Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Iau, 16 Ionawr 2014
Thursday, 16 January 2014

Cynnwys
Contents

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

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

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

Eraill yn bresennol
Others in attendance

Dr Andrew Goodall	Prif Weithredwr, Bwrdd Iechyd Lleol Aneurin Bevan Chief Executive, Aneurin Bevan Local Health Board
Dr Chris Jones	Cadeirydd, Bwrdd Iechyd Lleol Cwm Taf Chair, Cwm Taf Local Health Board
Dave Thomas	Swyddfa Archwilio Cymru Wales Audit Office

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

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

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

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Darren Millar:** Good morning, everybody. Happy new year, and welcome to the first Public Accounts Committee meeting of 2014. If I could just remind Members to switch off their BlackBerrys, mobiles and pagers, because, of course, they can interfere with the

broadcasting equipment, and encourage Members to use the language of their choice, either English or Welsh. The National Assembly is, of course, a bilingual institution, and there are headsets available for translation for those who require them. The headsets can also be used for sound amplification if required.

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

[2] **Darren Millar:** I am very pleased to be able to welcome Dr Andrew Goodall, who is the chief executive of Aneurin Bevan Local Health Board and is one of two chief executives who take the lead on unscheduled care in Wales. I am very pleased that you have been able to attend today. We were very grateful for the written evidence that you provided ahead of this meeting, which Members have had an opportunity to take a look at. As you know, we received a report from the auditor general back in November, and we have been taking evidence on this particular subject and concentrating our efforts on those people who are repeat patients, shall we say, at our emergency departments, the role of GPs, and the potential that the 111 service might bring in order to reduce some of the pressures on unscheduled care. We have a number of questions that we would like to ask you today.

[3] There was an interesting report in the media over Christmas about repeat attendances at NHS hospitals in England. Can you tell us whether the pattern of repeat business for our emergency departments in Wales is similar to that in England, or whether there are any significant differences?

[4] **Dr Goodall:** Good morning, bore da, and thank you for the invitation. As you know, I attend many of the committees, and hopefully help out as I can. I am very happy to take all of your questions.

[5] Obviously, the NHS is a UK institution, and as we looked at the pressures last year around unscheduled care and spoke to colleagues in Northern Ireland, Scotland and England, we found that they were experiencing the same pressures around emergencies as we were in Wales. Of course, there are perhaps different delivery elements to how we respond. We do see a number of similarities with some of the reports that came over from England. As you saw from the response that I gave you in advance, the nature of accident and emergency has changed to some extent, because what was an injury service, for example as a result of road traffic accidents, which had a focus on trauma, has ended up being more of a reflection of society, to some extent—dealing with people in vulnerable situations or with underlying concerns, not least alcohol issues. Of course, we see similar patterns with people who have been regularly coming in to some of our hospital facilities, and also with those who still need support and care from primary care.

[6] So, in terms of our own exercises, both on a national and a local basis in my health organisation, we have looked at those individuals who seem to be coming repeatedly into our particular settings, and the issues do seem to be driven by certain issues. Vulnerability is certainly one of the big issues, and we also have people with chronic conditions who, with better co-ordination and better oversight of their care, could have avoided a hospital admission of some kind. So, there is a familiarity with it. I would hope, however, that some of our approaches to co-ordinating care, focusing on some of our opportunities around primary care—which I am happy to explore with you, because certainly we are trying to do that within the Aneurin Bevan health board setting—would allow us to respond.

[7] I am happy, during the course of my commentary this morning, to go into a little bit more detail. One area that we have targeted in my health board area is chronic conditions, and the number of patients with multiple admissions. Our rate has significantly reduced over the

last four years in particular, and that is quite a lot of targeted action, so I would say that, even when the numbers are higher, you can actually put in actions that can reduce the number of attendances that are occurring.

[8] **Darren Millar:** We have had a worrying performance rate against the current performance targets that we have in Wales for a number of years now. There has been a bit of an improvement over the last 12 months, I think it is fair to say. Can you tell us whether that is because of the good practice that you might have undertaken in terms of chronic condition management et cetera, or is that just a blip? The weather has not been as cold, perhaps, over the last 12 months. What are the factors that have contributed to that improvement in recent months?

[9] **Dr Goodall:** The emergency and urgent care system has an awful lot of attention from us. We know that, if we get it right, it is the key to unlocking the way in which the whole of our system works, and our ability to make sure that we can target all of the different patient services that are needed for our populations. The performance over the last 12 months is not just a coincidence. There has been a lot of concerted effort. Some of the issues that we had introduced in our own health board over the last two or three years do not simply change overnight. I can show you trends where there was some early movement, but it was over the last two or three years that we have seen a significant change as people have become used to the services and you stop the cycle of that repeat attendance.

[10] We have introduced a lot of new services. I have contact in my own organisation. Of course, I have daily updates on where we are, but, every two weeks, I meet our accident and emergency and acute medicine staff to try to think about all of the next things that we need to do. Sometimes, we put in different developments of services. So, you will see that a feature of many hospitals across Wales will be things like clinical decision units that allow patients to be stabilised in a different way; it does not suck them into the hospital system, but makes sure that they get back quickly with the right packages and support. We have introduced that type of issue, but at the same time, we have also tried some different things. So, we have put in clinicians when receiving calls from GPs, allowing people to have more of a clinical conversation over the phone in support of, perhaps, attempting to make sure that somebody does not come into the hospital environment as well. So, there are a variety of actions.

[11] It is also right to say that pressures can be influenced by issues like cold weather. It was an exceptional experience last winter. However, we can also target other ways of improving things by simply increasing things like immunisation rates for children, and targeting that type of issue, as they generally give your population a better health level and status. We have also seen some influence over the last 12 months about some of the higher immunisation levels kicking in as well.

[12] **Darren Millar:** Okay; thank you for that. Julie wants to come in on this point.

[13] **Julie Morgan:** Yes, I would just like some information, really. You said that you had targeted the chronic conditions; which conditions in particular have you targeted?

[14] **Dr Goodall:** Respiratory problems, for example, and diabetes is an obvious area. In fact, we have even targeted some areas—and people sometimes worry about the labels—like support on the mental health side. We have had primary care mental health workers who have been put in place over the last two years or so. However, it is predominantly the areas that will lead to people needing some acute intervention and admission—such as heart disease. It is about putting that kind of practice in place. They are the areas in which we have put in support.

[15] I will give you an example: we have put a lot of focus over the last two-and-a-half

years in the Aneurin Bevan health board on respiratory care, trying to get the education of practice nurses up, introducing very clear pathways for people to use, making sure that the hospital side is connected to the primary care side. What I really liked in our local initiative was the fact that we had a lead GP and a lead hospital consultant, both of whom knew their business, being able to bring people together very well in terms of developing a team. We have seen a definite improvement in our outcomes locally, but in terms of the level of hospital admissions as well.

[16] **Darren Millar:** Sandy, do you have a brief supplementary question?

[17] **Sandy Mewies:** Yes, thank you, Chair. Good morning, Dr Goodall. What you have just said really underlines for me the interdependence of every stage in the NHS, and making sure that people keep healthy. You talked about lung problems, for instance, and pulmonary rehabilitation is an issue; you also talked about immunisation, which would be seen as a public health issue. So, how do you say, 'Well, these are areas that we think now need to be concentrated on', because they are away from your targets? How do you have that exchange of information and try to drive that process yourself?

[18] **Dr Goodall:** I always remind myself, my team and my board that we are a population health organisation and that we are not just a delivery unit. When we came through the reorganisation four-and-a-half years or so ago, it was very important to make sure that, of course, we deal with the delivery aspects and that, of course, we have targets and keep services, but we were looking to make sure that we were able to strongly influence the population health provision. We have a duty and a responsibility to do both. The danger is that, sometimes, we can be sucked in to focusing only on the targets and the delivery side. However, we are here for the longer game, and we are here to improve our population's health and responsibility. So, from my perspective, it is about making sure that you do not allow yourself to do just one rather than the other. You have to find some effective and symbolic areas to get into.

[19] The reason that we focused on respiratory illnesses locally was simply because the highest level of hospital admissions in relation to emergency pressures are for respiratory problems. So, although it was a population health factor, we also know that we were driving it because it was where we thought that there would be the greatest impact if we were able to alter these kinds of services. However, it is also to make sure that we always look behind the reasons for some of these admissions as well, and that is why health has a far broader role. I do a lot of work with agencies locally, because we have a responsibility to make sure that we are looking as much at poverty, employment opportunities, regeneration or education, in many respects, as we do at delivering just the pure health component.

[20] I have been a chief executive for nine years, and when I was working in the original health boards, a big part of our role was the delivery of the statutory plans with our local partners, which absolutely go for these prevention aspects to make sure that they are very strong roles. However, public health directors were made executive directors in my organisation, which I thought was a real positive about our arrangements.

[21] **Darren Millar:** Mike, you wanted to ask a very brief supplementary question.

[22] **Mike Hedges:** What progress are you making on immunisation? I speak as someone who lives in the Swansea area, which had a very bad measles outbreak last earlier, which would have been totally preventable if everyone had taken the immunisation available. What progress are you making?

[23] **Dr Goodall:** Immunisation levels across the whole of Wales have been improving and the uptake in areas such as the MMR vaccine, very specifically, have improved across

Wales. Although the circumstances that arose gave a profile around this, it allowed us to demonstrate to people that the reason for immunisation is to make sure that people do not end up with very bad conditions that will impact very severely on their health. In an area such as measles, in some respects because of the success of immunisation over the years, people have forgotten what it is like to have measles, in that it has become a very rare event these days, and people thought that we had worked it through. We have had to use the profile of that to get through, so although I know that the Abertawe Bro Morgannwg University Local Health Board area, very specifically, had to improve it, because of that we were able to increase our levels within Aneurin Bevan and Gwent as a community also.

[24] However, we have to make sure that it is not just about MMR. I am hoping that the public generally has got some education about making sure that the general immunisation and vaccination levels are achieved. In the winter period, we need to make sure that areas such as flu are targeted, because we can prevent it and support people so that they do not suffer in the worst sense.

[25] **Darren Millar:** What percentage of your hospital front-line staff were immunised against flu, for example, this year?

[26] **Dr Goodall:** At the moment, we have a target locally of about 50%. We are currently heading for about 40%, and we are trying to make sure that we push it through to 50% by the end of January.

[27] **Darren Millar:** Is 50% not a bit unambitious?

[28] **Dr Goodall:** It is not unambitious at all. From a personal perspective, I would like to see a 75% or 80% level being achieved to get the coverage. It is a very personal choice that is made by people. It is not a mandatory requirement on people working within the NHS at this stage. So, we very much target campaigns—we run it through our occupational health areas—but we need people to accept it. It is also important to show that it is contact right through the organisation, so although we look to healthcare professionals to take up that role, it includes others as well. For the record, I am immunised myself for flu because, in asking our staff to be vaccinated in that kind of way, you would expect it to be done from the organisation itself.

[29] **Darren Millar:** Should it be mandatory for front-line staff?

[30] **Dr Goodall:** We have some choices to make over the next year or two, because if we are still seeing lower levels than we would wish at this stage and there are opportunities to make sure that staff could be immunised, it is something that should be reflected on. I would hope that most of our staff would get there for the right reasons, because they understand that they can prevent some exposure to patients and that it is part of the care ethos that we have for the NHS in Wales generally. It is something for consideration, Chair.

[31] **Jenny Rathbone:** I would first of all want to see an analysis of who got sick and who did not in terms of vaccination rates.

[32] Moving back to your more general responsibilities for improving unscheduled care across the patch, we have some good examples of the initiatives that you and Cwm Taf are taking with advanced emergency nurse practitioners, and the close working that you have done with your GP practices in Aneurin Bevan. I want to focus on the two groups of people that you say are dominating A&E attendances at the moment: (a) older people and (b) those with alcohol-related issues. Could you talk to us about how you are managing those two groups of people?

[33] **Dr Goodall:** We have spent a number of years talking about the fact that there is

going to be a big demographic impact around older people. At times, it has probably felt as though we were talking about events in maybe 10 or 15 years' time, and that it would gradually build up and that we would remember the day when that impact happened. Our experience over the last four years or so is that, having the good news that life expectancy is growing, and therefore that there will be more older people for us to support, the impact has been seen very speedily within the NHS setting.

09:15

[34] Acute medicine, typically, is seeing a very different mix of people. I have seen a number of A&E presentations from across Wales and from England as well. I described earlier the change in the nature of the patient arriving, but the typical patient that will now be described within an A&E department will probably have an average age of 80, if you do the assessments across most of the units at this stage. I think that what we need to do there is understand some of the reasons why people are being admitted. Certainly, if you are elderly and anxious, one of the worst places to be sitting would be in an A&E department, when you want to have the proper support and structure around you. Across the whole of Wales, most of the health board areas—I think that it is without exception—now have community-based alternatives in place that have been developed. So, whether it is the Wyn project in Cardiff, the at-home mechanisms within Cwm Taf, or our frailty programme, they are really about targeting a high volume of people who simply do not need to be in that hospital environment and can be given different support. So, within my own area, if you will allow me to default to it, our frailty service receives in excess of 16,000 referrals across the whole of the Gwent area in order to make sure that people are retained within their homes.

[35] One of the things that we have to appreciate about alcohol, and perhaps substance misuse more broadly, is that there is a pattern around society that has changed to some extent. We are also seeing that whereas people attended A&E more typically during normal hours—between 8 a.m. and 8 p.m., perhaps in that way—there has definitely been a different shift where we are seeing high level of attendances. I know that people always described the A&E experience of a Friday night, for example, but we are typically seeing a lot more admissions happening in the late hours and the early hours of the morning, and that includes both frail people and these targeted groups. Clearly, you are more than aware as Assembly Members of general problems and pressures around alcohol issues. What we have to do is try to adapt our services to meet some of those changing patterns as well.

[36] If I may, I will give you a personal experience. Ten years ago, from an A&E department perspective, by the time that you got to 9 p.m., you would pretty much know your ability to manage the pressures through the night, and you would have a very clear view of the capacity and the number of people who were likely to turn up. These days, although we may be clear on numbers, you can have pretty much normal levels of activity going right through to 2 a.m. or 3 a.m. and it is quite a different shift of pattern. We have had to adapt our staffing arrangements to make sure that we can reconcile some of those areas as well. As with the areas that I was describing earlier, I think that, with the vulnerable people, and perhaps less so on the alcohol side, it is about taking a preventative approach. I think that the tipping point is that somebody might come in once for an A&E admission, but we should be trying to make sure that they do not come in for that second or third admission as well.

[37] **Jenny Rathbone:** So, on the former, do you have any concerns about the over-medicalisation of end-of-life care? I have had several cases of people being sent inappropriately to A&E. On the alcohol one, in Cardiff, we have a service in the city centre to divert people who have been excessively drinking from A&E and to deal with them there in a sort of minor injury capacity. I wonder whether that is appropriate for other parts of the country or whether it is because the city centre of Cardiff is such a focus for drinking.

[38] **Dr Goodall:** On the latter issue, Professor Jon Shepherd's work is not only known about in Wales; it is a template for us, but it has a UK status now in terms of what has happened. It is right to reflect that it is probably a model that is more suitable to the city environment, where there is a higher volume of people within a city centre at this stage. Having said that, I know that we have used the template in my area to try to run a number of these—certainly at specific points of the year, when we know that pressures are going to be higher. We have done it within the Newport context, but we have also actually targeted it at some of our other outlying areas. However, it will tend to coincide with whether it is bank holiday arrangements or very specific arrangements being in place. ABMU health board has done some work in Swansea on a very similar basis. I think that any attempt to make sure that people can be managed differently, often in terms of the pressures that we receive, is a positive thing. It is the number of majors patients who come into our A&E departments that causes the pressure, and anything that we can do that will mean that even six or 12 patients do not have to go there will makes a difference to not only the staff environment, but the patient environment within the A&E.

