



Cynulliad Cenedlaethol Cymru **The National Assembly for Wales**

Y Pwyllgor Iechyd a Gofal Cymdeithasol **The Health and Social Care Committee**

Dydd Iau, 5 Mawrth 2014
Thursday, 5 March 2014

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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 reported 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

Peter Black	Democratiaid Rhyddfrydol Cymru (yn dirprwyo ar ran Kirsty Williams) Welsh Liberal Democrats (substitute for Kirsty Williams)
Alun Davies	Llafur Labour
John Griffiths	Llafur Labour
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Adam Cairns	Bwrdd Iechyd Prifysgol Lleol Caerdydd a'r Fro Cardiff and Vale University Local Health Board
Fiona Davies	Cyfreithiwr Lawyer
Mark Drakeford	Aelod Cynulliad, Llafur (y Gweinidog Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (the Minister for Health and Social Services)
Mick Giannasi	Ymddiriedolaeth GIG Gwasanaethau Ambiwylans Cymru Welsh Ambulance Services NHS Trust
Stephen HARRY	Prif Gomisiynydd Gwasanaethau Ambiwylans Chief Ambulance Services Commissioner
Yr Athro/Professor Siobhan McClelland Tracy Myhill	Cadeirydd y Pwyllgor Gwasanaethau Ambiwylans Brys Chair, Emergency Ambulance Services Committee Ymddiriedolaeth GIG Gwasanaethau Ambiwylans Cymru Welsh Ambulance Services NHS Trust
Dr Jean White	Prif Swyddog Nyrzio Chief Nursing Officer

Helen Whyley	Swyddog Nyrsio Nursing Officer
Alison Williams	Bwrdd Iechyd Lleol Cwm Taf Cwm Taf Local Health Board

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

Amy Clifton	Y Gwasanaeth Ymchwil The Research Service
Gwyn Griffiths	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser
Helen Finlayson	Ail Glerc Second Clerk
Sian Giddins	Dirprwy Glerc Deputy Clerk
Llinos Madeley	Clerc Clerk
Rhys Morgan	Rheolwr Craffu Scrutiny Manager
Siân Thomas	Y Gwasanaeth Ymchwil Research Service
Philippa Watkins	Y Gwasanaeth Ymchwil The Research Service

Dechreuodd y cyfarfod am 09:02.

The meeting began at 09:02.

**Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions**

[1] **David Rees:** Good morning. Can I welcome Members and the public to this morning's session of the Health and Social Care Committee, where we will be continuing our inquiry at Stage 1 into the Safe Nurse Staffing Levels (Wales) Bill? Can I remind Members, please, to turn all your mobile phones off, or to silent, or any electronic equipment that may interfere with the broadcasting equipment? We are not scheduled for any fire alarm this morning, so if one does occur, please follow the directions of the ushers. The meeting is bilingual, and if you wish to use the headphones for simultaneous translation from Welsh to English, that's on channel 1—they should be set for you—or for amplification, if you need amplification, that's on channel 2. We've received apologies from Janet Finch-Saunders, who has had personal sickness and has had to leave at the last minute. Peter Black will be substituting for Kirsty Williams, because obviously she is the Member in charge of this particular Bill.

09:03

**Y Bil Lefelau Diogel Staff Nyrsio (Cymru): Sesiwn Systiolaeth 12
Safe Nurse Staffing Levels (Wales) Bill: Evidence Session 12**

[2] **David Rees:** Can I welcome the chief nursing officer, Dr Jean White, to this morning's session? Would you like to introduce your colleagues?

[3] **Dr White:** Thank you very much, committee. On my right is Helen Whyley, who is a nursing officer within my team, and on my left is Fiona Davies, who is a solicitor in the

Welsh Government.

[4] **David Rees:** Okay, thank you. Before we continue, can I remind Members that, unfortunately, Kirsty Williams is actually unable to be with us today due to illness? I am sure Members will join me in wishing Kirsty a speedy recovery. As a consequence, we've had to rearrange the day's business. We will be rearranging a date for this session with Kirsty, as she is the Member in charge of the Bill. We'll make that available as soon as we're able to confirm that date.

[5] Can I first of all thank you for rearranging, and we offer the condolences of the committee on your recent bereavement, which was the reason why we were unable to do the session last week?

[6] **Dr White:** Thank you very much; that's very kind of you.

[7] **David Rees:** Can we therefore move straight into questions? We are tight on time this morning. I ask Members, therefore, to be succinct with their questions and I ask witnesses to be succinct in their answers if possible.

[8] **Dr White:** We'll try.

[9] **David Rees:** Gwyn Price, do you want to start?

[10] **Gwyn R. Price:** Thank you, Chair. Good morning, everybody. Could we ask the CNO whether she is confident that the LHBs will eventually be fully compliant with their nursing staffing ratios in the all-Wales nurse staffing principles guide issued in 2012? If yes, is there a timescale for that?

[11] **Dr White:** Thank you. I'm fairly confident that the direction of travel demonstrated by the LHBs—. They have demonstrated that they are going to—. I wouldn't say be fully compliant, because what we want to have is a replacement of the principles with the acuity tool. So, at the moment, the direction of travel for the principles demonstrates that, yes, they are doing that. If I can give you some examples of evidence to support that: between October 2013 and December of last year, we saw an increase in the number of wards that were compliant with the 1.1:1 staff-to-bed ratio from 35% to 93%. In December of last year, 95% of them were compliant with the 1:7 registered nurse-to-patient ratio. So, the evidence that I'm having back is a very strong direction of travel of compliance with the principles. But as I say, the idea is that the principles will be replaced by the use of the acuity tool and a triangulated methodology to determine what is the appropriate staffing level and skill mix within each clinical area. So, there is no sort of end point for the principles. There is a change of direction, if you like; they were an interim measure.

[12] **Gwyn R. Price:** So, you're confident you're going in the right direction.

[13] **Dr White:** The evidence would suggest that, yes, we are, and quite good progress has been made, at least in the last 15 months or so.

[14] **Gwyn R. Price:** Thank you, Chair.

[15] **David Rees:** You've mentioned triangulation there. Do you not actually think that the triangulation approach is the way forward?

[16] **Dr White:** Indeed. It's very important that, in each clinical area, when you look at it, the variety of factors that affect what is an appropriate level of staff, and skill mix and competence within the team, is considered at a local level. So, you need to look at not just

numbers, but how sick the patients are and how dependent they are. You need to have a number of ways of determining what is appropriate for that area. So, blanket just saying, 'Every medical ward must have so many nurses on it' is not enough to be sure that what you end up with is right for that clinical area and those patients who are being looked after. So, we need to take a number of different factors into account in doing that.

[17] **David Rees:** Okay, thank you. We have questions now from John, followed by Lynne.

[18] **John Griffiths:** Given that you think that that approach of triangulation is the best approach, could you tell the committee why you still believe that it is necessary to provide guidance on the minimum nurse-to-patient ratio, and the significance of ensuring that there are certain guidelines that are adhered to as far as those minimums are concerned, given that it's the triangulated approach that you consider to be the most effective and appropriate?

[19] **Dr White:** Okay. It would be useful to say that we've been on a journey that has taken a number of years to get us to this point. So, when we started this work back in 2012, we determined that we needed to have a set of tools to help determine the appropriate way forward, and that would take a number of years to develop. So, the principles were set out as a guide to help the beginning of the journey. It was never seen as an end point. So, we have brought ourselves to this point, where we're saying, 'Now that we have a validated tool that is appropriate for use within Wales, we have now an approach that is well evidenced in other countries from around the world, and the research should demonstrate that what we are setting out to do is the right way forward.' The principles were never really seen as the answer. They were a stepping stone to being an answer. So, while the principles set out things like the guide on the number of nursing staff to bed, or the number of nurses to patient ratio, they were a direction of travel; they were advisory for the health boards to start thinking about how they were going to tackle this in a much more consistent way across NHS Wales. So, they were never designed to be on their own, which is why, when we say, 'Now, we've come to the point where we believe this is the right way forward', you need to have not just a workforce tool that'll sort out generally how many folk you should have employed in that area, but you also have other factors to be taken into account, which help you determine what's right, right now, for these patients in that area.

[20] **John Griffiths:** Could I just ask a follow-up on that, Chair? If, then, you believe that nurse staffing ratios are part of the picture in terms of ensuring appropriate standards and safe staffing levels, could you tell the committee a little bit about the practicalities of that? I think we've heard that it's often a very fluid situation on the ward: the number of patients; the acuity of their conditions changes from hour to hour; there are difficulties in terms of what constitutes a shift with nurses starting at different times; and all sorts of other practical problems. Do you believe that those practical problems can be overcome in terms of having a clear picture as to whether particular ratios are being met or not?

[21] **Dr White:** To go back to what I said earlier, I don't feel that having a fixed ratio is actually terribly helpful to local decision making. Where they can be advisory, they can be one of the factors you take into account. The tool certainly does that. I'm not sure whether you've had evidence on how the tool works, but it gives you an average over a month period about how many staff you should have in that area against the types of patients being cared for. But if you look at the run rate in that month, it'll vary hugely because—as you say, quite rightly—things will change, mid-shift, part of the way through the day, as patients are admitted and discharged or deteriorate. The complexity of care in our health boards is very great. We have very sick, very ill people coming in, and you will have great variation. So, what we have to have is local flexibility to make sure what we end up with is appropriate for the needs of those patients. So, setting a fixed-rate ratio on its own isn't safe, to be honest. It has to be what is appropriate at that time. Even tools, on their own, are not sufficient. To

slavishly follow something that you run a couple of times a year, where you take averages—again, that’s not enough on its own. You have to have local flexibility to work out what you need during the day, and that’s done best by those on the front line, to be honest.

[22] **David Rees:** Okay, John? Lindsay, you wanted to come in specifically on this question?

[23] **Lindsay Whittle:** You talk about flexibility during the day. What about in the nights? There are some wards where nursing staff could be very busy indeed during the night, and other wards, of course, where most of the patients, thankfully, are having their good night’s rest. How do you—

[24] **Dr White:** Absolutely. Care is 24 hours a day, and what you have to make sure of is that, throughout the 24-hour period, seven days a week, you have safe levels of staffing that are appropriate to the needs of those patients. Admittedly, in the night, sometimes, you’re going to have to look within a unit of a number of wards to see whether you need to move some staff around to make sure that that is the case, because patients will deteriorate in the night, as they do in the daytime. There’s no difference.

[25] **Lindsay Whittle:** Of course. Okay. Thank you.

[26] **David Rees:** Okay. Lynne.

[27] **Lynne Neagle:** Thanks, Chair. I wonder whether you could take us through the monitoring of the existing guidance that you operate. When we had the nursing officers from the LHBs in, they indicated that there was a level of monitoring, but I’m not clear how often that takes place, and I wonder whether you could take us through that in a bit of detail and maybe also say what happens then when there are health boards that aren’t complying, as clearly there are.

[28] **Dr White:** Indeed. So, if I talk about compliance with the principles to start off with, because there is quite a lot of monitoring of the NHS—so I’ll start with that. When we introduced the principles—the chief executives signed it off in May of 2012—I asked on a regular basis, so that’s every three or four months from that time onwards, how they were applying the principles. In the first year, I was much more interested in assurance that what they had was safe. So, I wanted to know very much about how they were ensuring that what was happening in the clinical areas was safe for the patients. As time has gone on, I’ve been asking, ‘So, how many of your wards now fully meet the various elements within the principles?’ So, as I gave the answer to the first question, I’ve seen a direction of travel on a number of wards. There are 185 medical and surgical wards in Wales; how many of them have 1:7, for example? So, I write to the chief execs and they give me a written statement on that, and I’m seeing a direction of travel.

[29] Now, that’s not the only way that we monitor how the health boards do their business. We have, of course, a framework that allows us to identify certain indicators around the care of patients. So, the tier 1 principles around pressure ulcers, for example, enable us to ask questions through our regular monthly monitoring meetings with health boards and our six monthly joint executive team meetings, to say, ‘So, what is it around the rates of your pressure ulcers—is there something else going on?’ So, there is a relationship with some of the high-level NHS indicators that allow us to drill down and ask questions, because it might be that there may be medical shortages or physiotherapist shortages or difficulties in discharges of patients. Some of the high-level indicators lead us to ask questions about that. So, it’s a combination, if you like, of certain elements that I’m asking specifically about the principles. In the last year, we’ve had the adult acuity tool going through a validation process, so I’ve asked about making sure that it has been tested on every single ward where it’s going

to be used. Once we have confirmation that there are no more glitches in the system to do with IT, then the tool will be ready to roll later on this year. So, there are a number of things that we're doing.

09:15

[30] **Lynne Neagle:** So, are there any examples of you maybe taking action in relation to particular health boards where you were not satisfied with progress on this?

[31] **Dr White:** Not action, but conversations certainly. So, what I'm interested in is not just the numbers that come back to me. When I write out to the health boards I want to know the story. I want to know how seriously they're taking the idea of having the appropriate staffing levels. So, I talk to the nurse directors. We have a standing committee that meets every month, and this is a standing item on it. But I also have one-to-ones with the nurse directors, and it's part of my conversation with them to say, 'Okay, so are you having difficulties recruiting in particular areas? Are you having the right kind of support from your board around driving professional standards in areas?' So, my conversations are on a one-to-one basis rather than action per se. It is about their commitment as a board to take this very seriously, and I am reassured by my conversations that they all do take it very seriously. But there are challenges; let's not kid ourselves. There is a global shortage of health workers, and the UK is affected by that. As we have increased our expectations around staffing levels across the UK, our ability to keep pace with that demand means it's very challenging to fill all vacancies when they come up. So, it's those sorts of conversations that I'm having with the health boards around the practicalities, not just the principle of raising the number of staff they should have. It's also how do they fill the vacancies, how do they manage the risk, and how do they actually operationalise the things that they need to do to have the right level of staff?

[32] **Lynne Neagle:** How confident are you that that is a sufficiently robust mechanism, given that the nurse directors are only one member of the executive team and obviously they're competing with other priorities as part of the corporate team?

[33] **Dr White:** Indeed. As I say, we have also conversations as an executive team on a six-monthly basis. I can escalate things to my chief exec and he talks to the chief execs. I can escalate things to the Minister and he talks to the chairs. So, there is an appropriate escalation methodology in the NHS that I can use should I feel that things are not going in the direction that they should be going.

[34] **Lynne Neagle:** Can I just ask one final question? We have had evidence that, if this Bill were to go through, nurses on the front line would feel empowered to raise concerns about staffing in a way that they're not now, and that is a theme that this committee has heard before when we looked at complaints: that nurses don't feel they can speak out. What do you think of that point of view? Do you think that nurses in the current situation are sufficiently empowered to speak out when they're worried about staffing levels?

[35] **Dr White:** I think it's always been a challenge for front-line staff to speak up. The whole idea of whistleblowing—that term that's been used in the past; 'raising concerns' is the way that we tend to describe it now—it's very difficult for people to speak out. There has been a degree of revision in the national guidance. The Nursing and Midwifery Council, the UK regulator, has given out guidance to professionals about their responsibility to speak up, and the Evans review, as you know, of the complaints and concerns in the NHS has been clearly saying to health boards, 'You must enable staff to feel confident to be able to do it'. I do think it's always been difficult for staff to speak up, but I'm seeing much more attention being paid to that now, particularly post the Francis inquiry into Mid Staffs. I think that the world has turned a little bit since then, particularly on a UK level. For the Nursing and

Midwifery Council, that means they've revised their code of conduct, and it has actually set out new guidance about how you raise concerns. So, if you like, there's an elevation around this.

[36] I was talking to the Professional Standards Authority for Health and Social Care recently, which is the super-regulator for all the health regulators, and it's one of the things that they are planning to have a conversation about with the regulators—how do we enable professionals to speak up? It's not just nurses—it's the doctors, the physios, the pharmacists. Everybody who is a professional has a responsibility to speak up. It's been quite interesting, some of the campaigns that have been running in some of the health boards. 'If you see it—say it!' are posters you'll find in some hospitals. 'The care you walk past is the care you accept' is another sort of strapline that's being used. It's all about encouraging people to come forward, but it still remains quite a difficult thing for people to do, to be honest. Whether this Bill will help, I don't know. I think it remains a challenge for people to be able to do that. What we want to see is organisations that encourage people to come forward and encourage opportunities for them to speak up.

[37] **David Rees:** We have Elin and Darren who want to pursue this theme. So, Elin first.

[38] **Elin Jones:** I was struck with the evidence that we heard about the powerlessness of nurses at times in difficult ward situations and how this Bill would give a basis for nurses to make complaints within the system and have the backing of this Bill, or this legislation, then, for that purpose. But I want to ask you in particular—everything you've said so far has been about the direction of travel towards appropriate staffing levels, and it strikes me that there's nothing in this Bill that goes against that direction of travel. Would you agree with that and would you think that there are aspects of providing the statutory basis that will just enforce the direction of travel that you want to see?

[39] **Dr White:** Absolutely. I agree wholeheartedly with the principle behind the Bill. We want to make sure that we've got the right level of staff, with the right skill mix, with the right competence to look after the patients to make sure that care is safe. So, if you like, the underlying principle of the Bill, I have absolutely no debate over. I think it's that the way that some of the elements are written in the Bill that aren't quite right, and they would need to be looked at. So, I suppose it's more the detail within the Bill, rather than the principle of the Bill, that I have issue with.

[40] **Elin Jones:** Okay. I'm interested in the detail as well. I agree with you on the principle. You've talked a bit about flexibility and acuity and needing to change mid shift, almost, the actual appropriate level of staffing on a ward. This Bill talks about that as well, and about that being part of the guidance that would be issued to local health boards. So, isn't there sufficient flexibility in this Bill, because it's talking about a statutory basis for guidance on minimum staffing? Don't you think that it's flexible enough as it is, or how could it be made more flexible to meet those complex issues you've talked about?

[41] **Dr White:** I suppose my underlying concern is around the ratios and mention of having a ratio. As you heard me say around the principles, they were advisory. The principle has an advisory ratio within it. It wasn't mandated in any particular way that people had to have it. Having something in legislation that could lend us to having a fixed ratio around something—. The way the Bill is currently constructed suggests that might be one of the consequences of the way it's set out. That's what causes me some anxiety.

[42] I think the committee's heard from a variety of sources around some of the concerns others have had around ratios and I mirror those. The National Institute for Health and Care Excellence, which I think you heard from, certainly don't talk about setting fixed ratios. So, it's that sort of language that I have problems with, rather than the principle. Most of what is

written down actually mirrors the direction of travel we've already got around guidance and so on, and using tools—that sort of thing.

[43] **Elin Jones:** Just on, then, possible unintended consequences of setting ratios—fixed minimum ratios—we've heard evidence to suggest that a health board, with a given budget and possibly a given access to a nursing pool, would make decisions, possibly, to meet the ratios on acute adult wards, because they don't have any statutory duty on any ratios in other settings they're responsible for, and I'm thinking particularly of community hospital settings or community nursing settings. Do you have a concern about that? Would the health boards that you work with be likely to do that in order to meet a statutory requirement? Another interesting consequence that we came across also was that, on a ward, a decision could be taken to reduce the number of patients in order to meet the staffing ratio.

[44] **Dr White:** Indeed. I think the health boards, if they have a piece of legislation that fixes something in one area, will have to make decisions locally. Some of those decisions will be whether or not they look at the patients in their care in that particular unit—that area—and say, 'Okay. Do we comply with the legislation by moving patients or staff, or do we choose not to comply with the legislation, because we know that the consequences in other parts of our system would actually put people at risk?' So, that, I think, is a legitimate question for the committee to ask itself about: 'So, if we fix this in one place, what will be the consequences for decision making by the health boards?', because there are a finite number of staff that they will have, and if things change within an area during a shift that is much outside of what they would expect—. At winter time, we know that—winter surge beds, for example—you sometimes have to take on additional patients at quite short notice.

[45] So, locally, they're going to have to decide, 'Well, if the law says we have to have this number of staff and this number of people here' what they are going to do. Are they going to choose to move people around? Patients—it could be late at night, which is not ideal, or it could be staff from other areas, or they could end up saying, 'Actually, it's not right and safe for us to do this' and then they would have to choose not to comply with a piece of legislation. I do think we'll be setting up our front-line staff to have to make quite difficult decisions around that.

[46] **Elin Jones:** So, as a committee, we're asking ourselves that question in terms of that risk existing or not. Do you think that that risk exists, then, that there could be a shift of staff that could have a consequence of unsafe staffing in particular parts of the LHB in order to meet the legislative base?

[47] **Dr White:** Sure. It's quite difficult to answer absolutely, because we don't have legislation of this nature anywhere in the UK, because most of the examples we have from other parts of the world don't have an NHS system. So, they're different kinds of systems. So, you can't say, 'Yes, yes—well, it didn't happen here in this country, so it won't happen here in Wales or in the UK', because our NHS is a slightly different beast to other health systems. I'm just thinking it is a possibility that we will set up our front-line staff to have to make quite interesting decisions—often when they are, in the middle of the night, trying to deal with very sick patients—around compliance with legislation. These things don't happen in a planned way, sometimes, you know. You're going to have to have people make decisions and that's quite tough for us to determine.

[48] **David Rees:** Can I just clarify that? You mentioned front-line staff there, so it's your view that, in situations like that, it would be the front-line staff who'll make the decision, but there will surely be guidance and leadership from board level.

[49] **Dr White:** Indeed, but, if you take last weekend, you'll have staff in the hospitals making decisions about where to place patients, you'll have bed managers who'll look to see

where there are vacancies and you'll have flows through hospitals that'll have to be determined. These will be managers of the system—this won't be the chief exec making those operational decisions, this'll be within particular policies and arrangements that the hospital works under. And they'll have to move patients around, otherwise the hospital won't work. You have to have flows of patients in and out of clinical areas and decisions have to be made operationally in quite a reasonably paced manner; it can't be delayed. So, yes, front-line staff—managers of the service—have to make those decisions every day.

[50] **David Rees:** Thank you. Darren.

[51] **Darren Millar:** Yes. I just wanted to follow up on the monitoring issues, if I can for a few moments, before turning to another subject area. I'm just not sure about the teeth that the Welsh Government has to be able to hold health boards to account here, because, of course, you're relying very much on self-reporting, aren't you? So, what independent work is being done to monitor the self-reporting—the quality of the reporting that is coming back to Welsh Government? I mean, we've obviously, as a committee, sought further information from health boards and, you know, they can give us a one-liner saying, 'Yes, we meet these ratios and, yes, 60:40 is the split', but how can we really be sure and how can you really be sure that that is what's going on on the ground?

