I still work clinically and I know that even when a healthcare professional phones me up about a patient for advice, the picture I get over the phone often bears little relation to the patient I see, if I decide to go and see that person.

[168] You get a verbal portrait of a situation, but, over the phone, you do not know whether this is somebody who tends to exaggerate, or somebody who downplays things. You do not know what they look like. If we were doing it all with Skype calls, you might at least be able to see the person, but that is not what we are doing at the moment; we are relying on the telephone. I cannot help feeling that, while it is there as an additional service, I do not think that it is going to divert patients out of the system. Inevitably, it is going to have to say, 'Well, I think you ought to be seen and you ought to be examined'. We always say in medicine that the basis is a good history. You should be able to get nearly there with a good history, but you need to examine the patient to confirm it, and then the investigations are simply to confirm your clinical suspicion and diagnosis.

[169] However, with the telephone, you are only doing the first bit. You are not even doing it face to face where you are picking up all the non-verbal clues in communicating. We know that about 20% to 25% of communication is verbal. A huge amount is non verbal. You are making it really difficult, if you rely on the telephone, to provide clinical advice to people who might be terribly ill. A classic, for example, might be a headache. There is the complete range from absolutely life threatening down to totally incidental, a bit of stress, have a cup of tea, benign. However, it is a headache, and the person might describe it as a blinding headache. It is really difficult to tell over the phone, however much you question. I cannot help feeling that, at the end of the day, if people really think that they are ill they need to be seen.

[170] **Sandy Mewies:** I agree with what you say there completely. Are you saying that 111 will have a use but it is certainly never going to be the tool that people think that it is going to be and that instead of spending a fortune on that, more money should go into direct services?

[171] **Baroness Finlay:** One of the problems if you take healthcare professionals into a service like that is that you are removing them from front-line clinical services, and you have a limited pool of people who are trained. So, you have to think where to use people best. I am not sure what the policy is going to be in terms of NHS Direct fading out and the 111 service coming in. However, unless 111 is directly linked in, so that it can see what is happening in accident and emergency departments, how busy they are and what is happening with the

ambulance service, and so that it has direct access to general practice, I do not see how it can really be an effective signposting service. The other thing is that, if it does not do that, it will work in isolation, and I wonder how it is going to audit its outcomes. Unless you have a follow-up system, how are you going to know how effective you are being?

[172] **Sandy Mewies:** That is very useful; thank you.

[173] **Darren Millar:** I know that Jenny has a supplementary question.

[174] **Jenny Rathbone:** In England, the Government has asked GPs to have a named individual responsible for much older people. What is your view of that as a way of making telephone interviews relevant? If you have seen a person over the last week, you know whether they are someone who exaggerates or downplays things. Also, this is about not having to ask the patient the basic questions that are in the patient's notes.

[175] **Baroness Finlay:** This is the new GP contract, where a lot of the quality and outcomes framework requirements have been stripped out. I think that this is to be welcomed. I am glad that there has been agreement with the BMA and with the Department of Health over it. I personally think that there is merit in saying that, if you are contracting with GPs to provide general medical services for a population that often has multiple co-morbidities, they need general medical services more than they need specialist services, by and large. They need good general medical services that will refer them for a specialist opinion or view and that can pick up and carry on. That continuity of care is important. What we heard from the conversations is that patients want to know who is looking after them, what is wrong and, if they are in hospital, when they can go home. They want to know who is looking after them, and this seems to make a lot of sense.

[176] Many years ago, when I was a GP—that is a long time ago now, and it has all changed a lot—we had a visiting book. We had a list of elderly patients who were frail, and we would visit them. Now, I know that that does not happen, it probably was not always a terribly good use of time, and you could do this by phone. If you know the old person, you will pick up just from their voice that they are less well. Old people's voices become trembly and frail quite rapidly when they are not well. So, for them, if you know them from beforehand, you can get a pretty good idea just by listening to them on the phone. A phone call might only last for 10 minutes, but they know that they are being followed up. That may also give them the confidence to do a bit more as well, rather than feeling at sea.

