Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Iechyd a Gofal Cymdeithasol

The Health and Social Care Committee

03/12/2015

Trawsgrifiadau'r Pwyllgor
Committee Transcripts

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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 reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Alun Davies	Llafur Labour
John Griffiths	Llafur Labour
Altaf Hussain	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Adam Cairns	Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Cardiff and Vale University Local Health Board
Darron Dupre	Unsain Cymru Unison Cymru Wales
Mick Giannasi	Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Welsh Ambulance Services NHS Trust
Stephen Harrhy	Prif Gomisiynydd Gwasanaethau Ambiwlans Cymru Chief Ambulance Services Commissioner for Wales
Nathan Holman	GMB
Yr Athro/Professor Siobhan McClelland	Cadeirydd, y Pwyllgor Gwasanaethau Ambiwlans Brys Chair, Emergency Ambulance Services Committee
Richard Munn	Undeb Unite Unite the Union
Tracy Myhill	Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru

	Welsh Ambulance Services NHS Trust
Lisa Turnbull	Y Coleg Nyrsio Brenhinol Royal College of Nursing
Allison Williams	Bwrdd Iechyd Lleol Cwm Taf Cwm Taf Local Health Board

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

Llinos Madeley	Clerc Clerk
Rhys Morgan	Rheolwr Craffu Scrutiny Manager
Dr Paul Worthington	Y Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 09:16.
The meeting began at 09:16.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning. Can I welcome Members and the public to this morning's meeting of the Health and Social Care Committee, where we will be undertaking a review of our previous work into the performance of the ambulance services? Can I remind Members that the meeting is bilingual, and if you require translation from Welsh to English, the headphones are available on channel 1? If you require amplification, then please turn over to channel 2. We have no scheduled fire alarm this morning, so, if one does occur, please follow the directions of the ushers to the assembly point. If you have any mobile phones or other electronic equipment, please ensure that they are either on silent or switched off so that they don't interfere with the broadcast equipment. We've received apologies this morning from Darren Millar and Kirsty Williams; we've had no substitutes identified.

09:17

Ymchwiliad Dilynol i Berfformiad y Gwasanaethau Ambiwlans yng Nghymru: Sesiwn Dystiolaeth 1
Follow-up Inquiry into the Performance of Ambulance Services in Wales: Evidence Session 1

[2] **David Rees:** We'll move on to our next item, and that's the first evidence session this morning. Can I welcome, from the trade union section, Darron Dupre, who is from Unison Cymru? We have Nathan Holman from the GMB, Richard Munn representing Unite the Union and Lisa Turnbull from the Royal College of Nursing? Can I thank you all for the written submissions we've received as a committee in relation to this matter? As I'm sure you're well aware, the reason you're here is to answer some questions. We'll go straight into those questions, if that's okay with you, and we'll start with Gwyn Price.

[3] **Gwyn R. Price:** Thank you, Chair. Good morning, everybody. Do you believe that industrial relations have improved over the last couple of months or the last year? In your written evidence, you seem to point that way. Are you confident that performance can improve against the new emergency response performance targets? Any one of you can start off.

[4] **David Rees:** Darron, do you want to start?

[5] **Mr Dupre:** I think since Tracy Myhill's appointment in particular, around about September of last year, I would say that the corporate industrial relations have transformed, in many ways. I wouldn't say at the moment that it's completely embedded, because we still have some difficulties around the trust, but in terms of trying to deliver real partnership working with its staff around high trust, high-performance issues, and challenging behaviours as well—I think that one of the key issues that we had prior to Tracy's appointment was behavioural issues, both occasionally on the staff side but also the management side—I think, to an extent, a lot of those have been completely transformed. But I think Tracy herself—I'm not going to speak for Tracy, because she's here later—probably would be the first to say that it's not completely where she wants it to be, but it's a work in progress.

[6] **Gwyn R. Price:** Do you think performance and targets are achievable?

[7] **Mr Dupre:** We and a number of our colleagues have long asked the question about whether A8 response targets were necessarily the best way—the only way, actually, prior to October—to performance measure an ambulance service. We'd always argued that it only really measured how fast an ambulance driver—a technician or paramedic, not an ambulance driver, was able to drive to an incident. It never measured some of the most inspirational skills and magic dust that they are able to provide—that Nathan provides—on a daily basis to bring people back to life in some of the most difficult and harrowing of circumstances. What we're really, really hoping for, with some proper transparency and accountability, is to measure the work that our men and women in green do on a daily basis, and not just how fast they've driven, when, sometimes, how fast they drive is not as important to the patient, whereas the outcome is.

[8] **Gwyn R. Price:** Do you think the five-step model is a way forward?

[9] **Mr Dupre:** I think that we're all pretty much signed up to the model and we have been. One of the key issues, I think, with the new model is that first conversation with the patient when they phone 999. And, hopefully, we can now decide whether it is a true red call, which is immediately life-threatening, or whether there may be some other care pathways. That could still include a fast response, but it could also include, potentially, NHS Direct Wales, and the entire Choose Well campaign that we're signed up to as well about alternative pathways. That will probably lead us on to a question about whether those pathways are currently all on, and that's another debate, because they're probably not. But that's the sort of direction of travel that we want to be going to.

[10] **David Rees:** I'm sure those questions will come later on. Richard.

[11] **Mr Munn:** Yes, can I just come in on the partnership working and the industrial relations. I think, from Unite's point of view, they've really improved. At the sort of high level, and filtering down through the organisation, we've seen, since Tracy's appointment, a real marked improvement. So, I suppose, I just wanted to go on the record, from Unite's point of view, and say that that's our case. And, I guess, anecdotally, the amount of calls, as an officer, that I would get prior to Tracy's appointment, compared to after Tracy's appointment—they've dropped away, and the frustrations that our reps have felt are—. So, I think, in terms of industrial relations, things are going very well. The other thing that I suppose I wanted

to point out on that is, contrast that to England and the reports that I get—and I'm sure it's the same for other colleagues from various ambulance trusts in England—things are better here.

[12] **David Rees**: Nathan, I just want to bring you in, because, obviously, in your paper you actually highlighted some concerns that you still had with—.

[13] **Mr Holman**: I would agree with my colleagues, in the sense that we are in a far better place than we have been in previous years, but we still have a long way to go. The new management structure that we have at the top is trying to change things, but those things are not going to change overnight. It needs things that we need to change as an organisation, and that's going to take time to work its way through. We're having a lot of workshops and meetings to try to resolve those issues that we've had in the past, and things are starting to improve, but there is a long way for us to go.

[14] **Gwyn R. Price**: Do you believe now, though, that you've got quicker access to solving these problems than you did before?

[15] **Mr Holman**: Yes.

[16] **David Rees**: Alun.

[17] **Alun Davies**: Thank you very much. I should put on the record a declaration that I am a member of Unison before contributing. I'm interested in the somewhat difference in tone from the three of you who just answered those questions from Gwyn. I think it's fair to say, Darron, that you were the most guarded in terms of your response—you know, it's very much work in progress, and you weren't anything close to as emollient, possibly, as Richard was in answering that question. I'm interested in understanding the reasons for that somewhat guarded tone: that things are better than they were, however, there's still a long way to go. I think Nathan said something very similar. That indicates to me that you still have some concerns, perhaps structural concerns, about the management and operation of the service, or are those concerns about the way in which the decisions have been taken, and how those decisions are being implemented?

[18] **Mr Dupre**: If I'm really honest with you, I think it comes more from the experience of industrial relations in all sorts of organisations. I think one of the exciting parts of the journey have been within the Welsh ambulance service and working around the Welsh ambulance service. It was in a very,

very, very difficult position 18 months ago—really, really bad. It wasn't just politicians worried about monthly response targets; internally, many things were sort of collapsing. Certainly, in terms of industrial relations, there were ballots here and ballots there—a really, really difficult time for everyone. And I think it would probably be naive in my experience to be able to come to you and look you really in the eyes and say that within 12 months of somebody coming in, the whole place has been transformed into a world-class organisation, and you can take your eye off the ball. Actually, there are many, many things that have been put in and are absolutely right, and we're working to embed those throughout the organisation. So, in terms of being guarded, I think I'm trying not to be naïve, really, and I think what we want to do is consistently keep our eye on the bigger picture and move the ball along. Because I think that there's an exciting place that the Welsh Ambulance Services NHS Trust potentially could be going to, and we just don't want it to row back. I think all of us, and certainly the senior leadership of the trust, in my personal opinion, are probably of a similar mind.

[19] **Alun Davies:** Okay. Can I just ask you about the Aneurin Bevan area, which I represent in Blaenau Gwent? You had particular concerns, and I think concerns were expressed both from your side and also from management a year ago about some particular issues in and around the Aneurin Bevan area. Are those issues being resolved in the same way—I presume you're talking across the whole of Wales in your earlier answers—but are the issues in Aneurin Bevan being resolved as well?

[20] **Mr Dupre:** Would you forgive me if I asked if Nathan could comment on that as well, because Nathan's a paramedic and he's hands-on. We did have some issues in terms of, generally, some industrial relations last year and especially how rotas were being dealt with. As far as I understand now, the way those rotas have been dealt with is more in partnership. I think we've probably got fewer concerns in terms of how ABH is being looked after.

[21] **Alun Davies:** Sorry, but from a Unison point of view, you are content with the progress that is being made and content with the relationship? You might not be content with every single decision, but with the relationship and the nature of the debate and discussion that's taking place within the service—just for us to understand that. I know you told us—[*Inaudible.*]

[22] **Mr Dupre:** I think that it has significantly improved.

[23] **Alun Davies:** Okay. Fine.

[24] **Mr Holman:** I would support that. In all organisations, you will have areas that are in different circumstances to others. Some areas are working very well; other areas need a little bit more support. Aneurin Bevan is one area that does need a little bit more support. The evidence that's been produced is that they are very short-staffed in those areas, so that then increases the difficulties of being able to hit response targets et cetera.

[25] **David Rees:** Lisa, do you want to come in on this?

[26] **Ms Turnbull:** Yes, I just wanted to say that, from our perspective, we also very much recognise the really positive changes that have actually happened, especially in terms of the senior leadership. It's also important to say there's clearly a lot of work still to do in terms of some of the issues around some of the historical cases that need to be sorted out in terms of the rota issues. Although there are issues to be dealt with, if you look at the progress in some of the areas like continuing professional development, appraisals—it really is very good. I think it's important for us, as trade unions, to say where we do feel there has been a significant change, and certainly at the senior leadership level, that's really evident in terms of our partnership working.

[27] **Alun Davies:** Why are you emphasising senior leadership? Why aren't you just saying management? Is there a reason why?

[28] **Ms Turnbull:** I think it's because, as one of my colleagues alluded to earlier, cultural change in an organisation does take time and you do need that example of leadership from the top in order to transform that culture. But that takes time. It's still relatively early days of that transformation, but I think it's important to recognise that, so far, our experience has been very positive. So, that's probably why you're hearing some of that language; it's because it's about that balance, from our perspective, of being very positive—. At this point in time, I think it's important to be optimistic when you can be, but at the same time I think we're all realistic enough to know that there's still a journey ahead.

[29] **Alun Davies:** So, that cultural change in management, which is what you seem to be saying, is being led very well, and that cultural change is taking place in a dynamic fashion, if you like, across and throughout the different layers of management. You all agree. That's fine.

[30] **David Rees:** Can I ask one further question on that? Cultural change, obviously, is important, and it's led. Are you seeing enough progress as it works down, at this point in time, to be confident that no matter what happens at senior level that cultural change will continue?

09:30

[31] **Mr Dupre:** Well, we've spoken to—we'll call them managers now instead of leaders, because that changes the tone slightly—. Certainly, a number of managers who are members of Unison have reported that they've now been having their annual one-to-ones and performance appraisal and development reviews and stuff, and the issue of culture, behaviour, language and how you involve staff has been reinforced. I think the issue was raised robustly, and read into that what you will. Some managers have been told that if they don't want to fit into the new culture, there may be an alternative career opportunity, possibly outside the Welsh ambulance service. I don't think that's been said in a bullying way, but I think it's certainly been said that, as far as the leadership are concerned, the behaviours that they want are to be good, of a high-standard, clinically led, and none, really, of the shenanigans that we sort of had to put up with in the past where consultation was—. Well, depending on which manager you dealt with, depending on which unions were brought in—and sometimes unions were pitted against unions and we had different messages from different managers—. That sort of behaviour, I think, has been challenged.

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

[33] **Lindsay Whittle:** Thanks, Chair. Good morning. It's the job of opposition Members to highlight inefficiencies in the Welsh Government and in particular this service. You'd have to accept that. I am wondering, because this conversation has gone very much around industrial relations, have you, as trade unions, done any work on the effect that that has on staff morale? I think, Darron, as you rightly mentioned, whilst the media would highlight a particular case where an ambulance took an hour or two to get there, it doesn't obviously highlight the hundreds and hundreds, or possibly thousands, of times when you are actually saving lives. I for one—you may be pleased to know—as an opposition Member, am no longer going to be issuing press releases to embarrass the Government because I'm getting embarrassed doing it, and I think I don't emphasise enough the good work that you've done. Are the health boards and you doing any work to look at the effects on staff morale, please?

[34] **David Rees:** Darron.

[35] **Mr Dupre:** Oh, gosh.

[36] **Lindsay Whittle:** Or anybody.

[37] **David Rees:** Nathan.

[38] **Mr Holman:** The health boards and WAST are working together to look at staff morale. At this moment in time, I do not believe that that is happening.

[39] **Lindsay Whittle:** Right. Thank you.

[40] **Mr Munn:** Can I ask what sort of work you mean? Like surveys or—

[41] **Lindsay Whittle:** Well, you know, looking at what the sickness records are like, with people going off with stress, you know, because it's a very stressful job—. There must be some post-traumatic stress in these posts. What has been done there? We've heard a lot about post-traumatic stress disorder in the army, but we never hear it for the emergency services. You know, it's an unsung issue there, really.

[42] **David Rees:** Lisa.

[43] **Ms Turnbull:** Just to say, it's possible that we could come back to you by having a look down at some of the data that are available for things like general surveys within the NHS in terms of staff, and actually come back to you with some of that information. I did want to pick up on your point about the performance and how that's captured, because one of the earlier questions was, I think, around some of those performance data. We are very, very firm supporters of this new clinical model of working, but I think it is fair to say that—and it's very early days at the moment—at the national level, sometimes the data aren't quite there yet in terms of its transparency and how clear they are about performance.

[44] The reason why I'm linking this to your question is because I think, although that could obviously be of huge benefit to people whose rightful role is to scrutinise the efficiency of the service, it's also incredibly useful to the people in the service when they actually see the good news that they're

doing being celebrated and being recorded very clearly. So, I just wanted to link your point about staff morale to the earlier point about, 'Let's make the performance data more clearly available', because I think there are a lot of good-news stories there as well as highlighting, and rightfully so, the things that need to be improved, such as some of the issues I'm sure we'll come on to discuss, like handover issues and some of those other areas as well.

[45] **Lindsay Whittle**: Okay. Thanks.

[46] **David Rees**: We will come onto that. Richard.

[47] **Mr Munn**: Just in terms of the statistics about sickness, wouldn't that be a better question to put to the trusts?

[48] **David Rees**: We will be putting—

[49] **Lindsay Whittle**: Well, yes—

[50] **Mr Munn**: I think they're in a better position to sort of collate that information that—

[51] **David Rees**: I suppose that the question being asked is—as we've heard so much about staff morale being poor and low as a consequence of various issues—do you have any evidence other than anecdotal evidence to support how that is improved? I think that's the question we were putting in front of you.

[52] **Lindsay Whittle**: Yes, because you have a duty, as trade unionists as well, to take your members' issues to the management, don't you? I'm sure you must have some information as well. I'm not teaching granny how to suck eggs, by the way.

[53] **David Rees**: Nathan.

[54] **Mr Holman**: Just to expand on that, there's currently a trial ongoing within the Cwm Taf area and some of the data that have come out of that are towards staff morale, and staff morale is extremely high in that area. Now, if you look at that trial, there's been an increase in staffing, we've brought in external ambulance services et cetera, to bolster the number of resources that are in that area. Also, the area is being ring-fenced so that we're not losing vehicles out of that area constantly and leaving that area short. The

knock-on effect to that is that staff are getting their rest breaks on time. We've got to remember that, you know, we constantly talk about a vehicle, but that vehicle is staffed by either one or two human beings, and those human beings need certain things—rest breaks to be able to go to the toilet et cetera. When you're looking at a vehicle, that vehicle can run 24/7, because it's a machine, but the people who staff that vehicle don't. So, it's very important that they get their rest breaks.