[52] **Dr White:** Indeed. Of course, the responsibility for delivering services does sit with the health board. The board of the health board has a responsibility to make sure that it holds its executives to account to make sure that they're delivering services to a particular standard. So, I don't want to go away from saying, 'Well, it has to be all external'; the first assurance has to be with the organisation itself to deliver the services that they are responsible for delivering. So, our external views will be around having reports given to us at executive meetings, we have monthly quality meetings, we have evidence that comes that way reported to us and then, of course, we have the inspectorates going in, and, when they do their reviews at a clinical level, they will look at a variety of factors around what is happening on the ground. So, whether we could do more—of course, you can always change a system and do more.

09:30

[53] **Darren Millar:** But your monthly meetings are still relying on information that is provided by the board. In terms of external review, the inspectorates visit hospitals very rarely, don't they, if you're honest. So, what other external assurances are you able to have a hand on to be able to demonstrate that these ratios—the ratios behind the principles, that is—are being met? It sounds to me as though the only one you've listed there is the inspectorate.

[54] **Dr White:** Well, that is our external arm to go and do reviews, and we can, in fact, instruct the inspector to do themed reviews, should we choose to do so. The way that our current system is based is absolutely as you say; it is on reported evidence to us that we then drill down into and explore during our regular monitoring and meetings with them, but it is based on the evidence that they provide. Now, we do have systems, obviously, so that we can work out how many staff are employed in the NHS, so I know—. So, I know we've just breached the 22,000 level of nurses working in the NHS—whole-time equivalents, that is. So, we know the number of staff; but I don't drill down to what's happening on ward B at this precise moment in time; I have to rely on operational data coming back, and those are self-reported by the boards, you're right.

[55] **Darren Millar:** Okay. Can I just check, then, in terms of the sanctions that are available to you, you said that you have this six-monthly meeting that determines whether there's going to be intervention of any kind in respect of a hospital that isn't meeting its duties or targets: is, really, once every six months sufficient to be able to review those sorts of data?

[56] **Dr White:** It's the current system that we have, obviously. We do have evidence coming to us from a variety of sources that would indicate that there are problems developing, which then can spur us to have more regular conversations. At the moment, for example, because of the winter challenges, we have a Monday morning conversation with the chief execs about how unscheduled care is going. We know it's always a challenge through the winter. So, every winter, we have an arrangement that, every Monday morning, we talk to the chief execs, chaired by our chief exec, the director general in the Government. So, we can escalate the number of contacts that we have; it's not a fixed thing. If, for example, the community health councils should start saying to us, 'Look, we've got real concerns here' or the Royal College of Nursing comes to us and says, 'We've got real concerns here', we can change from a routine monitoring to a drill-down. So, I have conversations with the RCN and, if the director tells me there is a problem in a particular area, I can change and do a drill-down at that time. So, there's some ad hoc, once we know from feedback that we get from a variety of sources that we need to change something that we do.

[57] **Darren Millar:** Because I think, like you, every member of this committee is very satisfied that we need to have safe nurse staffing levels, I'm trying to be persuaded that there's a need to legislate to be able to do that, but, I'm sorry, you're not giving me much confidence, actually, that the Welsh Government systems to be able to deliver this are sufficiently robust to require health boards to meet the safe nurse staffing levels at the moment, given that it seems to me that the intervention is a few more phone calls than usual in order to chivvy them along. The data suggest here that, actually, most health boards are now meeting the suggested ratios that you have put out. Just a few weeks ago, though, we were told by the Abertawe Bro Morgannwg nursing director that they were hundreds of people short in their own health board—about 150 short, if I remember—in terms of their nursing complement, and that they were having recruitment difficulties. So, if they were having recruitment difficulties, and that was their excuse for not reaching the ratios previously, how are they able to reach these ratios now? I assume it's large agency numbers, is it?

[58] **Dr White:** That's exactly right. We have to be very careful when talking about what we mean by some of the data. So, the principles I ask about are: have they set their establishments, have they funded posts in their establishments for those clinical areas—and the direction of travel is absolutely that they are actually designing the service so they will actively recruit to the standards that are being set.

[59] The challenge we have at the moment, which is a global issue, is that there are not enough health professionals in the system. The UK, like the rest of Europe, doesn't have enough nurses to fill all of the vacancies easily. This is part of a much wider problem. There have been some changes in our expectations about staffing levels, particularly if England, post the Francis inquiry into Mid Staffordshire, has significantly increased the number of staff they wish to employ. The difficulty we have is that it takes about four years from making a decision to having a new nurse produced. So, you can't suddenly say, 'Yes, we need to have lots more nurses'. It's going to be four years down the line before you can put lots more nurses into the system. So, there are lots of pulls around us increasing our expectations and then the lag it takes to get more nurses. So, the principles and the evidence I'm having back is about the funded establishments. There are challenges about filling to those posts, hence we are seeing agency rates and bank use going up, because what the health boards want to do is actually deliver on their funded establishments rather than having this disjunction, and that, of course, costs a lot of money.

[60] **Darren Millar:** Can I ask you about a slightly different topic now?

[61] **David Rees:** I just want one clarification before I let Darren continue. Is it that the

numbers we're talking about, which are the data we have, are for the number of funded places in the ward or the number of actual posts filled on the ward?

[62] **Dr White:** Every day, there are going to be vacancies and staff movements, so the numbers we're talking about are the funded establishment. You can fill them in a variety of ways. You can fill them with a full-time member of staff, you can fill them with bank additional staff, or you can pay for an agency person, but what you have to have is an agreement that that ward will have that number of staff. So, that's the most important bit, if you like: having the funded establishment. As to how you fill the gap then, you have a variety of methodology to do that.

[63] **David Rees:** Thank you; I just wanted clarification.

[64] **John Griffiths:** Chair, just before we move on from the subject matter that Darren was pursuing around monitoring and compliance, I just wonder whether you have any views as to what might be done to create a more robust system. I know that the National Institute for Health and Care Excellence's red flag system, for example, is one area of interest in terms of how we might get to that more robust system. Would you have a view on that or anything else that we should be considering in terms of this Bill and what might be done to get that more robust system?

[65] **Dr White:** Indeed. The NICE guidance is something we're currently looking at. You've got to bear in mind the time frame we're working on. Wales has been looking at this issue very seriously for over three years. It was 2012 when we started this. NICE has more recently come to this agenda in its guidance. So, as evidence comes along, we are actually duty bound to make sure that we are looking at that and seeing how it fits the Welsh context. They're currently consulting on maternity standards for the number of midwives and obstetricians, and so on. Well, we have already got an arrangement in place under our vision for maternity services around the standards for both obstetricians and midwives and I, on a six-monthly basis, monitor compliance with Birthrate Plus, which is the acuity tool that works out how many midwives and midwifery assistants you should have so I know that we are Birthrate Plus compliant. However, when NICE comes out with its guidance around maternity, I'll certainly look to see whether there's something more we can be doing, how we can refine that to make sure that the Welsh system is the best that it can be. So, that is generally how we approach this. So, the red flag bit that you're talking about, which is the adult acuity tool, is certainly something we're currently looking at now.

[66] We have, as you know, My Local Health Service, which is the website that records some information about staffing in the hospital. I think we could probably do more with that so that the public can understand a little bit about it. That could be something that we could consider. So, at the moment, we're looking at some of the evidence that NICE is coming out with to see how we can do some additionality to what we've already got because, as I say, they've more recently come to this agenda than we have.

[67] **David Rees:** Okay. Thank you, Darren; we'll go back to you.

[68] **Darren Millar:** Does the extent of your monitoring apply to NHS-commissioned care in non-NHS facilities?

[69] **Dr White:** My monitoring, no; the health boards certainly have to ensure that what they have commissioned does bear in mind things like appropriate staffing levels. At the moment, we're exploring, through the care home task and finish group, whether or not we should have some additional guidance as part of the commissioning process to look at nurse staffing levels in care homes.

[70] **Darren Millar:** When was that task and finish group established?

[71] **Dr White:** It was this side of Christmas, so it was very recent. So, probably from April, we'll set up a pilot to explore how you can do that. Unfortunately, the adult acuity tool that we've currently got isn't designed for a care home, because the kind of dependency and chronicity of the diseases in a care home are very different to acutely ill, very sick patients you find in a hospital. So, you have to have a tool with algorithms that are appropriate to the area. So, there isn't one we can take off the shelf and just try it out; we're going to actually go from the first principles to say 'Okay, what kind of guidance should you have that looks at care homes?' So, we've identified a health board to lead on this with a collection of care homes to start testing some of this out.

[72] **Darren Millar:** And not just care homes; what about NHS work that is commissioned in independent hospitals?

[73] **Dr White:** I haven't got any work planned in that particular area, but the health boards—

[74] **Darren Millar:** Why not?

[75] **Dr White:** There is only a certain number of pieces of work to be done at one time, and I'm trying to work through a series of them. So, we started off with adult acute, we're now working on mental health in-patients, we're looking at district nurse-led teams, health visitor generic services, we are exploring the NICE guidance on emergency departments and, we're looking at some of the tools that are used for paediatric in-patients. Now we're starting to look at care homes. This is a long programme of work, and so, as time goes by, we're working through methodically those areas where additional guidance needs to be done.

[76] **Darren Millar:** So, you are planning to do some work on NHS care in independent hospitals.

[77] **Dr White:** At the moment, I don't have any plans to do that. That's not to say in the future I wouldn't do that, but, at the moment, we're looking more at the care of patients receiving care in care homes. It will be a new piece of work for April.

[78] **Darren Millar:** And what about NHS care that is commissioned in England, as it were?

[79] **Dr White:** Yes. There are certain challenges that the Bill would present for us. Whereas through our commissioning arrangements you can set out the parameters that you would expect as part of the delivery of your contract, and things around staffing and compliance with the various standards can certainly be elements of that, and that should already be in place, with regard to some of the reporting mechanisms that are talked about, the Bill may be a little difficult for us to demand of systems outside of Wales.

[80] **Darren Millar:** Do you have model contracts that commissioners can use?

[81] **Dr White:** I'm not aware of model contracts; I'm sorry, I don't know if there's—

[82] **David Rees:** We'll check with the Minister, when he comes in, on that one.

[83] **Darren Millar:** Okay. And just one final question: do you think that one of the potential unintended consequences of a minimum ratio, if you like, is increased litigation against the national health service?

[84] **Dr White:** All things are possible. Certainly, if there is evidence of non-compliance with a piece of legislation, logically, it would suggest that that could be a consequence. I have no evidence. As I say, there is no legislation equivalent to this anywhere in the UK, so it's very difficult to know precisely what could happen. But, certainly, that is a real possibility.

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

[86] **David Rees:** I will call this session to an end. Thank you very much. We're aware that you will be returning with the Minister, and Fiona Davies will also return with the Minister, for the next session. So, thank you for coming this morning and for the evidence. You will receive a copy of the transcript for any factual inaccuracies you may identify, and please let us know if there are. Thank you very much.

[87] I intend to have a five minute break now to allow you an opportunity to have a comfort break before you come back in.

*Gohiriwyd y cyfarfod rhwng 09:44 a 09:50.
The meeting adjourned between 09:44 and 09:50.*

Y Bil Lefelau Diogel Staff Nyrsio (Cymru): Sesiwn Dystiolaeth 13 Safe Nurse Staffing Levels (Wales) Bill: Evidence Session 13

[88] **David Rees:** Can I welcome Members and the public back to this morning's session? We continue with our evidence gathering for Stage 1 of the Safe Nurse Staffing Levels (Wales) Bill. We have the Minister for Health and Social Services with us this morning. I welcome Professor Mark Drakeford, and I welcome back Dr Jean White, who is accompanying the Minister, and Fiona Davies, this morning. Minister, would you like to make some opening remarks this morning?

[89] **The Minister for Health and Social Services (Mark Drakeford):** Thank you, Chair. Just briefly then to say that since the Member in charge of the Bill won her ballot, my aim has been to engage constructively with the legislative process and to see if the proposed legislation the committee has in front of it can contribute positively to the aim that we all share of making sure that we have the right number of nurses on the right sort of wards to provide the care we would like to see. So, the principle has never been a matter of dispute; it's whether the Bill provides us with a useful additional tool to achieve those shared ambitions.

[90] I think if the Bill were in front of the National Assembly today, and was being voted on as it currently stands, the Government would not be able to support it. But that is not to say that it is impossible to imagine an amended Bill that the Government could support. I think there are three broad things that would need to be done with the Bill. The first is a series of relatively technical matters, but I don't think they need to detain us too much this morning; they were rehearsed in front of the Constitutional and Legislative Affairs Committee—things to do with where definitions are contained, consistency between different parts, different bits of legislation and so on. A set of relatively technical things that would need to be put right.

[91] There are two, however, more significant policy matters that I think would need to be addressed as the Bill makes its way, if it makes its way, beyond Stage 1. The first thing would be that, in part 2 of the Bill, the inclusion of minimum ratios would not be acceptable to the Government. It drives us down the road of inflexible numerical rigidity. It creates a Bill where we would be hidebound by rigid ratios. I think there are ways around that, and, if the Member in charge is open to discussions around that issue, I think there are ways in which that drawback in the Bill could be overcome.

[92] The second big policy area lies in part 3 of the Bill, which, at the moment, sets out a lengthy list of mandatory conditions, which would be required in reporting on the Bill. Now, I accept that if you set up a system, you must have a form of reporting against that system, but, at the moment, part 3 is not proportionate to the task, and it is too often flawed by a sense of imputed causality. It sets out a set of things that you have to report on, on the basis that these things tell you something significant about the number of nurses on the wards, and too many of them simply don't. So, I will be looking for a part 3 of the Bill that is slimmed down, that identifies things that genuinely do tell you something about the number of nurses you have on the ward that are capable of being reported using data systems that are already available in the NHS. I would not be easily persuaded that this Bill should require health boards to set up a huge new data collection exercise, so that we end up, potentially, with more nurses on the ward and they spend all their time filling in forms to satisfy this Bill that they're there. Thirdly, we would need to see an alignment between the reporting time frames. The Bill requires reporting every two years, but we have a new three-year reporting regime for the health service in Wales, as a result of a Bill passed by the Assembly last year. So, I'd need to see an alignment between those reporting cycles. Again, I don't think those things could not be remediated during the passage of the Bill, but they would need to be so if they were to obtain Government support.

[93] **David Rees:** Thank you for that introduction, Minister, and I'm sure there will be questions coming towards you now to explore some of the thinking behind that, which will inform the committee when it takes its decision on this. Gwyn.

[94] **Gwyn R. Price:** Good morning. Could you tell me, Minister, whether you are confident that all the LHBs will eventually be fully compliant with the staffing ratios in the chief nursing officer's guidelines, issued in 2012?

[95] **Mark Drakeford:** Thank you, Gwyn. I'm sure the committee will have taken some of its own evidence in this matter, and I think we will have supplied some of the information that we already have. What the information we have shows is that, during the period the chief nursing officer's work has been put into practice in the Welsh NHS, very significant progress has been made. In October 2013, 63 wards—that's 35%—were compliant with the one-to-one staff-to-bed ratio and, by December of last year, so that's just over a year later, 93% of wards were compliant. In December of last year, 171 wards, or 95%, complied with the one-nurse-to-seven-patients ratio as well. So, the journey has been a significant one of improvement. I think we can take confidence from that that with further effort and additional investment, which we have provided, we would reach compliance as things are now.

[96] **Gwyn R. Price:** Just going back to what the CNO told us a couple of minutes ago, actually, the flexibility really is what it stems from. Any time of the day—or night, as Lindsay would say—things could change, and you do need the flexibility, in your opinion, to adjust these ratios.

[97] **Mark Drakeford:** Chair, that is where my difficulty with the 'minimum' phrase in section 2 of the Bill comes in, because we have a triangulated, three-part approach to all of this: we rely on the acuity tool that the chief nursing officer has developed, the professional judgment of staff on the spot and nurse-sensitive indicators—those things that we think you can genuinely say are correlated with the number of nurses you have on the ward. That is a flexible way of making decisions at the ward level. My problem with the minimum-ratios approach in the Bill is, while it still refers to acuity tools and still refers to professional judgment, it sets up a three-legged stool in which one leg is absolutely rigid, and that inevitably compromises the flexibility of the other components that the Bill includes, so flexibility and the ability to rely on what is sometimes called, when you read about this, a 'consensus model' of nurse staffing. That's when the number of nurses you need emerges by agreement through the professional workers who are there and able to contribute to that

decision, rather than a top-down legislatively required way of doing things, where you may get compliance, but you will not get buy-in necessarily from the people who you really need to have buy-in from in order to do things successfully.

[98] **Gwyn R. Price:** Thank you, Chair.

[99] **David Rees:** Minister, I understand the fixed nature of the minimum level you talk about, but can you just confirm that the validated acuity tool will have nursing ratios within it?

[100] **Mark Drakeford:** It does have nursing levels within it and they are a very important driver of it, but they are capable of being modified by those other factors that a person on the spot is needing to take into account.

[101] **David Rees:** Okay. John?

10:00

[102] **John Griffiths:** Minister, I was just going to ask you really about the need for legislation because, obviously, the first test, when we're considering proposed legislation is whether it is necessary to legislate on the particular subject matter in question. So, you've told us this morning that, subject to certain concerns of yours being effectively addressed, you might be in a position to support this legislation. So, could you then tell the committee, if those difficulties were overcome, why you believe legislation is necessary to take forward these particular matters of concern?

[103] **Mark Drakeford:** To be completely accurate, Chair, I'm not sure that I would sign up to the word 'necessary' in the question that John just asked, because I believe that a great deal of what the Bill sets out to achieve is achievable through other tools that we have at our disposal. I think I indicated in my written evidence to the committee, for example, that we could make use of the acuity tool mandatory in hospital settings, rather than advisory, as it is at the moment, and that, by itself, would go a long way to achieving what the Bill sets out to do. So, for me, it's not a question of whether we can achieve it with the Bill or we can't achieve it without it, in which case, the Bill becomes necessary, but more one of whether a proper Bill would help us to get there quicker and in a more effective way? Does it add to the tools that we have? I think, very much subject to what you conclude—because you will have heard all the evidence at Stage 1, and I will be relying a lot on what the committee concludes in its Stage 1 report—but I have come to the conclusion so far that a proper Bill would be a useful additional tool that would help us to achieve what we want to achieve. I'm not saying that, without it, we can't achieve what we want to achieve, because I think there are other means we could deploy.

[104] **Lindsay Whittle:** Sorry, Chair, but could I ask why we haven't achieved it, then? If there are other ways of achieving it, why haven't we achieved it?

[105] **Mark Drakeford:** Well, we are very close to achieving it, and a lot of the progress we've made in recent years, since the use of the acuity tool and the approach we've got, I think can give us some confidence that we are moving very much in the direction of achieving it. Now, there are some barriers in the way. I didn't hear all the chief nursing officer's evidence, but I heard the bulk of what you heard earlier, and I think she identified two of the difficulties that we faced. One is that we've upped the ask here. You know, we've become more aware of the need to make sure we've got the right number of nurses in the settings, and we've increased the ratio of nurses that we need. So, it's a more difficult hill to climb. Secondly, we have this global issue, driven by Obamacare in many ways, which is, you know, requiring 100,000 extra nurses in the United States, and so some of the places we

have recruited from in the past are not as fertile ground for recruiting to the United Kingdom as they were. So, there's also the number of nurses available, and both of those are challenges to achievement, but I don't think we should underestimate the extent to which we have managed to do better, to have the right number of nurses on our acute medical and surgical wards in Wales, and the closeness that we are coming to getting to exactly where we would like to be.

[106] **David Rees:** Elin.

[107] **Elin Jones:** To date, we've had evidence from those who've been against the Bill because they don't support minimum ratios. We've had evidence from people who've been for the Bill because they support minimum ratios. Now, you've given us a third alternative, which is to be against minimum ratios but for the Bill. Now, I'm struggling to understand what is left of value in this Bill if you take out the statutory minimum ratios. As far as I can see, you would have the duty for health boards to meet—the duty of safe staffing levels—and then you wouldn't have anything on the definition of the guidance on minimum ratios. That would all go, and then you'd have the duty to report on the duty to maintain safe staffing levels. So, perhaps you could help me: explain what you think is left in the Bill that merits our further consideration for retaining the Bill but considering taking out the minimum staffing ratios.

[108] **Mark Drakeford:** Chair, I will try. I think it's important for me to just emphasise that this is not my Bill, so it really isn't for me to be solving some of the issues that, from my point of view, the Bill currently presents. But, in the spirit of being helpful, what I would say is this: I think that if the Bill had the minimum staffing issue resolved, and a different phrase were found to put in the Bill at that point—and I think that's what the Royal College of Nursing told you in their evidence: they're not in favour of the word 'minimum' either—then what the Bill would do is it would put a legislative footing under that triangulated method. It would require health boards to take those three components into account, and it would provide a reporting framework for their compliance with that new, more flexible, more professionally driven duty, and, I would argue, one with fewer risks of unintended consequences. It would put that into law and it would make health boards openly accountable for the way in which they have achieved the outcome—because that set of ways of doing things drives the outcome that we are all agreed we want to achieve in having the right number of nurses on the ward. So, I think that would be preferable to the system the Bill sets out, where one component of the three that it includes risks overbalancing the system and driving some potentially serious unintended consequences.

[109] **Elin Jones:** For clarity, is your problem with the word 'minimum' or with having ratios, because there you said that you didn't support the concept of minimum? Would you support—and the chief nursing officer has spoken about these—'appropriate' ratios?

[110] **Mark Drakeford:** I'm neither a lawyer nor a drafter. We would need the help of both of those voices, but—

[111] **Elin Jones:** So, ratios, as in clarity around ratios, is not the problem,

[112] **Mark Drakeford:** We have ratios.

[113] **Elin Jones:** It's the fact that they are set in this draft as 'minimum' ratios rather than it reading as, I guess it could be 'safe' ratios or it could be 'appropriate' ratios, which allows more flexibility then.

[114] **Dr White:** I think we just have to be very careful with tying things down too tightly. The acuity tool does actually indicate how many staff should be employed in the area with a

skill mix. So, if you like, the acuity tool will indicate how many people of what grade you need to look after those patients. So, it doesn't talk about ratios; it'll tell you what you need and then you can modify that, given local knowledge and understanding of the geography of the ward, if it's single rooms rather than Nightingale bays or whatever. You can modify it. So, the tool itself will give you the right number, if you like, because it's numbers we're after here, but it has to be modified with the knowledge of the staff in those areas and the skills they have, to the geography and a whole load of other factors, which is the professional judgment bit. There's always going to be a danger if we start talking about ratios, that it almost leads you inevitably to say what must you have on that ward. But it'll be whatever the tool says, plus the judgment, and whatever evidence you've got of whether there is a problem on that area that you need to revisit the staffing levels. I think that's our anxiety.

[115] **Elin Jones:** So, at any one point in time, in any acute ward in Wales, there is a number that the tool has provided. It's that number a ratio? It's a number of nurses, isn't it? So, that must—

[116] **Dr White:** It's a number of nurses, and nursing staff assistants that you'd have.