[177] The other thing that we heard from elderly people was that they did not know who to phone, and that they thought that the only thing that they could do if they were ill out of hours was phone 999. They did not really understand how the out-of-hours service worked or what they could access, and they felt frightened and felt at sea. I was on call last weekend, talking to a relative. This lady was saying that it was so worrying, particularly at nights and weekends, in respect of her husband. She was worried, if he suddenly got worse, about what she would do. Would she phone 999? She did not want him carted off in the back of an ambulance.

[178] **Darren Millar:** Mike, I know that you have a question on this. I ask Members to brief, and—

[179] **Baroness Finlay:** I will try to be brief; I am sorry.

[180] **Darren Millar:** If everyone can be brief, we will get through everything that we want to achieve.

[181] **Mike Hedges:** I have two questions, and you heard part of this earlier. Do you agree

with the co-location of out-of-hours GP services with accident and emergency, as we have at Morriston Hospital and—I am sure—at other hospitals? My other question is this: do you find that older people are having difficulty accessing urgent GP appointments? You might be able to tell how ill people are, but I am not sure about the receptionists, some of whom think that they should be the doctor and make decisions on the issues and tell them to ring back tomorrow. I would also like to say that there are some GPs who still do home visits.

10:15

[182] **Baroness Finlay:** There are GPs who still do home visits; I was talking about the proactive ones. Regarding co-location of GP services with accident and emergency, I think that the analogy is with the high street. People vote with their feet, do they not? They go to the place that they know is open, where they know that they can get what they think that they need. We see high-street shops closing down and we see the big supermarkets open, where people can park and feel that they can get there. I think that part of it is that people are, in a way, voting with their feet. They are deciding that they would rather go to sit for several hours in A&E than not, for whatever reason. They decide to sit there on uncomfortable seats for a long time. It makes a lot of sense. It also means that you can divert patients in both directions. You increase your clinical resource that is there, but it also means that the GPs there have better access to x-ray, ultrasound and some straightforward blood tests, which may be the thing that you need to do to decide whether they are really sick. A white count, for example, can be really helpful in detecting whether someone's infection is something that you really need to jump on fast or not.

[183] **Mike Hedges:** There was the other question about older people trying to get access to GPs and being turned back.

[184] **Baroness Finlay:** Yes. I do not have any data on it. Anecdotally, we were picking up a sense that people just felt that there was difficulty. We do not know whether there really is, but, again, if we do proper patient questionnaires and surveys, we will get a handle on the problem. I think that we really need to go for some real-time sampling. Otherwise, you get the data and you might just get the answer to the question that someone wants to answer rather than really get a handle on it.

[185] **Darren Millar:** Sandy, did you want to move back?

[186] **Sandy Mewies:** No, I did not, actually.

[187] **Darren Millar:** Okay. Thank you. I therefore turn to Oscar.

[188] **Mohammad Asghar:** Thank you, Chair, and thank you, Baroness. You mentioned earlier that you had engaged with older people. I am sure that you must be getting all of this information about what the needs and requirements are in terms of the ageing population. You also said, in the same statement, that you need radical changes in certain areas in terms of how older people are treated and looked after by the NHS. My question is about the skills of the staff when they go to hospital or an emergency department. What are your views on that, or do you have solutions for when they see the staff who were trained to understand the needs of the ageing population when they visit hospitals?

[189] **Baroness Finlay:** Do you mean the skill set of the staff, overall?

[190] **Mohammad Asghar:** Yes.

[191] **Baroness Finlay:** We have trained staff across Wales. I think that, sometimes, we do not free them up to take as many decisions as they could, because they feel that they are

operating in a risk-averse environment. One thing that we picked up from staff, as we went around, was that they feel inhibited from taking what might appear to be bold decisions for patients because they are frightened that they will be told off, that they should not be doing it, that it is outside the guidelines for the unit, and so on. It is a real fear of being disciplined instead of feeling confident in providing what they view is the best care for that person in front of them, and being prepared to take risks. The one department that takes risks all of the time—and everything that it does is a risk, in a way—is accident and emergency. It is taking risk-assessment decisions all of the time. Once a patient is in a bed in an in-patient unit, it is easier to be risk-averse and say, 'They can't really go home until A, B and C are in place'. Social care providers out there will have a limited resource and say, 'We can't do it until A, B and C are in place'.