[55] The other knock-on effect to having the correct level of staffing there and the correct amount of resources is the overruns—the situation where you get a late call and therefore you don't finish at the time that you're due to finish. You continue that detail, looking after that person until you finish—those have reduced as well. The knock-on effect, then, within Cwm Taf is that the morale of staff has increased and also the sickness levels have decreased.

[56] **Lindsay Whittle**: That's interesting. Thank you.

[57] **David Rees**: John.

[58] **Mr Dupre**: Sorry—

[59] **David Rees**: Darron, do you want to add anything?

[60] **Mr Dupre**: I'm terribly sorry, but I wanted to go back in terms of what Mr Whittle said. At Unison, we do have some evidence and I'd be really, really happy to share this on an annual basis with the committee. Unison runs an annual stress survey for ambulance staff all across the UK, but we can pinpoint it down to Wales. You're absolutely right in terms of PTSD and issues that affect certainly front-line paramedic ambulance staff. One of the things that is a challenge, I think, to all of us is that many people, for lots of different reasons, don't want to admit that they've got a mental health problem and it becomes a problem when they end up falling off the end of a cliff. So, in terms of your question, just next week I'm going to be meeting with the head of health and wellbeing at the Welsh ambulance service to run through last year's stress survey—or, in fact, this year's stress survey—and there's going to be a new one in April. I'll be sharing that, then, with all of my colleagues, because mental health in particular and the support that people get is going to be absolutely critical. I'm happy to share that with you.

[61] **Lindsay Whittle**: Okay. I've opened up a can of worms here, Chair.

[62] **Mr Holman:** If I could just add to that. The new health and wellbeing team that's been set up within the Welsh ambulance service is something that we've never had before, and this is bringing out these issues now, whereas before, when I first joined the ambulance service, I heard on numerous occasions, 'Well, you knew the job when you started, so put up with it', and that culture's changing. There is a realisation that different people need different things and that support mechanism has started to be put in place.

[63] **Lindsay Whittle:** That's good. If you have that information, that would be excellent. Thank you.

[64] **David Rees:** Thank you. John.

[65] **John Griffiths:** Yes. I think all of us are familiar with the recent history of the ambulance service and the problems in terms of the quality of service and standards of service that we would all want to see existing in Wales. Regular changes have taken place in leadership and in culture, in the organisation and in the delivery of the services. And many times, I think, we've been told that something has happened in terms of leadership or cultural change that is going to deliver a consistent, improved service, but unfortunately it hasn't proven to be the case.

[66] Picking up on what the Chair said about this particular change in leadership and culture and how deep-seated it is, how thorough it is, how embedded it's becoming, I'd be interested in your view in terms of, you know, the service, the performance and the delivery to communities in Wales, and to what extent we can be reasonably confident now, as a committee, that we are on the right upward trend in terms of service delivery and that we can expect to see sustained improvements over a period of time. In the written evidence of the trust there was reference to fragility and some inconsistency in terms of the improvement that's taking place, so I'd be interested to hear what your view is of what we can now expect in terms of future service delivery.

[67] **David Rees:** Lisa has got her hand up first, so it'll give you a chance to think.

[68] **Ms Turnbull:** I think I just wanted to say that there's this link to the way that the professional delivery of the performance of the services is

changing, and, we believe, in the right way, to this clinically led model. There are a number of areas that are under way at the moment, or being piloted at the moment, that really show us the way forward. If they can be carried through, that will transform the service and the performance. So, specifically, the Cwm Taf pilot has already been mentioned, and we also believe that that's showing incredibly promising results and we would like to see that sort of model expanded in terms of how people are deployed. Also, general issues, such as using clinical people with advanced skills to actually do the deployment and the decision making and be the first people to reach the patients. That links to the third area that I would highlight, which is about the joint working with the health boards and is about getting those, kind of, right professional protocols in place so that people can be appropriately diverted to the right clinical pathway for them, thus relieving some of the burden on the ambulance service.

[69] So, there's a number of—they may at first glance look disparate—initiatives that are going on at the moment, but they actually have one thing in common, and that's about this clinically led model and putting clinicians in charge of that process of making sure that patients get the best care. All of those disparate initiatives are linked by that theme. If we can continue with rolling out that theme and continue with, crucially, getting the health boards to work together with WAST on these issues, then that, I think, is what will ensure that this promising beginning actually continues and delivers improvements in care for people across Wales.

[70] **David Rees**: Darron.

[71] **Mr Dupre**: Well, I think, if it's possible to take the politics, both the small 'p' and the capital 'P', out of WAST, just for one second, the new clinical response model is something that has been welcomed right across the emergency medical community, not just in Wales, but across the UK. I certainly know that Unison's been contacted by ambulance services overseas that are keen, really, to be seeing how this works out. There's a lot of goodwill around this.

[72] One of the difficult sells that I've got, personally, and this is a personal view, rather than, necessarily, a Unison view, is that we're absolutely committed to the clinical response model, but, at the moment, there appears to be a lack of transparency—I don't think there is, but there appears to be a lack of accountability and transparency—in that none of the clinical outcome data have yet been published. There's been a decision that has been taken

that these data will be published quarterly. I'm particularly looking forward to these data being published, because we can then see what is actually happening on the ground.

[73] At the moment, the only data that are being published are the red call response times, and I understand, somewhere on StatsWales, the amber call response times are also being published. I would really like to know what is happening with patients who have cardiac arrests, strokes, neck or femur fractures and things like that. At the moment, that hasn't yet been published. I think the data are there, but they are being put together by people. So, until those come, it's very, very difficult for us to be able to say, 'Well, the service has been transformed'.

[74] **David Rees:** Okay. Altaf.

[75] **John Griffiths:** Could I just, very quickly, Chair—? I was listening to what you said about the need for the health boards, the ambulance service and others to really work together in a new and, hopefully, much more effective way. Are you confident that the structures that bring the necessary people together are in place now?

[76] **Ms Turnbull:** I think there's a huge variation between health boards and, sometimes, huge variation between initiatives within health boards. To try and give a practical example, one of the initiatives is, obviously, to make sure that the paramedics or the clinicians who reach the patient first have the appropriate skills. Now, if WAST were investing into upskilling people, as we think they should be, that would be fine. But if there isn't an appropriate agreement in place that everybody's aware of, including the GP, the community nursing team and the accident and emergency department, if everybody in the health board is not on board with this new way of working, then that's obviously a wasted effort, because that patient can't be treated appropriately, because other people are not aware of what's happening.

09:45

[77] So, that kind of joint working has to be put in place first, and that's an example of the kind of issue that is not quite there yet. So, I think that's where the effort needs to be put in, is in bringing the health boards on board with these various initiatives.

[78] **John Griffiths:** And there are examples in Wales where those

arrangements are in place—

[79] **Ms Turnbull:** Yes, and working very well. It's the variation that's interesting, because I think each health board has approached these issues of joint working in a slightly different way and sometimes, as I say, it's even within a health board—for example, relationships on a particular initiative might be working incredibly well, but then they may not have been put in place on another initiative. For example, relationships on, say, handovers might be working very well in a particular health board, but perhaps the appropriate governance relationships haven't been worked out with, say, community nursing or GPs. So, there are variations within health boards as well as between health boards; that's what I'm trying to say. I do think that that is a huge area that needs to almost be the next step, really, in terms of delivering this transformation.

[80] **John Griffiths:** Is there one health board in particular that's got it right, as far as you're concerned, more than any other?

[81] **Ms Turnbull:** I'm not sure if I would go that far, but certainly, for example, I've heard good reports on handovers in that I believe it was Cardiff and Vale that made a specific effort in terms of appointing a particular member of staff to lead on that area, and people have said to me, from the service, that that, for example, has worked incredibly well. I've had other examples from other health boards, but, as I say, from my knowledge, I wouldn't say that there was one health board in particular that had got everything right. I think it's more a case of particular initiatives in particular health boards working well.

[82] **David Rees:** Can any of the other unions actually comment upon handovers? Are there still major issues? Last time we were here in the inquiry, we were told there was a handover framework, which has been, hopefully, rolled out across Wales. Has anything happened recently?

[83] **Mr Holman:** Things started to improve, but unfortunately, due to pressures, those situations are starting to deteriorate again. If there are no beds in the hospital and you're bringing more people in, where can they go? That's the biggest issue. Yes, we can prevent people from going in if, as a paramedic, I'm given the appropriate skills to be able to ascertain where else I can send this person. But, at the same time, those pathways need to be in place for me to be able to send them as well.

[84] **David Rees:** And, at this point in time, there are many gaps in those pathways.

[85] **Mr Holman:** Yes.

[86] **Ms Turnbull:** Can I just add to this, because we probably have slightly more to say on this particular point? Because of course our membership straddles both sectors, so we do get perspectives from both sides, which is quite interesting, from our nurses working on the ground. There are a number of issues, I think, in the inconsistency of approach between health boards. Certainly, patient flow is a huge problem, in terms of actual capacity for people being discharged from hospital, which then means that people can't be moved from A&E. So, that is an issue—capacity in the A&E department itself. But, I also want to say there's something about governance as well in terms of the actual handover.

[87] For example, something that should be relatively easy to sort out on an all-Wales basis, but hasn't been done, is that, if a nurse, for example, goes into an ambulance, where are they physically in terms of the governance procedures? Have they left the hospital? Different health boards have a different approach to that. What's important is the patient is safe. If the patient is leaving a safe environment, they have to go to a safe environment, and that's the difficulty. So, there are some issues that are practical issues in terms of the governance relationships that need to be thrashed out, and different health boards have taken a different approach to that, and there should really be all-Wales consistency on that. So, that is an important point I think we'd quite like to make.

[88] **David Rees:** Okay. I've got Altaf, and then Elin. Altaf.

[89] **Altaf Hussain:** Thank you very much. You've really said about the transference not being there, and there is a disconnect. We don't know about the misses in the red calls so far, because no figures are out. Listening to you, really, the first time, I, so far, was thinking that there are the front-line staff who are doing a great job—and they are doing a great job—but there is no connection between the front-line staff and the management, who probably are there without any job description, and they don't know what their jobs are. That's No. 1.

[90] No. 2 is regarding the handover of the patients. If this is a clinically led call, then it should be the clinician in any department in charge. He needs

to take over from the ambulance people, rather than the nurse going into the ambulance and the ambulance staff handing over the patient. It's not the health board, because we already know most of the management don't have any job descriptions. It is the clinician of an A&E department. You are putting that patient in. So, if the service is clinically led, by that I mean these red, green number of calls, so to say, and it is decided on clinical grounds by somebody, I don't know whether that is a clinician or how many misses have there been; we don't know. And the time you are deciding that these are clinically led calls, they should be dealt with clinically by the clinical staff. That may not be the nurse first; it may be the clinician itself. So, what is your opinion about that? It looks like there is a disconnect.

[91] **David Rees**: I'll go to Darron and then Richard, okay?

[92] **Mr Dupre**: I would say I think that that is already happening, that if you are the most seriously and life-threatened person in an emergency department, you will probably get to be seen first. It's the front of the queue that nobody ever wants to be in, and I think if you ever go to an emergency department and you're seen first, that's not a good thing; that's a really bad thing. It's a good thing for the patient that they're seen first. I think that—. Well, I'm advised by emergency medicine consultants that if you're the most seriously ill, you will be seen first—no doubt about it. I think that the people that we see stacked up in ambulances are probably the less life-threatened, but who still need to be brought into hospital.

[93] **Altaf Hussain**: So, who is responsible for that—[Inaudible.]

[94] **Mr Dupre**: The most responsible clinician at the time.

[95] **Mr Holmes**: It would be the ambulance staff—

[96] **Altaf Hussain**: Which is wrong. And we don't get any figures when you say that the clinician has not taken over the patient. You always say that the patients have been staying in the ambulance outside the A&E department, but you never tell us that the clinician has told you to keep the patient there.

[97] **David Rees**: Can I remind Members it's actually not the trade union's position to give the information?

[98] **Altaf Hussain**: Well, they need to protect their staff and other things and we need to know what they are doing there.

[99] **David Rees:** But, do you want to add anything, Richard?

[100] **Mr Munn:** Just a very small point. I didn't really understand what the question was, but everyone in the NHS does have a job description and as trade unions we're very much involved in the analysing and matching of these job descriptions. So, managers do have job descriptions.

[101] **Altaf Hussain:** So, you're happy with those and they are carrying on with the job descriptions that they should be.

[102] **Mr Munn:** You said that managers don't have job descriptions, and I'm pointing out that they do have job descriptions; people have written job descriptions; that's part of the whole pay and grade structure in the NHS.

[103] **Altaf Hussain:** The senior management as well—

[104] **David Rees:** Can I ask a question following on from what Altaf has raised, because there's concern about the lack of detail sometimes of the green and amber calls? Do any slip through that should have been red or weren't classified as red? Do we have any indication as to whether that's recorded or not?

[105] **Mr Holmes:** I believe that there should be data there where, if I'm given an amber call, I respond to that call, I turn up on scene and I will then assess that patient. If I deem that that patient is an emergency case because I've now seen what's going on, I will then personally, as a clinician, upgrade that call to a red call. So, those data should be there.

[106] **David Rees:** Okay, thank you. Elin.

[107] **Elin Jones:** Apologies for being late, and if my question's been covered already, you stop me, Chair. I just wanted to ask you about the capacity of staff for the ambulance service. Do you believe that the workforce planning, to ensure that there is a big enough pool of staff available to cover the rotas and shifts that are required in the ambulance service, is sufficient, and that planning for the future of that is done well enough? Do you have any concerns as trade unions that there could be places and rotas and shifts in Wales that are not staffed sufficiently at various points in time, and is this something that's expressed to you as trade unions as a concern from some of your members?

[108] **David Rees:** Can I add to that, before you answer the question, also the qualifications of the staff—are they appropriate now with the new clinical model as well?

[109] **Mr Holman:** I think that, because the new clinical model has come in, ascertaining whether we have the right levels of appropriate skilled staff is difficult to say at this moment in time and those data are being looked at.

[110] With regard to the concerns around the rotas that are short-staffed—yes, there are many rotas within the trust that are short-staffed. The Cwm Taf trial is one area that demonstrates the necessity to have the appropriate level of resources to be able to fulfil the functions that we have, and that clearly shows that we are short-staffed. Those areas that have more difficulties in reaching the targets tend to be the ones that have fewer staff. But, as to what level of staff we actually need to fill those vacancies with, we still need to go through that process with the new response model to ascertain what level of staff we need.

[111] **David Rees:** Does anyone else want to add to that? No? Elin.

[112] **Elin Jones:** I'd be right in thinking, then, that there are rotas and shifts in Wales that are insufficiently staffed at various times, and that it's not a perfect complement of staffing that's out there, even to meet the trust's own set rotas and shifts.

[113] **Mr Holman:** At this moment in time, yes, the data show that we have rotas that are short of staff.

[114] **Elin Jones:** Could I just ask about the Cwm Taf trial? I'm not sure whether you've discussed it to date. [*Interruption*.] Yes. Do you have views on how the Cwm Taf trial is going and whether it should be a model that is replicated in other parts of Wales in order to meet some of the challenges in other parts of Wales?

[115] **Mr Holman:** Data have been collated for what has happened so far and, looking at it from a staff perspective, morale is higher among staff within that area. The main reasons for that seem to be that staff are having their rest periods at appropriate times and they've also reduced extended overruns at the end of the shift as well. So, the evidence that is being shown there is that, if you have the right amount of staff to deal with that area, it is

beneficial. There are concerns around other areas that are close by—the knock-on effect of not being able to use them—but that clearly shows that you're constantly robbing Peter to pay Paul. So, if everywhere had the correct level of resources, it wouldn't be necessary to rob Peter to pay Paul.

[116] **David Rees**: Can I ask a question, then, on that particular issue? As well as yourselves, as trade unions, are you involved in the analysis and evaluation of that project—as trade unions?

[117] **Mr Holman**: We are being given the data. We're not involved at that level, of actually—

[118] **David Rees**: Yes, I know what you mean.

[119] **Mr Holman**: —being involved before that.

[120] **David Rees**: Gwyn, do you want to come in with a question?

[121] **Gwyn R. Price**: Just to follow up, if you could clear up a mystery that my constituents are putting to me: as paramedics, when you turn up at a scene—and I've experienced that in the last couple of weeks with relatives and there's a hospital close to where the relative has been taken ill—are your members fully updated, or are your members frustrated, that certain hospitals will not take certain patients?