[117] **Elin Jones:** Yes, as this Bill outlines. So, it reflects the number of patients on the ward because that's the acuity tool working. So, why is it not possible to have that appropriate number or ratio as part of the legislation? That could be, couldn't it? Because if you come up with a number at any point in time on any ward, then this legislation can provide a statutory basis for that number.

[118] **Dr White:** I think it's the way that the drafters would help us to write it. I think we just have to be really mindful not to get trapped into something that's really rigid, which is why having a tool—with some flexibility that will tell you the number, based on your local intelligence—would be helpful.

[119] **David Rees:** Just to clarify, the RCN evidence actually talked about safe ratios.

[120] **Elin Jones:** Yes. What I'm trying to get at is—. You want to come up with a number. You do come up with a number: day to day; ward to ward; shift to shift; mid-shift, even. That number is, in effect, a ratio.

[121] **Mark Drakeford:** I don't think that is a problem. The word 'minimum'—

[122] **Elin Jones:** 'Minimum' is the problem.

[123] **Mark Drakeford:** —is the real issue here. Our system at the moment is a guide that is applied, rather than a statutory, in-the-law minimum figure. Chair, I was speaking to some people who work in the service and wrote down what they told me about, you know, a typical morning on a ward—hour by hour, from 7 o'clock in the morning onwards. Would you give me a minute just to illustrate it?

[124] **David Rees:** We haven't got a lot of time because your schedule is very tight, Minister.

[125] **Elin Jones:** We've got quite a lot of time if you want to stay longer.

[126] **Mark Drakeford:** [*Inaudible.*]

[127] **David Rees:** Perhaps we'll come back to it another time.

[128] **Mark Drakeford:** Okay. It just illustrates this. I'll do it very quickly. The point is to

illustrate the difference between the approach that I think we are advocating, which has that flexibility around it, and a fixed minimum number. How would you have that in-law minimum against this sort of background? You come to work at 7 o'clock in the morning, as a nurse. You go to a ward. It has 26 patients, at 7 o'clock, and there are three beds empty. Now, if you have a minimum written ratio, that would imply not an agreed, consensus-based model, but what the law says you now must have. At 8 o'clock, the three beds are filled—the hospital is getting under way, and the three beds that were empty are filled. At 9 o'clock, two patients leave to go to theatre. At 10 o'clock, a consultant arrives, does a ward round and says that four patients are capable of being discharged. At 11 o'clock, one patient deteriorates, and a decision is made that they have to be transferred to another hospital, and that a nurse must go with them. So, one of the nurses that you were relying on for your minimum ratio now has to go with that one patient to a different hospital. At 12 o'clock, the bed manager phones the ward to say that there has been a road traffic accident—that A&E has some major casualties coming in and that a surge bed needs to be open on that ward, to help to cope. At 1 o'clock, a confused patient becomes upset, and you need to allocate a one-to-one nurse with them, to make sure that their care is properly attended to. At 2 o'clock, several of the nurses who came on at 7 o'clock, their shifts end and they leave, and a different number of nurses appear to start the 2 o'clock shift. Now, at every hour, the number of nurses that you need will be altering—remembering that, I think, less than a third of the wards that we have in Wales are actually divisible by seven. So, if you have a 1:7 minimum ratio, most wards can't—. They've either got to have a little bit more or a little bit less at any one time. The system we are suggesting would allow all of that to be accommodated, because it is a combination of those three factors, and professional judgment on the spot actually allows you to do it. The word 'minimum' in section 2 puts a rigidity into all of that, which makes that very, very difficult to work in a sensible way.

[129] **David Rees:** Can I clarify something, Minister? Obviously, we are talking about the purpose of the Bill and whether the Bill is actually necessary, and I think John highlighted that question. At this point in time, you have the tools to be able to deliver on those things that you just talked about, as part of the Government.

[130] **Mark Drakeford:** Yes, but they are advisory. The Bill would make them—

[131] **David Rees:** Statutory.

[132] **Mark Drakeford:** Statutory.

[133] **David Rees:** Okay. Peter.

[134] **Peter Black:** Yes, thank you. I think that, actually, Minister, your elucidation of how the Bill needs to be amended was very helpful. I think it's worth noting that, though I understand your point about 'minimum', section 2 of the Bill relies on guidance issued by you, so you are able to build some flexibility into that. But I understand the point that you are making. Can I just ask a question about section 3? You said, in terms of the indicators, that the indicators set out in section 3(5) were inappropriate. I'm just interested in what indicators you would be looking to put specifically into that particular section.

10:15

[135] **Mark Drakeford:** Well, I think there are two points, Chair, for me in section 3. One is the use of the word 'must'. The Bill uses the word 'must' quite a lot actually. It uses it a lot in section 2 and a lot in section 3—

[136] **Peter Black:** It's an opposition thing. [*Laughter.*]

[137] **Mark Drakeford:** I think there may be some useful discussion with the Member in charge as to whether or not these are indicative things rather than absolutely obligatory. I mean, if I was identifying indicators myself, then the nurse-sensitive indicators that we use are the number of falls on the ward, pressure sores and medication errors. Those are the three factors where I think the evidence is strong. I'm looking to Jean because she knows this so much better than me, but my understanding of the evidence is that those are the three indicators where the evidence is strongest in linking the number of nurses on the ward with the quality of the care.

[138] **Peter Black:** So, d, e and f from that section.

[139] **Mark Drakeford:** Yes. They are there on the list.

[140] **Peter Black:** Okay, thank you. And in terms of the other ones, would you not, for instance, be looking for public satisfaction, or would that be too wide a measure for you as part of that?

[141] **Mark Drakeford:** My problem with something like public satisfaction is how you distinguish whether the satisfaction that the person is reporting is as a result of nurses on the ward or the quality of care that the doctor has provided or the way that the receptionist dealt with them on arrival or the way the porter looked after your family member as they took them from one part of the hospital to another. It's just not related specifically enough to nurse staffing numbers for me to believe that it is a useful enough indicator, particularly when, in my view, the Bill does not rely sufficiently on the data collection that is already available. We would have to invent, maybe, a whole new way of collecting and reporting quality assuring data on patient satisfaction levels at that ward-based level to be compliant with the Bill. It would be disproportionate.

[142] **Peter Black:** Okay. That's very helpful. Assuming we got a Bill that fits in with how you would view this, you'd have an additional tool in your box in terms of a statutory underpinning of the acuity tool that you use at the moment. The question I think everyone is asking is: how would you then enforce those statutory ratios? What tools are available to you to actually enforce it?

[143] **Mark Drakeford:** Well, the Bill, Chair, as you know, does not include any new or separate enforcement measures. I heard, as I was waiting outside, the discussion that Darren was having with our chief nursing officer about just that issue, and it seems to me that there's a whole range of ways of making sure that what is now a statutory requirement would be delivered on the ground. For a start, it relies on people at ward level themselves. I heard a bit of the discussion about staff and their ability to speak up about things. My own experience of meeting ward sisters has not been that they are quite the shrinking violets that some of the discussion seems to suggest. We know that, particularly through the Free to Lead, Free to Care agenda we've had in Wales, ward staff themselves at that level would have a powerful new thing that they could refer to in making sure that the right number of nurses were available. You've then got all the internal mechanisms of the health board itself, right up to board level.

[144] We have a wide range of ways in which we, as Welsh Government, have intelligence about the way in which this sort of arrangement would be being delivered on the ground. Of course, we have the inspectorate itself, but we have many other ways in which we would have an insight into it. There is the work of the royal colleges themselves. They are regularly, in all our hospitals, reporting on what they find. There are community health councils. Again, they turn up unannounced on wards. They would know what the law said, and they would be undoubtedly reporting on it. We have national clinical audits, independent of the NHS in Wales, which would be including this as part of what they do. In the end, if it comes to it, I

have powers of direction, as a Welsh Minister, set out in section 12 of the National Health Service Act of 2006, which allow me, under a different section of the Act, to issue directions to health boards to require actions to be taken. So, I think there's a pretty widespread range of tools already available, both from intelligence that you gather and actions that you can take, which would allow a Minister who was anxious that this Bill was not being delivered in practice to take action, both to discover that and then to respond to it.

[145] **David Rees:** Okay, Peter? Darren.

[146] **Darren Millar:** Thank you. You've said two things today, Minister, which have struck me. One is that you could change the basis of the existing guidance to make it mandatory, and you have also just inferred that you have these powers of direction. So, why on earth do we need a piece of legislation if you already have those powers and the ability to make these things mandatory for the Welsh NHS?

[147] **Mark Drakeford:** Well, Chair, I do think that's a very proper questions and it's a very proper question for the committee to be thinking about at Stage 1. I've tried to indicate to the committee that my view is that the Bill is not a necessary condition for achieving what we want to achieve. But I'm open to the possibility that, suitably amended, it could be an additional tool. The force of law does underpin something with more significance than even, you know, statutory guidance and mandation through the action of a Minister. Whether that's enough to make a law worth having is a question that I'm sure you will want collectively to think about in making your Stage 1 report. I'm open minded that it could make a difference, and a difference worth having. But I think it's a very proper question to be weighing up.

[148] **Darren Millar:** But you've also indicated that the existing work that is already being done—we heard evidence from Dr White—is, you know, pretty much achieving what this Bill intends to achieve. So, if the existing stuff is achieving what is envisaged by this Bill as being necessary—safe nurse staffing levels—you have powers of direction, you have the ability to make the existing guidance mandatory, surely you should do those things first, and then, if you are unsuccessful, consider legislation. Legislation should be, you know, the last possible requirement, shouldn't it?

[149] **Mark Drakeford:** Well, I think when the Bill was very first introduced, I made that point to the Member in charge—that legislation should be a last, not a first, resort. I have indicated in my written evidence to the committee that, if the Bill does not succeed, then there are other things that I will be able to do to try and meet some of the concerns that you will have heard from those powerful voices who are very keen on the Bill. I think I've gone as far as I'm able to go this morning in telling you where my thinking currently lies, but as I say, I will be reading the committee's conclusions very carefully on exactly this point.

[150] **Darren Millar:** Can I ask you: if the committee were to conclude that the Bill should not proceed to Stage 2, and recommend that to the Assembly, would you be intending to make the existing guidance mandatory and to use your powers of direction to require some of the things that this Bill sets out of health boards—some of the monitoring arrangements?

[151] **Mark Drakeford:** I'm slightly inclined to say that I would cross that bridge if I came to it.

[152] **Darren Millar:** It would be very helpful if you were able to tell us.

[153] **Mark Drakeford:** I think I did, probably, imply quite strongly in my written evidence that if there were to be no Bill, then the case for doing those things would be strengthened.

[154] **Darren Millar:** Okay; thank you, Minister. You made reference to some of the indicators that you do think are linked directly to nurse staffing and healthcare support worker staffing levels. Some of the others that spring to mind from the work of other committees in the Assembly are hydration and nutrition, particularly in view of the ‘Trusted to Care’ report. Do you think that those are also potential indicators that the Government could support in terms of required information from health boards to demonstrate that nurse staffing levels are being met, as another form of assurance?

[155] **Mark Drakeford:** [*Inaudible.*]—more likely to get the professional view than my own.

[156] **Dr White:** Obviously, having the right number of staff would affect all aspects of care delivery and you could possibly make an argument for lots of things, whether it is continence care or hydration. In the case of hydration and nutrition, we already have other arrangements to try to mitigate any problems. So, if you’ve got a lot of very dependent people who need to have assistance when they eat, we’ve got arrangements for family members to come in if they want. We’re looking at volunteers to come and give support. We’re looking at configuring the workforce so that there are more people available at meal times. So, there are things you can do within current structures that enable us to do that. But, I mean, your point is well made. There will be other aspects of care that you could consider and we could certainly look at that.

[157] Some of the other indicators that are listed down here are so multifactorial. I think that’s the challenge we have. If we pick any others, again, the same sort of rigour should be applied to it. How many other factors would need to be considered, other than just, ‘Have you got x number of nurses on duty at that time?’ Is it about their competence? Is it about other arrangements, or about the geography of the area that requires you to behave in a different way? So, all of these things are not a single—. What do they say, correlation is not causation? Just because you can correlate these two sets of factors, they don’t necessarily have a direct relationship. We just have to be really mindful of that when we try to do that.

[158] **Darren Millar:** We’ve heard lots of evidence as well from different organisations and individuals about the potential extension of the scope of the Bill to apply to care that is not provided within NHS acute hospital wards, so, for example, in the nursing home sector, Minister, and, indeed, in the independent hospital sector and, of course, the complications around NHS commissioned care, wherever it may arise, including over the border in England. Do you think the Bill says enough about those things, or sufficient consideration has been given? If not, what are your views on extending the provisions of the Bill to community hospitals, children’s wards and elsewhere?

[159] **Mark Drakeford:** There are two slightly different questions, I think, there, Chair. As far as extending the Bill to other settings within the NHS, then I think the Bill gets it right in saying that we should start with acute clinical and surgical wards, because that’s where the evidence is clearest. If I were the Minister at the time that the Bill was being implemented, then I would certainly want to gather the experience of it in practice in those settings before wanting to take a decision to extend it to further settings within the Welsh NHS.

[160] The first question that Darren asked about extending it beyond the scope of the Welsh NHS I think is an important one and one that will need to be thought through. Again, for me, it comes down a bit to getting section 2 right, so that section 2 can be more a matter of professional judgment than mathematical formulae, because, to take one of the things that Darren suggested, what about care provided across our border? We know that lots of Powys residents, for example, will get this care in an English hospital. If we set up a system that was over rigid and had an over-rigid reporting requirement, those hospitals would not have any pre-existing regime in place to report against it, and it could be very difficult for them to

invent a whole system just for that relatively small number, in their eyes, of Welsh patients who they were looking after.

[161] So, if a system was the right system, I think some of those anxieties would recede. If we had the system that the Bill currently suggests, then I think those questions of how it could be applied in other places would become significantly more difficult.

[162] **Darren Millar:** I have no doubt that health boards, as commissioners of care in other places, rather than just their own hospitals, take their commissioning arrangements seriously, but they're not monitored directly by the Welsh Government in terms of the commissioning arrangements and the enforcement of conditions in the contracts, no?

[163] **Mark Drakeford:** No, not for that.

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

[165] **David Rees:** Alun, did you want to come back on the first set of questions on the need for legislation?

10:30

[166] **Alun Davies:** Yes. Minister, you were very generous in your response to Darren on that series of questions on the alternatives to legislation. If I were a manager in the national health service, I wouldn't want this legislation. I'm quite clear on that, because it's a very blunt weapon that does not provide you with the flexibility that I would argue that you probably need. And the chief nursing officer, in her written evidence, certainly appears to be arguing that a level of flexibility is required in order to deliver the nature of care. In your explanation of a morning on the ward, you indicated that yourself.

[167] I'm interested in the alternative of statutory guidance, because it would appear to me that statutory guidance would enable you to do all these different things and have the sophistication of advice to practitioners and to managers without the straitjacket of legislation, which does not, and cannot and will not, be able to have the level of sophistication that would be required in managing a busy ward on a day-to-day basis.

[168] **Mark Drakeford:** Well, if the choice that I was offered as a Minister was between legislation that is a straitjacket and the flexibility of statutory guidance, then I would completely agree with the way that Alun put it. I think statutory guidance would trump a straitjacket legislation quite clearly. If it's possible to craft legislation that is not a straitjacket, but that provides a fresh statutory underpinning to achieving the shared ambition of having the right number of nurses and safe nursing care, then I'm leaving that open with the committee, as saying the Bill could still be one worth having. But I don't want to put myself in the position of looking like I'm the Member in charge here and trying to make the case for the Bill to you; I'm not. I'm trying to explain what the Government's position would be, depending on the way the legislative process works its way out and very significantly, as well, depending on the views that this committee will come to, having heard the evidence both from those, as Elin said, who are strong supporters of the proposition, and those who have more doubts about the way the Bill is currently constructed.

[169] **Alun Davies:** I accept that, but if this Bill isn't a straitjacket, if it doesn't say, 'You must do this at this particular time in this particular way'—very prescriptive—then it is simply a statutory backdrop to non-statutory guidance.

[170] **Mark Drakeford:** I think that's a very fair way of putting it and I'm sure that those who are supporters of the Bill—and you'll have heard from them—would say that that's

something worth having. You know, the committee may conclude that the prize to be won is not worth the effort that the Bill would require.

[171] **David Rees:** Lynne.

[172] **Lynne Neagle:** Thanks. I wanted to ask about unintended consequences. Your written evidence provides us with a list of where you think there could be problems if this Bill goes ahead, including the impact on the rest of the team and resources being pulled from other places, and you've also raised some concerns about the impact on skill mix. I wanted to ask, first of all, whether you've seen any of those unintended consequences in action so far, as a result of the existing guidance issued by the CNO.

[173] **Dr White:** Because these are operational decisions, that sort of level of detail is not normally reported to us. So, I wouldn't know, on a day-to-day basis, whether staff have been taken from one area to another to cover. We've not had evidence of any seismic consequences of introducing the principles, because we did it in a consensual, developmental way, with an appropriate run-in. So, it wasn't that we said, 'Okay, here are the principles you have to comply with in the next 12 months'. Even when California brought in its legislation, it gave a five-year run-in to do that. So, always, we're working on a length of time. So, giving people time to actually change how they manage their establishments and recruit staff and so on has not necessarily seen that kind of seismic problem that could happen. So, there is something about timing, about how much pace you put behind things, and how rigid they are in their compliance with certain aspects of the legislation.

[174] **Lynne Neagle:** And could I ask the Minister: are there any unintended consequences that you feel more worried about than others, that you feel might be more likely to come to fruition?

[175] **Mark Drakeford:** I think you're right in the four that you identified. If we had a straitjacket Bill in the way that Alun described it, you can see how a health board faced with a fixed number of nurses and some settings that now have the force of law behind them would solve that problem by taking nurses from other areas in order to comply in the ones where there's a statutory requirement, and rob ones where there isn't. I think the Californian experience, which we mustn't rely on too much, because the systems are very different, shows us that what then happens is that you end up inventing ratios in all sorts of settings. So, they had 21 different ratios in the Californian system in order, I think, to respond to that problem.

[176] I think the other thing you see in California is the recruitment of more junior staff and a reduction in the recruitment of advanced practice and specialist nurses. So, the skill mix argument that you've heard from Jean comes under pressure. It's cheaper to recruit people who are called nurses, so you comply with the ratio, but they're not nurses that are that much use to you, because they're very new and they don't have the skills that you need. You have skill substitution. I think there is evidence from California and other places that nurses spend their time cleaning, because you can't employ cleaners now, because there's no statutory ratio for cleaners, so you dismiss your cleaners and you employ nurses, and nurses spend their time cleaning. That would be the absolute opposite of the prudent healthcare principle that nobody should be routinely spending time doing work that does not require their level of clinical skill.

[177] Then I heard you rehearse earlier a point that I know Darren raised very early on about how, you know, in the worst of circumstances, a health board could solve an immediate problem by moving patients, rather than moving staff. That would be a very sad and unintended consequence of the Bill, but you can see how, at 2.30 a.m., when you haven't got another member of staff to be found, moving a patient off the ward would render it compliant, and, if you thought that the law was breathing down your neck to be compliant, you could

imagine how that could happen.

[178] **David Rees:** Lindsay.

[179] **Lindsay Whittle:** Minister, your department is the big spender here in Tiger bay. I wonder: is finance an issue on this matter?

[180] **Mark Drakeford:** Finance is a matter, Lindsay, but not quite in the sense of, you know, is there enough money in the system to comply with the Bill? But I think my current anxiety about the Bill is in being able to provide credible financial information to go alongside the Bill. I don't think the information provided by the Member in charge, to date, does accurately cost the consequences of the Bill itself. The Member in charge assumes that no ICT system will need to be adapted for the reporting requirements it sets out in section 3, nor that there will be any extra staff time needed to collect, input and process the data needed to meet those new reporting requirements. I don't agree with that conclusion and, therefore, at the moment, I think that the assessment that the Member in charge has made of the direct costs of the Bill would be underrepresent what the costs would actually turn out to be if we did it in the way that the Bill currently proposes. It then becomes difficult to offer Assembly committees reliable information about the consequences of the Bill, if you're relying on the Bill being amended, because, you know, I'm not in a position to predict what conclusion the Assembly as a whole would come to in relation to amendments. So, I do have some anxieties about the current reliability of the financial information that is available to give you, in making decisions, confidence that, if this Bill were to be enacted, this is how much it would, by itself, cost. That's a slightly different question to can the system then find the number of nurses that the Bill would require.

[181] **Lindsay Whittle:** Do you think, Minister, then—. We spend a lot of money on agency nurses. Would there be a saving there?

[182] **Mark Drakeford:** I think you've heard evidence from the perfect ward experiment in Aneurin Bevan, and I'm relying on memory, but I think what you have been told by Aneurin Bevan is that the financial consequences were inconclusive in terms of whether or not having a perfectly staffed ward meant that you could now attract people on permanent contracts to work there and therefore reduce the number of bank and agency staff that you needed. It certainly wasn't a, sort of, slam-dunk conclusion, and they are running that experiment again.

[183] I have seen suggestions in parts of the professional press that if you have a system in which in order to be compliant with a rigid formula a health board decided that it would reduce the flexibility of shifts, because the way to be compliant is to have 12-hour shifts and three-hour shifts; that is how you manage to make yourself compliant. If you reduce the flexibility of shifts that are available to staff currently, then actually it might be more difficult to persuade people to take up shifts on those wards as part of your permanent establishment, and you could end up, in the short run at least, having a greater reliance on agency and bank staff. So, I see the case; I've read the evidence that Dame June Clark and others gave you, that, if you get the right number of nurses on the ward, it will make people more willing to work there and it will reduce your reliance on agency and bank staff. It's a perfectly coherent argument, but I don't know that the empirical evidence is all on that side, and I think the Bill, if it were to go the wrong way, could actually, in a perverse way, make it less attractive to work in these settings, rather than more.

[184] **Lindsay Whittle:** Would it encourage nurses to return to the profession, perhaps?

[185] **Mark Drakeford:** Well, if that were the case, that would be excellent, because one of our main aims is to try to tap into that pool of people who we know are there who, with relatively swift retraining, could become members of the workforce once again. But, again, I

know you've had evidence from health boards directly; the numbers are not huge coming forward and, when they are trained at local health board level, lots of those people then go on to take up jobs not directly in the health service, but in nursing home settings, as school nurses, and in many of the other places where nurses are needed.

[186] **Elin Jones:** I wanted to ask you, following on from Lynne Neagle's questions, about the unintended consequences of this legislation as it's currently drafted, or as you would seek, possibly, to amend it or see it revised with statutory underpinning of the acuity tool that ends up with a number. There will be unintended consequences there, because there will be a statutory duty on the local health boards to ensure safe staffing on a ward, and there will be statutory guidance on meeting the acuity tool's eventual number. With regard to those unintended consequences in terms of moving staff around, or reducing the number of patients on wards, those arguments still exist with the revisions that you've made, don't they?