[192] I think that there is also a question of responsibility on the family. I have heard sometimes of families who have refused to take someone home and refused to care. It has not been for clinical reasons. I worry, in a way, that we do not have any pressures within the system to say, 'Look, you are a member of society', as we all have a duty to other people in society, but also that we are not harnessing adequately the volunteer potential. There are some schemes around—and we came across on in Powys—that discharge patients to home. Patients would be accompanied, there would be someone to check that they had a cup of tea and that they were settled at home, and they would check up on them the next day. There are some schemes like that going in England, using the Royal Voluntary Service. It seems incredibly sensible to use local populations of volunteers, who would be very happy to pop in, but I think that, in our risk-averse culture, we are almost disempowering them.

[193] **Mohammad Asghar:** I come from a culture where we never let our elders go to a care home—or very rarely. We keep them at home, and we look after them ourselves, which we believe is our moral duty. That is our culture. We should learn from each other. Politeness and courtesy, as well as the treatment by staff of aged or senior citizens, actually helps a lot, along with the treatment and medicine, which is paramount. As you said, rightly, old people's voices go very low, and they also listen low—they love to not— . I have some complaints from some constituents about the behaviour of certain staff, which puts them off, and makes them more sick, or upset, rather than going to hospital or to a doctor.

[194] **Baroness Finlay:** I think that, if you are looking at standards in care, perhaps the one question that everyone has to ask is, 'Is it good enough for my mother?', or 'Is it good enough for my father?' If it is not, it is not good enough for someone else. We are possibly overtolerant of attitudes, because, for various reasons, people in a team do not want to report someone whose attitude is not brilliant. The other difficulty is that I think that the HR systems in the NHS are such that it makes it quite difficult to pull someone aside and say, 'Sorry, but that sounded awful'. I think that we have gone so much the other way, against bullying and harassment and various procedures, that it becomes difficult to hold people to account, just on an everyday basis.

[195] However, the other thing is that we are working our staff very hard, and they are really exhausted. If you do not look after your staff from the top, the behaviours that they get right from the top determine the culture of the organisation. If all the staff feel that they are valued, that their professionalism is valued, that they are empowered to do what they view is right for a patient, and that they will get a fair hearing, I think that you will get much more positive behaviours than if you create a punitive environment, in which people are frightened of being told off, or feel that they are not sure what they should do or feel that they have to write something down rather than spend time at the patient's bedside, and so on. So, the culture frame is set right from the top, and, possibly, in the health service we could learn from organisations outside.

[196] **Julie Morgan:** Is there much evidence of patients who would really want to die at

home being admitted through the emergency department, and then dying in hospital?

[197] **Baroness Finlay:** That is a really difficult one. For a start, some people do not want to have that conversation, so you can do harm by forcing that conversation on people. However, the other thing is that things change. So, there will be people, if you ask them early on in their illness, who will say that they want to die at home, but then they may become clinically unstable and then it gets too difficult, and, later on, they are glad to be somewhere. However, I would have to say that, by and large, they are glad to be in a hospice bed, in one of the hospices that are around; an A&E department, and an acute ward, is often not the right place for someone who is dying, and who is known to be dying. We have tried to tackle it by having seven-day specialist nursing available in the community, but, until we have proper seven-day services, and we have proper overnight—or, certainly, into the night or into the evening—nursing and social care support, I think that it will be difficult to meet those needs.