[122] **Mr Holman**: It is very frustrating at times when we have a patient who is close to a hospital, but that hospital does not deal with that type of patient. I cover the west Wales area—the Carmarthenshire and Llanelli area—and my own personal experience is that I cannot take children into Prince Philip Hospital. So, I may be in Llanelli and I pick up a child, but I have to take that child to Carmarthen. On the one hand, it's frustrating because I could take this child to the appropriate care or to a hospital that is closer and therefore wouldn't tie myself up and therefore prevent me from responding to another call. But, at the same time, I know that the skilled staff that can deal with this child are in Glangwili. So, it's a mixed emotion, if you know what I'm saying.

10:00

[123] **Gwyn R. Price**: I can understand that you've got to go to where the experts are best for the patients, but I've had experience where local

hospitals have said, 'No, we can't take that patient', and the paramedics are just shaking their heads and I'm trying to get through to say, 'You think, don't you, that you could go there, don't you?', and they've nodded their heads. And I'm not naming their names, and I never will, but is that frustration out there?

[124] **Mr Holman:** Yes.

[125] **Gwyn R. Price:** Thank you.

[126] **David Rees:** Alun, just a short one on this point.

[127] **Alun Davies:** I'm interested by your response to those questions, because, if we're seeing the development of different specialisms in different hospitals and medical facilities, then surely it's in the patient's best interest to be treated at those places. So, if you take Aneurin Bevan again, then you've got stroke services now being focused on Royal Gwent, so people in Blaenau Gwent, in my constituency, although they are physically, geographically, closer to Nevill Hall, the specialisms are in Newport, so it must be in their best interests to go to that specialist centre to receive the care that could either save or transform their lives in terms of their recovery. Now surely that's better for them than just going to the local A&E where those specialisms don't exist.

[128] **Mr Holman:** It is better for them. I totally accept that; it is better for them. My concern is that I am not being given the appropriate skills to be able to take that patient further. The longer my journey is, the more skills I need to be able to look after that patient. I can understand why it's necessary to put specialist skills in certain areas—I completely accept that—but, for me to be able to do that, I need to be given the skills to be able to stabilise that person, so that that person does not deteriorate in my care.

[129] **Alun Davies:** Yes, that's absolutely key, I agree with you.

[130] **Mr Holman:** And, currently, that's not happening.

[131] **Alun Davies:** All right. Okay, so what we need—. We've got this jigsaw, if you like, being put together, and, when you get to the physical, medical resource there, wherever that hospital happens to be, we've got the skills provided and all that. What we don't have, and what we haven't put sufficient investment in—is what you're saying—is that journey, how that patient

comes from their home or wherever, through to that, and that's what we need to do. I think that's very important.

[132] **David Rees**: Thank you for that. Our time is up. So, can I thank you very much for your time this morning and the evidence? You will receive a copy of the transcript. If there are any factual inaccuracies, please let us know. On behalf of the committee, can you please take back to your members our great appreciation for the work they do on the front line? It's very much appreciated by Members here. And we appreciate and accept that, on many occasions, they're unfairly labelled when they shouldn't be. So, thank you very much.

[133] For Members' information, our next session is with the Emergency Ambulance Services Committee, which is the commissioners, who have been here last time. The Emergency Ambulance Services Committee. They are the next witnesses.

10:04

Ymchwiliad Dilynol i Berfformiad y Gwasanaethau Ambiwlans yng Nghymru: Sesiwn Dystiolaeth 2
Follow-up Inquiry into the Performance of Ambulance Services in Wales: Evidence Session 2

[134] **David Rees**: Good morning and welcome. Obviously, you've been here before so you are familiar with the equipment. Can I welcome Professor Siobhan McClelland, who is chair of the Emergency Ambulance Services Committee, and Stephen Harrhy, who is the chief ambulance services commissioner? Thank you very much. Can I thank you for your written paper in advance of today's evidence session? Clearly, we have some questions for you, if that's okay with yourselves, and we'll go straight into them. Gwyn.

[135] **Gwyn R. Price**: Thank you, Chair. Good morning to you both.

[136] **Professor McClelland**: Good morning.

[137] **Gwyn R. Price**: In your opinion, are you confident that performance can improve against the new emergency response performance targets?

[138] **Professor McClelland**: I think I'll let Stephen answer that with some detail.

[139] **Mr Harrhy:** I think we had some confidence from the first month of the new red 1 performance target where, across Wales, there was a performance of over 65 per cent, which I think was a good start. There was some variation across Wales, of course, which we need to improve upon, and also I think we need to make sure we build continuous improvement into what we do. So, I think there is some room for improvement; I think we will get improvement.

[140] The other important issue, I think, is that at the end of January we're going to have a wider set of indicators—new ambulance quality indicators—that are going to be published. That will be important information for us as well to get a rounder feel for how the service is doing and what progress they are making, and where they've got further opportunities to make progress. But, in summary, I think they've made a good start and I think they will continue to make progress.

[141] **Professor McClelland:** I think the point about placing that in the context of the wider ambulance quality indicators that are going to be published in January is really key, because that's what's going to give us—. I think you've heard already from the staff side about looking more widely than a time target. This is a better time target, but it's not the only measure, and what we should be careful of is replacing one single focus with another single focus. So, the ambulance quality indicators allow us to look at clinical outcomes, allow us to look at patient experience, and allow us to look at value for money, and we need to place that time target within that context. As Stephen said, those are due to be published in January.

[142] **Gwyn R. Price:** We've just taken evidence, really, that there was a good start and things did improve, but they seem to be standing still at the moment or even going backwards. So, that's the point of the committee—to take evidence on this. Thumbs up for a good start, but we need to continue with this, don't we?

[143] **Mr Harrhy:** We certainly do, and we need to do that across all of the five steps in the five-step model. So, we need to make sure that we're concentrating on steps one, two and three as well as steps four and five. So, as well as taking patients to hospital, we also need to make sure that we're clear, if a patient doesn't need to go to a hospital, there's a better place for that patient to be treated, or there's a better way to treat that patient, we should be encouraging that, we should be supporting that, and we should be enabling that through the commissioning process to allow that to happen.

So, I agree with you—a good start, but a bit more to do.

[144] **Gwyn R. Price**: So, you do accept the slight criticism that it's a good start but there's more to do.

[145] **Mr Harrhy**: Oh, I do. I do, absolutely.

[146] **Gwyn R. Price**: Thank you very much. Thank you, Chair.

[147] **David Rees**: Can I ask, to follow up two points on that—? The first one—you talked about the data coming out at the end of January.

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

[149] **David Rees**: There has been a concern expressed about whether, actually, three-monthly data are sufficient or whether it should be more frequent than that. What are your views on that?

[150] **Mr Harrhy**: Two points, I think. I think the first point is that this is new information, so we need to make sure, as far the quality of that information is concerned, that it's of the same quality as the previous information that was published, and that takes a little bit of time. Also, in terms of the indicators that we're using, and the trend information that we'll get from that, I think looking at that over a three-monthly basis is the right period, because I think, in that way, we're going to get a real picture on this journey of continuous improvement.

[151] In terms of any specific issues of a clinical governance nature, of course, there are other mechanisms in place to make sure we're on top of those quickly so we're not waiting for three months if there are any clinical issues that are coming out of the system that need to be addressed. We've got prompt processes in place that will allow those to be resolved.

[152] **David Rees**: Okay. Are you of the same view?

[153] **Professor McClelland**: Yes, absolutely. I think we need to be sure that the data are valid, that they are robust and that they stand up. We also need to find a way that we can explain what is a more complex picture, because it's quite easy to focus on one time target. So, we're working very hard on how we can represent these data in a way that lots of people can understand, and we'd be quite happy to talk to any Members who are interested about

how they'd like to see those data being presented in a way that would be meaningful to them and to the public. That's an important part of this, because it's much easier with one time standard, but, when you're looking at a range of indicators, how do you look at those and how do you make sense of it? I agree on the three-month—quarterly—publication because of the issue of the size of the numbers and the trends, and what will make the data meaningful. Looking at most of those indicators on a monthly basis is not likely to be particularly meaningful.

[154] **David Rees**: Okay, thank you. Elin.

[155] **Elin Jones**: Yes. Just, first of all, on the categorisation and the red and amber, there has been some concern that there are no longer targets for some conditions that are in amber, such as stroke. There's been a particular reference to stroke, I believe, and that that's uncovered by the new target, or a red call. And whether you're completely comfortable that the categorisation that has been agreed upon now is the correct one for the long term, or whether it's something that will be assessed over time.

[156] Then, just my second question on something slightly different, and that's the Cwm Taf trial. What are your views on how that is going? Is it looking as if it's presenting a model that can be replicated in other parts of Wales? Because one of the concerns that I have, representing a rural area—and I've probably said this to you before—is that ambulances are very often out of area for long periods of time, possibly entire shift periods, and that there are very risky situations, at times, where there is probably insufficient staff and ambulance cover, should there be red calls in some rural areas, because of ambulances being out of area.

[157] **Mr Harrhy**: Okay. So, if I take the first question, first. In terms of the categorisation of the calls into the red, amber and green, that was a clinically-led process. So, in terms of the clinical evidence that was presented, I thought that that evidence was compelling and that, as far as the red calls were concerned, those calls were for those patients that would benefit most by having a response within 8 minutes. There was compelling evidence for that.

[158] As far as the amber calls are concerned, you're quite right, there are far more amber calls than there are red calls. Those calls still require a blue-light response and, to a degree, we need to be sure that those patients are getting a prompt response, and that we're measuring how long it takes for

an ambulance to get to the scene. In the ambulance quality indicators, that is included. That information is included in the ambulance quality indicators. However, what is more important, I think—or equally important—is that the individual who is attending that patient has got the right skills to be able to treat them properly. One of the advantages of the new clinical model is that it gives the ambulance service some time to make sure that they can dispatch the right skill and then the right resource to the right call. We need to keep a watchful eye on that to make sure that that is happening, which is why we have introduced the ambulance quality indicators.

[159] What we've also done is set up, in the ambulance quality indicators, a series of clinical audits. So, we will be able to map through for patients with particular conditions whether we are getting the improvement in the clinical outcome that we would expect through the introduction of the new model. So, the evidence base that we've used—is that materialising? One of the things that we've just agreed is that we've found a way of mapping a patient through the system. Previously, the information from the ambulance service has ended at the time that the patient is handed over. What we're now able to do, for particular conditions, stroke being one of them, is track that patient through the system. So, how has the intervention at the various points in that pathway proved beneficial for that patient; and are there any areas that we've got for improvement on that?

[160] The other thing that we're looking to do in the five-step model is to make sure that we have a directory of services so that we can dispatch the right type of person to attend the right type of call. For some conditions, of course, you won't need to be taken to hospital. Actually, we can treat you better at home. So, this model gives us an opportunity to do that. What is really important is that we're tracking that through, and what is really important is that we're putting the alternatives in place before we make the change so that we've got that confidence that we're able to continue to build upon some of the progress that's been made.

[161] In terms of your second—

[162] **Professor McClelland**: Sorry, Stephen, can I just add into that first one? I think what that demonstrates is how important it is that we are looking at clinical outcomes against particular conditions.

10:15

[163] So, as Stephen says, within the ambulance quality indicators, there are stroke-specific indicators. What's also helpful about that is it can have a patient-centred approach, as Stephen has explained. You can look at what part the emergency ambulance service played within the wider targets and standards that we have for outcomes for people with strokes. So, this moves us from simply looking at time, other than when time is very important, as it would be if someone's having a cardiac or respiratory arrest, to really looking at what difference that makes to that patient as part of their pathway.

[164] **David Rees**: Before you answer the second question, can I come in there? Obviously, you mentioned earlier about pathways and this links in very closely with pathways. The previous witnesses indicated the fact that it was not quite clear what pathways were available to those patients who were not deemed to be in need of attendance at a hospital. Is that a problem that the pathways aren't there, yet?

[165] **Mr Harrhy**: I don't think it—. In the agreement, the collaborative commissioning agreement that we put together, we've been very explicit in that agreement about who has got responsibility for what and what key products we need. Now, one of those key products is to make sure that we have those pathways in place. I'd say two things about that. There are pathways that are already in place and I think the challenge for us is to say if a pathway is working well in one part of Wales, it should work well in other parts of Wales. Now, by adopting this collaborative commissioning approach and by having the governance arrangement that we've got to support that, we are able to roll those out far more quickly across Wales than we've ever been able to do. So, I think this is the start of that process and we have more work to be done, but I think the signs are positive in terms of where we've got to already. So, there's more to be done, but I think we have a framework and a collaborative approach that will encourage that and which we can monitor closely—the progress against that. It's a priority that we've identified.

[166] **David Rees**: Do we have any figures at this point in time as to whether patients are being taken to hospital because those pathways are not in place?

[167] **Mr Harrhy**: We have some information about specific initiatives. So, there is an initiative in Cardiff around mental health patients. Now, we know that the last place that we'd want some mental health patients to be is in a busy emergency department—that's not going to help their condition at all—and that, actually, we should be having an alternative for them. Either a

community-based alternative, or they might need to be taken into an in-patient facility. They don't need to be in an emergency department.

[168] So, in Cardiff and the Vale, there is a trial that is under way, which is providing that alternative pathway. The results for that are looking very positive and one of the sub-committees that we have under the emergency ambulance services committee is an evaluation panel. So, we are expecting to receive a report back on that pilot shortly to the evaluation panel. Then, we would expect to be able to roll that initiative out across Wales. Because of the collaborative nature of the committee, each chief exec is a member of the committee and that enables us to get some pace into that process, more than we've been able to do in the past.

[169] **David Rees:** I appreciate the pathway you've explained is the alternative, but I suppose I'd ask the question: do we have figures for those people for whom there is no pathway, and who end up in hospital, as a consequence?

[170] **Mr Harrhy:** We don't have them in the way that you describe. We can look at that in terms of the development of the framework to see if it's possible for us to gather that information. I wouldn't want to commit, today, to say that we could do that, but we'll certainly look at that.

[171] **David Rees:** I'll leave you to go back to Elin's second question, now.

[172] **Professor McClelland:** Just to place some context to the second question, which links to what Stephen was saying at the end, the Cwm Taf Explorer pilot, like the mental health pilot, is something that we take through our quality assurance and improvement panel that sits beneath the committee. We think it's very important that we robustly evaluate these initiatives on the basis, again, of clinical outcomes, patient experience and value for money. Stephen can talk a little bit more about where we've got to on that with the Cwm Taf pilot and the roll-out that has happened.

[173] **Mr Harrhy:** So, there are two elements to the Cwm Taf pilot. The first element to the Cwm Taf pilot is something called 'return to footprint', which is basically, if a vehicle has been taken out of area, then it goes back into that area. That's the one element of that pilot and I'll talk about that in a minute. The second is a dedicated service for healthcare professional calls. So, healthcare professional calls are those patients who need to be admitted into hospital. So, a GP, a midwife or another practitioner might say, 'This

patient needs to have a direct admission into hospital'. What we've done in Cwm Taf is we've put a dedicated service in place. That's about 25 per cent of the emergency calls, to set that into context for you. So, the Cwm Taf pilot has two elements to it. Both of those elements, I think, are working well.

[174] So, if I do the healthcare professional calls pilot first, one of the reasons that we've been able to get sustained improved performance against the time-based standard in Cwm Taf is because we've put this healthcare professionals pilot in. That pilot has recently gone into AB, and, yesterday, that model started in Swansea and in Carmarthen.

[175] **Elin Jones**: When you said it's 'gone into AB', what do you mean?

[176] **Mr Harrhy**: Aneurin Bevan, sorry.

[177] **Elin Jones**: Oh, Aneurin Bevan.

[178] **Mr Harrhy**: Sorry, I talk in acronyms; I do apologise.

[179] **Elin Jones**: I thought it was Abertawe Bro Morgannwg.

[180] **Professor McClelland**: That's ABMU.

[181] **Mr Harrhy**: Sorry. I do apologise. It's gone into Gwent. So, that's the first part of it, and we think that's sensible, because it is beneficial for the patient and it's also beneficial for the practitioner.

[182] **Elin Jones**: How does that work differently to how it works with healthcare professional calls in other parts of Wales?

[183] **Mr Harrhy**: So, the healthcare professional calls, otherwise, would be picked up by the resource that's available. There wouldn't be a dedicated resource, okay? One of the main advantages that this has is it allows the patient to get into the hospital at the right time, so that you don't get an unnecessary delay for the patient in the hospital.

[184] The second one, then, is the return to footprint. Now, there are two solutions across Wales, I think. One is return to footprint, which is: you do your work and then you go back to your area. I think that works for Cwm Taf, because there are particular circumstances in Cwm Taf that make that work—the geography, essentially, within Cwm Taf. I'm not so sure as to whether

that will work across other parts of Wales, so we're looking at that very closely to see whether that will work across other parts of Wales.