[39] On the first issue about the over-medicalisation that may be exposed, there is a danger and that, again, is why I think that the chronic condition approach is so important for us in our community services, and also through our GPs and our GP practices. When you come into a hospital environment, the range of diagnostics and investigations that we do for people will find lots of other conditions and issues that are wrong. We have to be very clear about addressing the pertinent reason why somebody has arrived in the A&E department. There is a danger that we can almost end up over-intervening. If somebody is able to manage a series of chronic conditions, then just because they come into a hospital environment, perhaps because one of those has happened, does not suddenly mean that we need to be trying to resolve absolutely everything. We should be trying to keep them as stable as possible. We need to be very respectful when people are in their end-of-life period and discuss with families and make sure that it is the right arrangement for the individual. Technology allows us to do lots of things these days that were impossible 20 or so years ago. You have to have proper discussions with people and make sure that you operate in a caring environment. I feel that the default is that, as technology changes, there will be many things that we can resolve. People should have the opportunity to be just stabilised and then to manage all of their other conditions on an ongoing basis.

[40] **Jenny Rathbone:** In terms of building on your successful techniques for diverting people away from A&E who do not need to be there, you still have quite a large problem in your own area, where 50% of 999 ambulance conveyances did not result in hospital admission and 80% of those conveyed in a 999 ambulance were discharged and did not require any primary or secondary care follow-up. So, is it that people are inappropriately calling an ambulance instead of a taxi, or is it that the ambulance service does not know how to say, 'Actually, madam, you don't need to go to hospital'?

[41] **Dr Goodall:** There is a combination of factors that contribute. It is a useful figure to bear in mind because it is a time when our ambulance arrivals have increased. To contrast it for you in my own area, the Royal Gwent Hospital would typically have an average of 40 to 50 ambulance arrivals a day, maybe up to a peak of about 60. At the moment, it would typically have between 50 and 65 as an average and up to 90 for an individual site in a single day when it is at its peak. That clearly shows that we are still not signposting people to some of the other alternatives that we have. I had, in the response to the Chair, provided further information about survey work done within the Gwent area, with insight from the community health councils in particular about why people were choosing to come. There is an aspect that if people are struggling to have the transport access that they want to get to a centre, they will use an ambulance for that part of it, as well as being very concerned about their condition.

[42] From my perspective, it means that we have something more to go at. I may well

have to still have 50 or 60 patients being treated, but I would like to work on a Welsh basis and certainly with our Welsh Ambulance Services NHS Trust colleagues on a different way of managing the risks within the community and better signposting to other areas. Dr Jones will be talking to you later about 'phone first' opportunities and the 111-type environment to make sure that we have a clear directory of services, whereby we can divert people to somewhere else, rather than the default being the ambulance system. We use that measure locally to say that we could have allowed some people to go to a different level of service, whether a minor injuries unit or a GP practice, meaning that they did not necessarily need to be in a specialist A&E department at that stage. As you saw in the information, the fact that 80% do not even need any follow-up afterwards means that perhaps they were able to be stabilised very quickly and professionally, but they possibly could have developed an alternative outcome. Most of our patients are appropriate in the A&E environment though.

[43] **Jenny Rathbone:** There is nevertheless quite a lot of work to do on the proper use of the 999 service. Neatly moving on to the south Wales programme, I was disappointed on 11 December when you decided to delay making any announcement because you felt that there was a small but an important number of details that needed further work. I feel that we have been waiting for a very long time. Are we ever going to reach a decision?

[44] **Dr Goodall:** The south Wales programme has, as you know, been an exercise over the last number of months. It has been different to dealing with normal local health service discussions, where all of us have our own mechanisms to deal with that on a local basis, within now our larger health board areas. The fact that it has been a collaborative approach on a far broader scale, and the seriousness of some of the medical staffing issues that we have seen across the whole of south Wales, has made it necessary to make sure that for each stage we are able to move ahead collectively—I mean as organisations across south Wales on the one hand, but on the other hand as individuals who have participated, not least the clinicians who have been part of it. In December, we got to the point where we were very close to a final decision. We are very clear, from a programme perspective, that we will be making a final recommendation and that it will be imminent over these next few weeks or so. We want to make sure that we are able to not just make the decision, but actually follow through and make sure that it is delivered very quickly and with a clear transition plan for the arrangements. We need to know that we are able to discharge the clinical model that we have described through the process. I apologise for the delay that happened. It is always a difficult call in that sense. I know that it will have taken time. I can only argue about the complexity of trying to bring so many organisations together and have so much involvement, but, if you want to know whether we will be making a recommendation on the south Wales programme on everything that we have done through the consultation, the answer is 'yes'. We will be setting up board meetings that will make sure that our boards make their respective decisions on that, because the community health councils have had a chance and an opportunity.

[45] **Jenny Rathbone:** Having made that decision, you will then implement it quickly.

[46] **Dr Goodall:** Yes. We will need to get on and implement, because the pressures that we have been describing through that process—and it has happened in other areas of Wales over this number of months—around medical staffing are a real pressure for us. Every time that we hit a new junior doctor rotation, whether it is in the February rotation, or particularly in the August one, we know that there will be pressures around stabilising some of the local services, but, yes, the whole point for us at this stage is that it is not just about making future decisions, it is about making decisions that can be followed through very quickly.

[47] **Jenny Rathbone:** Okay. Obviously, it is key to improving unscheduled care, because that is your rationale for doing it.

[48] **Dr Goodall:** It is absolutely critical, and, of course, it was a major feature in the

Wales Audit Office's report that we have to take these opportunities.

[49] **Darren Millar:** However, a decision is imminent and will be made within the next few weeks.

[50] **Dr Goodall:** Absolutely.

[51] **Darren Millar:** Okay. Sandy Mewies is next.

[52] **Sandy Mewies:** Thank you, Chair. The new framework has included changes in targets and tiers, sometimes, but focusing on unscheduled care. How far away is it from establishing a suite of meaningful quality and outcome measures? Also, what are the impediments to getting that? You will never get a perfect set; I think that you said earlier on that things are changing all of the time. Alcohol and vulnerable people have become really meaningful issues within unscheduled care and that was not recognised some years ago. What are the impediments to developing a set of indicators that work? I would also be interested to know how consistently they are applied, because it is excellent if one health board works exactly and carries out the measures and measures the outcomes, but it is no good if that is not done consistently, because we will not get the all-Wales picture.

[53] **Dr Goodall:** To deal with the latter point on consistency very quickly, with all of the focus that we have had over many years on emergency care services, I think there is consistency about the suite of indicators that we have been using. Currently, there might not be, perhaps, quite the right set of indicators; they might focus more on process rather than outcomes, but, on the current set that we have had, with all of the external reviews that have happened on it—we have had audit teams across Wales reviewing it; there is guidance from the delivery and support unit and visits have taken place—I am pretty clear that they are consistent. There will always be some occasions when somebody just needs to check out the status of perhaps a category of patients, or some of the changes that are happening, to see where they fit, and that can lead to some clarification of the guidance.

[54] However, the opportunity to set a different set of indicators for our whole system right through from GPs to the local government areas of service, or the integrated services that we provide, so it is not a debate about A&E departments only, that really is for us to look at and develop. My strong recommendation would be to make sure that it is not simply about looking at that as an industry, but about making sure that the indicators are very meaningful, certainly at the clinical level, as far as the system works, and I think that there are ways in which we can work it through. As a local example, we have introduced over the last 12 months an aspect of wanting to have the modified early warning score allocated to patients as they come into our A&E departments. That is just a score simply to give you the status of a patient, whether they are deteriorating, and the severity of the clinical condition. It is the assessment of that score, as they move through our system, which tells us whether we have intervened appropriately and have been effective. So, rather than just measure the time that it originally took them to get in, it is about whether all of our suite of clinical interventions, ultimately, have worked, hopefully leading towards a proper discharge for somebody. It is about putting our focus on those types of choices and experiences.

[55] What we also need to do—and I thought that this was a fair comment in the WAO report—is make sure that the patient experience side of things is brought through more strongly. You will have seen from a couple of my submissions that we have tried to bring in our own attempts to capture some of the patient experience and perspective. I think that we can definitely do better on the clinical side. There are college standards that are developed by the College of Emergency Medicine, and, as well as tracking our four-hour target, our ambulance handover targets and discharge targets locally, we track the emergency medicine quality indicators at the same time, so that we have a feel for the general system.

09:30

[56] I am hoping that, as the suite of measures is developed for Welsh Government, with the support of the unscheduled care team, we can start to bring forward these types of areas, because we are not just starting from scratch on some of these; we have actually been looking at the quality side. At its strongest sense, of course, we are able to look at areas such as mortality. We are able to link back to some of the risk-adjusted mortality index areas, and, rather than just look at overall hospitals or organisational areas, to look at areas such stroke mortality, fractured neck of femurs, and heart disease. We are able to make sure that they are far more visible than perhaps they were two years ago. So, I look forward to working with the users of our services, but also with clinicians to produce that effective suite. However, I would not want to abandon all of the process measures, because I still think that they are a statement of some of the pressures that we are experiencing, and we still do need to address them.

[57] **Sandy Mewies:** You have talked about good practice in what you are doing, but how do you share that? How is that shared?

[58] **Dr Goodall:** I think that that is one of the roles of the unscheduled care programme. I am very clear, as a chief executive, that, in terms of the expectations from my local emergency system, the delivery of the targets and the patient experience, it is my accountability as the chief executive, and with my board, to make sure that we oversee it and make it happen. With my lead role on the unscheduled care system, I guess that, rather than me personally performance-managing the whole system, what I am trying to do is to make sure that we give people the flexibility to develop these things differently to give a bit of headroom for us to think about some of the options that even the WAO offers to us here. Otherwise, you can be sucked into the day-to-day matters, and, actually, part of it is about trying to promote the good things that people are getting up to, and making sure that we share that regularly. So, as a recent example, I shared with chief executive colleagues the fact that it was good to see that Cwm Taf Local Health Board was making some really good progress around some of its ambulance handovers, and therefore our performance. The unscheduled care team went in to just understand that very quickly, and we were able to circulate some of the interventions that were done in terms of improving some of the flow. I know that Dr Jones would be very happy to talk about some of those areas. However, we did not want it to just be left in Cwm Taf; we wanted to make sure that that would be promoted with everyone else. We have some choices. I have taken some of those actions myself within my own community to make sure that we could implement some of that experience ourselves.

[59] **Darren Millar:** Jocelyn is next.

[60] **Jocelyn Davies:** What are you doing to ensure that you have a balance of the competing needs of scheduled and unscheduled care? Did you have to postpone any elective surgery this winter? I should say that my husband had elective surgery this winter in your area—not that that will catch you out at all, because it was a very good experience.

[61] **Dr Goodall:** As I said at the very outset in response to one of the first questions, the focus on the emergency care system and getting it lined up and right, making sure that the patient experience is good there, but making sure that we can staff around it, is the key to unlocking the way in which our overall health services work. We have to, of course, respond to all of the pressures that come in through the front door, but the NHS also has to deliver everything else. The way that I would describe this—and I reflect on my experience over the past 22 years, working in the NHS—is that it is right for us to plan that, at certain stages of the year, there will clearly be different pressures and growth. On the one hand, in terms of what we have defined as winter pressures, I think that we have actually seen a change in that

pattern of services across Wales over the past six or seven years or so, because the emergencies coming in through our door are a far more sustained pressure. You can see that from the statistics and the figures. However, of course, during the winter period, not least due to the nature of some of the clinical conditions that people can have, you will see a rise over December, January and February in particular. Not just over this last winter period, but, actually, certainly in my experience, not least as an operational manager, over the past 18 years, we have always targeted the fact that January is always going to be a more difficult month. If we are able to plan differently through the January period and put all of our attention into making sure that we deal with all of the emergencies in what is always going to be the highest month of activity, we can, I hope, revert to a more normal set of planned operations and electives for the remainder of the year, and certainly through February and March. So, we have made judgments across Wales in our winter planning arrangements to generally slow down and reduce the elective activities, certainly during these first couple of weeks of January. I think that that is sensible and it is a commonsense area that we have tackled, and I have done so over the past 18 years or so. The important aspect is the extent to which you are able to bring it back up, hopefully, as you are managing some of those emergency pressures very effectively. Yes, we have made some local decisions within Aneurin Bevan Local Health Board to slow that down, and to not book in patients in the first place in order to avoid cancellations as such, so we are deferring some of that activity.

[62] **Jocelyn Davies:** Did you speed things up in October and November, because you were going to slow things down in January?

[63] **Dr Goodall:** What we were trying to do was to make sure that we do balance out the whole of the year, so, you do try to get ahead of some of these areas. We recognise that one of the key issues for patients is to ensure that they have access as quickly as possible. As an example, in December, we did far more orthopaedic activity on the premise that we knew that we were going to lose some of that available capacity through January. I was concerned last year that, despite best efforts—not least because of emergency pressures and how difficult it got during January last year—even in areas that we tried to protect more, and you do protect orthopaedics as a general area because of the infection exposure when other patients are placed on it, we ended up having to breach some of those ring-fenced environments because the emergency pressures were so acute and we had to focus on the front door. So, we have tried to alter it. However, I would say in answer—

[64] **Jocelyn Davies:** So, you did not postpone things; what you have done is to change the profile in advance so that you did not have to postpone things.

[65] **Dr Goodall:** Yes, we did, but we have lots of other opportunities to provide elective care in different ways. So, what I have been able to do instead is manoeuvre people so that we can do more work in Ysbyty Ystrad Fawr, because it has a different emphasis and we have been able to do operations over there. We have been able to focus more on our day surgery and our overnight care, and the one area we have looked to prioritise is our clinically urgent patients to make sure that, of course, they come in. However, over the past two weeks, even with the plans that we have had, we have still had around 1,000 procedures and interventions going on in our organisation.

[66] **Jocelyn Davies:** Obviously, we have had a milder winter, as was mentioned by the Chair earlier, certainly than we had last year. Have you had less demand then you were expecting?

[67] **Dr Goodall:** We have definitely benefited from the weather. Last year, by anyone's experience, was exceptional and it did have an impact. We have had high levels of activity on the one hand, so we have certainly had days when attendances and admissions have been at the very highest level, but, in general terms, when we look at the past few weeks in particular,

out-of-hours services across the whole of Wales, for example, have actually seen about an 8% difference between last year's calls and this year's. So, you can see that that would have a material effect, at least on the calls that are coming through. The counter issue that I would raise, however, is that we have also seen, certainly locally within the Aneurin Bevan health board on out of hours, a high level of home visits happening. So you might have fewer calls, but it is still definitely showing that there is a level of acuity of patients and a dependency of people, where they have had to have those sorts of visits.

[68] However, the past few weeks or so, which is where our winter planning arrangements that have been going on over recent months have really kicked in, have felt, for me, more stable. I think that NHS Wales has felt more stable. We have certainly had escalation levels that have been at the lower level more often. Yes, weather can be a feature, but, as I was saying earlier, things such as the immunisation rates seem to have been at a high level. Two years ago, of course, we were planning for a pandemic flu. Certainly, at this stage, we have not had any major outbreaks of flu. The numbers are very small.

[69] **Jocelyn Davies:** The national winter planning forum, as you know, was launched in September last year. How effective has that been in helping you to plan?

[70] **Dr Goodall:** To reassure you, every health board looks back at the month that has gone, and we do plan forward. I do think—

[71] **Jocelyn Davies:** I was not suggesting that, without the forum, no planning was going on, but has it made a difference?