[198] I came across a project in Lewes in Sussex where they are using doulas, who are like the birth partners for labour. They are volunteers who are being trained up at a minimal level to be with people who are dying. They are there to accompany them, to be in the house and to be available. I have only just come across it, but I thought that it was quite an important and exciting model that we should look at. If somebody is dying and they need someone overnight, they need them that night. It is no good saying to them, 'Oh, we can't get somebody tonight, we'll get somebody tomorrow or two days later', because the person may well have died by then. You have hit on something really important. A&E departments hate having somebody come in and then to die. The ambulance people do not like it—they feel that it is not right, but they are stuck with their protocols. We should empower staff, all the way back down the system, and empower the ambulance people and let them take decisions and show a little bit more good discrimination in their decision making. I know that they have their protocols, and they are there for good reason, but they are so frightened of being disciplined if they breach one of those for whatever reason that I think it works against patient care.

[199] **Julie Morgan:** You said right at the beginning in answer to the Chair that you thought there had to be radical solutions. Is freeing up staff one of the radical solutions?

[200] **Baroness Finlay:** I wonder whether we need to change the language from 'risk' to 'balanced outcomes' and get away from the 'Oh, this is risky, therefore, we shouldn't do it' view and say what the balanced outcomes are. The outcome of not doing something may be worse than the outcome of doing something. It is always a balance; it is always a weighing-up process, but that is not in the language. We will not change the culture until we address the language that people operate in.

[201] **Julie Morgan:** Finally, on improvements to end-of-life care, has there been an improvement since the board was set up and since the work has been done?

[202] **Baroness Finlay:** We have certainly tried. We have evidence of incredibly high satisfaction levels coming back from dynamic patient feedback. The scores are all the time over 95%, over 9.5 out of 10, across nine domains. We ask them about their experience of being listened to, whether they were trusted and whether their fears and problems were addressed. The one thing that tends to slip a little bit, but it still stays pretty high, is where there have been delays. The general sense coming through is that some people experienced delays in their care. That was with the implementation board. We have plugged gaps where there was nothing. We have been able to rapidly respond when a charity has folded by moving things around.

[203] **Ms Snow:** The seven-day working for clinical nurse specialists has reduced admissions for people at the end of life. Where a patient has been admitted to a medical

assessment unit, the acute CNSs have been able to turn that patient around and move them, either into a hospice bed or back home with support. So, that has definitely improved. We have improved the access to pharmacy with the just-in-case boxes in the community and in the patient's home. The Canisc, the palliative care information system, has improved access to clinical information for clinicians. So, on a weekend, a consultant in Neath can see a patient in Morriston and can see the patient's records and know exactly what is happening with that patient and is able to support that patient. We have definitely seen improvements there. We have probably seen, although we do not have the evidence yet, improvement in access to hospice beds by non-cancer patients for end-of-life care.

[204] **Baroness Finlay:** The numbers have gone up for people with neurological disease, cardiac disease and so on.

[205] **Jenny Rathbone:** Just sticking with this, on planning the inevitable decline, which Dr Poulden talked about, the spouse or partner may be in denial about what is about to happen, but the offspring and certainly the nursing home or care home staff ought to be able to cope with this and understand what additional services might need to be there when the inevitable decline happens. How could we get that to happen in a much more accelerated way?

10:30

[206] **Baroness Finlay:** It is fair to say that we need to have greater input at an educational and supportive level into nursing homes in a straightforward and simple way, without making it complicated but making it very simple. Our educational efforts in some areas have possibly been too complicated. The team in north Cwm Taf has been working and going into nursing homes and providing little vignettes of education: 10 or 15 minutes at a time during people's breaks. It looks as if that is much more effective than putting on an education programme.

[207] **Ms Snow:** Quite often, if you put on an education programme—for instance, on how to use a syringe driver—it might be that the nursing home will not need to use a syringe driver for another. So, rather than putting on planned education training, specific, targeted intervention is sometimes a better learning process and improves the outcome for the patients.

[208] **Jenny Rathbone:** Just going back to my question on empowering ambulance staff to balance risk, which you have partly answered already, are there any good examples of ambulance staff in particular areas feeling empowered to tell families that going to A&E is not necessarily going to be the best thing?