[185] What I do think will work across other parts of Wales, and we are encouraging, is dynamic control. So, by that, I mean that if, for example, there is a Hywel Dda vehicle that goes into Abertawe Bro Morgannwg, then what you'd expect is the control to look at, 'Well, what resources do I have available to cover all of that area and how do I move the vehicles that I have available to the right dynamic control point?' This would, in effect, mean that I'd need to move an Abertawe Bro Morgannwg vehicle out of their area to place them in a better area, because that would give us the best chance of being able to hit that call.

[186] What we're doing with the new standard is—the new red standard—because there aren't that many calls, we are able to look at every missed call and, on a daily basis, we're reviewing the reasons why a call wasn't got to within eight minutes. One of the reasons is because the ambulance service aren't using dynamic control as well as they could. So, they're picking that challenge up now, and saying, 'We need to do this better,' and we're able to monitor that.

[187] The second is around the use of first responders. So, we've recently made an investment into the ambulance service to enable them to co-ordinate the use of their first responders far better. There was disappointing performance in the Hywel Dda area, for the first month of the new red standard. I think there are two fundamental reasons for that, which the ambulance service are working on, and I would expect there to be an improved performance in Hywel Dda as a consequence of them doing these two things. One is dynamic control and the other is first responders. So, I'd expect there to be an improving performance in the Hywel Dda area as a consequence of taking those—but we're monitoring that closely in terms of those enablers to allow a better performance.

[188] **Elin Jones:** Can I ask, just on the return to footprint and your views that that may not be transferable or applicable in other areas—? I always expected it to be applicable to an area such as Ceredigion, for example, where, because of the geography, ambulance shifts from New Quay or Lampeter end up down in Swansea and then they're on call in the Swansea area, and not returning until after their shift is complete. So, perhaps you could just explain why you think it's not applicable to—

[189] **Mr Harrhy**: In that particular example, I'd agree with you that actually taking an ambulance so far out of area is not the best thing to do, because all you're doing is you're depriving the one area of the only resource that they probably had available. Where you go around more urban areas, you have a better chance to use this dynamic control. What you've also got are, generally, fewer out-of-area patient transfers in the more rural communities, unless there are particular specialist needs of a patient, in which case, you can generally plan those better. So, there isn't going to be one size that fits all here. What we do have to make sure, though, is that, wherever possible, we've got the right number of ambulances available at the right time of day to be able to hit the standards that we need to hit.

[190] **Elin Jones**: So, it may be that the return to footprint is replicated in some other areas, then.

[191] **Mr Harrhy**: Yes, absolutely.

[192] **Elin Jones**: What are the timescales that you envisage for some of these changes? Some of them are already happening, obviously.

[193] **Mr Harrhy**: Some of them are happening. I'm very keen to make sure that we're properly evaluating something before we move on to the next step. So, in terms of the return-to-footprint evaluation, by the end of December, we'll have some results in for that. That will then need to go through our evaluation process and we'll look at that. But, in terms of improving performance, we're also doing this daily checking.

[194] **David Rees**: Can I ask two questions on this? Just out of curiosity, is the project in Cwm Taf, the Explorer project, still operational now, and it's just that the new clinical model has been introduced?

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

[196] **David Rees**: So, they are going to be looked at, the operation of the previous model and the current model.

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

[198] **David Rees**: Okay, that's interesting. The second question I was going to ask is: obviously, you've talked about performance, location and deployment of the vehicles, basically, at points of importance to get to the

nearest place within eight minutes. What consideration—? Because we're hearing that, in fact, the delays being experienced in hospitals again are starting to increase once more, and that has a knock-on impact on the vehicles being available to be deployed. What discussions do you have with health boards in relation to ensuring that is minimised?

[199] **Professor McClelland:** I think it's important that—. Obviously, health boards own this process. Health boards are part of the—

[200] **David Rees:** We will be speaking to them afterwards, don't worry.

[201] **Professor McClelland:** Yes, absolutely. They comprise the ambulance services committee, so they own this. They also own the achievement of the target, and that's really important. We've seen a real sea change, I think, in how the health boards are talking to the ambulance service about achieving the standards. So, I think they much better understand their role in respect of handover and the impact that that has on releasing ambulances, and particularly now releasing ambulances under the new model, because it is very clear that those ambulances are needed to go to people who are having a cardiac or a respiratory arrest. Now, obviously, as we move into winter, the pressures start to build up again within the hospital, across the whole of the unscheduled care system, from what's happening in A&E to availability of beds to being able to discharge people out of hospitals. But I have been very struck, I think, particularly with some of the challenges we've seen in Hywel Dda in the first month of the clinical response model, how we've seen the health boards—both Hywel Dda and Abertawe Bro Morgannwg health boards—engage with WAST in looking at how we might address those issues. But I think Stephen can talk specifically about the policies that are in place.

[202] **Mr Harrhy:** In terms of my contact with health boards, on a monthly basis, I have a meeting with each of the chief operating officers in each of the health boards, and one of the issues that we talk through is handover delays and what actions are being taken locally to try and manage those. My role in that is not a performance management role; my role is more of a sharing of information role, and trying to share best practice. So, that's the role that I would play, working with health boards to try and get that improvement.

[203] **David Rees:** Alun.

[204] **Alun Davies:** Thank you. Professor McClelland, it's some time now since you completed your review.

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

[206] **Alun Davies**: How would you characterise the implementation of it?

10:30

[207] **Professor McClelland**: Yes. I mean, it's over two years, and I've been in an unusual position of being involved in implementing some of that. It's one thing writing a review and it's another trying to put it into practice. It would be the same comment I made when I was here the last time. Up until probably the point at which Stephen started in January, I think that progress was fairly slow. I think we had a strong decision about moving forward on the commissioning model, which I supported, because what is key about this is that the health boards own this, and that they are engaged in it. As I say, we've seen some really clear signs of that happening.

[208] I think that process was slow to get going. The health boards—. Change is difficult in the health service, and I think when you're engaged with it, then—as I say, it's kind of easy to write a review, and it's harder to move what is a really big and complex organisation to a different position. So I think it was a slow start in terms of the commissioning.

[209] Since Stephen has arrived, and since Tracy came into WAST, I think we've seen some really quite fast progress since January in terms of the development of the commissioning framework, in terms of the sorts of things we're seeing happening in WAST, and also in terms of the health boards' engagement. And that's manifested itself in improvements in performance, and in developing a range of standards that are going to tell us much more about what's really happening to people.

[210] So, I think it took a while to get going and now it's moving much more quickly, and I think we're going to see the benefits for patients from the model that we've got. I do think that some of the things we've put in the review about being clearer about accountabilities and responsibilities, transparent about performance—we have that, particularly through the commissioning framework.

[211] I do want to give some credit to Stephen, because he won't give any credit to himself. Stephen is part of a really small team that do the emergency ambulance service commissioning, and they've worked very hard

to get us to this point, and also the colleagues in WAST, particularly, who've really engaged with this process.

[212] **Alun Davies:** So, eight or nine out of 10.

[213] **Professor McClelland:** How many?

[214] **Alun Davies:** Eight or nine out of 10?

[215] **Professor McClelland:** Sort of seven, six out of—. You know, there's always quite a—

[216] **Alun Davies:** Progress hasn't been that good, then, has it?

[217] **Professor McClelland:** Progress has been—. Well, I'm an academic; I never give anybody tens. So, 7.5. I think there is still quite a lot to do in terms of delivery.

[218] **Alun Davies:** Okay, you say there's still something to do; that's fair enough. So, what's your priority, then? Where are the key areas where you would like to see significant improvement, because 7.5 is not too bad—it's better than I ever did in college—so, where would you say the key areas would be for improvement in, say, the next six to nine months?

[219] **Professor McClelland:** In terms of the workings of the committee—?

[220] **Alun Davies:** In terms of implementing the review.

[221] **Professor McClelland:** The main focus for us now is on using the commissioning and delivery framework, and demonstrating that that is making a difference in terms of clinical outcomes. So, what's going to give the evidence to me that this is working is when we have the—. This is not going to suddenly pop out of the air in January. We're obviously looking at them now, but if we can see in January what difference the way in which the new model, but also the delivery framework, is impacting on people who've suffered a stroke, people who've had a cardiac or respiratory arrest, what patient experience—. We're doing some work with the Picker Institute on developing patient experience metrics, so what are patients and the public telling us, and can we start to see an improving journey against those clinical indicators, those clinical outcomes and that patient experience? That's really critical for me, so January's an important point, but then, obviously, a quarter

later is a key point, because we want to have a clear trajectory of improvement there and see that happening. So, for me, that's the most important thing.

[222] Clearly, we'll be into negotiating the framework for next year. We want to be in a position at the beginning of April where we have an agreed delivery framework with WAST, and where we have an agreed financial position with WAST, because that's a very important thing in terms of moving forward. But, for me, clinical outcomes and patient experience, and demonstrating that those are improving, are the most important thing.

[223] **Alun Davies:** Okay. So, the numbers that I'm looking at at the moment show that our overall performance in Wales is probably a little better than it was this time last year, but not as good as it was two years ago. So, it's a bit of a mixed picture in terms of those actual response numbers. Now, what are the three things, if you like, that you believe could, over the next few months, fundamentally achieve the ambitions that you've set yourself in terms of patient experience and clinical outcomes?

[224] **Professor McClelland:** The work that Stephen is doing on an almost day-to-day basis with WAST and with the health boards, because that part of it is key. So, the work that he's doing on a day-to-day basis; how WAST are grasping that challenge, and their modernisation programme and their programme for improvement. So, that would be a core issue. And the other priority would be—it's not a priority for me, but for the system—how the local health boards are dealing with the issues around unscheduled care, moving into the winter and beyond, because this is only one part of that longer unscheduled care pathway. So, we can do some of this and it will impact on that, but if you don't deal, for example, with how we effectively discharge people from hospital, then some of that work is lost.

[225] You said three; I've said more than that. I blame being an academic, again. The other area that is really important to us is how we start—as Stephen mentioned earlier, if you look at the five-step model, starting to what we call 'shift left' and try and manage that demand more effectively. So, how do we more effectively answer people's calls, how do we more effectively give people options for where they might get an intervention that doesn't involve an ambulance coming or having to go to hospital? Because, unless we start to more effectively manage that demand at steps 1 and 2, then—. We've seen, over the last 10 years, that the demand for ambulances, emergency departments, has gone up by some 30 per cent. We have to do

something to try and manage that effectively. So, I think that's going to be a big priority for us. Older people with complex care needs are particularly a part of that, and thinking about how we manage those people and whether being put in an ambulance and being taken to hospital is the best thing. Stephen will give you more detail on it.

[226] **Mr Harrhy**: Sometimes, a figure can be helpful in explaining this. So, we know that 20 per cent of all of the patients that come into an emergency department on an ambulance don't stay in hospital. We know that they don't go beyond that emergency department. So, that gives us plenty of opportunity to say, 'Well, what alternatives could we put in place for those patients to make sure that they don't actually need to go into hospital?' They've got into hospital because the system is designed in a way that ends them up in a hospital. So, we have to redesign that system by working with health boards around alternative pathways and other initiatives to make sure that that does not happen.

[227] **Alun Davies**: Okay. I'm grateful to you for that response. So, how will you know, then, that you've achieved those objectives? You've said that good progress is being made, and the rest of it. You've described now the sorts of outcomes that you're looking for in the next period. So, I'd be grateful then if you could describe how you will know whether you've achieved those outcomes.

[228] **Professor McClelland**: That's in the quality and delivery framework. I think all of the things I spoke about are within that, and we're measuring those.

[229] **Mr Harrhy**: So, if we're looking for things on a system-wide basis—

[230] **Alun Davies**: Sorry, I just need to clarify: what are the key indicators? What are the key numbers that you're looking at that will mean that, when you see those data, you will know you've achieved your objectives? What's the key determinant?

[231] **Mr Harrhy**: So, they will be—. We have got key measures across each of the steps. Let me give you a couple of examples. So, we need to make sure that we are dispatching the right vehicle to the right call. So, one of the measures on that is—. There are two measures on that. The first one is: how many multiple vehicle responses do we have? With the old system, you used to have to send a resource to enable you to stop the clock. Well, we don't

need to do that in the new system. What we need to do is send the right resource. So, if you're sending the right resource, you then have fewer multiple vehicle responses. So, in the old system, for about 30 per cent of the calls, there was more than one vehicle that attended. So, we'll be able to track that indicator.

[232] The other thing that we've done is we've developed a matrix. And the matrix is, for each of the codes of calls that come into the ambulance service: what is an ideal response, what is a suitable response, and what is an unsuitable response? We can measure those. So, obviously, we want to make sure we don't have any unsuitable responses, and that, wherever possible, we have the most suitable response. How are we tracking that through? So, across each of these steps, we've got indicators.

[233] The other thing that we do is, where we've got a particular initiative, we have specific criteria which we'd be measuring a particular initiative on. So, has that initiative worked and, if it has worked, how do we roll that out across the rest of Wales?

[234] **Alun Davies:** Can I say that I understand all of that and it's very, very useful for us to appreciate that? My question was about the key indicator because you've got an enormous amount of data, which measure all the different aspects of a service in the way that you've described, and I think that's excellent—that's really very impressive and is what's needed. But what is the key determinant, what is the key number? Because we all, when we look at a data sheet, look at one number.

[235] **Mr Harrhy:** So, for me, it would be that what we're doing is that our conveyance rate into hospital has reduced—so we're taking fewer patients into hospital. So, if we're taking fewer patients into hospital, it means that we've got the rest of the system right. And how we are doing that. That's one of the things that I would have in my mind that I would be looking for. Then, you're right—what we'll then have is other indicators that are going to help us to say that that is working or not, because we should have the ambition of avoiding people going unnecessarily into hospital, I think.

[236] **David Rees:** Okay. Thank you. Altaf.

[237] **Altaf Hussain:** Just about that point really: maybe there's an amber response or green response and then you go back and it becomes red. Do you have the figures?

[238] **Mr Harrhy:** I don't have those on me, but you're quite right that what will happen is that there will be some calls that will be upgraded from a green or an amber call to a red call. Now there are two reasons for that. One is: did we get the right information from the caller initially? If we didn't, when we get the right information, it needs to be upgraded. The second is that a patient's condition can change and, if their condition changes, it's perfectly legitimate to upgrade that call from an amber call to a red call. I don't have that information on me, but, in terms of the way that we're tracking each of the calls, it is possible to get that information. Yes, we can get that information.

[239] **Altaf Hussain:** So what are clinically led calls? Who decides about these amber calls and green—

[240] **Mr Harrhy:** So, it's based on—. There is an evidence-based algorithm that is created. So, what the call taker will do is run the caller through a series of questions. Depending on the answer that that caller gives, you then get to a definitive code for the type of call—

[241] **Altaf Hussain:** So, you have to be a good caller. You have to be a good, clinically led caller.

[242] **Mr Harrhy:** No. What you have to be—you have to make sure that you are following the algorithm. The other thing that we've done and invested in is a clinical desk. So, if the caller is not sure, what they can do is ask that call to be transferred over to the clinical desk and the clinical desk will have clinicians on that desk who will, in effect, go outside of the algorithm and ask the patient other questions to get to that diagnosis a little bit quicker than they would otherwise have got to, or where the algorithm wasn't working as well as the algorithm should have worked. So, we're not totally reliant on that; we have that clinical back-up.

[243] **Altaf Hussain:** How long does it take to go through this?

[244] **Mr Harrhy:** The new system says that you have 120 seconds to get the code.

[245] **Altaf Hussain:** All right. Just a last question around when you said that you take the patients to an A&E department and many of them—20 per cent—are going back home. How many of them are coming back to an A&E

department? Because, every day, we know that, three or four times, a patient is getting into the hospital, and it is maybe the fifth time that he is getting in and they diagnose him correctly?

[246] **Mr Harrhy:** Okay. So, one of the other things that we've funded is a review of frequent callers. Part of that is frequent callers to the ambulance service—people dialling 999—and the second is frequent attenders at A&E departments. We are piloting with Cwm Taf some detail around those frequent attenders at A&E. People are coming into an A&E for a reason, so we need to understand what that reason is and, unless we resolve that properly, they're going to continue to come in. That reason might not be a condition that is best treated in an A&E department; it might be something that's treated best elsewhere. The important thing is that we understand that.

[247] **David Rees:** Elin, a last question.

10:45

[248] **Elin Jones:** Yes. I wanted to ask about the increase in the commissioning of private company ambulances, because there has been quite a significant increase in that. I'm assuming that that is done through the commissioning process that you're responsible for, or perhaps you can explain if I'm incorrect in that assumption. My question, really, is why do you think there had to be an increase in the commissioning of the private sector and how can we reverse that trend and increase the capacity of the public sector to deliver the service?