[72] **Dr Goodall:** No, I know, absolutely, but I think that the distinguishing feature of it has been that it has made us work through each of the health boards' experiences together. Everybody has different characteristics of positive actions that they put in their system—

[73] **Jocelyn Davies:** So, were you able to share best practice and perhaps learn—

[74] **Dr Goodall:** Yes, we share best practice, we have been given feedback, we have been able to do some evaluation of people's different plans, and we have had presentations in the sessions that show how people have taken different approaches to things. There are areas that have been able to put in additional capacity. There are some areas that have been able to demonstrate how they have had a lot more confidence about their community services—

[75] **Jocelyn Davies:** Of course, you can also learn from each other's mistakes.

[76] **Dr Goodall:** Yes, and, although we all started this planning work back in March, the September session that allowed us all to share everybody's plans and how they developed has helped. The winter planning this winter does feel far more robust, from the system perspective, even if we have had different good local practice.

[77] **Jocelyn Davies:** On community-based unscheduled services, can you give us something from your experience on how well that has worked as a genuine alternative to acute hospitals? I was wondering whether, after an ambulance has been called—and given that 50% of people are inappropriately turning up at accident and emergency departments, some of those are being brought in by ambulance, of course—paramedics routinely call out a GP rather than transport a patient?

[78] **Dr Goodall:** There are different mechanisms for doing it. To give you one example, the ambulance service brought in some different pathways, which started in the Abertawe Bro Morgannwg area and have now been extended to five health board areas. The predominant focus was falls pathways and ensuring that you do not simply bring people in to expose them

to the falls services, but prevent falls. Even over the first 12 months of that service and as it has been rolled out in some of the other areas—

[79] **Jocelyn Davies:** So, these are elderly people who have fallen—

[80] **Dr Goodall:** Generally, they are elderly people. It is not always so, but generally speaking, it will be older people coming in. Around 3,700 patients simply were not brought into the hospital environment when they would have been before. That would have led to 3,700 admissions, basically, and we would have probably brought them into our normal system.

[81] **Jocelyn Davies:** What proportion of the 50% is being brought by ambulance?

[82] **Dr Goodall:** Fifty per cent of—

[83] **Jocelyn Davies:** The 50% of inappropriate admissions into A&E that you mentioned earlier. How many of those people have been brought in by ambulance?

[84] **Dr Goodall:** The 50% figure in my paper is saying that, of all the people who came in by ambulance, 50% were sent home. It is 50% who went home, rather than carried on as an admission. So, they came in as an ambulance arrival. That does not necessarily say that it was inappropriate for them to receive an A&E service; it just says that they did not necessarily need to come in to be part of the hospital system.

[85] **Jocelyn Davies:** Do you know what proportion of those people being brought in by ambulance is inappropriately admitted to A&E?

[86] **Dr Goodall:** I could not give you a figure, but I can certainly give you a feel for Aneurin Bevan health board in response to today's session—

[87] **Jocelyn Davies:** I wondered whether there was a fear of lawsuits if somebody is not brought to hospital. Does that drive any of this action?

[88] **Dr Goodall:** I think that the figure of people going home shows that there is something to get at. There is definitely something about how individual practitioners will work, and I know that it is not just about what the system supports you in; it is your individual call as a clinician. Our paramedics are primary clinicians in the way that we receive these patients. I personally would like to see a clearer environment—I have been working on this locally, but I see this with the unscheduled care programme—to make sure that the risks that are being taken by, for examples, individual paramedics on the ground are part of a system response. So, it is about how you connect that to being done in agreement with A&E consultants, for example, through a telephone call and that it is part of the response to divert people to alternative services, so we are able to put in that kind of support. I think that, for paramedics, it can often feel like quite an individual issue. I think that we need to demonstrate that it is a system responsibility.

[89] **Jocelyn Davies:** Do you know whether there is a fear that the service might be sued if they do not bring somebody in if there is any doubt?

[90] **Dr Goodall:** I think that there is a danger with some of the expectations on this, and there is some technical guidance in place as well that if somebody insists that they should be brought in as to whether that has to happen. So, within ambulance service terms, if somebody demands that they are taken to A&E, there is, effectively, a requirement that is placed on them about that choice. It is partly where that clinician talks to people about the alternatives at this stage. I think that some of the coroners' cases that have happened, both in Wales and

across the UK, highlight some concerns and pressures. Obviously, a lot of the unscheduled care pressures that we talk about are simply about managing the risks of individual patients, and when you are managing risk, you have to make some of these day-to-day judgments and choices.

[91] **Jocelyn Davies:** However, of course, very often, hospitals can be dangerous places for elderly people to come to, because they can pick up infections.

[92] On delayed transfers of care, what are you doing now to prevent patients experiencing those delays?

[93] **Dr Goodall:** Compared with four or five years ago, our delayed transfers of care are at much lower levels; we have probably reduced ours by about 60% over that period of time. They are better than they were four or five years ago, but the numbers are still a cause for concern. Again, in such large organisations, they can add up very quickly to the equivalent of one ward or two wards in some of our individual areas. It requires really good relations to be in place with our local government colleagues. I think that it is also fair to make sure that people understand that not all delayed transfers of care are local government waits for social services. In fact, a number of the waits are about how you want to get people to access the next hospital or health service. You can see that in some of the figures.

[94] I think that, in some respects, it is not just about the number of delayed transfers of care that we have, it is the bed days that are associated with them. If we have a high number of delayed transfers of care, but people are turned around very quickly, actually, the hospital system works very well and we are able to keep up with it. It is more of a concern where we have long outstanding waits—

[95] **Jocelyn Davies:** What is a long outstanding wait?

[96] **Dr Goodall:** A long outstanding wait can be when you are working with families for a choice of nursing or residential home—

[97] **Jocelyn Davies:** What would you consider long?

[98] **Dr Goodall:** You can have long waits that are in excess of many months. The longest wait that we have experienced has been up to eight or nine months. They are often for exceptional reasons and, sometimes, we have people waiting as delayed transfers of care for access to, for example, specialist elderly mental illness beds, of which there is a shortfall in Wales, because of the independent sector and how it is responding, so we may have to put one in. People have been cared for very well, and they are actually accessing very specialist care, but the question is, however: do they really need to be in that more acute hospital environment? We have an opportunity to move people on. We have a chance to work differently with local government. I would say that winter planning arrangements have been more effective with our local government colleagues, because they have been drawn into the winter planning arrangements this year far more strongly; I have welcomed that.

09:45

[99] **Darren Millar:** We need to pick up the pace of questions and responses if we can. Aled is next.

[100] **Aled Roberts:** Rwyf eisiau gofyn yn Gymraeg.

Aled Roberts: I want to ask my question in Welsh.

[101] Rydych wedi sôn am ledaenu arfer

You talked about spreading good practice and

da, ac rwy'n meddwl ein bod fel pwyllgor yn awyddus iawn bod hyn yn digwydd yn y gwasanaeth iechyd. Fodd bynnag, nid wyf yn gyfarwydd iawn â'ch ardal chi, i fod yn hollol onest. Rydych wedi sôn am nifer o ysbytai. A fyddai'n bosibl ichi roi nodyn inni ynglŷn â'r boblogaeth rydych yn darparu gwasanaethau ar ei chyfer, a hefyd nifer yr unedau mân anafiadau a'r unedau gofal dwys sydd ar gael yn eich bwrdd iechyd? Mae rhai byrddau iechyd lle mae canolfannau mân anafiadau yn cael eu cau, felly mae'r ddarpariaeth ar draws Cymru yn wahanol iawn.

I think that the committee is very eager to see this happening in the health service. However, I am not familiar with your area, to be honest. You have talked about a number of hospitals. Would it be possible for you to give us a note on the population that you provide services for, and also the number of the minor injuries units and intensive care units in your health board? Some health boards have minor injuries units that are being closed, so the provision across Wales is very different.

[102] Pan oedd Sandy yn gofyn cwestiynau, roeddech yn sôn am raglen Gwent. Rwy'n ymwybodol, pan oeddwn i mewn llywodraeth leol, bod arian ychwanegol wedi cael ei roi i sefydlu'r prosiect hwnnw. A oes arian ychwanegol yn flynyddol yn cael ei roi i mewn? Mae'n ddigon teg dweud eich bod yn gwneud hyn a'r llall, ond os nad yw'r arian ar gael ym mhob ardal arall yng Nghymru, nid yw'n bosibl inni edrych ar y fath raglenni o ran y pwyllgor hwn. Roeddech yn sôn bod 16,000 o gleifion yn y rhaglen honno, neu wedi cael eu cyfeirio at y rhaglen, ond a yw hynny wedi cael unrhyw fath o effaith ar nifer y bobl hŷn sy'n ymweld â'ch adrannau brys, o gymharu â byrddau iechyd eraill? A yw'r rhaglen honno wedi cymryd pobl allan o'r system?

When Sandy was asking questions, you mentioned the Gwent programme. I am aware that, when I was in local government, additional money was given to establish that project. Is there additional money being put into that every year? It is fair enough to say that you are doing this, that and the other, but if the money is not available in every other part of Wales, it is not possible for us to look at that kind of programme as a committee. You mentioned that there are 16,000 patients within that programme, or who have been referred to that programme, but has that had any impact on the number of older people who visit your emergency departments compared with other health boards? Has that programme taken people out of the system?

[103] **Dr Goodall:** On the note, yes, I am very happy to give you an overview of the spread of services across Aneurin Bevan, just so that you are familiar. We have had the same choices to make around some of the supporting mechanisms—for example, around minor injuries units. It is a question of, on the one hand, how you make them work more effectively, and how you can develop them, but equally, the problems that exist when you simply do not get the numbers through to maintain skills. I am very happy to give you a note on that.

[104] In respect of the opportunities to develop community-based services, they are the right thing to do locally, but we have to find mechanisms for doing it. You are right around the frailty mechanism, not least because it was sitting across five local authority areas rather than just a single authority. The scale of it was such that we were supported around invest-to-save moneys that at least allowed us to pump prime the service to be able to demonstrate the impact that it would have on the ground, and be able to work it through. I am very happy to give you information, not just about the numbers for the service—and perhaps I can do that as part of the same note—but we have seen it impacting on the level of admissions to our services. It receives excellent individual patient-experience feedback as well—probably the strongest feedback that I have seen. It is important also to not just see it as the only solution, because the frailty service is one of a suite of community services that are available, including our core district nursing service, for example, which continues to deliver many of these aspects as well. From a funding perspective, yes, it was pump-priming, so what we have done is not just to pump prime the service, but budgets are then translated into our core budgets

going forward. So I, and we as colleagues across local government, have continued to develop that service over the last year or two. There are still developments going on on this side to target some of our outstanding commitments. Pump-priming means that we take on the recurrent responsibility for it thereafter, and we are doing so, because it is effective for us. So, the pump-priming was well worth it in the initial cases.

[105] From a general funding perspective, you recall that the Minister for health made an announcement, not least around NHS funding, but also about an intermediate care fund. I would expect, and I believe across Wales, that different areas will be using the opportunity of that fund to make sure that that is a real focus around the integrated services between health and social care, and people are developing similar kinds of templates across Wales. I know that we can still choose to do that locally, but from a national perspective, that also gives some extra opportunity for us in terms of the announcement that the Minister has made.

[106] I think that I have answered all your questions.

[107] **Jocelyn Davies:** If this is invest-to-save, do you have to pay it back?

[108] **Dr Goodall:** Invest-to-save does need to be paid back to Welsh Government, and we have been and are paying it back. From our perspective, it just allowed us to take that extra step forward for something that we knew would make a difference for our communities. It does get you into a different cycle of how you do it, and I think that many areas could look to their own local invest-to-save mechanisms as well.

[109] **Jocelyn Davies:** Did you make the savings that you predicted so that you were able to pay it back?

[110] **Dr Goodall:** We probably made less of a saving, but we have stabilised our demand. So, to take our area and contrast it with other parts of Wales in those areas where we have put in community services, rather than seeing significant increases in demand, not least for services for older people, which have been seen year on year, we have found that it has stabilised our demand locally and it has probably given greater certainty within our system. We have reduced some of our bed numbers on the back of dealing with it, so the system has gained and benefited from some of that. However, over the next two to three years, we will be continuing to hope that we can show that some of the capacity can change as well and that bed numbers can drop, but for the right reasons—because the length of stay is going down and because patients are accessing different services.

[111] **Darren Millar:** I will come back to you, Aled, but Sandy has a supplementary question on this point.

[112] **Sandy Mewies:** Yes, just in relation to one facet of what you said. In relation to minor injuries services, can you confirm something for me? Minor injuries services can play a very important part in the community, but am I correct in thinking that staff have to see sufficient numbers of patients? When safety is talked about in relation to minor injuries services, it is very much about staff dealing with the very wide variety of patients coming in, getting that experience and knowing how to deal with them. What is the best way of focusing minor injuries, in your view?

[113] **Dr Goodall:** You are absolutely right and, to be clear, in my area, we had to make changes to minor injuries units, not least because of those standards issues. So, I have very good examples of minor injury settings with nurse-led arrangements that are very effective and are able to deliver a high level of activity for our community. To its most significant level, we developed Ysbyty Ystrad Fawr in Caerphilly as an emergency nurse-led practitioner service, which deals with a suite of issues and is an enhanced level of minor injuries services.

We have increased the number of patients attending that hospital by over 50%. So, 20,000 patients were treated in the Caerphilly area through the previous arrangements of A&E-based services, but that figure is now up to 31,000. So, it does show that, when you can target it and get the volume and activity, you can really make a difference. However, you have to maintain a level of skills.

[114] The college recommendation for the maintenance of these skills is somewhere between 20 and 30 patients per day. That should give people the variety that they need to maintain their skills. Obviously, we can rotate staff and look at things differently. The problems that we have had with some of the minor injuries units in Wales is that levels of attendance have been down as low as one or even nil on certain days. It is that kind of experience, particularly in terms of using good resources and maintaining skills, that creates real problems for us. So, I have seen it working very well, but I have seen some of the difficulties involved. We have to change our mentality in relation to emergency services. Technology and clinical practice are changing very quickly and the techniques and approaches that a highly experienced, accredited, well-trained, senior emergency nurse can deliver—in contrast to a junior doctor, for example, in a traditional A&E department—are really significant. As we look at these different models of service, there are genuine workforce opportunities to make sure that we can stabilise and secure some of these services through that type of model as well. However, we have to be open with people about the safety issues relating to some of the models at the same time.

[115] **Sandy Mewies:** The problem is that, when you talk about safety to the general public, they do not see it as a matter of standards.

[116] **Dr Goodall:** I agree with you. As we move forward, we are also developing options like ‘phone first’. So, rather than somebody walking in to a unit, if there is an opportunity to have a conversation about the best location for them, we would direct them to a minor injuries unit, to an A&E department, or to an out-of-hours service as part of that phone call. We can not just educate people, but make sure that they are signposted. I hope that somebody phoning in the first place and then being told that their appointment is in an hour and a quarter in a minor injuries or a nurse-led unit, rather than A&E, would be seen very quickly. Our experience in Caerphilly is that that happens within an hour, typically. So, that is a good, responsive service. We hope that people will start to feel that that is a good service but that it is also relevant to their needs.

[117] **Darren Millar:** Mike, please keep your question very short.

[118] **Mike Hedges:** Would that problem not be resolved by co-location? As you know, in Morriston, there has been a co-location of the out-of-hours GP service with the A&E department. Surely, that solves a lot of the problems, because the decision is not made by the patient but by the clinicians.