[187] **Mark Drakeford:** Well, there are two points, I think, Chair. First of all, let's be clear: we want to have the right number of nurses on the ward, so, whatever way we do it, that is our ambition. The second point is that I think the flexibility of a triangulated method mitigates the risk of unintended consequences. It doesn't eliminate it, but it mitigates it, and it mitigates it, I think, quite significantly. The evidence that Jean gave when Lynne asked the first question about whether all the work that's happened so far and the improvements that there have been so far have been achieved at the expense of nurses being taken away from other work in order to meet this priority, I think the evidence is that in a triangulated, consensus-driven, professionally determined at ward level approach, it hasn't. So, I think it has been able to mitigate those potential unintended consequences in a way that a more rigid, formulaic system would not.

[188] **Elin Jones:** Just to say, finally, you must be the first Minister ever to come to a committee to say you have these powers anyway, but you are minded to support a piece of legislation if it was amended in a particular way. So, you've told us today that you have the powers to mandate local health boards to follow the guidance and the acuity tool. Are you able to provide us with a description of those powers, then, so that we are able to consider those against possibly thinking of changing this legislation?

10:45

[189] **Mark Drakeford:** You can ask Fiona now, but I'm sure we can.

[190] **Ms Davies:** Yes. Section 12 of the NHS Wales Act 2006 allows the Minister to issue directions to LHBs in the exercise of any of their functions. Under section 204 of that Act, those directions can either be put in writing or they can take it from the regulations. So, we already have quite powerful tools available to us.

[191] **Mark Drakeford:** Chair, we can provide a note as to what we would rely on if we were trying to put greater mandation into the system short of the Bill.

[192] **Elin Jones:** Okay, thank you.

[193] **David Rees:** Minister, I'm very conscious of the time and that you have to leave us. May I just ask one question, but you can write to us? On the commencement section, which is section 4, can you just give us your views on that, because, clearly, there's a timescale again involved in that, on when it commences after the Royal Assent?

[194] **Mark Drakeford:** The key thing there, it seems to me, is the reliance in the Bill on guidance. You couldn't commence the Bill until the guidance was available. The guidance will need to be very carefully crafted and it will need to be consulted on, I believe, to make

sure that it would be the best possible guidance. Jean, I think, indicated to you earlier that the Californian system, which does have rigid ratios in it at a five-year lead-in period—. I don't anticipate it would be as long as that, and I do think that the approach that I've been trying to advocate for a little would be quicker than the implementation of the Bill as currently drafted. But, the key thing for me to say is that guidance would have to be available prior to implementation and some time would be needed to make sure that that guidance was properly crafted, consulted upon and available.

[195] **David Rees:** Thank you, Minister. You will receive a copy of the transcript, and, for any factual inaccuracies you may identify, please let us know. Again, thank you for giving us your view, very clearly positioned as to your thinking and position on this. It's been very helpful to the committee. Thank you very much.

[196] **Mark Drakeford:** Thank you very much.

10:47

**Cynnig o dan Reolau Sefydlog 17.42(vi) a (ix) i Benderfynu Gwahardd y
Cyhoedd o'r Cyfarfod ar gyfer Eitemau 5, 6 ac 11
Motion under Standing Orders 17.42(vi) and (ix) to Resolve to Exclude the
Public from Items 5, 6 and 11 of the Meeting**

Cynnig:

Motion:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer eitemau 5,6 ac 11 yn unol â Rheol Sefydlog 17.42(vi) a (ix).

that the committee resolves to exclude the public from items 5, 6 and 11 of the meeting in accordance with Standing Order 17.42(vi) and (ix).

*Cynigiwyd y cynnig.
Motion moved.*

[197] **David Rees:** Therefore, to move on to business, I propose, in accordance with Standing Order 17.42 (vi) and (ix), that the committee resolves to meet in private for items 5 and 6 this morning and item 11 this afternoon. Are all Members content with that? Thank you very much. Therefore, we now go into private session.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 10:47.
The public part of the meeting ended at 10:47.*

*Ailymgynullodd y pwyllgor yn gyhoeddus am 13:01.
The committee reconvened in public at 13:01.*

**Ymchwiliad i Berfformiad y Gwasanaethau Ambiwylans yng Nghymru:
Sesiwn Dystiolaeth 1
Inquiry into the Performance of Ambulance Services in Wales:
Evidence Session 1**

[198] **David Rees:** Can I welcome Members back to the session on the Health and Social Care Committee? This afternoon, we actually are looking at the ambulance performance aspects, and we have three groups of witnesses. Can I welcome Professor Siobhan

McClelland and Stephen Harrhy here this afternoon? Thank you very much for attending. Professor Siobhan McClelland is actually chair of the emergency ambulance services committee, and Mr Harrhy is the chief ambulance services commissioner. So, if it's okay, I want to give you an opportunity to actually give introductory remarks, and then we'll go into questioning from that.

[199] **Professor McClelland:** Okay. So, I will kick off. Thank you very much. Thank you for inviting us to give evidence this afternoon. As the Chair said, I am Siobhan McClelland, and I'm the chair of the emergency ambulance service committee, sometimes known as EASC, and also the author of the eponymous strategic review of ambulance services of 2013. Just very briefly, I just want to give you an insight into the role of the committee. The strategic review of ambulance services was underpinned by a vision of the delivery of a robust clinical ambulance service that is a fundamental and embedded component of the unscheduled care system. This was to be accompanied by the clear lines of funding and accountability between Welsh Government, local health boards and the Welsh ambulance service. From the three strategic options identified in the review, the Minister for Health and Social Services identified a national commissioning model where the Welsh ambulance service provides services on behalf of local health boards, which commission emergency ambulance services jointly, based on local need.

[200] So, from April 2014, the local health boards were statutorily required to work together to form a joint committee—the emergency ambulance services committee—for the purpose of undertaking the functions of planning and securing the provision of emergency ambulance services on a joint basis. Additionally, the role of the chief ambulance services commissioner was created and tasked with holding responsibility for the commissioning of ambulance services and working with local health boards to ensure sufficient resources to allow the ambulance service to deliver against the commissioning framework. EASC comprises an independent chair—me—the chief ambulance services commissioner, and the chief executives of the seven local health boards, and has associate membership from Velindre NHS Trust, Public Health Wales and the Welsh Ambulance Services NHS Trust. The committee itself meets bimonthly and has also held additional emergency meetings, recognising the unacceptable position in respect of performance. The committee is supported in its work by the chief ambulance services commissioner and a small ambulance commissioning team. So, I'm going to pass you over to Stephen Harrhy, who is the new chief ambulance services commissioner, to explain a little bit more about his role and the commissioning function.

[201] **Mr Harrhy:** Thank you, Siobhan. Good afternoon, everybody. I'm Stephen Harrhy, as Siobhan said, and I'm the new chief ambulance services commissioner for Wales. I've been in post since January of this year.

[202] In terms of the role that I perform, I think my prime responsibility is to make sure that we have in place an appropriate commissioning quality and delivery framework for emergency ambulance services. I've also got a role in terms of co-ordination and liaison between all partners involved in the delivery of the service. I have a role in terms of the provision of advice and guidance, and I also have a role in terms of performance management to make sure that what we are saying we are going to do in the commissioning quality and delivery framework is being delivered, and how we're trying to get an improving picture in terms of the delivery of emergency ambulance services. So, I'll stop there because I'm sure you'll have questions for us.

[203] **David Rees:** Just to clarify, obviously, we are focusing on emergency ambulance services, but are you involved at all in patient transport services?

[204] **Professor McClelland:** No, the remit of the committee is specifically on emergency

ambulance services.

[205] **David Rees:** I just wanted to make that clear, thank you. Gwyn and then Lynne.

[206] **Gwyn R. Price:** Good afternoon, both. Do you feel that the eight-minute target for the most serious 999 calls is outdated?

[207] **Professor McClelland:** Shall I kick off? When we wrote the review, obviously one of the findings was that targets need to be based on optimising outcomes for patients. So, for some patients, eight minutes is too slow and they need to be seen more quickly. There is limited evidence to support the existence of the eight-minute target. I think there is a move towards looking specifically, in addition to the eight-minute target, at the most life-threatening or red 1 calls and focusing on those. That will need to be an ambitious focus as well: if they're life-threatening, they need to be addressed quickly. Then, we need to look at how best we can optimise the clinical outcomes for everybody else, because it's not that they don't have serious issues that need to be addressed, but they may not need to be seen quite as quickly.

[208] I think one of the problems with the eight-minute target—again, we said that in the review, and it's a comment that comes a lot from paramedics, for example—is that you can get there in seven minutes 59 seconds, the patient can die but it's seen as a success, or you can get there in eight minutes and 10 seconds, and you help them get the best outcome they can, but it's seen as a failure. I fully understand the anxiety that people have about moving away from the eight minutes, and seeing that potentially as 'Oh, well, we don't want to or we can't achieve that, so we're looking at something else'. If we do look at how we change that target, it needs to be clinically led, I think, and it needs to engage the public so that they have faith in what's happening. I don't know whether Stephen wants to add in to that.

[209] **Mr Harrhy:** I'd absolutely agree with that. I do think that there are a number of conditions where it is absolutely essential that we get to a patient as quickly as we possibly can. In some cases, eight minutes is an appropriate time for that; in some cases, it's less than eight minutes. So, we have to be ambitious. I also think that the standard is an old standard, and it is time to have a re-look at that.

[210] In terms of the approach that we take, it is important that any approach that we take is clinically led, as Siobhan was saying. I think we also need to make sure it's evidence based, and also that we understand the impact of that.

[211] There are three other things, I think. It is important, I think, that we get improved clinical outcomes from any review of the standard. It is also important that we get an improvement in the patient experience from a review of any standards, and also that we're able to demonstrate that we're making best use of resources—that we're getting value for money for that. So, for me, those are important criteria that we should also be mindful of if we were to have a re-look at what the standards ought to be.

[212] **Gwyn R. Price:** Yes, because the end result really is to take as much pressure, surely, off the eight-minute calls, so that perhaps certain patients could go down another avenue, rather than always 999 and the blue light.

[213] **Professor McClelland:** Yes, I think a singular focus on eight minutes doesn't give you necessarily the best outcomes for patients, and some of that, yes, is about patients going different ways. Not everybody has to come to the emergency department, so I'm sure you'll hear quite a lot this afternoon about the challenges that exist in terms of giving good care to older, frail people with multiple conditions. Sometimes, being on an ambulance and going to the emergency department isn't the best thing that can happen to them. For example, going to

an elderly frail assessment unit might be better—direct routes into different services. It's also about how we can more effectively manage some of that demand in people's homes, and that includes care homes and nursing homes, and working with those organisations to support that. The Welsh ambulance service is comparatively very good on conveyance. It does a lot of work in trying to keep people at home, but we recognise there's a lot more than can be done, not just by the ambulance service, but by the local health boards as well.

[214] **Gwyn R. Price:** Thank you, Chair.

[215] **David Rees:** Lynne?

[216] **Lynne Neagle:** Thanks, Chair. Siobhan, you said in your opening remarks that the establishment of the emergency ambulance services committee was a key part of the Welsh Government's response to your review. Can you tell us a bit more about how effective you think that new commissioner-provider role has been in driving up standards, given that we are seeing continued problems with delivery?

[217] **Professor McClelland:** Right. I think setting up that model was really about wanting to get the local health boards to take responsibility for the whole of the unscheduled care pathway, because the issues that we see with ambulance performance is not just about what the Welsh ambulance service does. The organisations are able to determine, as integrated health boards, what happens at the front end, so how effectively we're managing patients in primary and community settings, through to the flow through the hospital, which obviously impacts on the number of ambulances waiting outside and the ability to hand over as quickly as is needed. That lies with the health boards, and the ability to discharge effectively out of the hospital also lies with the health boards, working with local authority partners. So, I think the decision was very much about giving the local health boards a responsibility for taking that forward, and commissioning ambulance services to fit within that unscheduled care pathway. I think, to be fair, that was a much more radical change, perhaps, than everybody anticipated, and it required a lot of change in culture and ways of working and ways of looking at things on the part of the health boards, and the ambulance service. I think what we have seen now is that the health boards are much more engaged.

[218] I think it was a slow start and I think it's had challenges with it, but I do think we see health boards now as much more engaged in addressing those issues, and seeing their responsibility in respect of the ambulance service. We also have an ambulance service that is very much focusing on delivery issues—but it has been slow, and slower, I think, than I would've liked to see. The health service is a complex organisation that often does move slowly, and when you write a review, it's rather different when you take it into implementation. But I do think we have seen changes in terms of how the organisations work together and the responsibilities. I don't know whether Stephen wants to add into that at all.

[219] **Mr Harrhy:** I'm, as I said, new in post and I'm certainly seeing a commitment that this is a whole-system approach, not just an issue for the ambulance service. EASC, as a committee, I think enables us to have a rounded discussion about how we take forward that whole-system approach. I am seeing commitment, not only from the chief executives who sit around the EASC committee table, but also staff within health boards, as well. Previously, I was a director in Cwm Taf University Local Health Board, and I know that that organisation is committed to adopting a whole-system approach. I meet regularly with the chief operating officers from each of the health boards, and I have attended the directors of planning meeting recently, and I'm due to meet with other key director groups. So, I'm sensing that we're getting a whole-system approach. I think that is encouraging. As Siobhan has said, I think we've had a slow start. We need to pick up the pace now and we're determined to do that, and we will do that.

[220] **Lynne Neagle:** Okay, thank you. You said that you'd had a number of meetings to deal with the dips in performance where things have worsened recently. Are you able to share with us anything that came out? Were there any concrete actions agreed at those meetings?

[221] **Professor McClelland:** Perhaps the best thing—I mean, Stephen can probably give you some more specific detail on key actions that we are focusing on at the moment.

[222] **Mr Harrhy:** So, what we've done is we've picked up three groups of actions, really. The first is immediate actions—actions that we've already put in place. We're concentrating on three things there. Firstly is to make sure that we understand activity that's coming into the service as well as we can. The ambulance service has got a huge amount of information available, and I think we're able to predict activity better than we were before. We're starting to understand those trends. That's important, then, because we have to then deploy the right staffing resource to meet those peaks and troughs in demand. We've set a target to make sure that the ambulance service is staffing to at least 90% of all its rosters every day of the week, across the whole of Wales. Third then is to make sure that the amount of time lost due to handover is reducing—the hours lost are reducing. We're starting to see, from the peak that we had around December to early January, that coming down. So, that's the immediate actions, and we are monitoring those on a daily basis.

13:15

[223] Second, we do have an interim agreement in place with WAST, which is signed up to for 2014-15, and that identifies five key areas. One is that the service is too reliant on overtime, so how can we make sure that we are employing the right number of staff? WAST have had resources allocated to them to recruit additional staff. Then, it's to make sure that those staff are being recruited and they're in the right place. Thirdly is that the roster review programme, which WAST have implemented, is rolled out at pace. Then lastly, in the WAST control, it's that they put in place a clinical desk. We think that's important to make sure that we understand the type of calls that are coming in and that, where it is appropriate for clinicians to make decisions about how and when a resource should be deployed, we're using their skills. That's been trialled and we think that that could be rolled forward.

[224] The other area, in terms of the actions by the end of this year, is that we know that a number of pilots have been started across the whole of Wales. What we want to make sure about is that those have been properly evaluated. So, we've organised two evaluation events that are going to be held jointly between WAST, independent academics, and the service, and me, to make sure that we are looking at how effective those schemes have been. If they have worked, how could we roll them out across Wales? If they haven't worked, then, are there additional things we can do to make them work? If not, we're not short of ideas, so how do we then move on to the next set of ideas? So, we've got a number of key actions, both immediate and short term, which we are putting in place and which we believe will make a difference.

[225] Looking forward then into next year, we come on to the commissioning quality and delivery framework, making sure that we have that framework in place and that we're monitoring against the key actions within that framework.

[226] **Lynne Neagle:** Can I just ask one final question? There's a good 10% disparity between performance in south-east Wales and other parts of Wales. What's your view, as commissioners, as to the reason for that disparity?

[227] **Mr Harrhy:** I think it's making sure that we understand the peaks and troughs in demand better than we do at the moment. I think that we're starting to get better at that. I also think it's to make sure that the rosters that we have in place are improved, to make sure that

we're making staff available when we're getting those peaks and troughs in demand. We also have seen pressure, in terms of emergency departments, around handover delays, and so taking real actions to make sure that those handover delays are being reduced is going to be important as well.

[228] **John Griffiths:** A couple of things are coming out of that, really. In terms of handover, I think it's always a problem when you've got more than one organisation with responsibility for delivering something, in terms of being clear as to where accountability and responsibility lie. There's always a danger that one will try and shift responsibility to the other, and it's often not entirely clear where the truth lies, as it were. So, in terms of what you've spoken about, the new structures and the new arrangements, I understand that we're trying to bring things together with joint responsibility and accountability, but how is that going to work in practice so that we can be absolutely clear as to where responsibility lies?

[229] The other question I was going to ask is about the so-called 'restrictive' practices, which many of us have been told about and heard about: things like rostering, as you mentioned, in terms of the way the working day takes place for ambulance staff, meals and where they must be taken, having one ambulance person responsible for one patient within A&E, and much else besides, really. Could you give the committee a view as to the significance of these established working practices, of what you intend to do to get things changed, and when that might happen?

[230] **Professor McClelland:** Shall I start with the first question about accountability and responsibility? As I said, one of the key recommendations of the review was that we needed to have clear accountability and responsibility. The commissioning arrangements are such that the local health boards are responsible for the delivery of all those services across the unscheduled care pathway. It is their responsibility to commission the ambulance service to deliver against the commissioning framework that Stephen has talked about, to ensure that services are delivered as effectively as possible. So, that is clear. That is the local health boards' responsibility. They do commission other services as well; it varies from health board to health board. Powys, for example, commissions many of its services from outside. They would also be involved in commissioning specialist services. But the key thing about this is that they are required to commission that jointly and nationally, which comes to the point about looking across, not just at what they do as local health boards—they have role locally in working with the ambulance service to ensure that effective services are delivered—but also to look more widely than just the local health boards, across the south-east region, for example, because what one health board does will impact on the other. So, the responsibility and accountability clearly lies with the local health boards, which are then held accountable by the Welsh Government, and they hold WAST to account through the commissioning framework.

[231] **Mr Harry:** In terms of the interface issue that you talked about around handover, one of the important policies that have recently been agreed and implemented is a handover policy. So, last Friday, that handover policy was implemented, or came into place. That's important because that clarifies who has responsibility for what. The other point to make, I think, is that we're trying to encourage a collaborative commissioning approach, because there is a whole-system approach that's being required here. We're not going for 'us and them'. We're going for, 'How do we create this collaborative approach?'

[232] In terms of trying to move forward on that, there are other interfaces in the pathway. There will be interfaces around making sure that, if you don't need an ambulance to attend—you might need a community response—how we make that work better than it is at the moment. Getting clarity in the framework is important about that, but also creating this environment about working together is important as well. The governance arrangements support that, I believe, and the framework that we're developing will encourage that as well.

We're also, in terms of the evaluation process of pilot schemes, making that a key factor. Where there are schemes, we think that there will be three broad types of schemes: one of which will be WAST only; one of which we are calling 'Once for Wales', because we think that we can adopt this approach across Wales; and others that will then be local, to local circumstances. So, we might not need exactly the same pilot in a rural area that we do in an urban area, or a Valleys area compared with a city centre, for example. So, we're trying to make sure that the framework is responsive enough to enable us to take account of these, but that the principle of an integrated approach is fundamental to that.

[233] There are other policies—the working practice policies. As a commissioner, you're right that I want to make sure that we have the right HR policies in place for the organisation. It is the responsibility of the organisation to implement those. But I would be encouraging both the organisation and staff-side colleagues to make sure that they're working together for the good of patients and for the best clinical outcome, to make sure that we're introducing sensible and appropriate HR policies.

[234] **John Griffiths:** When can we expect change to take place?

[235] **Mr Harrhy:** You have the chief executive and the chair of the ambulance trust giving evidence to you later, I believe. My understanding is that a number of those policies have been agreed and are in the process of being implemented, and they have plans to take others forward. It's probably better to ask them in terms of the detail.

[236] **David Rees:** Members will, I'm sure. We now have questions from Alun, Elin and then Darren.

[237] **Alun Davies:** I want to know why my constituents in Blaenau Gwent are being so badly let down and failed by the ambulance service at the moment.

[238] **Mr Harrhy:** In terms of the response standard in Blaenau Gwent, it is—*[Inaudible.]* The response standard is nowhere near where we would want it to be at the moment. There are a number of reasons for that. What we need to make sure of is that we get to the bottom of those reasons. So, the framework that we are developing is built up in five steps. So, we're going to be developing a five-step model, and we have agreed care standards across each of those five steps. What we've also done is look at what level of activity and what level of resource we have across those five steps. So, if an ambulance has to go out of your area to go somewhere else, how are we replacing that resource back in the area and how quickly can we get the ambulance back in? More importantly, does an ambulance need to attend in the first place? So, how can we make sure that we have the right join-up in terms of community services and that we're putting the right alternatives in place? Just putting more ambulances and paramedics and emergency medical technicians on the road won't be the answer to improving the service across Wales, but particularly in areas where we know there is an improved performance required.

[239] The immediate action, I think, is around the roster management and to make sure that we have the right rosters in place, and the improvement in handover times. So, in terms of your constituents, those are the two fundamentals, I think, that we have to get right quickly to make sure that we get an immediate improvement in response times.

[240] **Professor McClelland:** We are very committed to ensuring that everybody across Wales gets a fair service and we recognise that that hasn't, for various reasons, been the case in a number of areas. As Stephen says, there are a number of reasons why that's occurred. That's why working jointly is really important in this, to ensure that we can match the capacity that's there to the demand in a way that is fair to everybody and so that some areas don't suffer disproportionately. Even if, for example, they're doing quite good work with

handover, it doesn't always directly correlate, so I think we are very conscious of those specific issues and, as Stephen said, of putting specific mechanisms in place to address those.

[241] **Alun Davies:** So, from what I understand from that answer, there are two reasons why, in Blaenau Gwent, my constituents are being failed at the moment. The first is transfer and the second is rotas. Is that right?

[242] **Mr Harrhy:** We have to make sure that there are the right number of staff available at the right times of day to be able to hit the response times—

[243] **Alun Davies:** So we're talking about the resource. So, there are three reasons.

[244] **Mr Harrhy:** —and that they are in the area that they need to be in. That's what we have to make sure of. Part of that is not just down to the ambulance service. There are alternatives as well. So, we have to get those fundamentals right, and getting those fundamentals right will help us in terms of improving the response standard.

[245] **Alun Davies:** So, there are three reasons—that's what you're saying—for the failures at the moment in Blaenau Gwent. Now, if I understand that correctly, if I got that right, I don't understand why the situation in this part of Wales is so poor as compared to other parts of Wales, where the situation is far better. You know, the targets are being exceeded in both Conwy and Wrexham, and places like Pembrokeshire, Denbighshire and Ceredigion are having far, far better response times than an area like Blaenau Gwent. Now, who is accountable for allowing that situation to have happened?