[249] **Mr Harrhy:** Okay. Fine. So, we have to make sure that we've got the right number of crews available at each hour of the day each day of the week. If there is a gap, that gap at the moment can be plugged by the use of a private provider. The contract with the private provider is between WAST and the private provider, so I don't personally get involved in that contracting process. Now, in terms of, 'Is that a sustainable way forward?' No, it's not. So, there are a number of things we've done around that. The first is, in terms of the extra investment that WAST has had—and it's had extra investment over the last two years—one of those allocations we've said we would want to be used to recruit extra staff, 119 extra staff. I think, once all of those staff have been recruited, then the requirement to use the private sector will reduce significantly. I can't say it will always go away, but, in terms of the frequency, it would be much reduced, I think. So, that's the first thing. The second thing is that WAST have been doing some work in terms of

rosters and rotas to make sure that, of the resource that they have available, those are in the right place at the right time. I think they're doing that in the right way, because they're doing that by working with staff-side organisations to make sure that those rosters are put in correctly and they're reviewed correctly. Now, the downside of that is it's taken a little bit longer than we would have expected for that to have happened. As a consequence, we've tended to use private ambulances for a longer period than I would have hoped we would have used them for. But I would expect that trend to be reducing over time.

[250] **Professor McClelland:** I think, as a committee, we are committed through the collaborative commissioning approach that we've taken—we call it 'partnership with grit'—about working with WAST to develop the capacity within WAST. As Stephen says, it's important that, if that capacity isn't there, there has to be a mechanism for making sure it is there. But our medium-term and longer-term clear aim is to work with them to develop that capacity across the pathway.

[251] **David Rees:** On that particular point about staffing and capacity, is it true that Cwm Taf have actually indicated that they require more staff as a consequence of the Explorer project? Because they use a lot of private ambulances.

[252] **Mr Harrhy:** They use some private ambulances; I don't think they're a particular outlier in terms of their use of private ambulances compared with other areas across Wales. As Siobhan has said, I think the real root answer to this is to make sure that WAST have the right internal resources to be able to deal with that, but Cwm Taf isn't a particular outlier on private ambulances.

[253] **David Rees:** But did Cwm Taf actually ask for more staff as a consequence of the Explorer project?

[254] **Mr Harrhy:** Cwm Taf were going through a rota change—. I don't have the precise detail available, sorry, in my head. In terms of the rota change, the rota change would have required extra staff to go in to staff those rotas as part of that change in rotas, as has been the case in other parts of Wales as well.

[255] **David Rees:** And is the change in rotas as a consequence of the Explorer project or—

[256] **Mr Harrhy:** I think it was happening anyway. What was important, though, was that the information and intelligence that was coming from the Explorer project was used in developing and implementing the new rotas.

[257] **David Rees:** Thank you. Any further questions? No. Thank you very much for your time. I've got one comment I want to make. The first question I asked you was about the three-month span, and everything you've said this morning to me indicates that, actually, monthly information would be far more helpful. Because it appears you are actually doing analysis monthly to understand some of the figures anyway. So, perhaps that's something you may want to take back and—

[258] **Professor McClelland:** As I say, we're very happy to talk to Members as well about those indicators and what might be meaningful. But we'll take that back and look at what might be possible on a monthly basis.

[259] **David Rees:** You'll receive a copy of the transcript. So, as per normal, any factual inaccuracies—. So, once again, thank you very much. I now suggest we have a break and reconvene at 11:05.

Gohiriwyd y cyfarfod rhwng 10:49 a 11:06.
The meeting adjourned between 10:49 and 11:06.

Ymchwiliad Dilynol i Berfformiad y Gwasanaethau Ambiwlans yng Nghymru: Sesiwn Dystiolaeth 3
Follow-up Inquiry into the Performance of Ambulance Services in Wales: Evidence Session 3

[260] **David Rees:** Good morning. Could I welcome Members and the public back to this morning's session of the Health and Social Care Committee, where we now have the next witnesses in our inquiry into the ambulance services? Can I welcome Adam Cairns, who's chief executive of Cardiff and Vale University Local Health Board, and Allison Williams, chief executive of Cwm Taf Local Health Board? Welcome and thank you for the written evidence we've received. Clearly, you're here because we have some questions for you. So, we'll go straight into questions. Gwyn.

[261] **Gwyn R. Price:** Thank you, Chair. Good morning. How are you? Are you confident that the performance can improve against the new emergency response performance targets?

[262] **Ms Williams:** Yes, I am, on a number of fronts. The new response targets are giving us an opportunity to be much more directive about the right resource going to the right patient. We know that in any change set of circumstances there is a building momentum and a building understanding of that. One of the big advantages is that we are having more crews and more facilities available to respond because we're not sending double crews chasing the eight-minute performance on a distance basis, which is making sure that there's not just an improvement for the patients who are the genuine red calls, but actually the distribution of the resource and the general improvement for all patients requiring any kind of ambulance response, even the non-red call response, is also an opportunity for improvement. But it is part of a whole system. It is about the alternative pathways that are available to the paramedics to direct patients to the appropriate health response. It's about the way that we deal with the GP calls, the health professional calls, that don't need to go into the 999 system. It's also about how we, as health boards, put alternative measures in place to be supporting people to access services that don't require the ambulance at all. So, I am confident that, with all of those measures coming together, those new performance indicators will enable us to better respond to the needs of the population.

[263] **Gwyn R. Price:** Are you confident with the five steps that, once the paramedic has been there and said, 'Well, perhaps you don't need to go to hospital', from there on somebody else will be available to come out and sort that patient out?

[264] **Ms Williams:** Again, there are a number of dimensions to that, because the five-step commissioning model, and—. As you probably will have heard from the commissioners earlier, the commissioners work on behalf of us as the health boards. This is a whole system. We are keen that we work with other health professionals, and we work with the public, so that the default is not a 999 position and people calling an ambulance. There is a huge amount of work to do prior to a paramedic ever being dispatched to a patient: so, what we're doing in terms of public education, what we're doing working with other health professionals in the community to make sure that people have an awareness of what the alternatives are. So, that's very much at step 1 of the pathway. And then, when the paramedic is dispatched to a patient that they believe needs that kind of response, that they've got alternative routes to signpost patients to as well. We recognise that we've still got a lot of work to do to develop a whole range of alternatives, which is why this is a

developmental process. There are some excellent examples already in place with mental pathways that Adam might want to say more about, with taking people or directing people to minor injuries, or directing people back to their general practitioner or the community pharmacy. One initiative that we're looking at, which is one of the next big initiatives, is patients with, for example, blocked catheters and how we can get better access to the district nursing service 24 hours a day so that if a paramedic is dispatched, they can then call upon the district nursing service so that patient doesn't have to be taken to hospital.

[265] **Mr Cairns:** The key bit of this, I think—I agree with everything that Allison said—is that, on the ground, people have got to have real choices that they know that they can trust to deploy in the event that they do something else. The methodology that we're using to develop those choices is what we refer to as a directory of services. Those might include services provided by the third sector and they might include formal services provided by local authority partners and also the health board, and, indeed, others as well. What we're trying to do is knit together a directory of service that is actually useful—that can tell people, 'Well, do you know that, around the corner, there's this service that you can call on and they'll pop in?' That kind of easy-to-use and well-organised directory of services is a really key part of this.

[266] **Gwyn R. Price:** I've had experience over the last few months—in fact, over the last year—of trying the system out. At 4.08 a.m. on Saturday morning I tried the system out and, actually, it did work very well for my family. But I wasn't convinced, by talking to the paramedics on the ambulance, that the next stage, if the patient had to stay there, would be available as quickly—. I'm sure, by the way you're nodding a little bit, that you recognise they're under tremendous pressure when they attend. Their heart is on their sleeve, a lot of the time, when they say, 'I don't know; if I left the patient here, I'm not sure whether this out-of-hours emergency doctor is going to turn up within the hour; it's not going to happen.' Do you agree with that?

[267] **Mr Cairns:** I think there are two points in the process where we need to intervene. One is: 'Are we absolutely sure that the GP—'. Let's say that it's a GP making the call—is the GP clear that really, really, really they need a 999 ambulance? So, one of the things that I know Allison's done, which she'll talk about, is how you can offer a different response for a GP that means you're not, necessarily, escalating it to a—

[268] **Gwyn R. Price:** Can I just intervene? What response are you offering the paramedic who's on site then? That's the one I'm more concerned about.

[269] **Mr Cairns:** Okay. So, the second bit then would be, for the paramedic, having made an assessment on site—. Ideally, we'd already know that the paramedic was attending through our communications hub. Then, we would be able to be in touch with the paramedic. The paramedic can literally ring—for part of our health board, they can ring—and we would have a conversation about, 'I'm about to leave. This patient looks to me like they need to be visited by—. Have you got anything available this morning?' 'Yes we have; we'll get it organised'. So, that kind of really fluid and immediate response is something that we're building up.

[270] **David Rees:** You're building it up, but you haven't got there yet—[*Inaudible*.]

[271] **Mr Cairns:** No, I'm not going to say the whole thing's fixed. As you know, the 111 phone line is going to be rolled out, and that's going to give us another platform, really, to run some of these things.

[272] **David Rees:** So, how far off are you?

[273] **Mr Cairns:** In our health board, we've got about a third of our population now fully covered by a very sophisticated communications hub, and we are rolling that out. So, we're making good progress.

[274] **David Rees:** When you say 'communications hub', you also looked at pathways in position for that hub?

[275] **Mr Cairns:** Absolutely, yes. So, in the hub—. Just to describe the hub, it's a big room full of telephonists, district nurses and, in the evening, the out-of-hours doctors, and the community resource teams make an appearance in there and other partners, too. What they've got in there is—on their computer screens, they've got lists of various different helpful services that can be matched to whatever it is that's coming into the communications hub from whoever it is. It might be a care worker who's been in and who's concerned that somebody might need to be seeing the district nurse a little bit earlier than they were planning to, or it might be that somebody who's been delivering meals on wheels is a bit concerned. They can contact the communications hub and the idea is that we can then deploy resources to

deal with what's emerged.

11:15

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

[277] **Lynne Neagle:** Thank you. I wanted to ask about handovers. Cwm Taf continues to have the best performance in Wales in terms of good handover times. Can I just ask what steps are being taken to ensure that that good practice is rolled out across Wales?

[278] **Ms Williams:** Shall I start and then Adam might want to talk about some work that he did last year with the visits to all of the health boards around this? There are probably three dimensions to this. One is about organisational culture within the hospital, the second is about managing the flow through the hospital and the third is about managing the flow into the hospital.

[279] If I take them in reverse order, one of the things that is very difficult for a hospital to manage is when ambulances all arrive at once, and that inevitably causes challenges in terms of the ability to offload patients, to hand over and release the ambulance. So, one of the things that we piloted as part of the Explorer programme in Cwm Taf was smoothing out the GP calls, the non-999 calls, because what you find is they tend to pulse at the end of surgery in the morning, when they've done their home visits, and then the same at the end of the afternoon. So, what we've done is we've worked with the ambulance service to take those away from the 999 system. We now use urgent care professionals within the ambulance service, linked in with our bed bureau and our acute physicians at the front door of the hospital, and we agree when those patients are going to come in. Even just staggering them by 20 minutes can make a huge difference to the ability to respond at the front door. That's been very successful for us and that is being rolled out across the whole of Wales. That will significantly help.

[280] The second bit, which is the flow through the hospital, is about the significant work that we're all driving forward around patient flow. That has seen a significant benefit in Cardiff over the last year, with improvements in handover. That's not about improving the A&E department; it's about improving discharge and flow through the whole hospital.

[281] The cultural bit is about the staff—the acceptability of keeping

somebody in an ambulance. Again, there's been a significant piece of work done across Wales, and what you're seeing is that the numbers of patients kept in the back of ambulances now is very small. But, sometimes, the difficulty is the crew being released in the A&E department. What I will say is we will never have 100 per cent compliance on that, because there will be times when the crew will be actively involved in the patient's care in the department. If you've had a major trauma and you can't offload the patient until you've checked their spine, the paramedics will be involved in, you know, the moving and handling of that patient. Even in a cardiac arrest situation, in resus, the paramedics may actually be putting lines in and working with the A&E team. So, you will never get to 100 per cent, but it's about the unavoidable.

[282] We have seen that the average daily handover hours lost across the whole of Wales are coming down, month on month. It is better this year than it was last year, and the pace of improvement is slightly better in some places than others, but, generally, everybody's on an improvement trajectory.

[283] **Mr Cairns**: Just to add a little to that, we were one of the biggest offenders this time last year, and we've done huge amounts of work over the last year to tackle that. I'm pleased to say that we've made really big improvements, so our numbers are 67 per cent better than they were this time last year. In terms of hours lost, if you want two numbers to work with, this time last year, in a month, we might have lost 750 hours. In a comparable time frame, the number we're running at now is 267. So, it's not all the way there, but it's a lot better than it was.

[284] We've also focused very hard on looking at the very long delays. That's another key part of this. We've done lots of work to improve that too, but, as Allison says, we've also got a challenge in Cardiff in that we have one funnel. We've only got the one A&E department. We do have over 100 ambulances a day turning up there. If, you know, a large number do turn up at once, that is a problem for us.

[285] The wider system-flow issues Allison's already described, but what we are doing is we are sharing what's working with colleagues. I did a piece of work, actually, this time last year, just visiting all the health boards on behalf of colleagues, and I compiled a view, really, about where practice seemed to be working, and why. We certainly learned quite a lot from that from Cwm Taf in terms of some of the flow work that they were doing at that point, and we've all adopted, where we can, those practices. But what I learned through

that process is that each of the health board contexts is quite different. It's very different in west Wales and north Wales—the wide open spaces, the geography are quite different to a city centre set-up like Cardiff or Newport. So, we've got to tailor what seems to be working in one context for the circumstances relevant to each organisation.

[286] **Lynne Neagle:** Obviously, we're in the winter now. It's not that cold at the moment, but we are probably going to have some sort of spike now, maybe if we have an increase in flu cases. Are there any specific measures in place now to deal with the fact that we could have additional pressures just around the corner?

[287] **Mr Cairns:** Yes, we've all got winter plans. We work all year long, reviewing what worked last year, and we try every year to improve on our planning for the winter ahead. One of our significant issues this year is: can we get enough of the staff that we need to run all the things we'd like to run? In our health board, we are currently not where I'd like us to be in terms of the numbers of staff, because we need to increase the numbers of hands on deck, as it were, but we're doing everything we can think of. So, we are actually recruiting from overseas. We're visiting Thailand, I think it is, or the Philippines, I should say, this month, and we've been into Europe, and we are being successful. There are people coming and joining us—good-quality nurses. We make sure that their quality is safeguarded. I think it would be fair to say, at this point in the year, I'm a little bit concerned that our overall resilience is something that we're going to need to pay very close attention to, because the staffing isn't quite where I'd like it to be just yet.

[288] **Ms Williams:** If I might add to that, the key for us is going to be, yes, what goes on in the hospital, but every winter, it's about increasing what we can do to avoid people coming into hospitals. That's working very closely with our community staff, and nursing homes and residential homes particularly, to be able to keep people there and wrap support around them, rather than bringing them into hospital. The other critical factor for us is keeping our back door moving, which is working with social services to make sure that people are not staying in hospital any longer than is clinically indicated. It's a year-round priority for us, but it's particularly important in winter that we keep that flow out of the hospital going, and that we keep as many people away from the hospital as we possibly can.

[289] **Mr Cairns:** Just to add one other bit to this, which is probably worth saying: again, just for our own organisation, we've developed—and many

health boards have these, too—a community resource team. So, this is a mixture of social workers, occupational therapists, physiotherapists and nurses working together in localities. That's been a template that we've been running now, quite successfully, for about three years, but we weren't able to stretch that over the weekend and into evenings. So, from the end of November, so the end of last month, we're now running that on seven days. We've got the staff in place to do that. From the end of January, or during January, I should say, we're going to be extending that into the evening. That very much plays to the point that Allison was making, which is that we need to find ways of helping people to stay well and to stay supported in their own homes, as far as we can. This is one intervention that I think will help us to do that.

[290] **Lynne Neagle:** Okay; thank you. In terms of social services, we know that the departments are feeling the pinch financially. Have you noticed any particular difficulties with ensuring that flow out because of the pressures in social services?

[291] **Ms Williams:** One of the things that we've been able to do this year is deploy the integrated care fund in a very targeted way, so that the things that will benefit both local government and health can be very specifically identified and their performance can be managed together. That's enabled us to do things like to put additional social work support into the hospitals so that we have not got the delays in assessments, which is generating some benefit from us. The challenge is the availability, sometimes, of domiciliary care workers and also nursing and residential home placements. Locally, within Cwm Taf, we haven't experienced any difficulty more than we would usually experience, but we're uncertain about what this winter will bring in terms of that, specifically.