[209] **Baroness Finlay:** The one area where we have come across problems has been in relation to 'do not attempt cardiopulmonary resuscitation' protocols, but that is being addressed. The new DNACPR policy will be launched pretty soon and is down to its final draft form. It has been widely consulted on and Paul Buss has led on that from Gwent and has done a huge amount of work. I think that the feedback that we have had from patients overall has been that the ambulance people have been superb—outstanding, actually—in how they have handled whatever they have come across. They are at the front line without many resources. I think that, sometimes, the ambulance crews can be the unsung heroes in the system. However, we did not hear really adverse reports from patient groups; that has not come through. The only one relates to CPR, where they have arrived and somebody has died. They felt that they had to go through CPR and they did not feel that whatever documentation in the house was adequate to allow them not to be forced to go down that route. I hope that that will be addressed.

[210] **Aled Roberts:** Byddaf yn gofyn fy nghwestiwn yn Gymraeg. Mae'r byrddau

Aled Roberts: I will be asking my question in Welsh. The health boards have done a lot

iechyd wedi gwneud llawer iawn o waith ar lif cleifion. A oes unrhyw negeseuon yn codi o'ch gwaith chi ynglŷn â phroblemau o fewn y gyfundrefn? Rydych wedi sôn bod angen edrych ar y gyfundrefn gyfan, ond a ydych yn ymwybodol bod dal i fod problemau o ran cael gafael ar ddoctoriaid arbenigol o fewn ysbytai ac nad yw cleifion yn symud ymlaen o ganlyniad i hynny? Hefyd, beth ydych chi'n teimlo am y gostyngiad yn nifer y gwlâu? Mae llawer iawn o ad-drefnu o fewn y byrddau iechyd ar hyn o bryd ac mae nifer y gwlâu yn dal i ostwng.

of work on patient flow. Have any messages arisen from your work regarding problems within the system? You have mentioned that there is a need to look at the whole system, but are you aware that there are still problems with regard to getting hold of specialist doctors within hospitals and that patients are not moving on because of that? Also, what do you feel about the reduction in the number of beds? There is a lot of reorganisation within the health boards at the moment and the number of beds is still falling.

[211] **Baroness Finlay:** You have to take doctors in the context of all the other staff as well. The physiotherapist or the occupational therapist, for example, may be particularly important to getting somebody home and for their rehabilitation, far more so than medical and nursing staff. Having the right people in the right place with the right skillset is a real challenge. I think that one of the important things is access as well. I have a simple anecdote. As we were driving here, the traffic stopped, by chance, outside a GP surgery. We looked across and it said that it was open from 8 a.m. to 4 p.m. If it is closing at 4 p.m., there is a real access problem for all the people who are registered with that practice, because then what happens for the second half of the afternoon? So, looking at radical solutions, one must look at the way that everybody works across the whole system to make access available.

[212] In terms of hospitals, it is not just about having a hospital there with a bed; it is about having the right staffing for that service. We need highly specialised tertiary services for very complex conditions. You would not want your GP, or a general physician, to determine your cancer treatment; you would want to see a site specialist oncologist linked to a site specialist surgeon, and similarly for complex cardiac issues. However, for most of the general issues, you need somebody who is a generalist and will look at your heart, your diabetes, your chest problems and bowel problems and all of your psychological worries, and possibly your depression, as one person, because the patient is a person, not a collection of filing cabinet diseases.

[213] In terms of staff and beds, there has been some work done in England suggesting that you need about six hours of consultant time to review about 30 in-patients at any one time, and evidence that you need a more senior person doing the reviewing. So, acutely ill patients should be seen every day, or at least every other day, by a consultant. The evidence from the London bombings was that the professor in A&E at St Mary's Hospital put himself on the front door of the hospital, because he was the most senior person to take the most difficult decisions.