[119] **Dr Goodall:** Co-location is one opportunity, but some of our experiences also show that it is not the only way that people behave. I guess that we are educating staff, patients and the public in much of this. In my area, I have one co-located unit, which has a high level of interaction between the two units, and I have two units where it is slightly more separate—on the Nevill Hall Hospital site and the Royal Gwent Hospital site. However, I agree with you—one of the first choices to make is to see whether we can physically bring those things together. Most areas of Wales are developing plans for that, because it is a good solution.

[120] **Aled Roberts:** I accept the point that Sandy is making regarding safety and minor injuries units. What is of interest to me is the consistency of provision across Wales. During the one period of time that I spent in the Ebbw Vale area, I was quite surprised at the number of new facilities that were being built there. If you are talking about provision of facilities for

a population of 20,000, for example, that is not the experience in other areas of Wales, where facilities for that type of population are being withdrawn. If the NHS is based on historical patterns of provision and historical patterns of funding, and those decisions are being taken for confined geographical areas within those patterns, in reality, we will not have a national health service. We will have a localised health service, where provision is very different across Wales, dependent on where you live.

[121] **Dr Goodall:** Irrespective of the local accountability of health boards in looking after their population, we are a national health service. We are NHS Wales, and we have duties and responsibilities. What I am hoping to do through the unscheduled care programme continuously—and one of the areas that we are overseeing and looking at is that we are taking all of the different models that are being highlighted through the different service configurations—is to try to give some of that consistency that you described and to make sure that we deliver it in a similar way. I do not think that we are trying to develop inequitable arrangements here; we are trying to standardise some of the approaches.

[122] Going back to the 'phone first' approach and the 111 mechanisms and how we deliver that, what we are trying to do there is make sure that that is a national module for Wales that allows us to signpost and hopefully develop the suite of facilities that are available locally at the same time.

[123] **Aled Roberts:** Your evidence suggests that people whom you would expect to go to Ysbyty Aneurin Bevan, for example, are attending the Royal Gwent, although it is a relatively new facility. Do you have any understanding as to why that is happening?

[124] **Dr Goodall:** That is true, and when the community health council did that survey, we were surprised about it ourselves. However, it did chime because, as we opened Ysbyty Aneurin Bevan, which was a longstanding commitment for our area, we were surprised initially at the level of community use of the facility, and wondered whether some of that was about communication or knowledge, or wanting to access the more specialist care. However, we have done quite a lot of communication and campaign work within that particular area over the last eight months or so, and we have seen a change in the numbers of attendances going through the unit. We were worried at one point that there were some days where as few as 10 people were going into the unit. However, we have done a really visible campaign, and I am pleased to say that on many days now, although we have to keep a focus on it, we have had between 20 and 30 patients arriving in the unit, but we have been exceeding the 30 level, which is the standard that we are trying to aim for at the moment. It showed that people and the public can still be unaware of what they need to choose and when. That is why I said that it would be good if you could revert to having a more personal conversation in the first place, and say, 'Rather than drive to the Royal Gwent, we can divert you to Ysbyty Aneurin Bevan and you can go there first'. It is about how we get to that public perspective first. That is where the national approaches systems can work.

[125] **Aled Roberts:** Is the national approach effective, where you have a new facility built where you are struggling to get 10 people through the door in a day, and you have other facilities that are being closed on the basis that they only have 30 people going through the door in a day?

[126] **Dr Goodall:** A national approach helps to have a different kind of conversation with the public if we are able to genuinely achieve what it says on the tin, which is 'phone first'. That is the discussion that I am going for there. In terms of getting our minor injuries unit to hit the kind of levels of activity and demand that it needs to do, that is absolutely a local discussion and a local profile to be worked through in all sorts of different ways. For us, locally, ranging from local Assembly Members to the *South Wales Argus*, it is about trying to make sure that there is a level of understanding out there. The good news for me was that

people responded to it, we saw an impact on our numbers and we were able to divert them to the right place because there was a facility available for them.

[127] **Aled Roberts:** Moving on to another of your programmes, the 'A' is for Access scheme, you mentioned patient satisfaction as far as the Gwent frailty project is concerned. Was any work done on the comparison with satisfaction rates before and after the introduction of 'A' is for Access?

[128] **Dr Goodall:** We developed 'A' is for Access through the community health council and the local medical committee, which is representative of our local GPs. That was not insignificant in taking it forward. One of the reasons for developing it was that, when the CHC did a number of surveys—including the one that I shared with you—although 70% of people at the time said that they were able to get an appointment when they wanted it if they were an urgent patient, there were clearly a number of people who were saying that they could not.

10:00

[129] So, we did it in response to the fact that the baseline was saying that 30% of people were feeling that they could not get the access on the day or to their satisfaction at this stage. So, from my perspective, we were not just setting a baseline; we were responding to the survey by trying to do something different with practice. It has been a really good initiative, to make sure that we focus on some of the basics around the hours and the expectations, but it has also been something that the practices have aspired to. So, at the moment, I know that 55% of our practices are achieving 'A' grades in all of the five criteria that we have set, so we have moved that on from the much lower baseline of two years ago, which was operating at about 11%. Actually, however, all of the other practices have improved their performance across the range, so the majority of the others are achieving four 'A' grades, even if they are not quite there on the final criterion.

[130] From my perspective, we have heard less noise in the system and less concern being expressed about access to GP practices. Inevitably, when you do any local or national survey, people will still say that they have outstanding concerns, but it was a much stronger feature with the community health council two and a half years ago. The CHC has been delighted about the response. What I liked about this was that it really knitted in the GP machinery as well, by using the local medical committee mechanism. There is some level of pride in hitting these criteria. It is a good service, but it means that we are providing the hours that the contract requires us to deliver as well.

[131] **Aled Roberts:** Os ydym yn symud at ddoctoriaid teuluol, mae eich perfformiad chi yn well na pherfformiad Cymru gyfan o ran practisiau sy'n agored drwy gydol eu horiau craidd, er bod y ffigur wedi gostwng tipyn bach y llynedd. Pam rydych chi wedi bod yn fwy llwyddiannus na byrddau iechyd eraill?

Aled Roberts: If we move on to GPs, your performance is better than the all-Wales performance in terms of practices that are open throughout their core hours, even though the figure decreased slightly last year. Why have you been more successful than other health boards?

[132] **Dr Goodall:** All of us are clearly targeting different ways of dealing with primary care. If I could speak locally and generally, that might help some of the understanding here. For us, we had to respond to a very specific problem. I was worried that, perhaps in contrast to other areas of Wales, it was being highlighted as perhaps a more significant issue for us. Although, on the one hand, the quality of the services was less of an issue—we have always achieved very good quality assessment framework scores around the quality agenda within Gwent—access will always remain one of the biggest issues for us to respond to for the public. So, I think that what is different here is that our trigger was different. We had to go

properly at a problem, rather than just look to incremental change and continuing to go at some of the existing targets. Having said that, we are sharing the scheme that we have developed with others in Wales. So, part of the national programme is to say, 'Look, this seems to be something that is working; it is a good thing'. It is good that it is knitted in to the local medical committee machinery as well, as people look to roll out in Wales.

[133] For all of us generally in Wales, it is about developing a different set of relationships with our GP practices. We cannot take away the fact that GPs will clearly work as independent contractors within the NHS system; they are not employees of us as organisations, although obviously, we do employ some GPs at this stage. We need to look at the spirit of what we are looking to do around emergency services in the first place, and with that local scheme, we started with that, which was about listening to what the patients wanted. All of us are developing mechanisms for having a different level of GP engagement around our services. So, if I describe to you—

[134] **Darren Millar:** Sorry to interrupt you, but you are rambling a bit on this question. What we are trying to establish here is that there are core hours that GP practices are supposed to be open; they have a contract with the NHS to deliver those core hours; and not everyone is delivering them. Why are health boards effectively not holding GPs to account and taking them to task for their failure to deliver on the contract?

[135] **Dr Goodall:** I was just going to draw on our locality networks as a way of creating part of that aspect, so I had not quite got to that part. I apologise for not necessarily answering your question.

[136] **Darren Millar:** That is okay. We are up against the clock.

[137] **Dr Goodall:** From a contractual perspective, it is about using the contract for its purposes, but it is also about having the relationships in place. I think that you need to blend both in taking it forward. I hope that our local success at this stage is because we are trying to balance the relationships with the contractual mechanisms. The Minister has recently announced some changes around the contract, which will allow us to again put a focus on the core services that are going to be provided in the normal hours and make sure that those things are delivered. Our responsibility in the health boards will be to make that happen and make sure that we oversee and monitor it.

[138] **Aled Roberts:** So, why do you get 48% of practices open for their full core hours and the national figure across Wales is only 35%?

[139] **Dr Goodall:** That is because we make it our core business; because we recognised that we had a problem; and because we use our annual contract mechanisms and our regular visits, including with the community health council, to try to reinforce that and make it happen.

[140] **Aled Roberts:** That suggests that others are not.

[141] **Dr Goodall:** They may not be, but I would hope—because I know that we have shared details about the 'A' is for Access scheme with all of our colleagues in Wales, not least over the last four months—that they will be looking to put in place some similar mechanisms. Equally, for me to get from 48% to a higher level, I will need to look at what they are doing across Wales as they start to increase it also.

[142] **Darren Millar:** You are obviously not satisfied with 48%; of course, you have to get that higher. However, are people taking advantage of the levers that they have within the contracts elsewhere in Wales, in your opinion, in order to deliver the improvement that the

public wants to see in terms of access within those core hours?

[143] **Dr Goodall:** The contracts are there to be used. We need to use them to make sure that they deliver the outcomes that we expect; I think that if I am at 48%, I probably still have more to go at within my own use of the contracts. However, the contracts are there to be used, absolutely.

[144] **Sandy Mewies:** We have heard quite a lot about recruitment difficulties for out-of-hour services, not least from Aneurin Bevan. What can you do, and what needs to be done, to ensure that services, when they are provided, have a safe and sustainable amount of staff? I appreciate that there are difficulties.

[145] **Dr Goodall:** All areas of Wales are having to work through this at the moment through their various service configuration proposals. We have been very explicit, reflecting on the south Wales programme, about those pressures and what they mean for medical staffing. Some of the difficulties are around recruiting, but they are also around some of the training experiences that need to be given. It is about adapting to different workforce opportunities. I can say that areas of Wales that have developed emergency nurse practitioners have made those decisions. The good news is that we have been able to recruit, and we have been able to do that very well. What you need to do, however, is make sure that you are recruiting to an infrastructure. There is no point in just recruiting one specialist emergency nurse practitioner. You have to make sure that you are recruiting to a team. That has been successful in working it through.

[146] Secondly, there are the choices that doctors will make about wanting to pursue careers in acute medicine in A&E. They are looking to be able to respond to some of the demands and workload pressures that they see. I hope that we are being innovative about our approach to show that we are able to stabilise some of these pressures and give a good patient environment and also a good staff environment, which is important. They are also reflecting that they are expecting to see more specialist units. If you are a consultant or a junior doctor wanting to be a consultant in the future, you want to be on a rota with a significant number of other colleagues to make sure that you are all able to provide that senior medical oversight. We have examples in Wales where rotas are very tight. You can be down to as few as two or three consultants in individual A&E units, which is well below standards. We have been open about that through the process. Where you are developing a more centralised approach, it tends to attract an interest in a more stable service for the future.

[147] In our patch, because we are centralising our A&E services for the future, we know that, as we have recruited new individuals, they have reflected that that was quite an important part of their choice to come to Aneurin Bevan health board as an area. Nevill Hall Hospital had only one consultant four years ago. We are now up to five consultants in post in that area, because they have signed up to a general strategy, which is going to be about the centralisation of services within our patch. It becomes quite a personal set of decisions that are taken.

[148] **Sandy Mewies:** So, what I think that you are talking about is that you have to have a strategic plan that says, ‘This is the team that we need, and this is how we have to recruit to it’. That is working quite successfully. Is that what you are saying?

[149] **Dr Goodall:** Yes. You give a clear plan to people, give them certainty about services, show how you are going to deal with standards and the development of specialisms—

[150] **Sandy Mewies:** That will help people come in.

[151] **Dr Goodall:** Our experience has been that that has helped us in our local area. I hope

that, as we give the final recommendation on the south Wales programme, that will allow us to unlock some of the recruitment that will have naturally been affected over the last 12 months, as we have been going through the engagement and consultation.

[152] **Sandy Mewies:** You have talked to us about the changes in A&E and the shifts that have occurred over the last 10 years, where you have alcohol abuse, presumably substance misuse, and the number of vulnerable and frail people on the increase. You also said that there has been a smoothing out, so that this is no longer about Friday nights, Saturday mornings or Saturday nights, as it was at one time. It has been smoothed out. Do you think that any part of that shift, where you are seeing more people regularly on a smoother basis, is because of problems with out-of-hours primary care?

[153] **Dr Goodall:** There were big changes to the contracts a number of years ago now; 10 years or so ago. I know that there is potential for that to be a factor, but we have had to just make the current system work effectively. There are always worries about continuity of care. From my perspective, it is an ability to make sure that you can give a more personal set of information and support for anybody who is passing through. From an IT perspective, it is possible—we are doing it in some areas of Wales—that the GP information is able to be available within the emergency unit as people arrive, so that you have some familiarity. One commentary that people are making is that we have broken up some of that care from being 24/7, which sometimes makes them feel like it is less personal. There is an awful lot more that we can do. Out-of-hours services have struggled at times in terms of their ability to manage some of this demand. Over recent months, however, we have been able to make that slightly more solid. A good decision with the Welsh risk pool about supporting some of the indemnity premiums has had a significant impact very quickly on our ability to recruit GPs to the out-of-hours services. The bit that we are always going to have to try to balance, if it is not your GP in your local practice, is how you can show people that you are still providing the same continuity of care, even with those out-of-hours services.

[154] **Darren Millar:** I apologise to everybody for the temperature, by the way. We are trying to sort it out. It is getting colder and colder in here.

[155] **Sandy Mewies:** It is a message. [*Laughter*.]

[156] **Darren Millar:** We need to warm things up. Apologies for that. Back to you, Sandy.

[157] **Sandy Mewies:** You talked about how your board in particular gets information about the performance and quality of out-of-hours services. You have also talked about how we can get comparability and improve consistency in the data. That is terribly important on a national basis, as we are a national health service. I do not know whether you wanted to add anything to that.

[158] **Dr Goodall:** I probably do not need to add to that. I agree with you and my comments stand.

[159] **Darren Millar:** I want to go back to the issue of recruitment, before I bring Julie in. In terms of the recruitment, what you are saying is that a move towards more solid services will help you to recruit. If you look at that from another angle, the uncertainty over services is not helping you to recruit to the levels that you would like, is it?

[160] **Dr Goodall:** All areas are struggling with their current service provision. We, in the south Wales programme, have to make a decision, because it has to be very clear to all those people who want to work within our system for the future. Although there will be interest, people will be waiting for that final call in terms of the security of their future, because people are looking to make careers. That is why I take very seriously the responsibility that we have

to make the final recommendation, as your colleague suggested.

[161] **Julie Morgan:** You have mentioned the 111 service; what are the benefits of that service and how are you going to avoid the problems that have occurred in England?

[162] **Dr Goodall:** We need to change the nature of the discussion. We need a national infrastructure, even if it is about local service provision. As I have articulated through this, it is an opportunity to not just make a technical solution; I see it as trying to make sure that we better co-ordinate the care and the choices that people have about the services that happen. I think that the 111 service, or 'phone first', as I would describe it in Wales, is not just about putting in an IT system or a telephony system; it is about changing the way in which people behave. I hope that people would see it as an opportunity to be clearer about how they manoeuvre through.