[292] **Mr Cairns:** Just to add to that, I think some health boards are seeing their delayed transfers of care falling—we are. Interestingly, people often think about delayed transfers of care—patients who are waiting to move out of hospital—and the solution, therefore, must be something to do with improving the transition from hospital at the end of a long stay back home again. Actually, we're getting much, much more benefit from intervening right at the very beginning and saying, 'Is this patient absolutely—do they really, really have to come into the hospital? Is there nothing that we can do to manage this patient appropriately outside of a hospital?' I think the more that we can do that appropriately—I'm not talking about denying people treatment, or anything like that—. If you talk to older people, as you will,

nobody really wants to be in hospital. So, if we can find a way of doing that safely and appropriately—listening to what our patients are telling us—that's a better model.

[293] **Lynne Neagle:** Thank you.

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

[295] **Elin Jones:** We've heard this morning already quite a few comments on the Cwm Taf trial. You've already referred to the health-professional part of it, but the return to footprint, I think, is the other part of it. We've had some quite positive comments from the unions and from the commissioners on that. I was wondering, from a Cwm Taf point of view, whether you would want to see that as a model continued for Cwm Taf, whether you think that it's a model that's applicable to other areas as well—the only negative comment that's been made is that it's had repercussions on surrounding areas, and Cardiff would be there—and whether there's been an impact that you've felt in terms of the return to footprint and ambulances not being as available in the Cardiff area as a result of returning to Cwm Taf.

[296] **Ms Williams:** It was the biggest driver for us in establishing the Explorer programme in the first place, for a number of reasons. One was the paramedic staff themselves, and, secondly, it was the availability and then the time to respond of the ambulances. At the time that we started the Explorer project, we were working with the old targets, which also meant that many more vehicles were being dispatched—multiple dispatches—to the red calls. Those red calls have gone from about 500 down to about 60 a day now across Wales. So, actually, the return to footprint and this multiple dispatching, together with the new targets, makes it much more feasible to have the return-to-footprint model more sustainably rolled out across Wales.

[297] **Elin Jones:** What does multiple dispatching mean?

[298] **Ms Williams:** That is that if, for example—. In the old system, when a patient would dial 999—and you may want to pick this up with Tracy a little bit later—what you would do is you deployed the nearest vehicle to that 999 call. That nearest vehicle may be a long way away at that point in time. So, you might deploy a second vehicle to the same call, and then stand the vehicle down. Now, that's happening an awful lot less, because the numbers of the red 1 calls are much smaller. So, in terms of the roll-out of that return-to-footprint principle, because the numbers of red 1 calls are smaller,

that should be much, much more feasible to achieve, and then that will help with the response locally within that eight-minute framework once that next red 1 call comes in.

[299] **Elin Jones:** Okay. So, in terms of Cwm Taf, the return-to-footprint model is one that you would want to see mainstreamed—become a permanent feature.

[300] **Ms Williams:** Yes, and the only time that is breached is for a red 1 call, because, obviously, if there was a red 1 call in the north of Cardiff and the only available ambulance was in Cwm Taf, you are not going to deny that patient the opportunity to get that ambulance. Bu, it means that, for all other calls, you wouldn't work outside of that footprint.

[301] **Elin Jones:** Right, okay; I understand.

[302] 11:30

[303] **David Rees:** On that particular point, can you just confirm that, as a consequence of the Explorer project, you've identified a staffing requirement to make sure that it works properly?

[304] **Ms Williams:** There were two dimensions that were running concurrently: one was that the Welsh Ambulance Service NHS Trust was working on the new shift systems that were looking at the demand and the resource deployment against demand. The second was the Explorer project itself, which was showing us the true local demand.

[305] The ambulance service's commissioner identified earlier to you that, as health boards, an additional £7.5 million was put into the Welsh ambulance service last year recurrently, and an additional £8 million was put into the Welsh ambulance service this year, and that is all about increasing the capacity to meet now what is a very clearly defined demand. So, of the 119 whole-time equivalent additional staff being recruited, some of those will be filling gaps in the rotas that have now been identified as necessary to meet the demand in Cwm Taf and in other health board areas.

[306] **David Rees:** John.

[307] **John Griffiths:** I was just going to ask about the structures because, obviously, it's quite a complex picture in terms of meeting the challenges of

providing emergency services and ambulance services, and there are many aspects to it in terms of health and social care services. Do you feel that you've got the appropriate structures in place to pull all of the necessary partners together to make sure that you're all united in terms of what needs to be done—it's a partnership effort, as it needs to be—and that you maintain the focus, as you go forward? Because, I think we've seen a lot of false storms, you might say, in terms of ambulance services and emergency services in Wales, where we've felt that significant new systems, new leadership and a new culture have been put in place that will hopefully lead to sustained improvement, but that, sadly, hasn't, up to now, proven to be the case. Do you feel that we're now in a position to have a sustained improvement in services with the right structures in place?

[308] **Mr Cairns:** So, the position for us in Cardiff is that we work with two local authorities, obviously—the Vale of Glamorgan Council and the City of Cardiff Council—and we've now developed very clear joint and agreed leadership arrangements. So, we meet regularly as a top team and we've agreed between us how we are going to conduct business together. That's led to the appointment of joint appointments. We have people now who straddle the health and social care workforce, often in community settings, and we've just appointed a new assistant director, who's going to be supporting us in the work that we've agreed to do to join things up even more out there in the community.

[309] The reason why that's working is because I think we've all concluded that many, many of the citizens who we are serving, with our different responsibilities, actually have an overlapping and intersecting need. It's very sensible for us to be thinking about how we can co-ordinate what we're doing for individuals, making sure that we're removing duplication and that we're providing quicker responses, where that's necessary, and trying to head problems off. So, it's a position, I think, where we—. It's very different to how it was two or three years ago, I would say. We've got much, much more to continue to do.

[310] One of our big challenges in Cardiff is the fact that the population is growing so quickly. So, we've got a big population increase to contend with. That's raising some questions for us about how we're going to respond to those numbers of people—20,000 people in the next five years. We've got some questions that we're working through together, looking at how we design housing developments that actually help us with housing accommodation and locality hubs and that kind of thing. So, there's quite a

lot of work going on, I think, in focusing on how we can help one another to do the best job that we can for our population. So, I think that's a fairly positive frame for us locally.

[311] **Ms Williams**: If I could add just two brief things to that, because I concur with everything that's been said, and you'll see similarities across all of the health board and local authority areas. The difference now is (a) the integrated care fund resource is not your money or my money; it's ours. It's our resource that we've got joint responsibility to deploy to the best effect—for the people that need our services—together. That has been hugely beneficial in trying to address some of those grey areas that sit between health and social care. The second issue is actually having a commissioning framework that is very, very clear and holds everybody to account—not just the Welsh ambulance services trust, but actually holding ourselves and each other as health boards to account for the bit of the system that we're responsible for, because just addressing one part of it won't work. So, those two factors, on top of everything else, are what give us the chance, really, to get a sustainable improvement in place that perhaps we haven't had before.

[312] **Altaf Hussain**: Regarding the delays, really, we have winter pressures all the time—. I've visited many hospitals and you can see 10 to 15 ambulances waiting outside. Now, on the predictabilities—that we have constant population and we have constant beds—what we don't have is additional cubicles in A&E departments: that's No. 1. No. 2: the staff in an A&E department. If that is rectified, do you think we'll still have these ambulances waiting outside A&E departments?

[313] **Mr Cairns**: So, there's a question there about, 'Our estate, our buildings—are those exactly as we'd like them to be?' My short answer to that is 'no'. We're thinking at the moment how we are going to design and pay for a new footprint, really, for our services. We're doing some active work on that now, and it's partly—it's a very short answer or quite a long answer, so I'll give you the short answer. The answer's 'no'.

[314] **Altaf Hussain**: That's right.

[315] **Mr Cairns**: We haven't got those facilities quite as we'd like them, but we are doing a lot of thinking about how we could redesign.

[316] **Altaf Hussain**: The second point is, again, about winter pressures. You'll have patients coming through with flu, and the A&E department will be

blocked, and there won't be any access because of these ambulances waiting outside. Do we have an alternate route for those patients to go into the medical department directly?

[317] **Mr Cairns**: One of the reasons why—and this is going to sound so obvious, and I'm not trying to be patronising—but one of the reasons why is that we have either too many people coming in and not enough people leaving, or the place that they're leaving to go to can't take any more patients. That's what happening to us at the moment. We've got an area where the doctors think, 'On the whole, you look like somebody who probably needs to come into hospital, at least for a day or two. We're not quite sure how long'. That's not an A&E patient now; that needs to be somebody who we're assessing. At the moment, our assessment space—the location in which that happens—is too small for the numbers of people who are coming in each day. As a consequence, what's happening is that we're not able to release those beds quickly enough so that people can move through the emergency unit. So, actually, if we could fix that problem, which is further up the stream, we'd have less of a problem in the EU department.

[318] So, the work we're doing right now is, 'How big does that space have to be and how can we get it to appear really, really quickly'. We're doing that work right now and I'm hoping that we'll have a model that we'll agree with our clinicians before Christmas, and then we'll be thinking about how we can create the space—it needs to be quite a big space for us, with about 90 beds: it's a big space—so that we can flow appropriately through the system. That will help us, not only with the EU problem, but also with ambulances of course, because people keep moving along the system.

[319] **Altaf Hussain**: Thanks.

[320] **David Rees**: I've got a couple of questions quickly. On the non-emergency patient transfer service, obviously, Siobhan McClelland in her report back in 2013 indicated that separation of that service from the emergency ambulance services, and that health boards would be taking over some responsibility for that. Where are we going at the moment with the non-emergency patient transfer service? Are health boards being proactive in looking at ways in which they can be involved in that, or have health boards and WAST now come to the conclusion that it remains totally with WAST?

[321] **Ms Williams**: Shall I start? The non-emergency patient transport service and the emergency transport service are all under the same umbrella

in WAST at the moment. The key when we gave evidence to the McClelland review was that, wherever the responsibility for providing that service is—whether it's WAST, whether it's the health board, wherever it is—it needs to be completely separated from the emergency ambulance service so that there's no contamination of the functions.

[322] There's been a significant piece of work that the health boards—every single one of them—WAST and the third sector have been engaged with over the last year, to develop a business case and a detailed option appraisal about the management arrangements and the functionality of the non-emergency patient transport service going forward. The recommendation coming out of that piece of work is that that should be separately commissioned through an entirely new commissioning framework. As health boards, our advice at the moment is that that should be commissioned by the ambulance services commissioner, but as a separate service, subject to the same rigour, standards and performance monitoring as we are now putting in place for the emergency ambulance service that you've heard about today.

[323] So, as things stand at the moment, we're awaiting approval of that business case and that'll come back in to the Emergency Ambulance Services Committee for consideration in January. If everybody's in agreement, the likelihood is that we will go through a transition year over the next 12 months, when that will be separated out completely within WAST from the emergency services. WAST will continue to run it, but as a separate entity in a partnership arrangement with the health boards, local authorities and the third sector, because we need to be looking at how we then join up all of those transport opportunities so that we get best value for the public purse, but also get the best services for the patient.

[324] So, I think we've moved a long, long way in the last 12 months. That business case came to us as chief executives last month, and it was the first time that I could really see that we've got a route map now to getting a robust and properly performance managed non-emergency patient transport service.

[325] **David Rees**: Thank you for that clarification. A lot of the answers have been focused around Cardiff and the Vale and Cwm Taf, understandably, but perhaps you can give us an idea as to whether this is consistent across Wales—so, in all other health boards. Are there areas where there are still some aspects that need to be addressed, because clearly there are large

populations outside your two home areas?

[326] **Mr Cairns:** If I start and then Allison perhaps can just comment a little. One of the reasons why I was asked to spend some time looking at different health boards last year was so that we could try and get some kind of understanding about the extent to which a one-size-fits-all or adopt-or-justify approach was sensible in terms of a way of dealing with things. I think that what I learnt from that is that there a different circumstances that are affecting the performance of different health boards in different ways. So, if you look at Morriston, Morriston looks to be, and is, a hospital under a huge amount of pressure at the moment. That's probably because, inside the hospital, it hasn't quite got the full range of capacity that it actually needs to deal with the flow every single day. If you look at other parts of Wales, there are other parts of Wales that are also experiencing pressure. They'll have their own unique factors that are driving that for them. What we're trying to do, and I think with some success, is to share first of all what we think is working—and we're getting better and better at doing that—and then we are beginning to build an ability to translate that into things that people can do locally that work for them. So, I think it's building, but I think that there are definitely pressure points around the system in Wales that are non-uniform, and their solutions are probably going to need to be non-uniform too.

[327] **David Rees:** I've got one final question, or maybe a point. You talked about the pathways, and you talked about trying to deal with patients in the community—there's no need to bring them into hospitals.

11:45

[328] I'll give you an example, and it's a personal example, where a family member has phoned up the GP practice, and the GP has actually indicated—and I understand the pressures they're under—'I'm busy, I can't come out. Phone 999'. On more than one occasion that's happened. Therefore, there is clearly a situation where health boards, I think, need to discuss with the primary sector how they will actually avoid the additional patients going to them at hospital who don't need to go there, and who also don't need a call-out from an ambulance.

[329] **Ms Williams:** It is a problem. What is really important is that, through the ambulance service, particularly, we have that information fed back to us as health boards. With the new systems and the new data capture, we can have that fed back, because if there are some practices that are repeatedly

doing that, then we have performance management arrangements where we can work with those practices, either through firm performance management or through helping them with access to alternatives, to ensure that that is minimised. But it is not uniform. We know that there are some pockets where this is happening, and that's got to be tackled directly with the individual practices.

[330] **Mr Cairns:** I agree with that. I just want to clarify that we wouldn't—. In most cases that isn't because the practice is being neglectful, or they just can't be bothered. Usually, it's because the practice is under huge pressure, and it might be a signal that they're not actually as aware as we'd like them to be of all the range of things that are available as an alternative. So, in a way, it's a signal that we need to respond to, and our opening expectation is that there's probably going to be something useful we can find out. If we know about those sorts of situations, often we can help provide better information, we can make it easier for the GP to do the right thing, and that's got to be the way that we see it.

[331] **David Rees:** It also impacts on the pathways the paramedics will be following as a consequence.

[332] **Mr Cairns:** Yes, it does. Absolutely.

[333] **David Rees:** Are there any other questions? We're coming to the end of our time anyway, so can I thank you very much for your time this morning? You will receive a copy of the transcript for any factual inaccuracies. If there are any, please let the clerking team know as soon as possible. Once again, thank you very much.

[334] For Members, the final session will be the chair and chief executive of the Welsh ambulance service trust.

11:48

Ymchwiliad Dilynol i Berfformiad Gwasanaethau Ambiwlans yng Nghymru: Sesiwn Dystiolaeth 4
Follow-up Inquiry into the Performance of Ambulance Services in Wales: Evidence Session 4

[335] **David Rees:** Good morning. Can I welcome Tracy Myhill, who is chief executive of the Welsh Ambulance Services NHS Trust, and Mick Giannasi,

who's the chair of the trust, to the final session this morning? Thank you for the written paper we've received in advance of the meeting. We'd like to go straight into questions, if that's okay with yourselves. Gwyn.

[336] **Gwyn R. Price**: Thank you, Chair. Good morning—it's still morning—to you both. Are you confident that performance can improve against the new emergency response performance targets?

[337] **Ms Myhill**: Yes, I am. You're looking at me, so yes, I am. I know you've spoken about this many times this morning, so I won't repeat what you already know in terms of the new model coming in on 1 October. But because of the low numbers that are now in that red category, we can analyse every single one of them, and we are, which means we can improve—

[338] **Gwyn R. Price**: Sorry to interrupt—coming in in October next year, or October already gone?

[339] **Ms Myhill**: No, the model that just came in now, this October: 1 October 2015. That new clinical response model, just in terms of the reds, for the moment, does enable us to look at every single call. We couldn't do that before, because 40 per cent of our work was red. Now it's 5 per cent of our work, so we can improve, because we can analyse every single call. Every call we miss we analyse, every single day, which gives us opportunities to improve, and we can see where improvements can be made. So, I'm very optimistic that that will continue to improve as we learn more about the model, and as we put improvements in place from that learning.

[340] **Gwyn R. Price**: We've heard a lot this morning about the five-step model. Are you confident that that is completely going through from one to five?