[246] **Mr Harrhy:** The responsibility for making sure the requirements laid out in the interim agreement, from an ambulance point of view, rests with WAST. So, in terms of the staffing availability, that lies with WAST. In terms of the whole-system approach, it is a joint approach between WAST and the health boards. Again, we've laid that out. We've made that clear. The collaborative approach is important there. What we do have to do, though, is make sure that we are changing the way that the service is being delivered. So, continuing to do what we always do is not going to do it. So, we do have to move this forward and we have to move it forward via the commissioning, quality and delivery framework, which I was talking to you about. That is a whole-system approach to that.

[247] **Alun Davies:** I get all of that, but, do you know, Mr Harrhy, what strikes me about the conversation we're having so far is that none of this is unknown. This is what I would have expected and anticipated senior managers to have been doing as a matter of course. When I was working, before I was elected to this place, I was delivering functional responsibilities. That was my job. So, how have we ended up in a situation where senior managers have been failing to get the basics right?

13:30

[248] **Mr Harrhy:** In terms of my role in that, and where I sit in that, well, of course, I've just come in, haven't I, to the role? There have been a number of reviews that have taken place and I think, as Professor McClelland was saying, making sure that we get commitment from all of the key players through the EASC is an important step forward in that—having clarity about the performance management arrangements and who's got responsibility for what. Monitoring that closely is going to be really important. I really can't answer for what may or may not have gone on in the service before that. I'm not the person to be answering that one.

[249] **Professor McClelland:** I think the responsibility does lie, and has from April onwards, with the committee, in terms of commissioning WAST to appropriately allocate

those resources in a way that is fair. It is a developmental process in terms of the committee; it's only been in place since April and Stephen has only relatively recently started. So, it is something that we have, as Stephen's explained, identified and are looking at and will be specifically addressing into next year. So, in terms of the responsibility, it does lie with the health boards, as the commissioners, working jointly together to address that. That's why that joint working is really important in terms of looking beyond the health board boundaries and thinking about how we best benefit the people of Wales fairly.

[250] **David Rees:** I want to move on because I have to watch the time. I know that Elin and Darren have got questions for you. Elin?

[251] **Elin Jones:** Diolch, Gadeirydd. Roeddwn eisiau gofyn cwestiwn ynglŷn â chomisiynu a'r lefel o risg sydd yn y gyfundrefn. Nawr, glywais i hanes un dyn yn ddiweddar a oedd yn dweud ei fod wedi ffonio ambiwlans yn Llanelli ar gyfer ei wraig. Roedd yn rhaid aros am gyfnod o dros awr i'r ambiwlans yna i ddod i ateb yr alwad, a'r ambiwlans hynny oedd criw Crucywel. Rwy'n ymwybodol iawn bod ambiwlansys o Geredigion yn gwario tipyn o amser o'u shifft yn ateb galwadau, o bosib, yng Nghastell-nedd neu yn Llanelli. Felly, o ystyried ein bod wedi cyrraedd rhyw bwynt yn y system lle mae'n dderbyniol i *ambulance crew* o Grucywel fod yn ateb galwad yn Llanelli, a ydy'r lefel yna o risg y mae hynny'n ei olygu, wedyn, i'r cymunedau hynny sy'n cael eu gadael heb ambiwlansys am y cyfnod yna yn dderbyniol i chi fel comisiynydd?

Elin Jones: Thank you, Chair. I wanted to ask a question about commissioning and the level of risk that is in the system. Now, I heard the story of one gentleman recently who was saying that he had rung for an ambulance in Llanelli for his wife. He had to wait for over an hour for that ambulance to respond to the call, and that that ambulance was the Crickhowell crew. I'm very aware that ambulances from Ceredigion spend a lot of their shift time responding to calls, possibly, in Neath or Llanelli. Therefore, considering that we've reached a point in the system where it's acceptable for an ambulance crew from Crickhowell to be responding to a call in Llanelli, is that level of risk that that entails, then, for those communities that are left without ambulances for that period acceptable to you as commissioner?

[252] **Mr Harrhy:** I think there's a system review that's required here, because one of the rules that applies at the moment is that the ambulance service is required to dispatch its nearest available resource. If its nearest available resource is out of area, then, in terms of that balancing-the-risk equation that you are describing, is that the safest and the best way to provide the service? I'm not convinced that it is. What we therefore need to make sure is that, in terms of taking that process forward, we're doing that in a proper and thorough and systematic way. That should be clinically led, it should be evidence based and it should be impact assessed.

[253] What we should also be making sure about is the number of calls that result in an ambulance being the only resource that can attend to that call, that we are getting that right at the moment; that isn't the case at the moment. We know ambulances are responding to calls that ambulances don't need to respond to.

[254] **Elin Jones:** I absolutely understand that ambulances are responding to calls when there could be far more appropriate 24-hour care—elderly care in particular—in place that would be a far more appropriate way. But, I am concerned that ambulances from Blaenau Gwent or Ceredigion or Powys, when they are making transfers to centres, Morriston or Cardiff, then end up as part of the response call in those areas and do not return, possibly for a whole shift, to the areas where they were meant to be serving to start with.

[255] **Mr Harrhy:** A number of the schemes that I said we were going to look at and

evaluate, in terms of piloting them, will be around how we could go about better retaining the resource within a particular area. What would it take to enable us to do that? What would the potential benefits and risks be that are associated with that? How could we move that at pace across Wales? That's one of the schemes that we will be evaluating and looking at, because you're right, it is important that we do that. It will give colleagues some assurance around making sure that we can get equitable standards of performance across Wales. That's a very important point.

[256] **Elin Jones:** Okay.

[257] **David Rees:** Darren.

[258] **Darren Millar:** Can I ask you, Professor McClelland, your review was completed in April 2013, we're now almost two years on and it was supposed to deliver the recommendations that would deliver the sea change in ambulance service performance and allow for the establishment of a service that was fit for purpose and going to deliver for the people of Wales? We haven't seen that sea change yet. Not all of your recommendations have been implemented. Are you happy with the pace of change that the Welsh Government has embarked upon?

[259] **Professor McClelland:** I think, as I said earlier, it's been much slower than I would have liked. I think the health service is a complex organisation that is sometimes very slow to change. Yes, I would have liked to have seen things move faster, but as I said, there is a difference between writing something and implementation. I think a number of the recommendations have been put in place and are in the process of being put in place, so we do have a decision on clear accountability and responsibility through a commissioning model. The ambulance service have been working on a transformation programme, which is around workforce, and particularly around upskilling of paramedics, which was a key issue, and we are talking about looking at the targets, which was another area of recommendation that was in the review. So, not all of that has been implemented to date, but many of those things are in progress. Has it been too slow? Yes, I think it probably has been slower than I would have wanted it to be.

[260] **Darren Millar:** And your committee was responsible for appointing the commissioner.

[261] **Professor McClelland:** Yes.

[262] **Darren Millar:** Why did it take you 12 months to get around to doing that?

[263] **Professor McClelland:** It didn't take 12 months to get around to doing that. We had a transitional ambulance service commissioner, who was appointed in July and took us up to the point at which Stephen took over, to help to develop the processes. It is quite a change, I think, in the way of working—probably, as I said, more radical and different than either the health boards or the Welsh ambulance service probably understood. It alters the way in which people have to behave and work. So we had someone in place to help us with that, and now we have Stephen in the substantive post.

[264] **Darren Millar:** Mr Harry, you've repeatedly said we need a whole-systems approach. I agree with you. You've also suggested that you've got full engagement and commitment of all the health boards in helping to drive some improvement, yet the figures don't bear that out, do they? I mean, the handover times have been increasing in the last 12 months, for example. Why is that? Why don't the figures bear out what you're saying to us?

[265] **Mr Harry:** It partly goes back to the answer that Siobhan gave you in terms of the

pace at which things have been implemented.

[266] **Darren Millar:** And when did they become engaged?

[267] **Mr Harry:** Well, I can comment from when I've been in post.

[268] **Darren Millar:** Okay. Can I go back to Professor McClelland, then, and ask you, perhaps: when did the boards give their full commitment to wanting to deliver these changes?

[269] **Professor McClelland:** I wouldn't characterise it that they were not committed or that they were not prepared to be involved. I think it has required them to change the way that they think and work. I would say, in the last two to three months we've seen a ratcheting up of that commitment and of that engagement. I think that would be a fair comment.

[270] **Darren Millar:** In the past two to three months we've also seen the worst ambulance performance figures on record and, yet, these are the last two months that you say they've been most engaged.

[271] **Professor McClelland:** Well, there's not a correlation between those two things. This is a complex problem that has taken a considerable period of time to get to the point that it is at, which is totally unacceptable; I don't think anybody is saying the situation that we're in is okay, because it's not. It takes a period of time to be able to deal with all of those issues. The part that WAST plays and the part that the health boards play in changing that does take time and there's not one thing that you can do that will alter everything very quickly, because if there was, then we would've done that.

[272] **Darren Millar:** Isn't the reality that the health boards aren't sufficiently engaged? You know, they're discharging people too early from hospital sometimes and they're ending up, then, requiring an emergency response for an ambulance; that their beds aren't sufficient in number, and as a result, people get clogged up in the A&E departments, so your ambulances are stacking up outside not able to respond to other people on 999 calls. Isn't that the big problem here?

[273] **Professor McClelland:** I don't think it's that they're not sufficiently engaged in that, and I think, when you talk to the local health board chief executives who are coming in later this afternoon, they will tell you that this is the top conversation that they are having every single day, in terms of looking across the system to how they can deal with that. It is their responsibility across the whole system, because you're quite right; they need to appropriately discharge patients, they need to look at the capacity that is available and the flow through the hospital. What's available to people when they go outside? How can they manage that in primary care? How do we deal with older people who're coming towards the end of their lives? I don't think they're not engaged in that. That needs to happen, probably, with some more pace, but I think it is the number one issue for most health boards.

[274] **David Rees:** I'm conscious of the time, because we are—

[275] **Darren Millar:** I've just got one more question, if I may.

[276] **David Rees:** Ask one more question.

[277] **Darren Millar:** How do you, as a committee, and you as commissioner, hold WAST to account for its delivery against its performance targets?

[278] **Mr Harry:** As I said, this year, there is an interim agreement in place for 2014-15, and we require WAST to report back against that. Going forward, we have the commissioning

quality and delivery framework that will extend that and there'll be clarity in that around who reports when and how that reporting takes place.

[279] **Darren Millar:** Is there a copy of that available for the committee to peruse?

[280] **Mr Harrhy:** The emergency ambulance services committee will be agreeing the draft of that at its next meeting.

[281] **Darren Millar:** So, it's not yet been published.

[282] **Mr Harrhy:** It's not yet been published.

[283] **Darren Millar:** Or finalised.

[284] **Mr Harrhy:** It hasn't yet been finalised. There is an EASC committee meeting in March and that's on the agenda of the EASC committee.

[285] **Darren Millar:** So, what have been the interim arrangements in terms of monitoring?

[286] **Mr Harrhy:** The interim arrangement is the interim agreement. That is a document that is in the public domain.

[287] **Darren Millar:** Okay.

[288] **David Rees:** Okay, thank you.

[289] **Professor McClelland:** We can let you have a copy of that.

[290] **David Rees:** I'm conscious of the time. We've come—

[291] **Alun Davies:** Could we have a copy of—

[292] **Mr Harrhy:** Yes.

[293] **David Rees:** It will be sent. I'm conscious of the time. We've come to the end of the session. Thank you very much for your evidence. You will receive a copy of the transcript for any factual inaccuracies you identify; please let us know if there are any. So, once again, thank you very much for attending.

[294] **Professor McClelland:** Thank you.

[295] **Mr Harrhy:** Thank you.

13:43

**Ymchwiliad i Berfformiad y Gwasanaethau Ambiwylans yng Nghymru: Sesiwn
Dystiolaeth 2
Inquiry into the Performance of Ambulance Services in Wales: Evidence
Session 2**

[296] **David Rees:** Members will be aware that we now move on to the next session, where the representatives of the Welsh Ambulance Services Trust will be attending.

[297] Good afternoon. Can I welcome Tracy Myhill, chief executive of the Welsh

Ambulances Services Trust, Mick Giannasi, the chair of the trust to this afternoon's session? Can I thank you for your written evidence that you submitted, as well, to the committee? Thank you for that. We'll give you an opportunity, perhaps, to make some opening remarks and then we'll go straight into questions, if that's okay.

[298] **Mr Giannasi:** Okay, thank you, Chairman, Members. If I may, I'd just like to make some brief opening remarks that will hopefully provide some context to the discussion that follows. On behalf of the trust, I, and Tracy as chief exec, absolutely acknowledge that the performance of the emergency ambulance service in Wales is not acceptable, particularly not in terms of its achievement against the eight-minute response time target and I hope that we can reassure you this afternoon that we understand the problems that we're facing, that we're working collaboratively with others to improve the situation, and that we're doing that as a matter of shared priority and as a matter of urgency.

13:45

[299] I don't want to dwell too much on the past, but I think it's widely recognised that the problems that the service is tackling are long-standing, they're deep-seated and they're quite complex in nature. Again, as a newcomer to the health service, the organisation, I didn't understand the complexity of what appeared to be quite a simple system. But, I think Siobhan McClelland's review started to, kind of, unwrap some of that. Our main challenges, I think, lie in improving critical areas like corporate governance, leadership capacity, workforce policies, organisational culture, stakeholder relationships, and all of those things are embedded within the complex dynamics of the wider unscheduled care system. As such, I don't think they'll be easily resolved and I don't think they'll be resolved overnight, and I think history has shown that to be the case.

[300] I think we can trace our current performance problems back to December 2011. We introduced a revised clinical response model, which incorporated healthcare professional calls into what you would know as 'red demand'. There were very sound clinical reasons for that, but actually it created a step-change in red demand overnight, and that had a consequent step down in performance against the A8 target. At the same time, we saw increasing demand for service, steady rises in level of acuity, and the organisation began to chase too much demand with too few resources and found itself increasingly having to prioritise to get to the most urgent things first. The committee will know that various operational interventions have been put in place over the last three years. Some of those have been successful, but in hindsight others haven't, and I think they may actually have exacerbated the problem, because I think we've been broadly trying to seek the symptoms, not necessarily getting to the causes.

[301] What we mustn't lose sight of—and I know from the feedback that we get from AMs and local politicians that, actually, there is recognition of this—is that, day in, day out, our staff delivery high-quality service, and it does actually make a real difference to people's lives. Few people ever complain about the service they get. The issue, as you know, is getting it there in the right time frame to meet people's needs. I know people say this as a throwaway remark, but actually our staff are our greatest asset. I think we can make our case, and I know Tracy will assist with this if you wish, that actually the productivity of the service, against that background of reducing performance, has actually improved. So, our staff are seeing more people in eight minutes than ever before. There have been improvements in other areas in terms of quality, in terms of the reduction in the number of people being taken to A&E—and I'm sure Tracy can expand on that.

[302] I hope this afternoon that we can reassure you that the board and the senior management team are committed to delivering an improved service. We've already started to put things in place at the foundations of a more sustainable future. So, you've heard about the new commissioning arrangements, which are bedding in; there is a new board; we have new

leadership within the organisation; we are strengthening the management team; we have an ambitious transformation programme; our industrial relations are improving significantly and quickly; and I hope you'll get the sense this afternoon that the partnership framework that underpins this is actually starting to strengthen.

[303] So, we accept progress is slow, but we passionately believe now that, I think, our plans will deliver. I think that view is now shared by our local health board colleagues. I would just really like to emphasise that this role, 12 or 18 months ago, was quite a lonely place to be. The ambulance service felt exposed in terms of the scrutiny around performance, but that's changed. We're increasingly working in a much better partnership-based framework with local health boards and the emergency ambulance services committee.

[304] Just finally, if I may—

[305] **David Rees:** We need to move on—[*Inaudible.*]

[306] **Mr Giannasi:** Okay. There are three critical areas, I think, where we need to make progress rapidly. One is about getting the right level of resource within the context of the system that we're operating in. We are negotiating around that. The second is to improve consistency of what works, and expand that out into all the local health boards. Finally, as you'll hear, hopefully, during this session, we need to sort out some of the things in the system that are inhibiting progress—so, hospital delays and a lack of alternate pathways. Those are the things that are currently happening and we'd be more than happy to share some of those things with you, Chairman.

[307] **David Rees:** I'm sure Members will be more than happy to ask some of the questions as well. Gwyn Price.

[308] **Gwyn R. Price:** Thank you, Chair. Good afternoon, both. How can the trust reduce staff sickness and absence levels and what discussions have you had with the trade union regarding the staff and the stress and the absenteeism?

[309] **Ms Myhill:** One of my key priorities since I joined the trust in October has been to transform relationships with trade unions and with staff, and to transform the way we communicate with one another. So, there's been a huge focus on that from my perspective. When I arrived, trade unions weren't prepared to sign up to behaviours and principles with the trust, for example. We've got to a place where we are all happy to sign up to those, which we did in a public trust board not that long ago, to show that we are prepared to work together in a professional way.

[310] The absence levels specifically you've asked about in the ambulance trust, they are nowhere near where they need to be; they are over 8% and they are depleting our capacity, because, when people aren't there, as one of our board members says to me, empty vehicles aren't much use if we haven't got the staff within them. So, it is a major challenge for us. We're working with the trade unions again on that. My last conversation with the trade unions has been to help us understand a number of things, actually, in relation to staffing—why people leave, why people join, what's good, what's not so good, and what can we do to respond to the stress and pressure that's on our staff. So, we have invested in occupational health. We've invested in internal counselling and support, so that we've got services there to help staff when they are stressed. Stress is not the major, top level of absence for us—it's more around musculoskeletal issues rather than stress—but nonetheless there is stress in the workplace.

[311] The biggest thing for me, though, is not about treating the symptoms—it's actually treating the cause, and that's about the culture, that's about the relationships, that's about

personal development reviews for staff; it's all of the things that are going to enable our staff to feel that we support them, and that they're working in a system, across the whole of the health system, that enables them to do the job that they love. When I go out with staff, and I spend a lot of time personally out with staff on ride-outs with them in their stations, without exception almost—can you say 'without exception almost'—the majority of staff tell me it's the best job in the world. That's what they say. So, we've got to make sure the system within which they work enables them to do that to the best of their ability.

[312] We have a plan—we have a sickness absence reduction plan. It's an all-encompassing plan. Part is about day-to-day management—meeting people when they come back from work and return-to-work interviews. There's evidence that those will make a big difference; they haven't been happening, because people have been focusing on performance, performance, performance, and forgetting about those really important line-manager responsibilities—or perhaps not forgetting, but being directed to get out there on the road to respond. So, it's basic management in that sense. There's also health promotion—supporting people with their own health through to, as I say, development, engagement and appraisal. So, it's quite an encompassing plan, and we've set ourselves an ambition to reduce our absence levels by 3% over the next three years, which is quite ambitious, given where we are. But I believe, with all the things we're putting in place, we can move towards that.

[313] **Gwyn R. Price:** You say that you've got timescales there of three years, really, but have you got any timescales in between that you will be bringing this to a conclusion at certain stages, because you can't go on and on and on, having meeting after meeting, without any improvement?

[314] **Ms Myhill:** In relation to sickness absence specifically, which was the key part of your question, we have set ourselves an ambition to reduce that by 1% in the first year, then a further 1% and a further 1%, so that's the improvement trajectory that we want. As I say, we're at 8% at the moment, but there's variation within that. So, we've got a plan with timelines to enable us to reduce that. What we're trying to do within the ambulance trust is to empower our managers and our clinical team leaders locally to engage more with their staff; it's been quite top-down, quite directional from the centre. We cover the whole of Wales; we can't work in that way. I need to empower the managers and the leaders locally, so we'll be working with them. They all will have their own plans for how they're going to reduce absence and how they're going to increase motivation and engagement. And together, then, that will make the whole organisation move forward.

[315] **Gwyn R. Price:** Thank you, Chair.

[316] **David Rees:** Lynne, on this particular point.

[317] **Lynne Neagle:** Yes. We know that absence is a problem and I'm aware from my discussions with you that you've got this plan in place, and I'm sure we all welcome that. Can you just talk to us a bit about the roster issues? We heard in the previous session that a key part of the problem is not having people in place at the times when they need to be in place. Are you able to tell us a bit more about that, and exactly how that's going to be dealt with?

[318] **Ms Myhill:** Yes, absolutely. We've got a programme of work to change our rosters so that they better meet our demand, so demand-led rostering is the project that we're looking at, so that the resource that we do have is as matched as best it can to the activity that we need to deliver. A lot of our rosters have not been changed for many, many years; they are way out of date. That's not the case across the whole of Wales, but, in the majority of Wales, our rosters don't match that demand. So, we've got lots of—. One example is 12-hour shifts, where demand isn't flat, yet our staffing is flat. So, we need to try to match that and we're doing that in partnership with our trade unions. That has been slower than anticipated. It's

very complex and I'm really pleased to say that we have now started to see some success there. So, Cardiff and the Vale is a good example, where we have now agreed all-new rosters that are demand-led, which, when you look at—. We have something called UHP, unit hours produced. I think our commissioner referenced that 90% is the target, where we want to be staffing rosters to 90%, and, in Cardiff and the Vale, on most days now, it's over 100%. So, by changing those rosters, by better aligning them to demand, we know that we're actually getting more people out on the ground. So, we've got that in Cardiff and the Vale. We've agreed rosters in north Wales and we've agreed rosters in the majority of Powys, just a couple to go, a couple of stations in Powys, and a couple to go in Hywel Dda. Our challenging areas are Cwm Taf, Aneurin Bevan, as you know, because we talked about that, and ABMU—Bro Morgannwg, Swansea. So, those are the three areas that we are focusing on—they will take a good couple more months before we're in a place to decide what we're going to do with those rotas.

[319] **Lynne Neagle:** Thanks.

[320] **David Rees:** John on this particular point.

[321] **John Griffiths:** Yes. In terms of the culture of the organisation and established working practices, I think many of us have heard of particular practices that perhaps do not facilitate best performance of the service. For example, the requirement for one ambulance person to be with one patient in the A&E rather than one ambulance person perhaps with several, and many other examples that are often quoted. I wonder if you could tell us, first of all, what agreement has been reached now in terms of changing those practices and how significant those changes will be, and also what further changes you would like to see. And, if I may, Chair, allied to that, in terms of training, I've heard it said that, if paramedics perhaps had training that enabled them to perform services they're not currently able to, they would be able to treat people at the scene of an accident, for example, rather than having to take them to the A&E department for them to have that particular service delivered there. Obviously, the more they can do at that time, rather than that service being provided later, presumably the more effective that would be for the patient's health and well-being.