[163] I appreciate that, for that public, it can be very difficult indeed to make the right choice about which particular service you should access based on different conditions. Even those of us who are very informed have to make sure that we can balance when we would go to NHS Direct as opposed to when we would go to an out-of-hours service. I hope that it gives us an opportunity to describe and have greater visibility around the local suite of services that are available, but we definitely need to learn from the experiences elsewhere in the system. I know that we are slightly behind on our implementation proposals. We are looking to make sure that we can roll this out in 2015. At the moment, we are looking to press the button in October 2015, but the English experience shows that you have to think through very carefully about what is there. I know that Dr Jones will be able to talk in a lot of detail about that and the opportunities for change. It is a significant opportunity for us.

[164] **Julie Morgan:** The Choose Well programme was not very successful, given what the report said. Why do you think that was?

[165] **Dr Goodall:** We are disappointed about the Choose Well campaign, because I think it makes a lot of sense and it helps the understanding of the general system. Maybe it is just something that you have to keep going at. I do not think that you can say that you have dealt with public education with a one-off initiative; I think that you have to deal with public education over a period of time and over a number of years.

10:15

[166] We are running a local version around Choose Well called Be Winter Wise. From our perspective, there has been a good feel for that locally. It is the third year that we have been running a similar type of scheme, all predicated around Choose Well. When you turn it into a local practice in terms of what it means, you start to find that it is effective. We did some evaluation locally of our local interpretation of Choose Well via our public health department. Although you could not say from the numbers that you had stopped all of the pressures within the system, you could see that it was having an impact, in that people were starting to think differently. However, in the scheme's second or third iteration, we worked differently with the media. The *South Wales Argus* has made it very visible for us. I think that we just have to keep at this each year. So, we should not just look at the outcome from one year; we should probably look at it over a three to five-year period.

[167] **Julie Morgan:** It would be interesting for us to look at that.

[168] **Dr Goodall:** Yes, okay.

[169] **Julie Morgan:** What about more use of community pharmacies? Do you see more potential there?

[170] **Dr Goodall:** It is probably easier for me to say 'yes'. There is a danger with primary care that we end up only focusing on the GP perspective, but I still think that there is a lot more that we can do around pharmacy provision, for example the minor ailments aspect. Of course, there are contracts in place there, and we have to utilise them to very similar levels. I think that it is about having a suite of primary care services, pharmacies and GP practices; it is definitely a part of working differently.

[171] **Darren Millar:** Aled Roberts has a brief supplementary question.

[172] **Aled Roberts:** A oes rhywun yn genedlaethol yn gyfrifol am ddiweddaru *Choose Well*? Mae beirniadaeth wedi bod yn y gogledd nad yw'r wybodaeth ar y wefan yn cael ei diweddaru; roedd pobl yn cael eu cyfeirio at unedau mân anafiadau a oedd wedi cau ers chwe mis.

Aled Roberts: Is there anyone nationally responsible for updating Choose Well? There has been criticism in north Wales that the information on the website is not updated; people were being directed to minor injuries units that had been closed for six months.

[173] **Jocelyn Davies:** Well, that is not his fault. [*Laughter.*]

[174] **Aled Roberts:** I am just asking who is responsible. Is it a national thing, or is it local?

[175] **Dr Goodall:** The scheme is overseen nationally, so it is done through Welsh Government auspices. However, accurate local information is something that local health boards should look to provide. What I will do—if you are raising that as a problem—is to take that away, because with my unscheduled-care-lead hat on, my role is to look at ways in which we signpost people. If it is simply inaccurate—

[176] **Aled Roberts:** This information is hot off the press, because it was only raised with me on Tuesday.

[177] **Dr Goodall:** Okay, well—

[178] **Jocelyn Davies:** That is hopeless.

[179] **Darren Millar:** He sneaked that in to try to raise the temperature of the room. That was very clever.

[180] **Dr Goodall:** I will pick that up with colleagues in Betsi Cadwaladr for you.

[181] **Mike Hedges:** Paragraph 1.51 of the auditor general's report highlights concerns about the morale of staff working in emergency departments relating to the frequent high workload pressures within these units. What are you doing to address that?

[182] **Dr Goodall:** I agree with his comment as well. There is a general worry about this and we have to make sure that A&E—and I would include acute medicine as well, because they are core services for us—have to appeal to all of our future professionals, doctors in particular. However, they are very busy areas. You can define people who go into different areas almost by types and they will make early choices in their careers about what happens. Interestingly, having reflected on this locally, we see people who like the busyness of the environment. I think that people are happy with the fact that A&E departments are designed to be busy and they will be designed to be busy through a 24-hour period. The frustrations appear when people feel that they have to care for people perhaps inappropriately, in the sense that they could have been cared for under medical care or under community services; they may feel that they are not the best fit.

[183] I think that there is a national discussion to be had on A&E specifically—whether it should be about providing emergency medicine and care for older people, or whether it should be around trauma and injuries, as has traditionally been the case in the service. It probably has to provide a bit of both, but the service may want to revert a little to being about emergency and trauma. Our main response to that is that it is around the service configuration agenda and what we are looking to do. What we are trying to do is to relieve the workload by centralising these services in the right areas—to provide the available suite of support services, to use practitioners properly, whether they be emergency nurse practitioners or junior doctors, and to try to mitigate the workload.

[184] Our final point is that we still have an opportunity to try to manage demand differently through the A&E front door. So, to go back to the ambulance service opportunity, if some of the people attending feel as though they have a different choice, and if we could take those away from the system, a department would be busy, but at least it would be busy with the right kind of people.

[185] **Mike Hedges:** I actually had to contact a doctor's surgery, not in my constituency but in a neighbouring one, over a constituent's issue and one of the first things that the recorded message told me was to go to A&E. That was the second thing that was said there, 'If you feel that you have a serious condition, or if it is an emergency or you desperately need to see a doctor, please go to A&E'. It said something along those lines. I think that that perhaps might be part of the problem. Leading on from what you were saying earlier about different specialities in A&E, is there any room for having specialists on the elderly or other specialists in A&E, rather than just having A&E specialists and people who specialise in medicine for the elderly, elderly care and other issues? Would that help recruitment?

[186] **Dr Goodall:** Yes. That is already happening. I think that, often, we can artificially distinguish an A&E department from a medical assessment unit and an emergency assessment unit. It is about aligning all of those together. You will find that all areas of Wales are developing acute care physician roles at the front door, and I think that, in terms of our services, we need to recognise that that co-ordination of older people's care, and having someone with that experience to move them from the front door to their final discharge, is important. You may have seen in the media recently that the Royal College of Physicians did a report around seven-day working and acute care physicians. Actually, the Royal Gwent Hospital is one of three sites in the whole of the UK that has been able to actually bring in those on a full seven-day-a-week basis for the first time, and they have a very close working relationship with the A&E department. So, we are trying to stream the emergency medical patients and older people into that kind of system. That is happening in all areas of Wales.

[187] **Darren Millar:** Just going back to ambulance handovers, one of the things that we did not seem to have any clarity on, until today, was when the counting starts, as it were, for an ambulance handover, so that the delay of a handover can be measured. We were told in a previous evidence session by Dr Poulden that, as a clinician, he would often be treating people in the back of ambulances. According to the flowchart that has been provided to us by the Wales Audit Office, that would mean that many of those individuals treated in the back of an ambulance would not have their delayed discharge into the A&E department recorded properly, from a handover point of view, because they would not be counted until they were out of the ambulance. Is that a cause for concern? To what extent is the under-reporting of delays in transfers of care between the ambulance service and the hospitals happening?

[188] **Dr Goodall:** I would say that it is about ensuring that we do not use single measures to tell us what the system is about. We do not do that, because, actually, we have our status levels, which are reported across Wales and are part of our daily calls. The respective position of the different sites across Wales is well understood in relation to that. The ambulance

service has its own tracking of any waits that are excessive across Wales, which is available to all of us. So, we actually oversee that within all of the local health boards in Wales and in our different departments. Although we use the handover measure as one part of the system, we also look at ambulance turnaround times in totality, and those measures are actually taken from when an ambulance is on the hospital site rather than when the patient is through the front door of the A&E department.

[189] **Darren Millar:** Does it not concern you that people are being treated in the back of ambulances rather than within an A&E department?

[190] **Dr Goodall:** It concerns me that people should be treated in the right environment. That will not necessarily be in the back of an ambulance; it may well be where they can be cared for safely. Our responsibility for emergency systems is to make sure that people can be dealt with in the right manner, whether it happens to be in a hospital environment or outside; we have to do that.

[191] **Darren Millar:** Are you confident that everything is being recorded consistently across Wales in terms of the way that these handovers are dealt with?

[192] **Dr Goodall:** If you take a handover on its own it will be absolutely right to say that it is only when a patient physically walks through a department that there is a trigger. That is why I look at the other measures as well. I know that other colleagues across Wales do so, too. I know, from my own participation in the escalation calls, that it is very visible and apparent where the pressures are across Wales at any one moment, and when there are difficulties with ambulances that need to be addressed. So, we do use other measures. A handover is not the only measure of how the system is performing.

[193] **Darren Millar:** However, it is a key measure.

[194] **Dr Goodall:** It is a key measure, but it is not the only one.

[195] **Darren Millar:** The clinician we spoke to was quite clear that he was not sure when the trigger point was, which I found very concerning, as did the committee as a whole. Aled?

[196] **Aled Roberts:** I must admit that I have asked about this. I met with a representative from the ambulance trust over the recess. Clearly, their feeling was that, as soon as they had put that pin number into the screen, the patient had been handed over and was the responsibility of the A&E department. So, there appears to be a bit of confusion if you are saying that the handover, from your point of view, is when they physically go into A&E.

[197] **Dr Goodall:** As I say, the ambulance service tracks turnovers and handovers. A paramedic would know that, as they hit a site and they hit their button, that had been recorded. That is absolutely right. However, there are different measures so that we can look at all of the different parts of that particular experience. Again, I am happy, with the chief executive of the Welsh ambulance service, to give you a note on that to clarify things. However, I personally use more than just the handover mechanism. We try to look at it in that more rounded manner.

[198] **Darren Millar:** Yes. It is quite right that there is a suite of measures. I appreciate that, but this is obviously a key measure, which has been a focus of debate for a number of years and which clearly needs to be reduced. My final question is on the ability of the national programme that you are leading to deliver on the improvements that the Welsh Government has an aspiration to see in the Welsh NHS. Are you confident that you are going to be able to deliver the change needed and that you have the resources, as health boards and health bodies, to be able to deliver the change that we need to see in the coming months and years?

[199] **Dr Goodall:** I will need to deliver it as a chief executive of a health board, first. However, as long as we can continue to focus on the unscheduled care programme and on the areas that will make a difference and that are of strategic importance rather than being in the mire of the day-to-day pressures—which is what we have devised through the programme to make sure we have headroom—and as long as we can bring in expertise that helps us to do that, and we are doing that with some of the national flow programme work, which is really focusing and working with our clinicians in a very different way, I think that we will continue to make progress in this area. Resources are tight for us. We have to balance all of those choices within the money we are given and allocated at this stage. Some of the improvement in performance over the past 12 months that we have seen even alongside the WAO report will, I hope, mean that we will be able to deliver and discharge proper care for the patients we support. I would definitely like to be describing to you in 12 months the areas that the unscheduled care programme has made feel different on the ground. Certainly, getting some confidence about areas like 111 and the 'phone first' approach happening will be part of that response as well.

[200] **Darren Millar:** If there are no further questions, that brings us to the end of this particular session. We are very grateful for your attendance today. We hope that you enjoy the rest of the NHS Confederation conference that I am sure that you are on your way to.

[201] **Jocelyn Davies:** Chair, do you think we could have a note on the financial profile of the invest-to-save programme and the Gwent frailty project, showing the amount borrowed, the amount saved and the amount paid back?

[202] **Darren Millar:** Are you happy to provide that, Mr Goodall? We already have another matter you said you would send a response to.

[203] **Dr Goodall:** I will need to check with the clerk, just to be clear, but I have those three or four areas.

[204] **Darren Millar:** The clerks will clarify that for you.

[205] **Sandy Mewies:** Could I ask for a short note from you to expand slightly on handovers, which we have been talking about? You said that there are different ways of measuring it. I certainly think that there are other ways, so could we have a note on that, please?

[206] **Darren Millar:** Also, to let Members know and for your information, we are going to drop a note to the Welsh Government, asking about the implications of the changes to the GP contract on access. Thanks ever so much for your attendance today.

[207] **Dr Goodall:** Thank you. Diolch.

10:28

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

[208] **Darren Millar:** We will move on to the next part of our meeting, continuing to take evidence on unscheduled care. I am very pleased to be able to welcome to the table Dr Chris Jones from Cwm Taf Local Health Board. He is the chair of Cwm Taf health board and the author of 'Setting the Direction', which sets out a framework aimed at assisting local health boards in the development and delivery of improved primary care and community-based services for their local populations, particularly for individuals who are frail, vulnerable and

have complex care needs. Of course, you are also the co-lead, as it were, with Andrew Goodall on this issue of unscheduled care in the NHS. We are very grateful to you for attending today. We obviously have not had a written paper from you, but I know that you are happy to provide clarifications as a result of the meeting, if Members require any. Do you want to make any opening comments before we go to questions?

[209] **Dr Jones:** I really welcome that this is a live subject that is being discussed. I come from a general practitioner background, so there is a bias in me. However, what I would like to say up front is that this is a continuum and it is a very complex Rubiks cube. There is a great tendency to look at conditions, to use 'health-speak', but there is a great importance to see the person behind those conditions. The other thing I would say up front is that you cannot put one bit right. You have to get a consistency of putting many things right, and those right things are changing.

10:30

[210] The part that citizens and carers play in the use of the system and in telling us when we are not doing it right is really important for the future of any national health service. I am very happy to answer, as best I can, any questions or areas that you may want to probe. I am not a chief executive, but I have a handle as a carer, as someone who struggled to find appropriate levels of care for elderly parents, as someone who has seen and advocated for the patient as a GP, and also someone who has had the pleasure of reviewing care systems and been able to do some blue-sky thinking about some of the things that we might do. So, that is my background, and I am happy to be the best resource that I can.

[211] **Darren Millar:** Thanks for that. We will move into questions then, if that is okay. One of the issues that I would like a bit of information on is related to the fact that you are the chair of a board rather than a member of an executive team. How empowered are independent members of boards to be able to challenge chief executives and other members of the executive team to make sure that they are delivering on unscheduled care?

[212] **Dr Jones:** First of all, you have got to know what is going on, and I think that across the health boards—I have been acting a bit like a lightning conductor among the chairs and the vice-chairs to say, 'We need our board members to know what it feels like out there'. So, for instance, my board members in Cwm Taf will participate in structured assessments of areas, but also when we know that it is hot, they will be out there, and we will do that in conjunction with our community health council. We also run community locality fora, which are widely advertised and to which people can turn up. My board members have certain localities that they are aligned with, and I do not think that that is particularly different to other places, but we have been doing it for a long time. One of the best things about the south Wales programme has been being out there, listening, and I have learned a lot more about real life and much more about how things affect real life and the changes that are happening. Some of those then are reflected upon to determine why people use different parts of the service and choose to do it at certain times.

[213] The scrutiny bit then comes from asking, 'What are the cold facts and figures and what's the reality check? Have you got a cunning plan? Are we hitting targets and what is the impact of not hitting those targets?' You can argue about targets, but they are targets. They are helpful, but it is about getting behind that. So, at board level, if you look at my board papers, you will see that I have one at-a-glance sheet, warts and all, but behind all that is a great deal of detailed information that every single member of my board has access to. We have a structured approach to it through sub-committees, but I also have an integrated governance committee. In that integrated governance committee, we bring together those areas that are potential gaps between the structured sub-committee things. My chief executive probably feels that we have a very straight relationship, where I straightforwardly ask,

‘What’s happening? Don’t give me any surprises and, by the way, can I help?’