[341] **Ms Myhill**: I think the five-step model is really important, because what it does for us is stop us from only focusing on steps four and five, which are going to see people and taking them to hospital. So, the five-step model enables us to go right back to giving people choices to make the right call in the first place and dealing with their calls in a different way. It enables us to focus on—we call it 'hear and treat'—so, we listen and we can treat by phone only. It focuses on us doing more of that, so we only dispatch our resources when we need to. So, it has changed the conversation, actually. It's a much broader conversation around the whole health system, which is what we said to you last time we wanted to be—part of the whole health system—

as opposed to focusing on that narrow bit, which is the bit that we often talk about, which is where we're going and what are we doing when we get there. So, I think it's been really good and we're trying to work everything we do around the five-step model to make sure there's a balance, because if we keep looking at steps four and five, we will never change the system in a way that we need to.

[342] **Gwyn R. Price**: Are you confident that it's a two-way system from the management right down to the staff and from the staff, more importantly in some cases, back up?

[343] **Ms Myhill**: In terms of the five-step model, do you mean?

[344] **Gwyn R. Price**: Well, in the reporting of an incident and any problems in that incident. You learn by any mistakes then in that incident and you can improve that model, as it goes on.

[345] **Ms Myhill**: Yes, absolutely. We worked very hard with our staff before the new model. Our medical director personally did many tours of Wales to speak to clinicians on the ground about what the new model would mean and what it would mean for clinicians, so we've done a lot to prepare people. We're about to do a survey from staff to get some more quantitative data, I guess, on how it feels and how it's been, and we test it anecdotally. But what we've got now that we didn't have before, we have digipens—digital pens—that enable our staff to record the patient care record digitally. All forms all over Wales—we would have paper records that we would have to collate from across Wales. We can now record what's happening immediately and that enables us to get better information and quicker information, and it will enable us, with our staff, to learn from the practice.

[346] **Gwyn R. Price**: Thank you.

[347] **Alun Davies**: I'm interested in your answer to Gwyn's first question on being able to understand, monitor and analyse all the calls that you receive—the emergency calls. I was wondering if you could characterise what you find when you complete that analysis and what you've learnt as a consequence of that analysis.

[348] **Ms Myhill**: In terms of the first month—obviously, we're going to be continuing to do this forever—but there are a number of things that are contributing to the missed reds. Some of it is our own practice, some of it is

about the way that we transfer an incident. If you call us, you call 999, we have a virtual telephony system, so you'll call your local area. So, you would call through to Vantage Point House in Cwmbran, but if we couldn't answer your call in a particular time, it would switch to north Wales or central and west. That's to enable us to respond to calls quickly. The dispatch, then, of a resource to your problem; if your call went to north Wales, it would go back to Cwmbran to dispatch the appropriate resource. That's causing a delay in the time. So, we've been able to identify that in some detail, which means we now need to look at what we can do to smooth that incident transfer, we call it.

[349] There are issues about deployment. Our vehicles were in the wrong place at the time and there was an opportunity for them not to be in the wrong place, so the dynamic deployment, deploying through our control rooms in a different way; we've learnt from that. Some of the incidents, we've learnt that it would've been virtually impossible to get to in eight minutes, but what we're also looking at is eight minutes three seconds, eight minutes 20 seconds, through to the longest wait, so we can get underneath all of that. So, there are definitely internal things that we can do. There are some things that we will do better when we have better technology and we're looking for a new computer-aided dispatch system in our control rooms, but there are internal errors that we can do. And what we've found, looking at our control rooms across Wales, is that different teams perform differently, and we can get into the level of detail and we could never do that with 40 per cent of the calls. So, performance management, development, improvement, feedback to staff; there are lots of opportunities for us to learn and to continue to improve.

[350] **Alun Davies**: Thank you for that. That's very illuminating. In terms of the session we've had this morning, I think it's fair to say it's a very much more positive and a very different session to that which we had, I think it was last March. I think everybody's very, very pleased with that. Looking at the category A calls, we've seen an improvement through 2015, but where we seem to be today is a little better than last year, but not quite as good as 2013 on the numbers that I'm looking at. When would you expect us to see that consistent improvement where we can expect, as a matter of course, targets to be met?

[351] **Ms Myhill**: When I spoke to you last time, I talked to you a lot about trying to make sure we've put in place sustainable change, so that we can build and continuously improve. I remember lots of pressure about, 'When

will you hit this? When will you hit that?' What I've been very cautious about, and positively cautious about, is not just picking numbers, I want to see continuous improvement. So, the example that you're quoting—I wasn't there at that time, but I do know, because we look back and we talk—was an unsustainable change. So, you can throw everything into improving performance for a very short period of time, you can give lots and lots of overtime, you can do nothing else except respond, morale goes down and people get ill, but your performance goes up. That's definitely related to the example that you've given there, and then it goes down—

[352] **Alun Davies:** In 2013 you mean.

[353] **Ms Myhill:** In 2013, yes. Boom and bust, I think, is the way that we would describe it. What we need to do is put things in place that are going to continuously improve, and we're in a much better place to do that. So, I would expect to see continuous improvement in our performance, going forward, as opposed to, you know, a lot of this. Do you want to say anything on that?

[354] **Mr Giannasi:** If I may, from my perspective, I think we learned an awful lot from the summer of 2013. If you remember, in 2012, there was a new response model, the clinical response model, which created adverse consequences. So, as demand increased in the system, as acuity increased, the system that we put in place wasn't able to cope with that increased demand, and so I think the phrase is, kind of, 'Hitting the target, missing the point'. We put focus into achieving the target, which resulted in perverse behaviours and the wrong outcomes. So, we've learned from that as a board and we're not going to allow that to happen again. I think what we have now is a fundamentally different opportunity, a different environment, a different relationship within the trust, with our staff, a different framework and a different kind of environment in terms of partnership, where we can do things in a much more sophisticated way, as part of a whole-system response. So, I don't think we'll make those mistakes.

[355] The difference for me is: if, two years ago, I'd have asked that question, 'What is our plan to deliver incremental improvement?', the answer would have been, 'We're just going to work hard and try our best'. The answer now is very clear: there are a series of steps we can take; there are areas we can improve geographically; there are systems and processes where we can drive our performance; and we have a whole series of strategic developments, like a new computer-aided dispatch system and like a new

analytical capability called Optima, which will start to analyse in real time where our resources ought to be. So, I can see very clearly now, from the chief exec, 'Here is our plan going forward, to deliver sustainable, incremental improvement over time'.

[356] **Alun Davies**: So, you're happy with the reporting mechanisms that you have in place from the executive team. But, can I just press you a little harder on when you expect to be able to deliver that consistent target-meeting performance?

[357] **Mr Giannasi**: It is early days. The relationship that we now have with the Emergency Ambulance Services Committee has been hugely powerful, really, in exposing the way that the organisation works and the way that our performance is delivered. So, we're now getting a much richer picture as a board, you know, as Welsh Government will and as the public will, about how our resources are deployed, what they're achieving in terms of outcomes, and how that's improving over time. So, we have a better insight into the organisation. Our objective, quite clearly, is to continue to improve incrementally as we go forward. So, what we now have is a series of steps. We know, although the figures are not yet published, that we're fairly confident that we will be better this month than last. We are fairly confident that some of the inequities that we saw in the first month's performance will start to be smoothed out. So, we have mechanisms in place now and we have performance-reporting systems that are much more sophisticated that give us that ability to analyse. As I say, I think there is a plan, whereas, previously, it was best endeavours and, you know, hoping for the best.

[358] **Alun Davies**: With all due respect, though, Mr Giannasi, the question was, 'When?' I understand the processes that you've put in place, and I appreciate that. That's been explained to us. But, my question was: when do you expect to be in a position, having all these new processes and much richer information, to be consistent in meeting the targets that are set?

12.00

[359] **Mr Giannasi**: Well, we met the target last time. We didn't achieve it everywhere. I think, this month, we will see an incremental improvement. We have measures in place that should deliver incremental improvement month on month. There are variances in the system, there are changes in demand, which will occasionally take us off course, but I'm confident there will be a continued trajectory. We start from the point where, in terms of the

quantitative target, we are meeting that. I hope that when the qualitative targets are produced in January we will be seen to be performing well, and that gives us the baseline then to move forward.

[360] **Alun Davies:** But the question is—. I'm sorry to keep pressing. I think it's important that you do answer the question. The question was very clear, I felt: when do you expect to be able to be consistently meeting the target?

[361] **Mr Giannasi:** Well, we are meeting the target.

[362] **Alun Davies:** So, you expect now, from your position now as an ambulance service trust, to be able to say that you're going to consistently meet the target that is set for you this month onwards.

[363] **Mr Giannasi:** That's my expectation.

[364] **Alun Davies:** Okay, and you expect to be meeting that target consistently across the whole of Wales.

[365] **Ms Myhill:** We won't do that immediately. There's more work to be done there. In terms of the national target, we've met that. We're not comfortable—. We obviously enjoy meeting the target—that's good for us and that is very good for the Welsh ambulance service and very good for our staff—but we're not satisfied with meeting the target. We want to continue to improve, and that's what we'll do. There is only the one national target, and that's being met, but we're not comfortable yet. It's one month in, but we're not comfortable that we are not at that level across the whole of Wales. That won't happen next month, but that will happen over the coming months, and that will be the focus that we'll have. We're going into the winter period. We know December. You know, December last year was the worst performance for many, many years, so, we need to take that into account. But we want to meet it everywhere, and we want to continue to improve it. That's the commitment we've got; that's the commitment we've given our commissioner; and that's what we're working with the commissioner on.

[366] **Alun Davies:** So, for my constituents in Blaenau Gwent, our performance has been amongst the worst, I think it's fair to say, in terms of consistently providing the sort of performance that you would expect and want to see. When would you expect my constituents to receive the sort of service that I think we're all agreed that we'd want them to receive, and to do so on a consistent basis?

[367] **Ms Myhill:** The performance in Blaenau Gwent for the first month of the model was 71 per cent. It was one of the best-performing areas in Wales, which is really encouraging. You know, because we met and talked about the improvement on the old model and the focus that we put into Blaenau Gwent. You raised those very issues with us last time and, in a way, it did help us focus more locally, as well as just looking nationally into some of the areas across Wales, which we've done. So, there has been, as you will know, improvement in Blaenau Gwent on the old model—almost 15 per cent improvement—but 71 per cent in October is really one of the highest and we would want that to—

[368] **Alun Davies:** And you expect that—. My concern is—.

[369] **Ms Myhill:** The target is a national target, and 65 per cent at a Welsh level is clearly what we will be measured on, but we don't ideally want to see any performance deteriorate anywhere.

[370] **David Rees:** I think you've had the answers that you're going to get now; so I'll move on. Lindsay.

[371] **Lindsay Whittle:** Yes. I don't know if it's—[*Inaudible*.] Look, it's the duty of opposition politicians to highlight failures in Welsh Government delivery of services, and ambulance response times are one of those figures that are often highlighted, not just by us but by the media as well. I wanted to ask the same question that I asked to the trade unions today. What is the Welsh ambulance trust doing to help the staff who deliver the service who must—. You know, probably by the time we started this meeting this morning, they may have saved—I don't know—half a dozen lives across Wales, but it is the one story where they unfortunately didn't get to in time that will hit the headlines. I'm wondering what you as a trust are doing to help staff morale. I don't do bad stories on ambulance times any longer. I think it's been done too much, and I think we need to concentrate on how we're going to improve the service now, which is what we're doing now. But what are you doing? Because post-traumatic stress disorder is often talked about amongst the military, and quite rightly so, but nobody ever talks about post-traumatic stress disorder amongst those who provide our emergency services, who have been going through this all their lives.

[372] **Mr Giannasi:** Can I, perhaps, answer from a board level, and then, perhaps, Tracy could talk about the operational issues? From a board level, I

think our relationship with the trade unions has been transformed, actually, over the last 12 months. We were in a very difficult place, as you know, 12 months ago, and it's fundamentally different now. We've remodelled the way that our trade union representatives sit with the board. They have a personal development review process, as everybody else does, and they've become much more of an integral part of that process.

[373] From my perspective, as non-executive directors, we have a programme of visibility, where we're out—quite frequently, actually—talking to staff on the front line. Only a few weeks ago, I was out in ABMU with the chair of the health board there, jointly visiting our staff to talk about some of the issues that we face. And, we are very keen to open up those two-way communication channels and to recognise some of the behaviours we're actually very proud of. Only last week, we had a very positive awards ceremony, where staff from all over Wales came to be congratulated on their success. But, we've also invested very significantly in communications capacity. We've brought in people of a different calibre and with different capabilities than we had previously, and we now have a strategic approach to communications, rather than the defensive, retrospective approach that we had previously. So, it's something that we as a board are very focused on.

[374] We are involving our staff—not just the representatives, but front-line staff—in the development of our integrated medium-term plan for the next three years. They are fundamental to our vision. They are describing the values that this organisation wants to have, going forward, and it genuinely is a very different place. As well as that, there are a significant amount of operational activities going on, which are about, really, changing the culture, which has, in the past, been unhelpful.

[375] **Ms Myhill:** I've just a few things to add. For me, there's a major focus on leadership—getting the right leaders with the right attitude, engaging leaders, having a coaching style of leadership as opposed to a tell or a command and control. So, I'm trying to change that, we are trying to change that. We have the saying, 'Ask, don't tell'. We need to add on to that, 'And listen'. When you ask, you need to listen, and you need to engage people. So, we're trying to change the culture that way and motivate our employees that way. Mick talked about our values and our behaviours; we had over 800 members of staff contribute to what we think the key behaviours should be in this organisation. One of them is that, 'Ask, don't tell', and 'Be kind', and 'Be open and be honest'. There are things like that that we're working through with our staff. And making expectations really clear, that's

something else that I'm very, very clear about: how I expect our managers and our leaders to behave and how I expect them to interact with our staff, and also the same with staff and the same with trade unions. We're all in this together. So, there's a big focus on that as well.

[376] On some of the very specific issues you talked about in terms of stress and the impact on our workers, because it is a very highly stressful role, we've invested in the last year through the invest-to-save process in Welsh Government in two occupational health vehicles. So, we have a mobile service. Our occupational health service is now mobile, and we take our occupational health vehicles out across the whole of Wales for things from flu jabs to stress advice, to counselling and support. That is really positive for us, because we can't expect our crews to travel to us all the time, so we need to travel to them.

[377] We're trying to make access to the wellbeing services that we have more visible, so people understand what is there. We've got cue codes so people can use their mobiles to get access to the support that is there for people. As I said, we're working very hard to do that. And, with our trade unions, we're piloting a very specific area of stress support. So, there's lots that we are doing to make sure that we support our staff in the stressful environments that they work in.

[378] **Lindsay Whittle:** Could I thank you for those answers? You've taken away most of my secondary questions, which is a good thing. One thing—and it's not a criticism—I do think, perhaps, if you have a public relations department, they need to do a bit more work, because I wasn't aware, for example, you had an awards ceremony. I've heard of other awards ceremonies amongst other services, but not yours, for some reason. I don't know why, but that's how it is.

[379] **Ms Myhill:** That's good advice for us; thank you.

[380] **Lindsay Whittle:** Thank you very much.

[381] **David Rees:** John.

[382] **John Griffiths:** You mentioned earlier, Tracy, the importance of having a whole health and, I guess, social care system approach to these issues, because, obviously, delivering emergency services and ambulance services is very complex, and there are many partners that need to play a role. Do you

feel that you've got the right structures in place now across Wales to bring the necessary partners together to make sure that everybody understands what needs to happen, and everybody is sufficiently focused so that, you know, hopefully we can maintain that partnership between all the necessary players as we go forward to get the sustained improvements that we've been talking about?

[383] **Ms Myhill:** Our partnerships are very complex, aren't they, because we're an all-Wales service and we have partnerships with all the health boards and emergency services across Wales and local authorities. So, it is a very complex picture for us, and we're working very hard, actually, on identifying better ways for us to engage with our partners, because we're a small organisation with a huge reach. So, there's a big focus on that.

[384] But, in terms of the health boards specifically, clearly, the Emergency Ambulance Services Committee is where health boards come together with us. That is developing, and it has developed immeasurably since we sat here last time. And we are working very collaboratively on taking the improvements forward. So, that's good.

[385] The other area that we've been focusing on—. I mentioned leadership earlier, and I've recruited a director of planning and performance, who was a head of planning in Welsh Government and has been an assistant director of planning in a health board. So, he has really relevant and huge experience for us in helping us connect with the health boards on their service plans, because we had a conversation last time about how we engage, whether it's with maternity in north Wales or what's happening in south Wales and the mid Wales collaborative. And it's hard for us to make sure that we're at the party at the right time. So, we're working through an infrastructure with health boards now to make sure that we maximise our input but that we don't kill ourselves in the process because there's seven of them and only one of us. So, we're making improvements there too. It definitely feels better.