[322] **Mr Gianassi:** Could I, Chair, just say something generally about culture, and then Tracy will obviously fill in the detail? That is an underlying issue that runs right through the trust and its problems. We have to change the culture of the organisation. The history has created the culture that we have, but it isn't just about the workforce. There are some really good people, there are some difficult people, and there are some practices that need to be changed. But it starts right from the top, and we've been focusing on a bottom-up, top-down review of the culture of the organisation. So, we've started with the board; we're going through development programmes. Tracy is working through the senior management team to develop a different culture and cascade that down. So, it will take a long time, but we're starting to see a shift.

[323] In the 12 months that I have been in the trust, I have seen a fundamental movement now to a much better place, where some of the things that were discussed—and some of those were myths, some of those were longstanding things; the history of the organisation seems to hang around for a long time—are systematically being shifted, removed, improved, but it will take time. But if I could reassure you that that is owned by the board; it is a fundamental part of our plans going forward and there is action being taken, which Tracy could expand upon.

[324] **Ms Myhill:** Thank you. I'm really trying to focus on building trust within the workforce and within the organisation. Culturally, there's not the level of trust that I would expect between staff and staff, staff and managers, managers and trade unions, trade unions and the board. There's lots of things that have happened. That is fundamental for me—that if we can't have trust, we're not going to go forward together. So, that is a massive plank of the

work that I'm doing. Part of that rebuilding trust is about ambition and a sense of vision and a sense of a brighter future.

14:00

[325] I'm not saying that glibly; it is really important for the staff who we employ that they see where we're taking this organisation and where we're taking their profession. We're moving the profession from a transport service to a clinical service. That's the direction, that's the development, that's the training, and that's what people in our service want, and they can do more. They can do a lot more at scene to not take people into hospital and that is a major focus of the work. We talk about—. The language you use is a 'mobile, emergency and urgent care service' as an integral and critical part of a wider, unscheduled care service. We have paramedics working with general practitioners—out of hours with GPs, sometimes covering some of the work with extended skills. So, the training is absolutely critical. We have a range of advanced practitioners within our service and we need to build that and we need to grow that.

[326] In terms of the working practices specifically, when I got to the organisation, we were at stalemate on a couple of really key working practice policies: one was about rest breaks and where people took their rest breaks and how that worked, and one was about lone working when people, perhaps, felt uncomfortable to be working as sole practitioners. Those were at stalemate. There were all sorts of issues—publicly known, no doubt—and threats of industrial action around those two policies. I'm really pleased that we've now been able to approve both those policies with our trade unions. They are significant policies, but, to me, they're also significant steps that show that we can work in partnership and we can start to begin to trust one another as trade unions and managers, for the better service for the patients. From my perspective—30 years of my experience is in the NHS—the patient's at the centre and that's the nature of our conversations; it's all about the patient. If the patients are getting the service they need and the staff are treated the way they should be, then everything else will flow. So, that's what we're trying to do.

[327] We've got a very good conveyance rate to A&E departments—'very good' means low in the sense of just over 60% of our patients get conveyed. When you compare that nationally, there are very few services that convey less than us. So, that is good; that's a very good foundation on which to build. But the point's already been made about referring patients elsewhere and we want our paramedics to have more and more power and more and more pathways so that we don't have to go to emergency departments and A&Es for the majority of our calls.

[328] **David Rees:** Okay, thank you. [*Interruption.*] No. I'm conscious of the time we've got left and I've got questions coming in. Alun.

[329] **Alun Davies:** I want to know why you are failing my constituents in Blaenau Gwent.

[330] **Mr Giannasi:** We absolutely accept and understand that performance is not equitable across Wales. All of our policies and processes and plans are about achieving that consistency. There are historical influences and dynamics that have led to that situation: some management decisions and some things driven by adverse incidents and coroners' rulings and those sorts of things. We are clinically evaluating our response model; we are looking at the way that we deploy our resources equitably across Wales to make sure that everybody gets the service they're entitled to. It's not currently happening. We have, in the past, relied on geography, as some of the reason for that.

[331] **Alun Davies:** Geography?

[332] **Mr Giannasi:** There are geographical issues in certain communities where—

[333] **Alun Davies:** Tell me what the geographical issues you are facing in Blaenau Gwent are, then.

[334] **Mr Giannasi:** I wasn't referring to Blaenau Gwent.

[335] **Alun Davies:** Well, the question was on Blaenau Gwent and I'd appreciate it.

[336] **Mr Giannasi:** It's about, if you live in a conurbation, and there's a kind of amalgamation of resources in a confined area, then it's much more likely that an ambulance will be close by and will respond more quickly. As the distance is spread out and, particularly with some of the Valleys communities, they are linear routes up and down valleys; that is a particular feature. We have to deal with that. I don't say that as an excuse—we have to compensate for that.

[337] **Alun Davies:** Right. Excuse me, but you do better in Powys than you do in Blaenau Gwent. The geography of the south Wales Valleys is not novel or new. I asked you why you were failing my constituents. I'd be grateful if you could answer that question directly.

[338] **Mr Giannasi:** Well, I think I have. I think—

[339] **Alun Davies:** No, you've talked around it, but you haven't answered it. Why is the ambulance service failing to reach the targets that are set for it for serving the people of Blaenau Gwent? You haven't answered that question.

[340] **Mr Giannasi:** We don't have the right level of resource in communities and kept within communities to be able to respond in an equitable way to calls for service. All the things that we are doing are about creating a model where that can be achieved much more consistently.

[341] **Alun Davies:** So, it's resource.

[342] **Mr Giannasi:** It's resource; it's the way we use those resources; it's about system flows. One of the particular problems is that resources are drawn into areas where there is an A&E, and that then creates a kind of vortex that draws out. So, because our deployment model relies on sending the closest available resource to an incident that is immediately life-threatening, then ambulances on their way back to their community quite often are pulled out to go to a closer incident. What that's based on is the immediate risk that is presented. What we have to take into account—and we're working our way through this in a clinically assessed and researched way—is the potential risk to people in communities who've not yet called the ambulance service, and that's a piece of work that is currently ongoing. The chief exec would be able to give you a bit more detail, but we are running what we are calling a pathfinder in Cwm Taf, which tests the viability of ring fencing and resources. But, it has to be clinically led and it has to be properly evidenced before we progress it further, but it potentially will solve some of the issues that we have.

[343] **Ms Myhill:** I've spent some time in Blaenau Gwent. I understand what you're saying about Blaenau Gwent, and when you look at the performance across Wales, it does vary. Blaenau Gwent is way down there in comparison with some of the others.

[344] **Alun Davies:** Well, it's bottom.

[345] **Ms Myhill:** Not always.

[346] **David Rees:** We won't argue at which bottom, but let's accept the fact that they're unacceptably low.

[347] **Ms Myhill:** Yes, it's very low. So, I spent some time with our crews in Blaenau Gwent, and Abertillery particularly, and we spent time in Ebbw Vale, and we spent time at Nevill Hall Hospital, and we spent time on the Heads of the Valleys roads, so I could feel it and understand it and see what life was like—I used to work on the board in Blaenau Gwent, so I know Blaenau Gwent, but it was interesting just to be there with the crews. There are lots of things that we're trying to do specifically in that area to support the community in terms of social deprivation, and need is greater in some of the areas in Blaenau Gwent, as you undoubtedly will know, and we've put some specific initiatives in Aneurin Bevan, but some specifically in the Blaenau Gwent area. For example, we've got a falls vehicle. We've got other initiatives where we can try to reduce the need for staff to take people to hospital. So, there are lots of initiatives within that area to try to support. Staffing is the biggest challenge in Aneurin Bevan as a whole, and that, undoubtedly, is impacting on the ability for us to get to patients as quickly as we would want in Blaenau Gwent, and hospital delays are clearly a part of that. So, it is an issue; it is a priority.

[348] There is virtually no relief in the rosters in Blaenau Gwent, which means that, if someone is off, there is no relief to cover. If you look at best practice, you need 30% relief in your rosters, because people are off for training, people are off because they're sick, people are off for all sorts of reasons, and we are really struggling to backfill. We've put a specific, targeted, enhanced overtime test in that area right now—Aneurin Bevan as well as Blaenau Gwent—just to help us over the weekends over the next couple of months whilst we work through those rotas. I think that Aneurin Bevan, and Blaenau Gwent particularly, is going to be an area where investment in rotas is what's going to be needed, as opposed to some of our other areas, where we can actually be more efficient, cost less and provide a better service.

[349] **Alun Davies:** So, rotas you see as the absolute key issue.

[350] **Ms Myhill:** It is absolutely one of the key issues.

[351] **Alun Davies:** I don't understand about the management of the ambulance service, because I really don't buy what you say about geography, frankly—I really don't buy that at all. What I don't understand is how you're able to manage a service and deliver such—to use your word—variable results across the face of the country. That tells me that there is very, very poor leadership and management at the heart of the organisation, because there is nothing unique or novel about either the population of Blaenau Gwent or the geography of Blaenau Gwent that you haven't already known and which hasn't been described a thousand times by different people. There's nothing new or different about it. So, if you're delivering very, very significantly different results in different parts of Wales, and in different parts of Aneurin Bevan as well, then that tells me that there is something not working at the senior leadership of the organisation.

[352] **Ms Myhill:** There is no doubt that, if you look across Wales, and if you look at north Wales, you'll see, on balance, a much better performance than you will in the areas that you're talking about. If you look at the rosters in north Wales, if you look at how often they've been reviewed, how often they been changed to meet demand, they've been regularly reviewed for many, many years. That's not happened in the area that you represent. That is a fact. Because of that, the rotas are nowhere near where they need to be and the challenge is much harder. Our job, across the whole of Wales, is to get that one organisation into a place where we provide the best service for our whole population. There are historical issues that we're trying to address. They don't happen overnight. We all want them to happen overnight, but they don't. Unfortunately, that's where we are. The starting point in particular parts of Wales is stronger and less strong in different areas. We're trying to accelerate those areas and

that's where we're trying to focus our effort: Cwm Taf, as my chairman has mentioned, and Blaenau Gwent and Aneurin Bevan is another area where we need to focus our efforts. If you just look at the top and look at the Welsh performance, and if you don't get underneath that, you can miss some really serious issues you need to get under. We had this conversation about Torfaen, as an example. Torfaen wasn't on my radar on day 1. It's on my radar now.

[353] **Alun Davies:** I hope Blaenau Gwent is as well.

[354] **Ms Myhill:** It is.

[355] **Alun Davies:** Also, when do you expect to be able to—

[356] **Elin Jones:** It's on all our radars.

[357] **Alun Davies:** Thank you.

[358] When do you expect to deliver these improvements? You say you can't do it overnight, but that means you're going to be failing my constituents this month and next month unless you do deliver these improvements. I'm not prepared to tolerate a situation whereby the people I represent receive a significantly worse service from the ambulance service than constituents represented by others around this table today.

[359] **Ms Myhill:** I think it does depend on the basis on which you're making that judgment. I do have to say that, because there's lots of things that are happening in Blaenau Gwent that aren't happening in any other parts of Wales. There are services that we're providing to the residents and your population that we aren't elsewhere, because we're testing lots of things and lots of services they don't get. If your conclusion is only based on the A8 target, then we are missing a lot of the good things that are happening. That is the point I would make in relation to that.

[360] As far as the rosters particularly in that area, we're talking May/June before we've done the work that we're doing at the moment and to see what we believe the rosters should be. We're working on improvements now. We've halved the level of sickness absence in that area in the last five months. There are improvements happening day by day. We've got to get to a position where all of those things come together, and we are talking months rather than days. But, I'm expecting and seeing incremental changes as we move along. Week by week, there are actions being taken. They're not showing you in that figure right now. I understand why, in looking at that figure, you would make that conclusion. But, it is more complicated and more complex than that.

[361] **David Rees:** I must stop the discussion, because obviously we are wider than Blaenau Gwent. We need to cover the whole of Wales and we have other questions and a timescale going on.

[362] **Alun Davies:** Perhaps we can ask Ms Myhill to write to committee with details of all those other good things that we are looking forward to in Blaenau Gwent.

[363] **David Rees:** Across Wales. Darren has a question—. [*Interruption.*] It's got to be quick because we are short on time.

[364] **Lindsay Whittle:** I just wondered whether you think the figures would be much worse if it wasn't for the fact that many people are taken to hospital by the police and the fire service. In particular, we know that Gwent police—and you know from your previous experience with Gwent police, Mr Giannasi—do a lot of good work in getting people to the hospitals without waiting for the ambulance service, because it'd be too late otherwise. There

are people in the south-east—. Three or four of the regions in the south-east are in the bottom quartile all of the time. I'm beginning to think, in the valleys, we're getting a second-class service.

[365] **Mr Giannasi:** I can perhaps answer that, because I'm currently in discussion with police and crime commissioners and fire authorities on this particular issue. It is a problem. It is part of our capacity issue. If our response times were better, the police would not be called on as frequently to deal with that. The scale of the problem is perhaps not as great as it might be anticipated. There were around about 50 incidents per month in the first half of the year. As the pressure on the service has increased over the winter, it's gone to about a 100. That's far too many. Within that, there are some very serious incidents. There's no doubt about that, and they quite rightly cause the greatest attention. But, most of them are about service. They're about the quality of service that we provide to patients. It does cause significant disruption for the police service. It's a reciprocal problem—the police service has an impact on the ambulance service. We are working very closely together to resolve that. We think around about 35% of those calls are about systems and processes and the way our staff work together. Around about 65% of those are to do with the lack of capacity and, quite often, that's linked to a hospital delay.

14:15

[366] There is a group called the joint emergency services group, which is working through these issues, and there is a series of initiatives. So, for example, there is an initiative in the Rhondda valley, which is about directly linking a police officer at the scene of an incident to a clinician in the NHS Direct call centre, where they can provide clinical advice. Quite often, it's a matter of risk management and expediency that the police choose to convey because they're waiting for the ambulance to attend and they don't have clinical or medical knowledge, which, in itself, is a problem, and they decide to deploy themselves because that is seen to be the most expedient thing to do. So, it is a problem and it has been a problem for a long time. It is being addressed. It is linked to the wider systems issues that we've been talking about, but there is much that we can do, working together, to do that.

[367] There is some really good practice in north Wales, where there is an exchange of staff within control rooms so that they can deal with some of those things at the point of contact—so, as they occur. We are looking now to extend that out. I don't know, Tracy, whether there is anything you would add from an operational perspective. But, it is an issue. It is a problem. It is predominantly in the south-east, and we are working with the police and fire service to try and resolve those issues.

[368] **Lindsay Whittle:** Thank you, Chair. I hope my comments weren't regarded as criticism of the front-line ambulance staff, for whom I have the utmost respect and admiration.

[369] **Darren Millar:** Can I ask you about some of the other barriers to improvement in your performance as an ambulance service? Isn't the truth of the matter that the health boards just aren't pulling their weight in terms of helping the ambulance service deliver against its targets—that they've axed too many beds in the hospitals, which is choking up our A&E departments, causing your ambulances to stack up outside?

[370] **Ms Myhill:** We need to work with the health boards. We can't do this on our own, absolutely. If we were perfect, if all our rotas were perfect and our sickness absence was really low, we still couldn't provide the service that we would need, because we can't do it without the whole system. We are working with the health boards. We are working closely with the health boards. I've come from a health board, so I have that relationship, that history, that experience, which helps. The handover delays that we've talked about are a contributing

factor, undoubtedly, to our ability to put staff on the ground because, when we've got staff, if they are then depleted because they are stuck, that does not enable them to do what needs to be done. But, as to all of those extra pathways that we've talked about, we're looking at direct access to mental health, particularly in Aneurin Bevan and Cardiff, and we've got physicians from emergency departments working in cars with our paramedics to deal with people in the community. All of those extra pathways and examples of initiatives to improve the situation, we are doing with health boards. They are paying for lots of them—

[371] **Darren Millar:** Are they sufficiently engaged?

[372] **Ms Myhill:** From my perspective, and I can only talk from my own perspective, they are engaged with me, for sure. I speak to my chief exec colleagues in health boards many, many times every single week, and we are meeting regularly to deal with this issue. This is a high priority on our agendas, and we are working together across the piece to get into a better place.

[373] **Darren Millar:** Are some health boards more engaged than others?

[374] **Ms Myhill:** There is a variability across Wales, and there's—

[375] **Darren Millar:** Where's it bad?

[376] **Ms Myhill:** There is a variability in terms of the initiatives we've got—

[377] **Darren Millar:** Come on, spit it out. Where's it bad?

[378] **Ms Myhill:** —and there's a variability in terms of the performance.

[379] **Darren Millar:** Where's it bad and where's it good?

[380] **Ms Myhill:** Cwm Taf is exceptional, in terms of being exceptionally good—

[381] **Darren Millar:** Okay. That's why I—

[382] **Ms Myhill:** —in terms of its clinical leadership and its leadership within A&E. We get complaints from our staff that the Cwm Taf people are sending them off too early. So, in terms of real ownership of that turnaround at the door, you absolutely can't fault the practice that we've got there. So, that's an example there.

[383] **Darren Millar:** Where's it bad?

[384] **Ms Myhill:** We have more challenges in Cardiff and we have more challenges in Wrexham, and we are having quite a lot of challenges at the moment in Morriston. Now, part of that is undoubtedly about the type of hospitals they are, the type of patients they see and the tertiary nature of some of the services, but, we are having bigger challenges there in terms of turnaround. That's why we've agreed this handover/turnaround policy that was mentioned earlier. That is going to really help, because that puts teeth into that turnaround process, and I know that, in Cardiff, they are working through that right now: 15 minutes; if it can't be done in 15 minutes, in 30 minutes, they need to physically assess the patient so that our staff feel supported when they're looking after patients. That's happening. I am very optimistic that we are going to see a turnaround in the number of hours that we lose in a positive way.

[385] **Darren Millar:** Isn't one of the other problems the breadth of the work that WAST has to do? So, it's not just the emergency side of the patient transport system; you've also got the non-clinical transport that you're also providing. When are we going to see that

disaggregated from the rest of your work and taken away from WAST, so that you can concentrate on what everybody thinks should be your most important business, which is getting to somebody in a life-threatening situation?

[386] **Ms Myhill:** We're working on a programme of non-emergency patient transport review, which is what you're talking about, really—patient care services, we used to call them. We've got a modernisation project that we're working on right now with our health boards and other colleagues in relation to that, and we anticipate, in September or October of this year, we will have recommendations for how that service will work going forward. I don't anticipate it will be working in the way it has in the past. I don't think the ambulance trust will provide all of those services, but we need to work with our partners to determine the best way to give our patients the most optimum transport when they need it. It is a part of critical care—of their clinical care. Some patients could not get to their appointments because of their situations, without transport. It's really important, but we need to get it right. So, that's where we are on that.

[387] **Darren Millar:** Can I just ask one final question as a point of information? We're told that the number of 999 calls to the ambulance service is increasing year on year, and that that's adding to the pressures and the demands on your service. We've got some figures here, which seem to demonstrate that, from 2012, the number of category A calls to the ambulance service have gone up from 164,861—very precise figures—to just under 171,000. Are they representative of 171,000 incidents or calls? If it's calls, what proportion of those are repeat calls because an ambulance has failed to turn up in the first place within the prescribed time?

[388] **Ms Myhill:** I haven't got those figures in front of me, so I don't want to guess the answer.

[389] **Darren Millar:** Okay. Well, perhaps I can ask the question in a slightly different way.

[390] **Ms Myhill:** I can answer that very specifically outside if you want me to—

[391] **David Rees:** We would be grateful if you could provide details as to the actual numbers. On that specific question, if you could identify the number of calls or incidents that you've received—

[392] **Darren Millar:** Incidents versus calls.

[393] **David Rees:** —and then the number of calls, which may include repeat calls.

[394] **Darren Millar:** Yes. I just wanted to know whether the number of calls is the same as the number of incidents, or whether you are able to track the proportion of calls that come in because they're second, third or even fourth calls.

[395] **Ms Myhill:** We are able to track, and those numbers are different. Not all calls result in a need for a response.

[396] **Darren Millar:** So, are the number of incidents going up or down? The calls are, but are the number of incidents going up or down?

[397] **Ms Myhill:** The incidents are going up as well.

[398] **Darren Millar:** Okay.

[399] **David Rees:** Okay, Darren? Elin?

[400] **Elin Jones:** Yes. There's been quite a bit of service change in the NHS over the last few years, for example fewer neonatal beds in Wales resulting in an occurrence recently in Ceredigion when a woman who became an emergency birth requiring a neonatal bed was transferred down to Carmarthen by ambulance. On the way to Carmarthen, there was no bed in Carmarthen, and no bed anywhere else in south Wales, and the ambulance had to be redirected up to Glan Clwyd. So, you can imagine the implications for that ambulance crew, the level of risk there, and for the woman herself. It resolved itself satisfactorily.

[401] In your paper, you also refer to the elderly frequent callers: the increase of 253% in seven years. Now, people haven't suddenly become much older—that's a long-term trend—but what's changed in the last seven years in particular has been the way that elderly people are looked after in communities. They're far more likely to be looked after in their own home, probably not 24 hours, as compared with possibly having been in a residential home or a community hospital setting previously.

[402] What I'd like to understand from you is: do you see yourself as an organisation that copes with the hand that you're dealt by the NHS and just delivers on what it requires, or do you fight back? When you see that there are service changes in the system being proposed by a health board, do you feel empowered to be able to say, 'Look, this is going to be an unbearable pressure on our service; unless we have the resource to adequately meet that, we can't guarantee that we can do this for you'? I haven't come across that response, on the whole, in the Welsh ambulance service as part of the reorganisation and reconfiguration of services. On the whole, I've seen you accept all of these additional pressures onto your system without really vocalising disquiet over them. It seems to me, especially on the elderly frequent calls that have increased, that you're having to cover now for where the rest of the NHS has changed its policy, and you're carrying these people to A&E unnecessarily.

[403] **Mr Giannasi:** I can perhaps talk more generally over a longer period, and Tracy could talk about some specifics, but I see the shift. If you'd have asked me the question 12 months ago about the support that we had from local health boards, diplomatically, I may have given a different answer. There has been a sea change, driven through the ministerial reform programme, the McClelland review, and there've been the new commissioning arrangements, so we're in a fundamentally different place. It isn't as lonely as it was; we are working together. Part of that has been a much greater willingness by local health boards to engage the ambulance service right upfront, when change is considered, in the consultation about the negotiations. Quite often, some of that can be managed through existing resources and can be, you know, about service change and the way that we configure ourselves, but, sometimes, there is a cost to that. What the new commissioning framework does is it gives us, very clearly, the means by which we can start to address that, and that's increasingly a feature of our discussions.

[404] We have been seen as the problem. The ambulance service has been seen as the problem for a long time. There is a change now that sees the ambulance service as part of the solution. There is so much more that we can do to act as the bridge between communities and the static health service, to improve the services we provide. So, we're increasingly looking at the range of skills and clinical tasks that our staff can do in order to keep people at home. We are looking at how we can take people onto alternative pathways. In our integrated medium-term plan, the vision is based around being that connecting service that provides the right care in the right place at the right time.