[214] So, it is not just about bed numbers. It is about having beds staffed at the right level with the right people. I think that we have to be real and honest with people that we cannot have highly specialised services everywhere in Wales. We need general services in the community, and we need some generalist in-patient beds that are there specifically for people with the aim of turning things around and transferring patients back to the community once they are stable. Then we need tertiary care, and highly specialised centres. We have done it with cancer, by and large, but we have not used that model for other things. Suggestions that have been put to me as we have been going around is that we need major trauma with neurosurgery, possibly, at the Cardiff end, and burns and trauma related to burns at the Morriston end, and be absolutely clear that everyone is directed in those ways. The evidence from London is that where you have concentrated stroke services, the ambulance might pass the door of one hospital to get to the stroke service, but that the clinical outcomes of that are

better and that survival is better. It is not just the time on the road; it is actually from the front door to the right things being done. If the front door is so teed up that things happen very rapidly, you will get better outcomes.

[215] However, we have a roads problem in Wales and rurality is a real problem, so the organisation of services will need some courageous template-developing for the whole of Wales. We will need to be absolutely clear with people about what they will have locally and the reason that it is not appropriate if somebody is only doing something occasionally—they will not have the skill set and they will not get the clinical outcomes. We know that from surgery—oesophageal surgery was an absolute classic, and gut surgery altogether. If you are going to have complex radiology, which may avoid surgery completely and deal with the conditions brilliantly, you need to concentrate it. Those are very expensive machines with very highly trained people who need to keep their skills up to date. So, it is not just about bed numbers, but it is about the whole organisation. You can then transfer the patient back from there, as soon as they are stable, for the next phase of their care, to be out nearer home, and then transferred back to home. I think that one of the other lessons is about being very clear as to who is in charge of a patient's care at any one time.

[216] **Aled Roberts:** Within that sort of radical re-look, is it the case that certain working practices in Wales are decades behind the curve? I was quite concerned last week, for example, to learn that, in a district general hospital, ward rounds are conducted on only two days. So, in view of your comments in the House of Lords about a four-and-a-half-day discharge routine, it may be that, in certain instances, you are down to two days.

[217] **Baroness Finlay:** There are lots of other people involved in the discharge process, of course, so you may say that someone is medically fit to go, but then all of the other bits have to be put in place. You must have the people there. If you expect people to do more on the wards, you have to free them up. You have to relieve them of some of the things that they are doing. I worry about the amount of administrative pressures that there are on clinicians. GPs complain about it, and clinicians complain about the relentless pressures. One cannot underestimate how exhausting it is to be dealing with really sick people all of the time. We need to look at that again. This goes back to how we look after our staff, how we care for our staff and how we rotate them around. Going back to England, some hospitals have done some interesting things. Salford has been using its staff in imaginative ways. I think that we possibly need to go to learn from other places. One of the key things is that they seem to have engaged all of their staff in the decision-making.

[218] **Darren Millar:** Very briefly, Aled. The clock is against us now; so, perhaps we could all be brief with our questions and answers.

[219] **Aled Roberts:** In improving the integration of health and social care, do you have any particular examples, either in Wales or further afield, where good practice has been shown?

[220] **Baroness Finlay:** We are going down to look at Torbay shortly, where they seem to have done it. The point seems to be that, if you have one person managing the lot, you force integration. In a way, that is really difficult, politically, because of the way that the budgets have come through and who is answerable for how that budget is spent. However, that is one that we are going to look at. I know that many people have been to look at Torbay.

[221] **Jocelyn Davies:** I think that my questions have been covered, but there was something that I did want to ask you. In terms of this risk-averse idea that you have been telling us about, does an old person always need to go into hospital if they have had a fall?

[222] **Baroness Finlay:** No.

[223] **Jocelyn Davies:** I find that this seems to be the policy, particularly in residential homes. A&E departments are very unpleasant, and hospital stays for older people, as I think that you would agree, are highly dangerous.

[224] **Baroness Finlay:** They are inappropriate.

[225] **Jocelyn Davies:** Yes, particularly if their discharge is delayed, because that can be life-changing for some because they do not go back home; they end up going somewhere else. You mentioned the patient survey and a low return rate. Can you tell us what you would consider to be a low return rate?

[226] **Baroness Finlay:** We have had some services where we have only had a few forms back. So, that is really low. I think that the highest return rate that we have had has been just under 10% of the patients. You cannot force people to fill something out, and you cannot confront them with questions that they are not ready to answer, but if you give them the opportunity they will tell you interesting things.