[214] In terms of the strategy, I like strategy and I like looking at the helicopter view. I definitely do not like going into the nitty-gritty, but I know one thing, I know when it is not on course. So, there is challenge, but there is also support. I think that the most important part of the relationship is honesty, and I think that we are developing a very honest relationship with our population. Every health board needs to be upfront.

[215] **Darren Millar:** So, we have seen a long-term deterioration of performance, but there has been a little bit of an improvement. Has the improvement come as a result of the work of the national programme board?

[216] **Dr Jones:** I think that the national programme board has brought together learning. I think that it has brought together a focus on the fact that, yes, these are targets, and they do mean something. I think the consistency of data, which I heard discussed, is the other bit that it is allowing. We are testing how consistent this is. The other thing is the alignment; it is a whole system, not a bit. Everybody will focus on that A&E issue. It is a red flashing light. There are ambulances queuing up. However, people’s experience behind that, out in the community, and those who cannot get care because of chaos, when it is chaotic, I think that those are things that boards have been focused on, through bringing together the national programme elements. One of the key challenges for the national programme is: can we paint the picture of what it is going to look like as a whole? That is our biggest challenge. Bringing together people like Ilora Finlay, who are not shrinking violets, and who bring a perspective, together with the ambulance service and social services, and public health—all those elements together— provides a really interesting focus. Then there are the working groups, and those are able to hold them to task about, ‘How is it going?’, ‘What are you doing?’, ‘Where do we need to innovate?’ So, I think it does bring a drive. Andrew’s chairmanship is one of facilitation, but it is challenging.

[217] **Jenny Rathbone:** Thank you for your detailed papers. I think that there were some really good examples of changing services to make them work better. Your ‘phone first’ service trialled in the Rhondda. That was very interesting. Also, you have used advanced emergency nurse practitioners in minor injuries units and in A&E. I wondered how you are going to spread the learning from those two excellent examples to the rest of your colleagues in Wales.

[218] **Dr Jones:** The penny has dropped that Wales is small, relatively, and I think we have a common problem: we have a medical manpower challenge that is faced right across the healthcare systems of the world. However, particularly in the UK, we have to innovate and not just do different things, but do different things differently. So, we cannot use the old ways of just changing people’s roles. We have to change the governance around the way they use their roles, and we have to change what they are actually going to be doing.

[219] I was very pleased that Cwm Taf health board has been recognised as a university health board, because I think that action research is aligned to service provision and excellence in training and support. We would not want to set up things in isolation. We have a network now, and where we have picked up good ideas, they need to be challenged by others to see if they fit the local circumstances. The ‘phone first’ service has shown that if members of the public pick up the phone, we can get them to the right place. I have bitter experience of a man with a sore throat who was having a little bit of difficulty breathing, who turned up and waited in a minor injuries unit, and had acute epiglottitis and died. If I had spoken to him on the phone, he would not have gone to a minor injuries unit; he would have been at a major A&E unit. Those experiences say that if we are getting people to work remotely, they have to be linked to the acute stuff at the highest level, so they can take that experience out. I think that is a way of sustaining local services very safely and very appropriately, and protecting

acute, hot centres from things that can quite appropriately be done elsewhere.

[220] The other effect it has is that we have had a real conversation with general practice and pharmacy, so, as you will see from those figures, we have been able to get more activity placed appropriately and challenge those practices where there are issues of access. So, it has become very practical.

[221] **Jenny Rathbone:** Excellent. Yes, I have no doubt that you will deal with the—

[222] **Darren Millar:** Seeing as we are on the subject of the 'phone first' programme—because Dr Goodall said that 'phone first' will be, effectively, the 111 service for Wales—I would like to bring Jocelyn in, and I will come back to you, Jenny, if that is okay.

[223] **Jocelyn Davies:** I have some questions on that, so I will do them now, as you have mentioned it.

[224] You mentioned a specific case in relation to 'phone first', but can you give us an update on progress in setting up the communication hubs, and perhaps on what the rest of Wales can learn from your board's experience with 'phone first'?

[225] **Dr Jones:** I have had the privilege of leading a piece of work to look at how we take forward out-of-hours services and 111. It started off as 111, but it was recognised two years ago that the English pell-mell run towards 111 was based on being able to do it technologically. I put together a group across the care sector in Wales, including community health councils, which looked at what is really needed. The opportunity for a Wales-wide communication network goes both ways: keeping people safe out there and getting people in appropriately, but, most importantly, getting people supported to get out, if they go into bed-based care.

[226] There was great resistance from the British Medical Association, because it was learning from its colleagues in England, particularly the out-of-hours providers, what chaos was occurring, and it was beginning to be seen in some of the pilot projects. I found it very difficult to get an evidence base from the pilot sites initially. We spoke to practitioners in Scotland, and went to Scotland to see what it has been doing, but the ambition is that we have a system that sifts and gives patients an easy chance to get it right: so, a big database of local services that they can access on an IT basis, or by phone, choosing a number from a menu.

[227] Already in Wales, we have the basics of that through NHS Direct, which has an amazing index of local services. That is kept live through the relationships with the local health boards. So, the vision is that someone who recognises that they have something very serious calls 999. That is easy-peasy. Then you come to the question of what is urgent. I read the BMA's evidence from Charlotte and David, and you asked them a question about what constitutes 'urgent'; it is the most difficult question to answer—it is difficult for me to answer. I could tell you what I think 'urgent' means, clinically, but 'urgent' means different things. If your mother is on the floor and you cannot blinking get her up, even though you know that she is all right, if you cannot lift her and she is on the floor, that is urgent; if you are flying to Abu Dhabi tomorrow and you have diarrhoea, then that is urgent. So, it means different things to different people. So, having somewhere to ring helps. In England, it was called 111, and the thing was that you could get through, but you could not get an answer; you could not get your problem dealt with. Where it worked really well, and there were areas where it worked very well, there was excellent connectivity of services before the number was put in front of that. So, the fact was that NHS Direct found it very difficult to continue with the contracts in England. It had a chance in England to get it right, but I think that the pressure to do it overtook it.

[228] **Jocelyn Davies:** So, it did it too quickly, did it?

[229] **Dr Jones:** Well, I think it could have learned more from what some of the evidence was showing. When you do something in a big bang, the chances are that it will go wrong—some bits of it will go wrong. So, I think it was brave, but we have learned a lot from it, and so has it, and it is improving.

10:45

[230] **Jocelyn Davies:** So, what is the future for us, because if we have NHS Direct Wales, and perhaps this 111/'phone first' service, the out-of-hours service—

[231] **Dr Jones:** We need to coalesce these things into one thing, so that there is 999, and your access to local services on a web base or what have you is available, but we also have a 111 number, which connects you to a place that can point you to the right thing. Some of that is easy-peasy and you can do it with significantly trained call handling, but, sitting alongside that, you have to have a clinical decisions desk. One of the opportunities that we have, which is the big challenge, is to start scheduling some of the unscheduled questions. When I look at GP out-of-hours services, you have to ring—people hate it, but they ring—and 38% to 40% of contacts are dealt with by advice. That advice can be practical, but it can also be about giving confidence.

[232] The second bit you can do is to see someone. You were asking about minor injuries units, and people seeing few. Well, actually, if you give people appointments instead of them just walking in, you can keep more access to local services by varying the times that those are available. The other thing is that you can stream those people with chronic conditions who have a breakdown in their care to people who can advise them specifically on their care speciality. So, you could align, from that one number, access to supporting people's end-of-life care, and access to support for your chronic obstructive airways disease patients. If you link that to having access to a care plan based in the GP record, you can start to get care that is much more consistent and more supportive. You can also pick out those people who may think that they have had something trivial, but it is more like a stroke; it is still amazing how people think, of a stroke, 'Oh, it is only a little pull'. The opportunities that we have now, compared with five years ago, to get better outcomes and to avoid huge suffering are immense. So, we will be saying to them, 'You need to be seen today—you need to go to this unit, because that's where we can deal with the issues, and, by the way, they're expecting you. Can you get there? If not, we'll get the transport for you'.

[233] The other bit is that we now have people with quite complex levels of care in community settings, much more than ever before. Doing a GP round in a nursing home and a residential home is not straightforward; it is highly complex. Having significant teams that can support people in those nursing homes to make good decisions about diarrhoea outbreaks and about end-of-life care means that, from that one number, we can co-ordinate that care. It is a big ask, and I think that we will have to do it in tranches. We will need to look at the most risky end—the bit that causes chaos for the patient and the service. The roll-out programme of this will be a real issue. There are technical issues, no doubt, but there are elements in this that can bring economies of scale. After midnight across Wales, we have 10 out-of-hours message-handling systems. It is expensive, but it is necessary. We could probably start doing these things from two systems—I would never say one, because you need to have resilience.

[234] The other thing is public health issues—getting public health messages out, such as when we have influenza outbreaks. I have never seen a health service work more like a national health service than when we had the pandemic flu outbreak. You saw it in a microcosm over the measles outbreak. When the health service gets its act together, it has a huge capacity. The core is communication, focus and a feeling that you are achieving. I think

having a 111 system aligned to a 999 system, with a clinical escalation behind it, takes us into territory that is really beginning to manage the situation.

[235] **Jocelyn Davies:** May I just ask what sort of timescales you envisage? Obviously, what you are saying is that this is blue-sky thinking and it will be an all-singing, all-dancing service; everybody is going to learn the 111 number and everybody is going to know, if it is not an absolute emergency, that is what they are going to call. What is the sort of timescale that you envisage?

[236] **Dr Jones:** What I have described to you is probably a five to 10-year journey.

[237] **Jocelyn Davies:** You have to start it somewhere, however.

[238] **Dr Jones:** You have to start somewhere, and I think that the starting somewhere has already started, because we are seeing much more activity in healthcare systems looking at the whole, not just at one bit. The A&E experience last winter, going through into the spring, has been a stimulus, I think, to do many more things in different ways. The south Wales programme, and whatever happens in north Wales, and whatever is happening in the Hywel Dda area, are clear signals that the care system needs to change for those very top end things and for getting services as local and as accessible as possible. I think that needs a vehicle and this is potentially one of the key drivers for the future.

[239] **Darren Millar:** So, how soon are people going to be able to dial 111 and get a service of some sort in Wales?

[240] **Dr Jones:** I think that we are looking towards 2015. There is a lot of work to be done about making sure that we have the services behind it. I know you took evidence from Ilora Finlay, but one of the things that the palliative care consultants have is this very network whereby patients can ring a particular number. That is at the very specialised end. A person going from a nursing home into an A&E department to die is sad, and, while we can work very hard with the nursing homes, we have to give them the tools to support them to look after those people.

[241] **Darren Millar:** So, we are going to have a 111 service, which rolls up, if you like, the current services from NHS Direct and picks up live data, for example, on waiting times in minor injuries units and other local access points for health services, and also provides public health information to the public as well.

[242] **Dr Jones:** That would be the vision, and, in articulating it, you have to persuade parts of the system that have been—. Let us face it; we have a health service that has been created from millions of bits. It is about bringing local health boards to be overarching in their responsibilities. I thought what Andrew said was very significant in saying that, at a health board level, we are looking at not just the medicalisation, but the health. That coherence with local authorities is something that is, potentially for us in Wales, and for this Government and Assembly, a massive opportunity.

[243] **Darren Millar:** Just to stick with this telephone issue for a few more moments, it will be 111 and will be marketed as a ‘phone first’ type service. The idea of ‘phone first’ is quite attractive, is it not—that is, nobody goes to an A&E department without picking up the phone first and trying to see whether there is another way to sort their problem out—in terms of helping to reduce demand?

[244] **Dr Jones:** I am not going to get stuck on a name, but, definitely, that philosophy of phoning first so that you get it right more of the time, I think, is a way of rationalising—not rationing, but rationalising—the way that we provide services. It is about the right patient, at

the right place, at the right time, getting the right service.

[245] **Darren Millar:** Jenny, I will come back to you.

[246] **Jenny Rathbone:** I just want to come back on the transport issue, because it is relevant to your having phoned—and then what? However, it is also relevant to the south Wales programme and how we structure our services. You did this interesting analysis of traffic in Royal Glamorgan Hospital, where you redirected 100 people, and, of the 161 who were suitable but could not be redirected, there were 61 patients who did not have transport to get to the minor injuries unit. That could also apply if they had phoned first, although there may not be a blue light. How do you envisage squaring that circle in terms of the probably 50% of the population who do not have a motor car?

[247] **Dr Jones:** One of the things about working as a local health board with local authorities and the voluntary sector is that you suddenly realise that community transport is alive and kicking—it is massive; it is just disparate. The ambulance service is huge—it has one end, which is the acute stuff, and, as you know from the McClelland review, there is another bit, which is about just getting people from A to B. We must be much more discerning about what the ambulance blue light is for. We must be much more flexible about how we use the other bits. It is necessary to do that at a local level, at the local health board level, because you will then get the right fit. The other thing is the helicopter bit in the very emergency bit; we need to be really on the money about how we use that resource. It can get someone to the right place, which makes access to the service a lot quicker. You would not want people with a cut finger using a helicopter, so why would we want people with a cut finger using an ambulance, unless it was a torrential bleed? We have to get real about the governance and safety issues and get some coherence around that across Wales.

[248] **Darren Millar:** Is the ambulance service a bit too risk-averse in that sense?

[249] **Dr Jones:** I think that the ambulance service has had to be risk-averse. We need to make sure that the front end of the ambulance service sees itself primarily as a clinical service and that those clinicians are supported within the body caucus of the national health service. On the debate that you were having about the paramedic bringing someone into the grounds of the hospital, the governance lines in that are very testy, I would say, and I am sure that they will be tested; they are real issues. One thing we have in Wales is the ability to see the governance lines very straight if we choose to.

[250] **Sandy Mewies:** Good morning, Chris.

[251] **Dr Jones:** How are you?

[252] **Sandy Mewies:** I am fine. One of the things I was thinking about with 111, or whatever you are going to call it—like the Chair, I think that it is a really good idea and it would work well.

[253] **Dr Jones:** '*Galwch yn gyntaf*'. **Dr Jones:** 'Phone first'.

[254] **Sandy Mewies:** A lot of the people who we would want to use that service are the vulnerable, frail elderly. In my experience, a lot of people in that group have never heard of 111. I wonder what mechanism you can use, or have used, to get 'phone first', or whatever you want to call that sort of phone service, into the public area so that people know that it is there.

[255] **Dr Jones:** When we go to do this, we need to do it as a structured campaign. When Aneurin Bevan launched the national health service, we heard, 'It's coming, it's coming, it's

coming', and then it was here. People will still turn up at A&E on foot and try to buck the system. However, for the frail elderly, we have opportunities with the variation within the GMS contract to make sure that we start to treat the elderly who are becoming frail. However, I would say that it is not just for the elderly; there are some very frail and vulnerable people—in my part of the world, they start to be frail at 50. We have significant numbers of young people out there who are vulnerable. We have to make it so that we almost give them the opportunity. I save seen people in north Wales—those having home dialysis who have a nurse to look after them who are covering 600 or 700 miles a week—totally changed by having an iPad to be able to use IT to Skype. They are having routine 'visits' on Skype and they are using Skype if there is a problem. That actually cut down the amount of unscheduled calls. We have to get into telemedicine and telecare in a big way. Digital television is a huge opportunity for communities, with messaging on digital televisions. The elderly spend a lot of time using the television. My 88-year-old mum, who died three years ago, was a nightmare on the computer. She was a silver surfer. We have networks like the University of the Third Age, for instance, and we have the National Federation of Women's Institutes. When we go into this, we have to really mean it. That is why it should not be a 'let's try it' service; there should be some certainties. Nursing and residential homes are probably good places to start that, because we have people who can help there. Then we have sheltered accommodation. So, there are ways. However, we will always have to compensate for the elderly, the frail and the vulnerable—the hard-to-reach people—getting in the wrong place.