[405] So, you know, we are part of the pressures in the system. We are affected by them, but, you know, it is no longer the case they're imposed on us. Sometimes, we have to cope with them and we have to subsume them, but it is now much more of a negotiated position, and I think there's a shared understanding of the challenges. I don't know whether you

would—.

[406] **Ms Myhill:** I'd just support that. We're a statutory organisation in our own right. We have our own accountabilities. We can't just 'be done to'. I wouldn't accept that. I wouldn't be able to accept that. I would have to make the noises that needed to be made if I thought something was happening that we just could not respond to. The door is open for us with health boards, with all of the service change across Wales. The key for us as a one-Wales organisation is to make sure we are locked into those debates in the appropriate places at the appropriate times, and that's a challenge for us. There is one of me but there are seven health boards, so it's about how we make that happen. But, certainly, the door's open, and on the specific changes that are happening, we are part of implementation plans and groups. We are part of the groups that develop the plans. So, we are a fundamental part of that, because some of the changes won't happen if we can't—

[407] **Elin Jones:** Have you ever said 'no' as an organisation?

[408] **Ms Myhill:** If we can't do our part of the bargain, they can't happen, sometimes. We have to be in there.

[409] **Elin Jones:** Yes, you have to be in there, but have you ever said, 'No, we can't do it this way. We'll have to do it a different way'?

[410] **Ms Myhill:** I've not been a position where I've needed to do that, but I would if I had to.

[411] **Darren Millar:** Could I just take issue, Chair, with what's being said? There's been quite a controversial proposal in north Wales in respect of maternity services, which emerged on the horizon less than a month ago. I know that there were no discussions whatsoever with the Welsh ambulance service prior to the health board making a decision, within a period of up to 6 April, that they were going to withdraw consultant-led care and require the ambulance service to ferry pregnant mothers, in life-threatening situations for them and their babies, from Glan Clwyd to either Wrexham Maelor or Ysbyty Gwynedd. You're telling us on the one hand that you're fully engaged prior to all these decisions, and that you're part of the planning for them before they're made, and, yet, I know that there were no discussions, because the health board has told me and confirmed that there were no discussions, and that it's only recently been discussing these issues with you.

[412] **Ms Myhill:** I personally was involved in discussions before that went to the board. So, I absolutely know—

[413] **Darren Millar:** From when?

[414] **Ms Myhill:** With Betsi. With the health board—

[415] **Darren Millar:** From when?

[416] **Ms Myhill:** Before the board took a decision that they needed to make emergency changes, I was involved.

[417] **Darren Millar:** From when? When? How far in advance?

[418] **David Rees:** Can I stop you at that point?

[419] **Darren Millar:** No, it's very important.

[420] **David Rees:** Darren—

[421] **Darren Millar:** Just one second. Chair, this is very important. We're told they're involved in the planning processes and in the detail prior to things arriving at the board. I was told before; 24 hours before. How much notice were you given? Was it sufficient notice for you to have proper discussions within your organisation about planning for any service change?

[422] **Ms Myhill:** I think that—

[423] **Darren Millar:** We need some information—

14:30

[424] **David Rees:** You've indicated that you were involved in the discussions. I think, if you write to the Member to inform him of the details of the dates, that'll give the information—

[425] **Darren Millar:** The chief executive can answer now, Chair.

[426] **David Rees:** The chief executive may need to check her diary to make sure she's accurate.

[427] **Darren Millar:** Oh, come on.

[428] **David Rees:** So, if you would, write to the Member to inform him clearly of the dates you've identified.

[429] **Alun Davies:** Actually, can she write to the committee, because I'd like to know that?

[430] **Darren Millar:** Hear, hear.

[431] **David Rees:** Yes, okay—to the committee, in that case, and we'll make sure that the Member has it.

[432] **Ms Myhill:** Okay.

[433] **David Rees:** Time is catching us up, and I'm going to take advantage with one last question. You very much talked about symptoms and said you didn't want to address the symptoms, but find the causes. Do you now believe you've identified all the causes so that you are starting to address the issues, so, in the future, when we look next winter time—because the summer's coming and there's a natural expectation that things will improve over the summer—we're not going to see another deterioration, because you've actually started addressing the causes, as you've identified them, and you've addressed all the causes?

[434] **Ms Myhill:** I think we understand what the causes are. I think we're clear about the causes that are influencing where we are. We've talked a bit about some of them today: the issues of demand, the rise in demand, the different type of demand that's putting pressure on the system, and our issues around staffing and the fact that our staffing rotas don't match that demand, and we lose staff for handover or absence. So, we're quite clear about what the issues are that we need to solve.

[435] We need, as I said at the beginning, to change our relationships, change the way the organisation runs, and we need to look at how our clinical response model works: how we

deal with the calls, how we despatch our vehicles, and we need to move much more upstream to reduce the demand that we've got on our service in the first place. All of our focus is on how we respond to those calls. We want to get to the position of asking is it the right call in the first place, and can we reduce calls to make sure we're responding to what we need to? So, we are clear about the diagnosis, and we have action in place against all of those issues, one way or another, either ourselves, ourselves with the health board, or ourselves with the health board and the Government. So, I believe we know what we're trying to do, I believe we know what needs to be done, and I believe there are actions in place to make progress against them.

[436] **David Rees:** So, there should be no identification of any new causes, in that case.

[437] **Alun Davies:** Could you possibly write to us with your action plan over the next year, giving us deadlines, timescales and your expectation of when you expect to reach targets?

[438] **Ms Myhill:** I can certainly share our plan for next year. Bear in mind I can share our trust plan. There is an integrated piece of work here with health boards, clearly, but, yes, I can share what we're doing and when we're doing it.

[439] **David Rees:** [*Inaudible.*]—target timescales.

[440] **Ms Myhill:** Yes.

[441] **Alun Davies:** You've given us an assurance now. I'd like you to give us that in writing, so that we can hold you to account for delivering on that.

[442] **Ms Myhill:** I've given you assurance that I believe we know what the issues are and we've got action plans in place to improve against them. Yes.

[443] **David Rees:** Yes.

[444] **Alun Davies:** We need to hold you to account.

[445] **David Rees:** The chief executive has indicated that. If you would also write to the committee indicating the information for Darren Millar with regard to the discussions you had with Betsi Cadwaladr—

[446] **Darren Millar:** And the calls versus incidents, Chair.

[447] **David Rees:** And the calls, yes, thank you. And clarification on the number of calls versus incidents, even though you did tell us, but just for confirmation.

[448] **Ms Myhill:** Yes, okay.

[449] **David Rees:** Thank you. Time is actually up. We extended the time to a bit longer than we had, as Members obviously wanted to take some points further, clearly. Thank you very much for the evidence, which has been very helpful. You will receive a copy of the transcript for any factual inaccuracies you may wish to identify. Please let us know if there are any as soon as possible.

[450] **Ms Myhill:** Okay. Thank you very much.

[451] **David Rees:** Because of the timescale, I'm not going to go to a break. I'm going to move straight on to finish off at the same time. If you want to nip out for two minutes—

We're going to move straight on. Therefore, we are still in public.

14:34

**Ymchwiliad i Berfformiad y Gwasanaethau Ambiwylans yng Nghymru: Sesiwn
Dystiolaeth 3
Inquiry into the Performance of Ambulance Services in Wales: Evidence
Session 3**

[452] **David Rees:** Can I welcome Adam Cairns, chief executive of Cardiff and Vale University Local Health Board? Good afternoon. And Alison Williams, chief executive of Cwm Taf University Local Health Board. Obviously, Adam Cairns also leads on the unscheduled care across Wales for the health boards. Thank you very much for coming. As we've given other witnesses a couple of minutes to make any brief opening remarks they wish to make, I'll give the same to you.

[453] **Mr Cairns:** No, we just think we should just get straight into questions.

[454] **David Rees:** Fair enough. In that case, we'll go straight into questions. Lynne first.

[455] **Lynne Neagle:** Thanks. Can I just ask why things are so good in Cwm Taf in terms of ambulance handovers and why they're so poor in Cardiff and the Vale?

[456] **Mr Cairns:** I'll lead off. So, the situation in Cardiff is: the two hours before I arrived here in this Assembly building today, we had 20 ambulances turn up in our department, 10 of which needed to be resuscitated. So, to put that into context, the number in Cwm Taf is between 35 and 40 over a 24-hour cycle, so we're talking about very different organisations. In Cardiff, we have a population that's growing, so we've got about 100 people a week being added to the population that we serve in Cardiff, and, on top of that, we also provide, and are doing so at an increasing rate, services for a much bigger catchment than our own population. For example, if somebody has a heart attack these days, they go straight into the Heath, they don't go to the local hospital, and for some kinds of stroke treatments and lots of the cancer treatments. So, what's happened to us in Cardiff is that all of those factors have come together, and then we have a big spike in our over-85-year-old admissions, which occurred at the back end of last year. We found ourselves in a position where we were clearly not delivering what we needed to do.

[457] We've been working very closely with WAST and other partners—the local authorities—and since the beginning of February, we're seeing significant—significant—improvements in our handover performance. We've halved the handover performance in February compared to the month before and the February the year before, and the trend is continuing this month. So, this month there have been penny numbers of hours lost and that's been brought about by a whole load of work, which, if we've got time, we can talk about, not just at the interface between the accident and emergency department and the ambulance, of course, but looking at pathways for people outside the hospital. Only 60% of people who call an ambulance now in Cardiff actually come to the department, because we've figured out a whole new way of getting people appropriate treatment in other settings. So, there's a whole range of things we have done and are doing.

[458] As of last week, one of the jobs I was given by my colleagues was to lead a process to agree a handover policy, and that was endorsed by all my chief executive colleagues a couple of weeks ago. That was issued for implementation last Friday, and that will help. That's going to add further impetus to the improvements we're already making.

[459] **Lynne Neagle:** Are you confident that this handover policy is going to be adopted consistently across Wales by all the health boards?

[460] **Mr Cairns:** I am. One of the things that I have done over the last six weeks, as part of the role I undertake on behalf of the collective chief execs, is that I have visited every single health board with a team comprised of people from Public Health Wales, from 1000 Lives and from the ambulance service, so that we could eyeball all the people in each of the health boards and ask them to take us through what they're doing and how they're doing it. There's quite a bit of learning that we've elicited from that process, which we are going to share shortly, and also some lessons learnt. We're going to loop back round in a couple of months' time to do that consistency checking piece and to see whether or not the good practice that we've identified, wherever it's been located, is being adopted.

[461] **David Rees:** Can I just clarify a few points? You said the two hours before you came in, 20 ambulances had turned up. That's during those two hours.

[462] **Mr Cairns:** Yes.

[463] **David Rees:** Therefore, and it's not a flippant comment, but I can assume that all those 20 ambulances have also now been released.

[464] **Mr Cairns:** As I came into the Assembly building, one ambulance was held up, and there were another couple that had just arrived, but they had been released.

[465] **Lynne Neagle:** Can I just add: how many of those ambulances were, sort of, from Cardiff and the Vale, and how many had come from Torfaen, Blaenau Gwent and other places outside Cardiff?

[466] **Mr Cairns:** I haven't got those details. All—

[467] **Lynne Neagle:** Can you write to the committee—

[468] **Mr Cairns:** I can certainly do that. I mean, it's a sample of two hours, that's all it is, and I mention that simply because it's really important—. You know, as I've gone round looking at the various different systems in Wales, our experience in Cardiff and the way in which the difficulties that we've been experiencing manifest themselves is clearly very different to how it looks in Powys or in Hywel Dda. There are different circumstances operating in different bits of the system, and no one size is going to fit all. So, it's in the detail of local services working with local communities that we're going to resolve this problem, not some silver bullet that we invent. It's going to be right down in the detail. One of the things I want to say is that you can be assured—you can be very assured—that, in every single case, each health board, together with its local authority partners and WAST are busy, engaged, and at it on this issue.

[469] **David Rees:** Thank you for that. Just so that you know, when you do give examples, you can expect to be quizzed on those examples.

[470] **Mr Cairns:** Yes, that's fine.

[471] **David Rees:** Elin.

[472] **Lynne Neagle:** Alison hasn't said about Cwm Taf.

[473] **David Rees:** On this particular point?

[474] **Lynne Neagle:** No, I asked the question to the two of them.

[475] **David Rees:** Sorry; yes, Alison on Cwm Taf.

[476] **Ms Williams:** If we think about it, the whole A&E and ambulance handover challenges are not the cause in themselves; they're a symptom of a whole system that needs to be aligned. If I look at the Cwm Taf position, we've been working on this very hard for the last two or two-and-a-half years. It's not just about your processes at the front door, it's about the whole of the hospital system. It's about understanding demand, it's about understanding how your hospital works, it's about the leadership, and it's very much about the back door as much as it is about the front door of the hospital. So, it's having the ability to predict your demand, to know what capacity you need to meet that demand, and to have the clinical ownership, then, of the system throughout the whole hospital, not just in the A&E department.

[477] As Adam has said, this is something that is different in every hospital, because the type of patient that arrives at the front door is very different, but actually there are very common themes. One of the real strengths of the work within the health boards in Wales is how we're sharing that. The lessons from Cwm Taf have been shared very widely with health board colleagues. Where they're applicable, they are in different stages of being implemented. Some of the improvements that Adam has described recently in Cardiff very much align to some of the work in Cwm Taf. So, we are sharing that good practice, but it has to be horses for courses. If you ask me what the key thing is here, it is the staff ownership in the hospital of patient care and safety throughout the whole system. That is something that, very positively, we've all been working on and we're seeing the benefits of.

[478] **David Rees:** Can I clarify one point? Do you keep data on the number of ambulances that arrive at your A&E departments for the year?

[479] **Ms Williams:** Yes.

[480] **David Rees:** It would be interesting, actually, to see those. When we talk about turnaround times and things, it would be interesting to see how many arrive at particular hospital sites.

[481] **Ms Williams:** Yes.

[482] **David Rees:** Adam Cairns, do you do the same thing?

[483] **Mr Cairns:** Absolutely, we've got those numbers.

[484] **David Rees:** Could you provide the committee with, perhaps, the last month's figures, for example, how many arrived over the last three months?

[485] **Ms Williams:** Yes, I'd be very happy to provide that.

[486] **Mr Cairns:** Yes.

[487] **David Rees:** That would be very helpful for us; thank you.

[488] John, on this particular point?

[489] **John Griffiths:** Yes. I think Adam described a situation where there had been these queuing ambulances at the Heath in Cardiff, and we know that there are particular problems there compared to other parts of Wales. You mentioned the big, and growing, population in

Cardiff and some of the particular issues that may apply to the Heath that do not apply elsewhere, growing numbers of 85-year-olds with complex health needs, and so on, and now measures are being put in place to improve that position and seem to be bearing fruit. But, to me, it begs a question, really, in terms of the role of the chief executive to be forward thinking and to plan ahead, so that you don't wait until this situation comes about and creates great problems for patients and others. Cardiff has been a capital city for a long time; it has had a big population for a long time; it's had a growing population for a long time; and the demographics of an ageing population have been forecast for a very long time. So, where was the forward thinking, where was the planning ahead to prevent these problems arising?

[490] **Mr Cairns:** I think that's a fair question, of course. The reason for mentioning Cardiff is that it's not so much to single Cardiff out, it's simply to say that each health board has its own unique challenges. So, down in Hywel Dda, there's one A&E consultant trying to cover four different A&E departments. Now, that's a very, very different set of challenges than the challenges we face in Cardiff, but, nevertheless, it is the case that, in a resource-constrained environment, the fact that our population is accelerating—so, we've got, as I said, 100 people a week being added to our population in Cardiff—that is undoubtedly going to cause us difficulties in terms of shaping a response to that that evolves in pace with the demands that population will reasonably put upon us. So, we are planning ahead.

14:45

[491] One of the issues that we might touch on later is the south Wales plan. There's another set of dynamics in play between health boards, looking at how the shape of services across south Wales needs to change to better reflect the way in which the scarce resources we have can be focused to best effect. Those changes are very much something that we are aiming to put into place to help us to deliver against some of those changes that we're talking about.

[492] **John Griffiths:** You're planning ahead now. So, was there planning ahead previously?

[493] **Mr Cairns:** Absolutely. So, we've put huge amounts of—. If you go back three years, we put huge amounts of resource into our community resource teams, we have changed the way that our out-of-hours service works, we've invested in more out-of-hours services, and we've changed the way that all of our GP practices work so that they're open all day, every day, through into the early evening. There's been a whole host of changes that we've been making. The issue for us is—and I'll be very candid about this—the pace at which we've been evolving hasn't been fast enough, and it's very clear that the circumstances that are at our door, literally, at the moment, are, I suppose, indicative of a system that has not managed to evolve fast enough. I can tell you that we're not focusing on very much more than finding even more ways of managing this situation, and what I can say to you very clearly—and I have to set this out for you in a note—is that on that one particular measure, one which people I know are very concerned about—the handover delay—there is a steep decline in the experience of patients in that situation. That's because we're putting our full effort behind dealing with that problem.

[494] **John Griffiths:** I think a note would be useful; these problems have existed for a long time, and it does beg the question as to what's been happening up to this point.

[495] **Mr Cairns:** I don't want the committee to think that we've been standing by spectating and just wringing our hands; we have been designing radically different solutions over the last two or three years. I think, if you look right across all of the health economies wherever you are in the western world, they're all experiencing many of the same pressures, and no-one has got exactly the right formula—if it existed, we'd be implementing it—and

we're all investigating our own circumstances and looking for the right ingredients at a local level to make sure that we can adapt and change at the pace we need to.

[496] **David Rees:** Thank you. Elin?

[497] **Elin Jones:** To follow up on that theme, you're not only not moving at pace with change; in fact, it could be said that you've been going in reverse gear. If we look at the statistic we've been given today, there has been a 253% increase in elderly frequent callers in the last seven years to the ambulance service. That's not because people have suddenly become much more ill or much older in the last seven years; it's because there's been a change of policy in how elderly people are being cared for, and they're far more being cared for in their own homes. There's been a reduction or a cut of community bed settings that were used as a means of looking after elderly people in the community, rather than in acute hospitals. So, paramedics are being called out, in the middle of the night quite often, by emergency-button ambulance calls to take care of that emergency call, and very often they feel at such a risk that they need them to transfer those individuals to an A&E setting as well, although it may be that it's inappropriate. We heard Siobhan McClelland earlier on say that they needed to look for elderly care centres as an alternative to A&E transfer. Well, elderly care centres sounds a lot like a community hospital, almost, to me. So, what I wanted to ask you is that, as you are preparing for next winter and the winter after in your unscheduled work, how are you providing these elderly frequent callers with sufficient 24-hour care to enable them not to be as frequent callers?

[498] **Mr Cairns:** So, there's quite a lot in that question. I'll be brief. The community of people that you're addressing are the—. If we can agree that we're talking about the frailest and the oldest; we're talking about that group of people.

[499] **Elin Jones:** Yes.

[500] **Mr Cairns:** The model that the health service, across the UK, has used for many, many years is to effectively hospitalise those patients and to treat them in hospital. The evidence is that that's probably not the right thing to do for many of those patients because, when the patient turns up at the A&E department, the staff there don't know what 'normal' for Mrs Jones is. All they can see is a frail old lady with lots of things going on, and what happens is we then admit and that patient will then have all the things that were wrong with them yesterday treated, plus—

[501] **Elin Jones:** I understand all that. I'm not speaking against the policy. I'm actually asking you to explain to me how you then provide enough care for that cohort of repeat users of the unscheduled care system, so that they don't become the frequent users of the ambulance service.

[502] **Mr Cairns:** Yes. So, the point I was trying to make was that, in order for us to respond, we've got to have a better understanding of who those people are, where they live and what their current circumstances are, and we need to have that rooted and based in locality—so, our locality teams, based around GP practices, understanding their local community and their patch, using the district nursing service, the community resource teams. In the Vale, we've now got a communication hub that knits all this together right across the health and social care setting, and I think that is something that we hope we'll be able to do for the whole of Cardiff. If we can do all of those things, we've now got on the pitch—. In the last two years, we've put out new services, so there's an elderly frailty service; there's the EASC service that Professor McClelland was talking about. A whole range of new services for older people that are aimed at sustaining and maintaining those people at home, which is where they need to be, many of them, not in hospital.

[503] **Elin Jones:** So, that 253% increase; we're going to see a decrease then at some point.

[504] **David Rees:** Alison wanted to comment as well.

[505] **Ms Williams:** Perhaps I could add to that. We know there's a lot of evidence that says that hospital is often the worst possible place for the frail elderly. And, if I take my own experience in Cwm Taf, over the last two winters, we have not put additional surge beds into the system. What we've done is put bed equivalents into the community. So, we've significantly increased our joint rehabilitation teams with local authorities; we've put additional therapists and volunteer services at the front doors of our hospitals, and we've looked at a different model of assessment, because often, even bringing these people to A&E for assessment is not the right place. An A&E department is not the place on a Saturday night for a frail elderly person. So, we've got to have a system whereby we can assess them if they have a fall—because that's often the common presentation—in the community, and then we wrap care around them wherever they are. So, the shift has to be around those bed equivalents in the community. And we have got evidence of pockets of that working very well across Wales. Part of the work that Adam referred to earlier is sharing that learning, so that the things that are working well in one place are perpetuated throughout the whole system. But we have got very clear examples of where beds have been reduced and community alternatives have been put in place, admissions are reduced and the quality of care and the outcomes for patients are better.

[506] **Elin Jones:** We used to call them community hospital beds in Ceredigion, until we lost 75% of them over the last three years.

[507] **Mr Cairns:** Just to answer your last question, if I may, just very briefly. All of the things I was saying—. Your question was 'So when's it going to get better?' So, as a result of those measures, there are now fewer people over the age of 65 being admitted to our hospitals in Cardiff and the Vale. There are fewer people being admitted from nursing homes and there are fewer people with long-term conditions being admitted and readmitted.

[508] **David Rees:** Okay. Alun.

[509] **Alun Davies:** I wanted to come back to the points that you made in reply to John Griffiths. You said that there was a significant reduction in handover delays taking place. I presume you mean at the moment, because, historically, over the last few years, we've seen a significant increase in handover delays, from 6,000 or 7,000 lost hours to 40,000 lost hours last year. So, I would be interested to know when you expect to be able to reduce that back to 2008 levels.

[510] **Mr Cairns:** Well, I'm not in a position to say what the all-Wales position on that is going to be, because, at the moment, I haven't got a line of sight to what all the health boards are doing in detail. Part of the reason for the growth in Cardiff is that we went through a phase where we were renovating our A&E department. It's very difficult to do that when you've got a busy department and a third of the department is closed at any one time. So, that's part of our back story.