[227] I would agree with you; lots of people have falls and they are fine. However, they do need to be reviewed by someone sensible. If they are in a nursing home, you have trained nurses on site, who can do baseline observations. If they have had a fractured femur it may be very obvious, but even for a minor laceration someone could come and sort it out without necessarily transferring the patient.

[228] **Jocelyn Davies:** When you were talking to older people about this idea that they were reluctant to push for a GP appointment, did you find any reluctance connected to a fear that they might be diagnosed with a terrible illness that they did not really want to hear about?

10:45

[229] **Baroness Finlay:** No, actually. Not at all. We found that the reluctance related to not wanting to be a nuisance. However, older people are very realistic. They know that they are not going to live forever. They talk about death among themselves a lot; they discuss dying over coffee et cetera a lot. They go to their friends' funerals. Black humour comes in and they will say, 'Oh, it will be me next'. They know when the person in the bay with them in a hospital has died and what has happened. I think that it is the rest of us who do not talk openly enough with them and do not let them talk about it.

[230] **Ms Snow:** I think that if they had any fear, it would be that they would end up in a bed 30 or 40 miles away in a high-tech unit that they did not feel that they needed to be in.

[231] **Baroness Finlay:** Also, they are frightened of being badly cared for. They are really frightened of being at the mercy of people who are uncaring and cruel to them. That fear has been exacerbated by the media. The sad thing is that we have not had all the stories of good care. If you go into a unit, you will see thank you cards all across the wall. If you talk to clinicians, they will have a file of thank you letters from people. That never hits the headlines. So, we have lots of people getting superb care that is kind, compassionate, gentle, appropriate and patient-focused and the message that people are getting all the time is, 'Watch out, because you might be on the receiving end of bad care'.

[232] **Darren Millar:** I call Mike, very briefly; this is the last question.

[233] **Mike Hedges**: If somebody is taking warfarin, which a large number of older people take, for heart conditions, every time that they have a fall, they get routinely taken to A&E. Is that not one of the problems? Do they have to be taken routinely to A&E or is there an

alternative solution? However, they are routinely taken there by nursing homes.

[234] **Baroness Finlay:** No, part of the problem has been the inspection. What we have heard from nursing homes is that the way that they are inspected means that if they have falls in their establishments and are not sending people to A&E, they get pretty punitively reported. So, actually, these people who have fallen need to be observed, they may need their INR checked, but what matters is whether they are getting a bleed, and you will only pick that up by observing them, and you can look at their pupils, check their consciousness rate, their pulse and their blood pressure. It is not rocket science; it is really basic stuff.

[235] **Darren Millar:** If there is one message that has come across very loudly and clearly from you this morning, it is this issue that there is a risk-averse culture out there, and that we need to offset that against balancing the outcomes for patients. We are really very grateful for that message; it has come across loud and clear. Thank you for your evidence, if there are any other points that you wanted to make to us that we have not had an opportunity to look at today, if you can send us some further data or evidence, we would be very happy to receive them. Baroness Finlay and Veronica Snow, thank you very much for your help with our inquiry.

[236] **Baroness Finlay:** Thank you for your searching questions. It has been really stimulating.

[237] **Darren Millar:** Thank you.

10:48

Papurau i'w Nodi
Papers to Note

[238] **Darren Millar:** We have a number of papers to note: the minutes of our meeting on 3 December; a very interesting letter from David Sissling in relation to our health finances report—I would encourage Members to take a look at that, particularly in terms of the Townsend formula, a review of the formula and the money that is being invested in consultancy services to support the development of savings plans within the NHS; some further information that we received from the British Medical Association on unscheduled care; and, finally, a letter from Carl Sargeant in relation to the Help to Buy scheme. I will take it that those items are noted.

10:49

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting

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

the committee resolves to exclude the public from the remainder of today's meeting in accordance with Standing Order 17.42.

[240] Does any Member object? There are no objections, so we will move into private session.

Derbyniwyd y cynnig.

Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10:49.
The public part of the meeting ended at 10:49.