11:00

[256] **Sandy Mewies:** I have one point on transport. I think that transport is not just a health issue in Wales. I am interested to learn how you are co-ordinating this. You have the ambulance car service drivers, those volunteers who travel miles from one end of the country to the other, and you have the blue-light service, the bus and the community transport services. I am interested to know how you are bringing those together.

[257] **Dr Jones:** I can talk specifically about Cwm Taf. Our out-of-hours service is run from Tŷ Elai, in a room that is co-located with the home press-button service. Right next door is social services. In the daytime, we also do the patient transport calls for the ambulance service for our area. So, what if we were to say to the voluntary sector, 'We'll co-ordinate voluntary transport, and, by the way, we're co-ordinating those contracts for the local authority'? We have to do a lot more of those sorts of things together with the single aim of benefiting the citizen.

[258] **Darren Millar:** Aled has a brief supplementary question, and then we will move on to Julie.

[259] **Aled Roberts:** How do we get from this nirvana to reality on the ground? I have had two cases this week. One person waited in the general hospital for three hours for an ambulance to pick him up. He told me that it was absolute chaos. Are the systems sufficiently robust to deliver this nirvana within the five years that we are talking about?

[260] The other issue is—I agree with Sandy—around older people. My mother, who is 76 and who was in a responsible job, on the computer and on the phone all day, now asks me to ring if there is a need to contact an official agency. That is the real barrier that we have. It is not necessarily about the frail elderly; it is about the people who have retired and who feel that they do not want to be a burden and feel very nervous regarding any contact. In effect, it is a confidence issue.

[261] **Dr Jones:** So, who rings 999 for them now?

[262] **Aled Roberts:** Well, I guess she would probably phone me, or my sister when I am

down here, and one of us would have to take the decision, because she would not do it herself.

[263] **Dr Jones:** So, at the moment, when you ring on someone else's behalf you are probably holding back, waiting until you reach your uncertainty level. At that moment, you have only three options. When you ring NHS Direct, they will go through an algorithmic assessment with you, which will end up with you choosing one of three options: the first is to take the responsibility yourself; the second is to go to A&E or contact the out-of-hours GP immediately; and the third is to make an appointment to see your GP. Those are, roughly, the options. They can get into giving you advice, but when you are uncertain and when you get into a complex situation, that uncertainty will mean having to choose a different way of dealing with the situation. You are probably very busy and you could not possibly wait until tomorrow morning to join the queue to try to get through to the GP, so you have already limited your options. That is where carers are. So, how certain am I that we will get there? We will never get there unless we have the vision. What we have is a determined group of people who can see that, at the minute, we have scarce resources that are being used widely. We must get more bang for our buck. We have already invested in the communications bit in in some ways, but we know that we will have to spend more on communications going forward. We have an ambulance service that needs to be brought into the clinical family. So, I think that there are all the right reasons for doing it, and giving people the certainty of response, so that it is not, 'I have to go to A&E and queue for that certainty', because at the minute A&E is seen as a universal panacea, which it is not. Was that person you mentioned in the right place?

[264] **Aled Roberts:** No.

[265] **Dr Jones:** No.

[266] **Julie Morgan:** I was interested in your comment about NHS Direct. Is it not a good idea to phone NHS Direct?

[267] **Dr Jones:** No, I think that it is helpful, because it does deal—

[268] **Julie Morgan:** It is limiting.

[269] **Dr Jones:** Yes, it is limiting. To be honest, I think that it does a great job. If I am honest, as a GP, I would say that it is 'NHS Redirect', because you are on the receiving end. Looking at it from a citizen's point of view, I can see that it gives people the ability to speak to somebody. It might be a bit mechanistic because of the algorithmic care, but that is because it has to be safe. Many people are given really good advice and have the opportunity to be directed to information. However, I think that it is a bit episodic. One of the things that I hear consistently is that people are missing the consistency of care that they used to get from the old-style general practice. The elderly are particularly vulnerable to that.

[270] However, I think that NHS Direct is the starting point of this journey and there are many bits of it that I would retain. The quality of the staff on the line is immense and I think that they can do more by using a different governance line. I am not certain that algorithmic care is always the right answer. I am worried about joining up the dots after the NHS Direct stage. Once you have given the advice, you do not know whether the patient has taken it. I would like that certainty. For instance, if I said, 'I've given you an appointment with your out-of-hours service at 4.15 p.m.', I would have some way of knowing whether that patient turned up or whether they went to a different place. So, I think that it is the starting point.

[271] **Julie Morgan:** Shall I move on, Chair?

[272] **Darren Millar:** Yes, please.

[273] **Dr Jones:** Is this okay?

[274] **Julie Morgan:** Yes, fine. I want to move on to winter pressures and how you have coped in your health board. Have you had to cancel any elective surgery?

[275] **Dr Jones:** Yes, 12.

[276] **Julie Morgan:** Twelve?

[277] **Dr Jones:** Yes. Over the last few weeks, we have had to cancel 12.

[278] **Julie Morgan:** Obviously, it has been a fairly mild winter so far, I think, so—

[279] **Dr Jones:** The weather has been mild, but acuity has not been so mild. I cannot give you figures for this, but I have had the pleasure of walking around most of the A&E departments and ambulance control teams across south Wales, and in the summer I was in north Wales. What I see is a lot of sick people in A&E departments. I think that this business of the appropriate use of A&E—last February, I was ashamed; I did not like what I saw, because we had lots of sick people and lots of people who were not that sick piling up everywhere. I looked into the faces of the staff and, you know, it is—. You walk out of a room having seen a kid die into a corridor and see people who have different ailments. You do not have time to recover. Seeing old people in a corridor in the cold is not something that a health board chair—

[280] **Julie Morgan:** That was last February?

[281] **Dr Jones:** That was last February. I could see that it was not right. It was in very unusual weather circumstances, but it was also on the back of an awful lot of bank holidays. I think that bank holidays are a major issue. Easter is just as testy as Christmas. So, here we go. Our surgeons were very fed up, because they were not able to operate. You get the drift. It is not a nice place to be.

[282] We decided that we would look at it. We did not want people waiting in ambulances outside. We were going to concentrate on all of the possible elements of flow, and we would work with our local authorities to make sure that we got the system. So, we did several things. We appointed a matron, if you like, for both our big hospitals, and we appointed chief nurses in the A&E departments, who did not necessarily know everything about A&E, but they knew everything about everything else. We put together teams that were there to support getting people out, but we also got together a thing called the CAIAS team, which supported general practitioners to have a different opportunity to refer people. That could give opportunities for quite high levels of sophisticated investigation without having to come to hospital. I have seen that my four-hour waits in both A&E departments have consistently been above 92%. Where we dropped below 92%, we have recovered very quickly.

[283] **Julie Morgan:** Have you been able to do that over that period of time since last February?

[284] **Dr Jones:** That is since September/October. There are some key messages that I can tell you about from the learning. However, to describe it, you have to see the whole thing. We have our pharmacists now. All of our wards know how busy they are. Our A&E department knows how busy all of the wards are. It is on a screen. We have escalation levels. For every patient coming in, we try to put an expected date of discharge. So, we are not expecting to keep people in; we are expecting to get them through. We have put acute physicians in and around medical assessment, and we have put therapy teams to work, which are walking around looking for cases that can benefit from having therapeutic interventions. We have

aligned our community hospital capacity; we have taken our bed days—some of them as long as 150 days—down to 60 days, and we are now working to do that. Every day, the senior nurses meet to discuss what is going on in the hospital—not just acute, but the planned care. Every day, there is a board round, which predicts what tomorrow is and what we need to do. We try to go into weekends making sure that those cohorts of patients with really acute stuff are in one place.

[285] It does work. How well it works is a matter of consistency, but we do know that it has not finished. This has meant that we have had a different management style. Even our porters now know where the hot wards are. Our porters are amazing. Also, if we know that we have beds shut because of diarrhoea, our cleaning staff, together with our infection team, can actually turn places around. They come in; they do not go home if it is still to be done. There are only three messages that I can say that really work. First, it is everyone's business; that front door is a signal. Secondly, teamwork means that it is a team; so everyone gets some part of the grief, and everyone gets some part of the praise. Thirdly, we have to be very clear that we are there to improve the patient experience. We will not always get it right. We have had the lowest ambulance rates in our department consistently since October. In terms of our relationship with local authorities, you will know that Merthyr Tydfil and Rhondda Cynon Taf are two local authorities with real financial challenges and they are having to do some very tough things, but we have still maintained and got the relationship right. It is about the person. We have teams going into nursing homes looking for collective problems as well as individual cases. So, it is a huge amount of activity and it needs leadership. We have a leadership structure where it is someone's business.

11:15

[286] **Julie Morgan:** So, in terms of the relationship with the local authorities, are you able to get transfers of care fairly easily?

[287] **Dr Jones:** Yes.

[288] **Julie Morgan:** Do you have all that under control?

[289] **Dr Jones:** It is always interesting, but that, I have to say, is honest, and they feel part of the solution. I think that the relationship is about the fact that we need this sort of capacity. This Christmas was also good, because Christmas was on a Wednesday, which meant that general practice was open on the Friday. Our general practitioners, for instance, did not do appointments; they had open sessions. It is about simple things like that. We are working with our general practitioners at locality level to look at how you change the work schedule in general practice to match the people, because there is a bunch of people—routine admissions—who come in late in the day, which causes problems going into the night. It helps if you can get them in earlier, but then the problem is about transport: how many of them need an ambulance or do they just need transport? We have medical assessment units that are turning patients out; they are getting completed episodes of care. If they come in early, they can get the complete cycle done or they can have a scheduled appointment the following day so that they have had their critical test. It has been a useful thing but I think that much more needs to be done. The next big piece of work is the effective use of community hospital beds.

[290] **Julie Morgan:** Have you got the right number of beds, do you think, in Cwm Taf?

[291] **Dr Jones:** I do not think that it is about beds—

[292] **Julie Morgan:** I know that it is not about beds, no—

[293] **Dr Jones:** The resource is the staff. I am very proud of the team we have, and I think that we have people who, if we support them, can extend their roles. The biggest message for me to do with beds is about adult mental health. We have managed to reduce our adult mental health bed base, change it, and, at the same time, build the community support. Mental health is one of the worst issues for any health professional to deal with, traditionally, in the out-of-hours period, and in A&E. We have now co-located the mental health assessment teams, our crisis teams, alongside our major A&E departments.

[294] **Darren Millar:** However, the emergency practitioners seem to suggest that one of the biggest reasons why their A&E departments are log-jammed is because they cannot get patients from A&E into in-patient beds within the hospital. I appreciate that that is all part of the flow system, so are there sufficient bed numbers, taking into account the effort that has been put into reducing demand on in-patient beds—

[295] **Dr Jones:** We have not had to put surge beds into Cwm Taf's systems—

[296] **Darren Millar:** But do you have the flexibility to do that?

[297] **Dr Jones:** If we wanted to we could, yes.

[298] **Jocelyn Davies:** May I ask the obvious question? It sounds fabulous, but why did you have to cancel operations?

[299] **Dr Jones:** There were 12—

[300] **Jocelyn Davies:** I know that it is not a huge number.

[301] **Dr Jones:** I think that it was because of sickness among medical staff or the potential that we would need an ITU bed and we had someone acutely ill in an ITU bed and we could not free that capacity up.

[302] **Jocelyn Davies:** So, this was not due to a lack of beds; they were clinical reasons.

[303] **Dr Jones:** Yes. There has been a huge change in clinical surgical practice. We have two wards where we are doing 23:59. We do not want to keep people in overnight, so the occupancy of that unit is 180%. It is a different way of thinking. The patients we send home at 20:00 are the ones we know have support when they go home. You do not bring the little old lady who lives on her own in at 16:00 to do her cataract. It is about being organised, and it is about being focused. I take my hat off to the professions who have supported this change and the unions, because it has meant a lot of work with the staff side and it will not finish; it is going to be ongoing.

[304] **Darren Millar:** I am afraid that the clock is against us, so we are going to have to move on from this particular subject, if that is okay, to the out-of-hours service and Aled.

[305] **Aled Roberts:** Os yw'r sefyllfa cystal yng Nghwm Taf, pam ydym yn cael tystiolaeth o Abertawe bod ymgynghorydd wedi treulio ei holl shifft mewn ambiwlans yn y maes parcio a bod gennym adrannau damweiniau sydd ar gau ar gyfer ambiwlansys yn y gogledd, gyda cleifion yn cael eu cyfeirio rhyw 90 milltir i lawr y ffordd? Pam nad yw'r gwersi hyn yn cael eu lledaenu ar draws Cymru os oes arfer da? Nid

Aled Roberts: If the situation is so good in Cwm Taf, why are we hearing evidence from Swansea that a consultant spent his whole shift in an ambulance in the car park, and why do we have A&E departments in north Wales that are closed to ambulances, with patients directed some 90 miles down the road? Why are these lessons not being spread across Wales if there is good practice? I cannot see that those lessons are being

wyf yn gweld bod y gwersi hynny yn cael eu lledaenu.

spread.

[306] **Dr Jones:** They are being learned, but we clocked a methodology in February. It took six months' very hard work to get things moving, and, because we have capacity in community beds outside of the acute site, we have already differentiated how to care for people in different situations. The problem, I think, in many places, is not the front door, but what lies behind the front door. So, you have to orchestrate the whole thing to turn the handle. Those things take a long time to embed. We, for instance, have had the Abertawe Bro Morgannwg University Local Health Board team come over to Cwm Taf to work with our people to see what we are doing. The delivery and service unit has been in and it spots good, bad or not-so-good practice and there is definitely sharing of information that way. You have been very lucky in north Wales, because you have had my ex-nurse director Angela Hopkins, who has gone to work up there. Angela was part of this. I am absolutely certain that all health boards are thinking this through. When putting it into operation, you have to take hearts and minds with you. The 'ologies' in care seem to be the gold standard, but even the royal colleges have realised that they must have more generalists. In doing things differently, public resistance is another factor. People do not like some changes. They must get used to change, because as long as we learn from change, I think that it is fine, but some change is very political.

[307] **Jocelyn Davies:** What did you mean by 'we clocked a methodology in February'? What does that mean?

[308] **Dr Jones:** We looked at the evidence base to see how we could possibly change what we were doing. We attended some seminars, looking at best practice in England and Scotland. The Warwick studies showed that relationships, being very clear about what you expect and working consistently to it—showing patient benefit from what you are doing across the whole system—

[309] **Jocelyn Davies:** So, this is a template.

[310] **Dr Jones:** This is almost like a philosophy, and you can motivate teams to do it. You must have good leadership to do that, and you must have trust. You have to break down some barriers that have been there because of the way that the NHS has constructed itself over the years.

[311] **Aled Roberts:** A oes problem o hyd o fewn eich bwrdd iechyd chi ynglŷn â chael apwyntiadau brys o fewn gofal sylfaenol? A yw hynny'n creu problemau i'r adrannau damweiniau?

Aled Roberts: Is there still a problem within your health board around having emergency appointments within primary care? Does that create problems for A&E departments?

[312] **Dr Jones:** In terms of clinical leaders, our A&E department in Royal Glamorgan has one substantive post and three locums, long-term locums, in A&E. Our services in terms of that sort of leadership are vulnerable, but our leadership in terms of what is behind, and our nursing leadership in extended roles, is massive. It will be different wherever you go, but if we expect to solve this by appointing more A&E consultants on their own, no; we need those emergency care consultants to be dealing with the top end of critical, critically injured and critically ill. The vast majority of people we have got are very ill, but not critically ill.