[511] What we are focusing on now—. The conversation that I left this morning, and that I'll return to when I finish here today, is about getting patients the right treatment in the right place, and the right place is not in the back of an ambulance; they need to be in the department. That's the conversation that we're having inside the hospital, and we're not talking about handovers in our organisation—and I'm sure in lots of others as well; we're talking about the right care. We're trying to change the frame, I suppose, that we're putting around this and I think, with some success. I hope that, as the figures start to be reported back—and I can only speak in this case for our own organisation—you will see that those

delays are falling.

[512] **Alun Davies:** But when?

[513] **Mr Cairns:** I haven't got in my head exactly what it was in 2008 for our organisation.

[514] **Alun Davies:** It was around 6,000 to 7,000 across Wales.

[515] **Mr Cairns:** Across Wales?

[516] **Alun Davies:** Yes.

[517] **Mr Cairns:** Yes, as I say, I can't give you a response for across Wales, because I haven't asked the health boards, in my role as a co-ordinating chief exec, that specific question, but I'm sure that's something that we'll all be focusing on.

[518] **David Rees:** What's your target, then, for this year?

[519] **Mr Cairns:** Our target this year is to improve to the point where we will be regarding all patients on—. Our local target is that, if you're in the ambulance for longer than 30 minutes, we are going to be regarding that as an untoward incident, and our goal is to not have untoward incidents.

[520] **Alun Davies:** My concern is that this happens across Wales. Clearly, my constituents are served by the Heath, but also by Nevill Hall and by the Royal Gwent as well, and we've seen some really very difficult issues, particularly in the Royal Gwent, possibly. So, my concern is that the learning that you are debating and discussing in the Heath is actually shared across the face of the country.

[521] **Mr Cairns:** One of the things we're about to do—. I chair an unscheduled care programme board, and it was the programme board that suggested that we do this visiting process that we've been doing. We're about to write up all of our learning. We've got one more visit still to do. And when we've done that, there will be a very clear story about where we are and what the practices are across the piece. I can say now that one of the themes that really comes out very strongly is that we need to do something at an all-Wales level about the market for long-term residential and nursing care. We are littered with small providers at the moment, often in poor accommodation. We need to do something different, because we are not in balance in that part of our system at the moment and we are going to give some thought to how we manage that differently. If we do that—and as Alison was saying, the backdoor is probably even more important than the front door—that will help us.

[522] **Alun Davies:** I accept that and I accept the wider point you make about that level of care and that particular part of the sector. I accept that and I think that's something that, as a committee, we have significant concerns about. However, we are where we are today and we know that this is the situation that we're going to be in for the rest of 2015, I would've anticipated. So, my question is: when do you expect to see significant improvements? How do we hold you to account for delivering on that? You come to this committee and you give us these assurances, but with all due respect, your predecessors have done the same. What I'm anxious to do is to be able to tell my constituents that you've given us an undertaking and that we believe that you're going to deliver on that undertaking. I want to know when we're going to see significant improvements. I want to know what you expect those significant improvements to be. I want to know what your targets are and what your deadlines are and I'd expect you to be able to come back to this committee in eight or nine months and say, 'We have delivered on all of our assurances'.

[523] **Mr Cairns:** I'm not in a position to do that on behalf of all of the health boards, for reasons I hope you'll understand. But I'm sure every health board will be thinking about its trajectory and what it's going to be able to do and by when. We've seen a 6% improvement in our overall category-A performance in the last six weeks. That's got to continue—the trend line has got to go up. So, if you want me to take that back to my colleagues, that's something I can do.

[524] **David Rees:** Perhaps you can write to your colleagues and ask that question, and perhaps you could write to us with your answers.

15:00

[525] **Ms Williams:** Could I just add to that? It is really important that, as you will have heard from other people giving evidence today, there is not an absolute and direct correlation between ambulance handover and category-A performance, because of the complexity of the situation and the factors that our WAST colleagues explained in terms of manpower, in terms of systems. The one thing that it is important that we also understand is that we need the help of the public in this process as well, to be using our ambulance services in dialling 999 appropriately. All of those things will ultimately combine to improve the category-A performance, of which the ambulance handover is significantly and importantly a part. But I wouldn't want you to go away from this committee thinking that there is a direct correlation between the improvement in ambulance handover and the absolute category-A performance, because of the complexity of the complex relationships.

[526] **David Rees:** I think I accept the fact that there's complexity, but I don't accept the argument there's not a direct correlation. There is a correlation, although it may not be the only issue in that correlation.

[527] **Ms Williams:** If I could just—

[528] **Alun Davies:** Can I just read to you the evidence that the ambulance service trust have given us?

[529] 'While there is generally a clear correlation between handover delay and performance against the A8 target in discrete LHB areas, this is not always the case.'

[530] So, the ambulance service are telling us that there is a clear correlation, but they accept that, at times, that is not always the case. I have to say to you, Mrs Williams, in both the previous sessions, the witnesses have been very clear that handover delays are a significant issue that they face in delivering against targets.

[531] **Ms Williams:** I wouldn't disagree with that at all; I just wouldn't want you to think there was an absolute and direct correlation between the two, and I speak for—

[532] **Alun Davies:** So, what's the difference between 'absolute and direct' and 'clear'?

[533] **Ms Williams:** Well, if you take the Cwm Taf position as a clear example, we have the best ambulance handover performance; we have the poorest category-A performance. So, I just want that to be clear, that it's a very significant contributory factor—I would absolutely agree with that—but the whole issue about the whole system, which is demand, the alternative ambulance pathways, the way that we're utilising our paramedic services, they all contribute towards the category-A performance, not just the ambulance handover. It was just to make sure that that point was properly understood, and if you look at the Cwm Taf data, they bear that out.

[534] **Alun Davies:** So, the ambulance service are wrong.

[535] **Ms Williams:** No, no; they're not wrong.

[536] **David Rees:** I think the point has been made, and we clearly have the information from the ambulance service, and there's not quite a clear joining up of thinking, but we understand the point. As I said to you, I believe there is a correlation. I understand your point, because the correlation might be slightly different—some of the ambulances you would have in your area, coming back to you, may be held up in delays in other places.

[537] **Ms Williams:** Sure.

[538] **David Rees:** So, there is, in a sense, a correlation, but that may not be directly with the nearest hospital, for example. But, on another point, you gave us an indication of the handover times and that work being done; of course, you're both members of the emergency ambulance service committee, which agreed on this. I'm assuming you're all signed up to the issues, so you must have some idea, as a collective, as to what targets you're hitting and by when.

[539] **Mr Cairns:** The thing is that, if we knew exactly what all the things were that needed to be done to fix this problem, we'd do them. There are so many moving parts—

[540] **Alun Davies:** That's what you're paid to do.

[541] **Mr Cairns:** Well, can I—

[542] **David Rees:** Alun, let Mr Cairns finish.

[543] **Alun Davies:** [*Inaudible.*]

[544] **Mr Cairns:** Yes. So, look, I could hazard a guess. We could all hazard a guess at what we think is driving demand. When we ask the question of our public health colleagues, 'What's driving demand?', we get a 14-page document full of all the detail of what is driving demand, including a whole range of things—education, the way people lead their lives, the way that society works. There's a whole load of stuff in there that is fuelling healthcare demand. If we're going to fix this problem, we don't fix it on a pivot between an ambulance and an A&E department. That is not going to give us the answer. The way to fix this is right up and down that whole care continuum. So, there are lots of things that we can do and are doing. What I'm trying to work out in my own organisation is, given that we're throwing everything we can think of at this problem, what are the particular initiatives that we're taking that are having the biggest effect.

[545] I'll give you an example. Some months ago, we were looking at the pattern of admissions from nursing homes, and we discovered that there were 20 nursing homes that appeared to be sending us more patients than seemed reasonable. So, we sent a team in, we had a look, and one of the things that was happening in the nursing home, depending on which shift a particular nurse—just one member of staff—was on—. That particular nurse would be more inclined to call an ambulance if somebody fell. So, the answer to that particular problem is that we've gone in, we've delivered hoists, we've done training and, in those 20 nursing homes, those calls have now fallen. But I could multiply that up by a hundredfold, because the detail here—it's in the detail that we get solutions. It's not just, 'Have a go'. We've got to understand it to be able to fix it, and that's why it's difficult—it's difficult to give you the kind of direct timeline that you are looking for. I can commit to, and I do commit to, continuously improving it from this point on. That's what I'm going to do.

[546] **Alun Davies:** I accept all of that, but the point I'm making—

[547] **David Rees:** Alun, I'm conscious of the time and we do have to move on. Darren.

[548] **Darren Millar:** Can I just ask a question? Why are we looking and searching for different solutions when we've got very similar ambulance services in Scotland and England? Why don't we look to them for the answers that they've implemented, the solutions that they've implemented, that have worked? And, if they've got solutions that haven't worked, don't repeat them over here on a pilot basis.

[549] **Mr Cairns:** Wales is a small country with a big geography, and—

[550] **Darren Millar:** As is Scotland.

[551] **Mr Cairns:** As is Scotland. There are differences. As a committee, one of the things we're looking at is—we call it benchmarking, but it's comparing. So, visiting: we've got a team going up to the Highlands to have a look at what they do up there and are there are things that they've got that we haven't. One of the things we've noticed is that, in Scotland, there is much more use of what we call telemedicine, so there's much more—. And that's because there are many more islands in Scotland so they've had to deploy that technology. We haven't got that same problem, but could we repurpose that kind of thinking to our situation here in Wales? Probably. So, we'll have a look at that. So, we are looking at all of those things, Darren. What we understand is that, even within Wales, if we were to take a solution that worked in Cwm Taf, exactly as it works in Cwm Taf, and take it to Cardiff, it wouldn't work, because our circumstances are different. Some of the elements might look the same, but how they work would probably need to be different, because the way that we work with our GPs is very different to the way they work in Cwm Taf. Our out-of-hours service is very, very different to the out-of-hours service in Cwm Taf. So, we have to make sure that our responses are tailored to our local situation.

[552] **Darren Millar:** I mean, there are only seven health boards, for goodness' sake. Why can't you get more consistency so that, if something is working somewhere else, it's rolled out in the neighbouring health board?

[553] **Mr Cairns:** That's exactly why we're doing this set of visits—

[554] **Darren Millar:** We've got a population of 3 million people. It can't be rocket science to repeat things that are working elsewhere in your own health board.

[555] **Mr Cairns:** Exactly. I took up this role about six or seven months ago. What we're doing is we are investigating, if you like, what each of the health boards is doing and what they think is contributing to their solution, what's driving their particular circumstances. We're writing that up. We've got one more visit to do. I'm happy to send the committee a copy of our report when it's produced. That will contain a set of lessons, if you like, that we are learning across the system, and it will also identify where there are good practices that we believe people should be adopting and implementing. So, that will be part of the process that we're following.

[556] **Darren Millar:** So, what's the timescale for the publication of your report?

[557] **Mr Cairns:** We've got one more visit to do this month. We're just trying to pin the date down for that to happen. I think it's now on 27 March. We'll probably need two or three weeks to write it up. So, I would have thought that, by the end of April, we should have something ready for publication.

[558] **Darren Millar:** And there'll be some timetable then for when you hope the recommendations in that will be implemented?

[559] **Mr Cairns:** So, the process that we would aim for is that I'm going to take that to my chief exec colleagues, we will look at that and endorse it and then I'm going to loop back round with my colleagues' support over the course of the following quarter to see where we are.

[560] **Ms Williams:** If I can just add to that, to be fair to Adam, we're not waiting for the report because, where there are key things that are coming out as good practice and that are easily adoptable, those are rapidly being taken through each of the individual health boards.

[561] **Darren Millar:** So, why have we had two record lows in ambulance performance? If all this good work is going on, if you're all committed and engaged as chief executives, if the health boards are doing everything they can to turn the ambulance service performance around, why have the past two months of published performance been the worst since records began?

[562] **Mr Cairns:** So, there's a whole series of factors that are driving that particular position. I have outlined some of them. What we know is that we haven't turned the corner. So, we haven't got on top of the things that are fuelling that demand in our system. What we have done is: we've circled the wagons and we are now thinking through a whole range of new approaches to this problem, which are going to have to be far more creative and much more imaginative because, clearly, all the work that we're doing—it's not that we're not doing things but we haven't been able to move this as fast as we want to. Now, there are elements of this that are to do with individual organisations and each organisation's got to play its full part. So, you know, local authorities, WAST, ourselves as health boards, we've all got to play our full role in this—and the independent sector for that matter.

[563] **Darren Millar:** But, of course, you are members of the board that the emergency part of WAST is accountable to. Yes?

[564] **Mr Cairns:** Yes.

[565] **Darren Millar:** Okay. So, you hold the purse strings.

[566] **Mr Cairns:** Yes, we do.

[567] **Darren Millar:** You commission the services. Are you therefore telling us that you're not commissioning the right service? Because they did complain about resources earlier on. They said that resources was one of the issues. That's what the chair of the board said. So, are you going to give them extra resources this year to help meet demand?

[568] **Ms Williams:** If I could try to answer that for you, Cwm Taf is a bit of a barometer of the system. Because the handover rates have been consistently very good in Cwm Taf over the last 18 months, it's a fairly good barometer of the system. What we've agreed with WAST is that we are going to take a different pilot during the month of April. It's going to be multifaceted, but there are two key components of this. One, we're going to implement and return to footprints protocol with them, and I think this is a question that—

[569] **Darren Millar:** What's a footprint protocol?

[570] **Ms Williams:** So, a Cwm Taf ambulance that goes out of Cwm Taf—and I think this was in response to Mr Davies's question earlier—that then is available for the next available

call and maybe, if they've taken a very sick patient to Cardiff, doesn't come back to Cwm Taf: we're going to operate a pilot system where they will come straight back onto the Cwm Taf footprints when they're released and then be available. Because we did that for 48 hours.

[571] **Darren Millar:** So, they'll be considered out of service while they travel back, effectively.

[572] **Ms Williams:** Unless there is an absolute life-or-limb call. We did that for 48 hours as a quick trial and we got the ambulance response time up to 63% in Cwm Taf.

[573] **Darren Millar:** So, why aren't you just doing it?

[574] **Ms Williams:** We have to do it because we've got to balance the system. So, the work that's been done in Cardiff and the work that's been done on the re-rosters will all be completed by the end of March, which will enable that to safely be put in place. The other thing that we're going to look at is how we manage the offload of elderly people. I'm a nurse; I trained a good many years ago. You didn't used to take an elderly very ill person, not an injured person, into the A&E department. You took them into an admissions unit, and you staffed that differently. So, we're going to pilot that in Cwm Taf. If that works, that is something that we're going to quickly look at how that rolls out across the rest of Wales.

[575] **Darren Millar:** Just to get back to this issue of resources, Mr Giannasi, the chair of WAST, suggested that there was a resourcing issue.

[576] **Ms Williams:** The commitment that we have given through the EASC committee is that, if, when that pilot is conducted, there is evidence that there is insufficient resource within Cwm Taf to meet the Cwm Taf demand, then we have to accept that there is an investment gap there. The issue at the moment is that the operating model's got to be properly aligned so that we can identify if there are any investment gaps. At the moment, with the downtime, with the sickness rates, and with some of the immature pathways, it is very difficult to know how much is improvement that can be achieved through efficiency and how much additional investment can we put in.

[577] **Darren Millar:** So, let me just get this right, because I need to understand in terms of how you release resources to WAST as a committee: you, as individual health boards, bring your slice of the cake to the table. Yes?

[578] **Ms Williams:** We do this on a risk share agreement—on a population-based risk share agreement.

[579] **Darren Millar:** So, you have a formula by which you all contribute to the pot. Yes?

[580] **Ms Williams:** We do. We have, over the last year—the last two consecutive years—provided £8 million additional funding to the Welsh Ambulance Services NHS Trust, and that's enabled them to increase their workforce.

[581] **Darren Millar:** So, you all collectively agree a budget and then the formula distributes that budget to each board to make a contribution.

[582] **Ms Williams:** Yes.

[583] **Darren Millar:** But, clearly, the formula, according to Mr Giannasi, isn't sufficiently resourcing the service at present for its current service proposals or delivery.

[584] **Ms Williams:** Well, this is a very specific task that we've given the commissioner

with WAST to—

[585] **Darren Millar:** Yes. You've not got long to plan, have you? Because the next financial year's going to be upon us soon.

[586] **Ms Williams:** No. It's weeks. What they've been looking at is the resources required and benchmarking that to meet the number of calls, and, at the moment, the benchmark information actually shows that the resourcing is slightly above the average in England and that that is now being tested jointly with the Welsh Ambulance Services NHS Trust. We have made a commitment that, if there is insufficient resource in the ambulance service, we would have to address that.

[587] 15:15

[588] **Darren Millar:** I'm very concerned about this. So, what you're telling us is that next year's finances for the Welsh ambulance service are not yet fixed.

[589] **Ms Williams:** All—

[590] **Darren Millar:** Is that what you're telling us? We're just weeks away from the year-end and the start of the financial—

[591] **David Rees:** Give them a chance to answer.

[592] **Darren Millar:** I mean, how on earth can they plan to deliver a service?

[593] **David Rees:** Darren, give them a chance to answer.

[594] **Ms Williams:** All of the health boards, as part of the three-year financial planning cycle, have to submit a three-year plan. Within that three-year plan, there is a demand and capacity plan, and, on the core resources, which is the historical budget, plus the additional £8 million to the Welsh ambulance services trust, they have already been notified that that money will be provided to them next year. The question is: is there an additional top-up required? That is part of the testing that the ambulance commissioner is doing on our collective behalf, with the benchmarking information with the ambulance services in England, Northern Ireland and Scotland.

[595] **Darren Millar:** But just to confirm on the record: the final budget for next year for the Welsh ambulance service has not yet been agreed. That's what you're telling us, isn't it?

[596] **Mr Cairns:** Darren—

[597] **David Rees:** No, please. Darren has asked a question. You have given a previous answer. You've indicated, if I'm right, that an allocation to the budget has been placed, but additional funding, which may occur as result of the pilots, is yet to be decided.

[598] **Ms Williams:** Yes.

[599] **David Rees:** And that's the current position.

[600] **Mr Cairns:** It's also true to say that if during the year we found there was something fantastic that they could do that we needed to resource, we'd resource it in-year. So, it's not that—. You know, I don't want to give the committee the impression that they're in a vacuum and not sure what they're doing. They've got a very clear set of numbers they're working to. If the evaluation that Alison's talking about proves to do the job, we'll have to put some more

resource in. If we can think of anything else that we need to do, we'll put some more resource in.

[601] **David Rees:** That's clear, thank you. That's clear. I've got a last question from Alun, because our time is up.

[602] **Alun Davies:** I'm quite content with that sort of dynamic managing of the budget. I'm quite relaxed about that. What I'm less relaxed about is the level of accountability, because you're the third group of witnesses that we've seen this afternoon and every one of them has, in different ways, pointed across the way—you know, 'I can't take responsibility for an all-Wales, I can't—'. To what extent, as professionals within the national health service, are you taking responsibility for these matters and to what extent is there a clear line of accountability?

[603] **Mr Cairns:** Well, on the question of the all-Wales position, there is a chief executive of the Welsh NHS and he is accountable for the performance of the Welsh NHS.

[604] **Alun Davies:** I understand that.

[605] **Mr Cairns:** In my role as co-ordinating chief executive for unscheduled care—. We have a number of these roles that each of us fulfils. We take responsibility, on behalf of the collective, for doing pieces of work we jointly agree would be better done collectively. So, that's what we do. Each of us is individually accountable for the health of our local population—that's completely clear—and we are accountable for everything that happens within our organisation. That is also completely clear. That includes, in respect of WAST, that very direct line that we have to our local population and to the ambulance service that provides that service to our local population. We come together collectively to agree, as a collective, how much resource we're going to provide to that contractor. So, I don't think that the accountability's unclear. I think we've got a system that, as Professor McClelland was saying, was a bit slow to get off the ground, but I think it's clear and I think it will begin to grip this much more closely.

[606] **Ms Williams:** If I could perhaps add that, very clearly, the accountability for everything that goes on in primary care and within the doors of my hospital is mine, and handover, flow through the hospital, the culture—everything is my responsibility. I also have a responsibility, as a chief executive, with my commissioning hat on, to commission sufficient ambulance services to meet the needs of my population. That is the responsibility I discharge sitting around the EASC table. When I'm satisfied that the ambulance service has a specification that meets the needs of my population and has the resources it requires to deliver that specification, then the accountability for delivery of that is very clearly ascribed to the ambulance service itself. That is a very clear separation of the accountabilities. As I said in response to Mr Millar's question earlier, the issue is: have we got to do any additional top-up investment in commissioning terms? But, you know, we're talking about at the margins here; we're talking whether there is, you know, a 0.5% or a 1% margin on that. It doesn't stop business carrying on as usual and that is the bit that will be resolved once the pilots are completed.

[607] **David Rees:** We've gone through that; I don't want to open that up again.

[608] **Gwyn R. Price:** Chair, just to finish—

[609] **David Rees:** Gwyn. The very, very last question.

[610] **Gwyn R. Price:** Just to finish, Chair. Adam, you said you were circling the wagons, well, Custer was the last one to circle the wagons, you know, and, we know what happened to

him. So, I want to wish you all the best. [*Laughter.*]

[611] **David Rees:** Thank you for attending this afternoon.

[612] **Ms Williams:** Thank you.

[613] **David Rees:** As you appreciate, it's a very important topic for many of our constituents across Wales.

[614] **Mr Cairns:** It is, yes.

[615] **David Rees:** I think Alun's highlighted Blaenau Gwent several times this afternoon, but, actually, this affects every single Member in the Assembly, and therefore thank you very much for the evidence on that. We have a very deep passion for our constituents. You will receive a transcript of the evidence this afternoon. Please correct any inaccuracies in the facts and let us know them as soon as possible. Once again, thank you very much.

[616] **Mr Cairns:** Okay, thank you.

[617] **Ms Williams:** Thank you.

15:21

Papurau i'w Nodi Papers to Note

[618] **David Rees:** Members, we have item 10 on the agenda, which is papers to note. Can I just go through them for the record? The correspondence from the Petitions Committee regarding the Safe Nursing Staffing Levels (Wales) Bill, but, as we are dealing with that anyway—. And the summary of evidence received from the Royal College of Nursing campaign. Just to remind Members, what has happened is the Royal College of Nursing has actually run a campaign across Wales encouraging patients and staff to send postcards or e-mails to the committee showing their support for that. We've received a lot. We have provided a summary of the details of the comments received. We are not publishing the postcards themselves or the e-mails, as there is no explicit permission to do so. But we have a summary of the comments included. So, that's the papers to note. Everyone happy with the papers to note?

[619] In that case, as we identified earlier this morning that we would go into private session for the next item, we will now go into private.

*Daeth rhan gyhoeddus y cyfarfod i ben am 15:22.
The public part of the meeting ended at 15:22.*