[313] My biggest worry for the future is that we need to work to make sure that medicine is a do-able profession for youngsters coming in. I think that the decision to go for a more generalist structure during the training for specialism is a really good idea. I also think that we have an opportunity with general practitioners. There is a view of looking at extended

vocational training to the fourth year. One of the key skills we need to retain in the fourth year is the focus on unscheduled care, on how to deal with sick people and spot sickness. I suggested doing a questionnaire that went out to general practitioners in Wales about doing out of hours. We did it with the BMA and the deanery, and the results of that are coming in, but the highlights are that we had about 600 responses. There were some who said, 'Never do that again', but there were a remarkable number who said, 'We would if we felt we had a supported environment to do it, if we had flexibility of shifts, and if we felt that we had a system that we could direct care to'. The money is important. It is now costing around—I do not know whether Charlotte explained that the indemnity is almost doubled if you do out-of-hours sessions, and it is not related to the number of sessions you do. I recommended that we explore using the Wales risk pool, but that only partially covers the risk that a GP takes. I would like to say to you here that we have an amazing number of people in out-of-hours general practice who have still got the skills to do out of hours.

[314] I also asked whether GPs would be prepared to do four sessions a year in out of hours if their indemnity was covered, and quite a percentage said that they would. The other thing that I have noticed is that GPs do out of hours where they live, and if you map out where GPs live, it is south of the M4 corridor, focused around Cardiff and Swansea in this area. So, it is clinical leadership, and I think that we are devaluing what GPs can do.

[315] **Darren Millar:** We are almost at the end of the time that is allocated to this session. I am going to come—if that is okay, Aled; unless you want to come back briefly on that—to Sandy and Mike and then we will close this session.

[316] **Aled Roberts:** Two brief points: the Minister announced yesterday that he was looking at restructuring the workforce planning arrangements and that he had written to the deanery. The figures regarding GPs nearing retirement age are pretty concerning. Do you have a view regarding the number of GPs that are being trained? Also, I am a bit concerned that you appear to have done extraordinarily well in getting to 60% of your GPs operating the core hours from, I think, 6% two years ago, but the average then is 35% across Wales. That would suggest that there are some health boards that must be around 10%. Why is action not being taken by NHS Wales to bring those health boards to account and get them to do their job?

[317] **Dr Jones:** I am responsible for my health board. I am very clear that, working with the GPs, we have seen the benefit of having those hours. I also want to make sure that what the GPs are doing is valued, because it is as cheap as chips, is it not? You can just ring and you will be seen.

11:30

[318] The changes to the general medical services contract in Wales will be very helpful. In a different life, I chaired a GP commissioning group, which was comprised of fund holders and non-fund holders. There is nothing like peer pressure. I want to tell you one thing about GPs: they really do care. No matter what the outward thing is, they are very vulnerable, because they care. Facing up to your colleagues by saying, 'What?' is one way. So, one of the things that we are working on in locality levels—and this needs to be done across Wales—is to say, 'You play an important part in ensuring that your patient gets to the right place, and unscheduled care is where they are most vulnerable'. It is okay to make sure that they are open, but it is about making sure that GPs are doing things that they feel are important during those times.

[319] We are doing annual reviews and mechanistic things, and we are looking at their data inputting. I am 58 and I was a GP for 33 years. That is a long time to be doing it, and you are making decisions with patients. This is the difference: you are not just saying, 'You will do

this'; the relationship is much more sophisticated now and is about helping people to make decisions. We are dealing, I think, in an average consultation, with 10 decisions. It is something that people get tired of, so we need flexibility of career. I would say to you that we need to make sure that health board colleagues are working to drive the contract, but we need to make sure that the value of the contract is getting the right things done at the right level in general practice.

[320] **Aled Roberts:** Where is the oversight by NHS Wales, with such patchy provision?

[321] **Dr Jones:** Every health board has a director of community, primary and mental health, and they all meet. The leadership in primary care at the centre needs to be very clear.

[322] **Darren Millar:** I call on Sandy; please be very brief, and then I will call on Mike.

[323] **Sandy Mewies:** Dr Jones, you have talked about the contract that we have with GPs, and Baroness Finlay—I am sure that you read that she was here on 10 December—highlighted the importance of continuity of care for older patients. Do you have a view on the change in England that will ensure that a named GP will be assigned to each patient aged 75 and over? Will the national programme look at this issue?

[324] **Dr Jones:** It is an interesting way of looking at it. In the future, continuity will be much more about consistency and planning. A key worker, whether a GP or someone else, needs to provide that sort of thing. However, I think that how we communicate and risk-manage the care is more important, for example, than accessing the record and risk-managing polypharmacy in the elderly. The thing I miss is awareness of the colour of the carpet in the house; that was nice and cosy, but in terms of whether that was productive, I do not know.

[325] **Sandy Mewies:** So, you are not hung up on this. All right.

[326] I am going to diversify a little bit; what do you think about the idea that GPs do not review regularly enough the medications that their patients get, which can be harmful and unnecessary? Is this something that should happen?

[327] **Dr Jones:** I am a bell ringer—

[328] **Darren Millar:** To what extent does that contribute to pressures on unscheduled care?

[329] **Dr Jones:** I think it contributes significantly—iatrogenicity. There was a very good article in the *British Medical Journal* by Fiona Godlee at the beginning of December. Medication is a complex area. The evidence base for the use of individual elements is based on using individual elements. When you bring three, four, five, six or 10 elements together, you have to have the wit of Solomon. Sometimes, it is about treating the patient not the condition.

[330] To take one thing, statins seem to be good stuff. If you get a leg cramp in the middle of the night, and you get up and trip over the carpet and you are 86 years old, the evidence base for using the statins shows you a 10-year survival improvement. However, if you fall over and break your femur and are left on a floor overnight, that caboodles that one. So, one of the things that a good medicine review is about is saying, 'This is the drug, this is the evidence, do you want to take it? Do you understand?' Again, a good piece of work was done in north Wales, in Gwynedd, which showed that a third of people discharged from hospital were taking the wrong thing the right way, the right thing the wrong way, or not taking it at all. Within six weeks, a third of that one third had had an acute episode that necessitated an unscheduled care appointment or admission. So, I think that iatrogenicity, which is the

medical term for this, is key.

[331] Medicines management is about taking the right drug, the right way, in the right combination. That is a trick in itself. So, we have people taking their isosorbide mononitrate, for instance, for angina, and they are taking it willy-nilly at any old time. You want them to go through the night without it being in the system, so taking it at the right time matters. So, I think that the pharmacists' role is key. The experiment that they are doing in Scotland by using a pharmacist in a clinical role outside of the community pharmacy structure, getting pharmacists to work with practices and general practitioners in a clinical role, is another way of getting continuity around complexity.

[332] **Sandy Mewies:** Thank you for allowing that digression, Chair. I felt it was important because it has an effect. You chaired the national out-of-hours steering group, which has been superseded now by the national urgent and emergency care group—I do not know how anybody remembers all these names. What progress has been made in implementing the recommendations from the steering group?

[333] **Dr Jones:** I am happy to give you a written update, but I can tell you that standards in the out-of-hours service are being worked through. We have had a process to generate it, and I think that that will come to fruition in the early spring. The key messages from that are that it is aligned to unscheduled care; it is aligned to outcomes for people who fall, for end-of-life care, and for making sure that you pick out those people who call out-of-hours services who could have had a stroke or a heart attack. It is about making sure that we are doing the right things for those where we know the outcomes could be changed.

[334] **Darren Millar:** If you could you provide us with a written update, that would be very useful.

[335] **Dr Jones:** When we have got the thing signed off, it might be worth sending it in at that point, but I will give you an update on where we are across the piste.

[336] **Darren Millar:** That would be very helpful.

[337] **Sandy Mewies:** Chair, I think that we have had the—. We have discussed the benefits here of co-locating out-of-hours services in emergency departments. What do you think about that?

[338] **Dr Jones:** If you co-locate, people will know exactly where to come. So, if you want people to come, just co-locate. If you get co-location with a different way of working, so that primary care and the acute end benefit from the experienced practitioners, that is a great thing. However, you cannot do that everywhere. Our population in Cwm Taf very much values its out-of-hours service in the Rhondda and Cynon valleys. I have been round all of the out-of-hours services. You cannot do it in Powys—it would be impossible—but you can get a benefit from general practitioners. We are going to be working on a new scheme in the future in Cwm Taf around placing general practitioners and acute physicians together near the front door.

[339] **Mike Hedges:** That leads on to one of my questions. There have been problems with the recruitment of emergency consultants. Would co-location and having more GPs available there reduce the need to have extra emergency consultants? I am just going back to what you were saying about the mix.

[340] **Dr Jones:** For the vast majority, yes, but for those few cases where—. You have to be around them when they go into emergency physician mode. If you are ever in a critical condition, your outcome will be based on what that team does, and the risk management from

having an emergency physician there is immense. They have a very, very special skillset. They are able to take multiple issues and condense them very quickly and make those critical decisions. We are never going to be able to put that 24/7 everywhere. So, if we do not bring together those hyper acute things and get the patient to the right place, not just the nearest place, then we are not going to achieve it. The Keogh report in England makes it very clear. We cannot do that everywhere. They do not have a snowball's chance of producing enough people who want to be emergency care physicians in the numbers that would be necessary to put them on every street corner. It is not nice; it is not everybody's cup of tea. You are dealing with people at a very acute place. I was in Morriston the other day, and what a team. What a team. They dealt with four really acute and really difficult cases, including a very sick child, and they dealt with those things in a very focused way. We cannot do that everywhere. So, my worry is that, by saying, 'Yes, it would help'—. It would help make the whole system better if we coalesce them.

[341] **Mike Hedges:** I thank you for that answer, if only because I spend most of my time telling everybody else in here how wonderful Morriston Hospital is; I am glad to see somebody else coming along and saying exactly the same thing. Really, you have hit on something that is a huge problem, namely getting people to the right place, because most people want to go to the nearest place and hope it is the right one. That is the health problem, is it not? People want to go to the nearest place, and hope it is the right one, without actually having given any thought to the right place. If we could get that out into discussion in the world, it would perhaps make life a lot easier.

[342] You heard what I said about the auditor general's report about morale and staff pressures in emergency departments. Do you have that problem in Cwm Taf?

[343] **Dr Jones:** We have had it, but the morale in our A&E departments is improving. Our staff sickness rate has improved, but you only have to have someone violent or nasty who manages to injure a member of staff, and the wake of that is difficult. The other thing is if something goes wrong. People do not have time to recover from dealing with that before they are on to the next thing.

[344] **Mike Hedges:** I hate to go back to talk about Morriston again, but Morriston has a police community support officer on site in its emergency department, which makes the staff feel more secure, if nothing else.

[345] **Dr Jones:** Most of us do and we also have this blinking videoing, where you have to press a button. However, my staff in Prince Charles Hospital will say that they get lip, but they do not get fist. It is like policing—you wear a gun, and it sets an ambience. We are there to care. I am immensely proud of the professions, as I have said before, and they are coping, but they are stressed.

[346] **Darren Millar:** On that note, that down note, unfortunately, about stress in the workforce, we are going to have to conclude this particular evidence session, but we are grateful to you for coming to help us with our inquiry today, Dr Jones, and we look forward to receipt of the update on the out-of-hours steering group implementations and anything else that you might think is relevant to the committee's inquiry. Thank you very much indeed for your attendance today.

[347] **Dr Jones:** Thank you.

[348] **Darren Millar:** Before we move on to item 4 on today's agenda, I apologise for the temperature fluctuations. There are problems with the temperature, so if anybody wants to grab a quick coffee, please do so—warm yourself up.

Gohiriwyd y cyfarfod rhwng 11:45 a 11:52.
The meeting adjourned between 11:45 and 11:52.

Bwrdd Draenio Mewnol Gwastadeddau Cil-y-coed a Gwynllŵg: Trafod yr Ymateb gan Lywodraeth Cymru
Caldicot and Wentlooge Levels Internal Drainage Board: Consideration of Welsh Government Response

[349] **Darren Millar:** I hope that everybody has warmed up during that short break. We move on to item 4 on the agenda, considering the Welsh Government's response to the Caldicot and Wentlooge Levels Internal Drainage Board report that the committee produced. We have received a response from Alun Davies, the Minister for Natural Resources and Food. You will have noted that most of the recommendations have been accepted, either in principle or partially, but most of them fully, I am pleased to say. Are there any comments that Members want to make on the Government's response? There were clearly some bits of the report that were more appropriate to local authorities and, indeed, the Wales Audit Office. Are we content? Do we want to enter into further correspondence? No? Okay, that is great.

[350] One thing that I need to draw Members' attention to is the fact that the auditor general has not provided a response to the report yet. However, there was a recommendation pertinent to the Wales Audit Office in respect of the work being done on audit methodology and proposals to make improvements in the future. So, we will need to follow that up at some point.

[351] We have had a letter from the Wales Audit Office about the auditing regime for internal drainage boards in future. It is important that we note the contents of that. It is a letter from Anthony Barratt, which just spells out, as a result of the decision the Assembly took late last year in respect of the auditing arrangements—. We were obviously keen that the two internal drainage boards that are mainly in Wales that are currently not audited by the Wales Audit Office would be so audited in the future, but, of course, other events have overtaken that decision in many respects. I will take it that that item of correspondence is noted. We will move on then—

[352] **Jocelyn Davies:** I just have a point there. I was just wondering whether the Minister could make it a condition of grant that it is audited in the way that we recommend.

[353] **Darren Millar:** It is a suggestion, if Members are happy to—

[354] **Jocelyn Davies:** I just wondered why that has not been considered. It could be just a condition of grant; I do not know whether that is possible.

[355] **Darren Millar:** Is that something that you think might be useful, Joanest?

[356] **Ms Jackson:** Members might be aware that there were issues in the Local Audit and Accountability Bill, which had provided that the cross-border bodies would be audited in accordance with the new regime for England. However, there is an amendment down to that Bill that takes the cross-border bodies out of that provision. So, work will have to be dovetailed with the current arrangements and the arrangements proposed for taking in the internal drainage boards to Natural Resources Wales to sort out the arrangements in that regard. So, perhaps we should not be too hasty in any recommendation there.

[357] **Jocelyn Davies:** Well, I would not be too hasty with regard to the Minister assuming that he can take it into Natural Resources Wales, if he needs legislation for it. [*Laughter.*]

[358] **Darren Millar:** What we can do is write to him, perhaps, and ask whether there might be any other vehicles for securing the audit regime that we recommended, including the possibility of using it as a grant condition. Are Members content to do that? You are. Okay, we will do that.

11:56

Papurau i'w Nodi
Papers to Note

[359] **Darren Millar:** We have a number of papers to note, including the minutes of the meeting on 10 December and a letter from David Sissling dated 9 December in respect of the Betsi Cadwaladr University Local Health Board governance arrangements report. That letter was actually dated the date of the publication of the report. So, it is not a response, it is an 'anticipated findings in the report' sort of letter. We have already drawn into the discussion today some of the information in the letter from Cwm Taf and Aneurin Bevan health boards on unscheduled care. You will note that there has also been a letter from Geoff Lang, chief executive of Betsi Cadwaladr, on some of the analysis work that it has undertaken in terms of some of the patients who have been through the department. We have also had a letter on the national framework for continuing NHS healthcare in respect of the future work that is going on with that. I take it that all those papers are noted. Are there comments that anybody wishes to make? I see that there are none.

11:57

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

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

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

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

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11:58.
The public part of the meeting ended at 11:58.