[386] And then, of course, operationally, we have a structure where heads of operations cover local patches, so there are lots of conversations going on at health board area level.

[387] I still think there's more to do. I think there's more to do to get our structure more solid, and those relationships will continue to develop. But it's definitely moving in the right direction, I would say.

[388] **John Griffiths:** Do you feel that you're in a position to help spread best practice—because, obviously, you can see what's happening in terms of the services that you're responsible for—from one part of Wales to another? Is there enough spreading of best practice, and do you have the ability to say to one health board, 'This seems to be working well here; perhaps you might consider adopting it also'?

[389] **Ms Myhill:** We do. We have the all-Wales view that health boards don't, actually, because they're responsible for their local population and we've got the whole population. So, we are very much able to look at something in a particular area of Wales, have a view and advise as to whether that can be rolled out for Wales. We now have a system of doing that in a much more formal and structured way with the commissioner and their committee, and a sub-group of the committee—a quality improvement panel—where service change ideas, as we call them, or roll-out plans go, and one outcome could be one for Wales: that this is something that must happen everywhere. The mental health pathway is a good example that we have in Cardiff—164 people in Cardiff referred to the mental health pathway, and 132 not needing to go anywhere near a hospital. It's a really good pathway; it's something we need for Wales. So, the conversation is that that needs to happen everywhere, and can happen everywhere and should happen everywhere. So, that's the way that we do that collectively, with the health boards brought into the quality improvement panel that Siobhan McClelland personally chairs.

[390] **Mr Giannasi:** Could I just add that that too is increasingly supported at the governance level as well, because the chairs meet as a group and there is an increasing interest in ambulance services? I think that transition of ownership, where the local health boards now do actually own the outcomes of ambulance performances, is now quite clear. And I have regular conversations with my fellow chairs about their performance and about some things they can do. But we've kind of supported that with a network of links between our non-executive directors—we have seven; there are seven local health boards—and each one of those is linked through a protocol to one of the local health boards. So, the idea of that is that there is a conduit for the flow of information between different health boards, and there are regular conversations about, 'This happens here; have a look at it'. So, you know, there isn't a one size that fits all, but we are putting the conduits in place for that information to start to flow to create ideas that people can think about.

12.15

[391] **John Griffiths:** Is there a health board area in Wales, you know, this coming together to make sure there's a common agenda, which then feeds through to better practices and performances, that you would point to as, perhaps, having got it more right than any of the others?

[392] **Ms Myhill:** I thought you were going to ask, 'Is there a health board you would point to that's not?' [*Laughter.*]

[393] **David Rees:** I thought that as well.

[394] **Ms Myhill:** And my answer was going to be 'no', actually, because we've seen, again, improvements in all areas of Wales. I might not have said that a year ago, but I can't pinpoint any health board that is not actively engaging with us now on issues of interest to us both, which is a really, really positive place to be. Is anyone better than anyone else? It's different—I mean, we have different issues. So, we're working with them on the issues that are relevant to them, but they are all—the chief executives, certainly, from my perspective—very, very committed to working with us. It feels in a much better place and it feels like we're equal, you know, in that debate. It's not the little organisation and the big health boards; we're equal and we talk together. So, I'm not sure I would put anyone above anyone else in that sense. They are all working with us and I really do genuinely feel that commitment from all areas.

[395] **David Rees:** So, there is no single health board you would go to as an exemplar of good practice. There is good practice across different parts of all health boards?

[396] **Ms Myhill:** I think there are different health boards that you could go to for different things. We've heard about Cwm Taf and, in terms of handover delays, they are virtually non-existent. Some of the partnership work we've done there has been really good, and we're rolling that out where it's relevant to roll it out in other places. The mental health pathway and the work we've done in Cardiff is hugely significant for everyone else. We're working very, very closely with Hywel Dda at the moment on joint improvements to improve our performance in that area. In Powys, we're working with Carol Shillabeer, who wants to know every detail about every call from every resident in Powys in relation to the ambulance service, which is good. And I could go on. So, I think it depends on the area. There are good things to share from them all.

[397] **Elin Jones:** I want to go back to clinical outcomes and clinical outcomes are as important to non-red calls as well and, for example, stroke victims are no longer in the red call and they are, technically, without target in terms of ambulance response times. So, what work are you doing to monitor and keep data on clinical outcomes for amber calls as well, and do you think that that is information that will be released into the public domain?

[398] On staff capacity, we've heard some views this morning that there are shifts and rotas in different parts of Wales that are insufficiently staffed at various times. Do you recognise that as something that's happening in the ambulance service of today? There's been a growth in the numbers of private companies providing ambulance cover, and what are you intending to do? Are you intending to change that trend in any way and, again, increase the capacity of your own direct service? It's been announced and it's been referred to this morning that part of the answer to this is the 119 additional staff that you've been funded for by Welsh Government. Are there 119 additional paramedics in the system today compared to this time last year?

[399] And then, finally, on the Cwm Taf trial and the return-to-footprint part of that trial in particular, it seems to have been quite well received by staff working in that model of service and by those people in that area represented by the health board. Do you believe that that kind of model is something that is applicable to other areas—and if I can be parochial just for one moment—such as Ceredigion, where I certainly am aware that ambulances can be out of the area for a long time after they may have needed to transfer patients to Morriston or Llanelli and then, suddenly, they're on call and responding to calls in those areas and not able to return during their shift to their place of origin?

[400] **Ms Myhill:** I think there were about six questions—I'll try and get them.

[401] **Elin Jones:** Yes, I know—I'll come back if you haven't answered them.

[402] **Ms Myhill:** Your first question was about amber calls. I don't want you to think that I think time is most important, because clearly it's not, in the amber calls, and that's why they're categorised as amber. But, for our own security, we measure the time of our amber calls, and we measure those calls ourselves against the 20-minute backstop target. So, 73.5 per cent of our amber calls were seen within 20 minutes in the first month of the trial in

October. The median for our amber 1, which are the most serious of the amber calls, was 10 minutes and seven seconds, and the mean was 14 minutes and 12 seconds. Ninety-five per cent of amber 1 calls were seen in 40 minutes. So, we are watching that, because it's a new model, and we're all learning, so we need as much security as others to make sure that we're not losing the amber because of the focus on the red. We're certainly not, and if you look at that performance in comparison, it's better than it was in the old model. So, everything is moving up, and that's because we can identify resources more appropriately. We've got a bit more time to send the right resource, we're sending fewer resources per incident—there are lots things that are contributing to that improvement.

[403] You said there's no measure in terms of—you used the example of stroke. Well, in the new year, that's when we can start to have the discussion about those things that really matter in that category, which is about the clinical indicator. Stroke is one that will be part of the first set of indicators that we report, along with heart attack, along with fractured hips and cardiac arrests, and we will then develop, with our commissioner, a growing suite of clinical information and outcome data that we will be able to share. So, we will look at sepsis, we'll look at convulsions. We've got a whole piece of work in train so we'll be able to do that. The Emergency Ambulance Services Committee will publish that across the system, and I think that's really exciting and I think that's really good, because those are the conversations that we want to have. So, you will see that, but, because we're seeing you now, all we've got in terms of anything published are those red October figures.

[404] **Elin Jones**: So, those clinical outcome figures, when they're published, will include some of the amber category of diseases or conditions.

[405] **Ms Myhill**: Yes, definitely.

[406] **Elin Jones**: Okay. That's fine.

[407] **Mr Giannasi**: Can I say, from my perspective, as Chair of the board, obviously my responsibility is to hold the chief executive to account, as you do. We used to look at red performance, response time performance, and ask the question, 'So what?' because it just didn't give you an insight into anything to do with quality, safety or patient experience. What we will get now is actually quite exciting. So, I think you heard from the commissioner this morning that we will be doing mortality reviews. We will be following

cases through into the hospital to see what the outcome was. We will know whether the standards of care that we expect to be applied to victims of stroke and other conditions are actually being applied, and, most importantly, we will get that information in real time, because previously we had a paper-based system where people ticked boxes and it was analysed at great expense and in a very inefficient way. We've invested in the last 12 months in the digipen solution, which is a very staff-friendly way of recording information in real time about their clinical treatment of patients, and that information will be available almost instantly. So, as a board, we are really looking forward to the future because we will get a much better picture of what this organisation is doing.

[408] **David Rees**: And the other questions?

[409] **Ms Myhill**: In terms of the staff numbers, no, we don't have 119 extra people. We have 51 more in our emergency medical services than we did a year ago. So, we have increased our base level of staffing, but it's not where it needs to be yet, which is why we have private crews supporting us, which is why we have more overtime than we would want. We have a recruitment plan in place. We anticipate that we will recruit to all of those gaps by April of next year, and we know that there's a training pipeline coming that will enable us to be fairly confident about some of those posts. What we haven't done before—. We've recruited the 119—it's very frustrating—but we did not plan for the fact that some of those would be recruited internally and we'd have a gap behind. So, the workforce plan was a little bit disjointed. Now the workforce and training plan is joint, and that gives us a lot more confidence that, when we look at the numbers, we can see, because we know that people are coming out of college, or they're coming out of training, or they're booked into our own training. So that's where we are—

[410] **Elin Jones**: So, it will probably take another year to get to that 119 additional—.

[411] **Ms Myhill**: I'm hoping that, by the spring of next year, all of those posts will be in place. For some of our posts, we are becoming more popular. The clinical model—people want to work with us. It's a much more positive picture. Our trade union relations—all of those things—help. People want to come to work in Wales as opposed to not wanting to come anywhere near the Welsh ambulance service. All of those things are going to definitely help us.

[412] So, we're on a road there, and then we will be able to continue to

focus on overtime only where we need it and privates only where we need them. I don't think we'll eradicate it. Because of the nature of the job we've got, we'll have short-term gaps. We've got a bank, so we have got paramedics and other staff on a bank that we can call in, but I think there will always be some need for some of that short gap to be filled.

[413] **Elin Jones:** And then the return-to-footprint model and whether that's applicable, in your view, in other areas—? I'm thinking in particular of more rural areas where distance and being out of area can be particularly problematic.

[414] **Ms Myhill:** So, you've heard—I'm sure you've heard—from Allison Williams about the Cwm Taf experience, which has been a very positive experience and a significant improvement in performance from a very low base, I think we would all accept, as a consequence of that pilot. What we're doing is, where we can learn from the Cwm Taf pilot, we are rolling that out. So, the healthcare professional call separation I think you've heard about this morning, we're doing that in other parts of Wales—in Aneurin Bevan and in Carmarthen. The return to footprint specific part of that pilot we now need to review in line with our new clinical response model, because we did that when we were in a different world. So, everything we're doing now is very, very different. We will learn from that and, where we can and should roll it out, we will, but I wouldn't sit here and say it's suitable for everywhere. We've got to make sure we've got a need; we've got to make sure that we can respond to that need and that it will get the right outcomes. Ceredigion—very interesting—was 68 per cent in October, which is a remarkable performance, in terms of where we've been with some of our performance of late. So, we would need to just look to see what is most appropriate for different areas; we're very committed to doing that and we're doing that with our commissioner.

[415] **David Rees:** Okay?

[416] **Elin Jones:** Okay, that's fine.

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

[418] **Lynne Neagle:** Thanks, Chair. The figures on the Welsh Government website weren't broken down by local authority. You said that Blaenau Gwent was 71 per cent; I just wondered what the percentage was for Torfaen.

[419] **Ms Myhill:** Thanks. Torfaen and Carmarthen are the two areas that—. Every area improved apart from Torfaen and Carmarthen, so they didn't shift. So, we are—

[420] **Lynne Neagle:** What was the percentage for Torfaen?

[421] **Ms Myhill:** Torfaen was 52.

[422] **Lynne Neagle:** Right, okay. Well—

[423] **Ms Myhill:** Which is sort of consistent—a bit more than where it was in March and April. You know that we've mentioned that we've rolled out—we are now rolling out—the healthcare professional call separation in Aneurin Bevan. That is going to have a significant impact and it will impact positively, I have absolutely no doubt, within Aneurin Bevan, particularly in areas like Torfaen. I am expecting—maybe you can ring me in a month—genuinely to see a significant improvement in Torfaen and an improvement in Carmarthen. Because, as we said earlier, we've got to get underneath the Welsh figure. There's no point us saying, 'We've met 65 per cent on a Welsh level, but we're not meeting it all across Wales'. So, there are a number of things that we're doing in both those areas to learn from that first month to bring that up, and I would really hope that you'll see that move.

[424] **Lynne Neagle:** That is very disappointing, because, obviously, we met a few months ago, didn't we—

[425] **Ms Myhill:** We did.

[426] **Lynne Neagle:** —and you said, 'Ask me in six months where we are in Torfaen', and—

[427] **Ms Myhill:** We went from 44 to 58, which was good.

[428] **Lynne Neagle:** —when I heard Alun's figure, I thought, 'Oh, yes, you know, we're going to have a really good figure for Torfaen', so that is disappointing.

[429] One of my concerns is similar to Elin's, really, because I've got the situation as well where, anecdotally, I'm told that ambulances are being pulled out all the time, either to the Gwent or to Nevill Hall. So, have you got any plans—? It's not just about rural areas. If Torfaen is still consistently

performing badly, then there needs to be some focused effort on tackling that in Torfaen, doesn't there?

12:30

[430] **Ms Myhill:** There is. As I've said, I anticipate—. We're in December now; there's been a lot of work over the last month in Torfaen and surrounding areas, and in Carmarthen. That's the beauty of this model: that we can go to every single call and understand what happened. There are lots of things that have contributed to that. Earlier I talked about some of our own issues, about how we dispatch, how we transfer calls. There are improvements being put in place right now as a consequence of that. You will see an improvement in Torfaen and we want Torfaen to be up there with the others.

[431] **Lynne Neagle:** So, is it your intention when the next month's figures are published to break them down by local authority? And when you come to doing the amber publication of information, will that also be broken down to local authority—which is something that I personally would like to see?

[432] **Ms Myhill:** I'm happy to talk to you next month anyway, if you want to come and talk to me, and we can talk about where it's got to and what's happened. I'm very happy to do that. In terms of what's officially published, of course, it's the national target, isn't it? I don't know the detail that is published; I don't think the intention is that that level of detail—. I don't think it would be appropriate to go to that level in terms of publication. But I'm happy to talk to anyone about their own area.

[433] **Mr Giannasi:** Can I just say, we have a conversation that is about, 'There is now no hiding place'? In the old model, there was a huge over-response to calls. So, those very serious calls were crowded out by some that were unnecessary, some which weren't so serious. These are serious calls; they are clinically assessed as requiring an eight-minute response, and if it's 52 per cent, quite frankly, that's not acceptable. That's a conversation that we have very bluntly, and we can now focus down on those areas to say, 'Why is this happening? Is it eight minutes and five seconds? Is it 10 minutes? Is it 12 minutes? What do we have to do in order to get performance in this area acceptable?' Because, there is no hiding place; these are critical calls. So, just an assurance from my perspective as the chair of the board that we are unequivocally focused on an equitable service. Because these are now the most serious calls that we have to deal with.

[434] **David Rees**: Can I ask, therefore, that, if the figures are not published in the public domain, perhaps you could provide the committee with the figures for the breakdown per county?

[435] **Ms Myhill**: I haven't got a problem with that.

[436] **Lynne Neagle**: Can I just ask one final question on the rotas? I did just want to say that I've had very good feedback from paramedics about your working style, Tracy, and they feel that the atmosphere and the engagement with staff has been good—so that's very encouraging. You've reported in your written paper that you're making progress on the issues with the rotas. Are you confident now that we are going to crack this, that we are going to be able to match staffing resource to demand—because, we know that there has been resistance to that across the trust?

[437] **Ms Myhill**: In terms of the rotas, we've reviewed all of the rotas with the exception of Cwm Taf, because we're doing that as part of the pilot review in the new year, and Aneurin Bevan is the one area where we're just about to conclude the rota discussions. So, we've done a lot of work on that, but what we now need to do is look at the new model. I think the new model will change how we staff, who we staff, our mix of vehicles—do we need the same ambulance and rapid-response vehicle mix, what skills do we need? We talk about an ideal response to incidents as well a suitable response. That ideal response is not just the right vehicle, it's the right member of staff with the right skills and the right education for the call. So, there's lots of work that we're now doing to review all of that, and the rosters have to be part of that and it needs to be an ongoing process. I think we talked about this last time—. In some areas of Wales, it's an ongoing process. In north Wales, it happens regularly; in other parts of Wales, it hasn't happened for 10 years, and that can't be because we need to keep moving. In terms of, 'Will we have the right numbers to meet the demand?', we're also doing some demand and capacity work now, again directed by Siobhan McClelland and Stephen as the commissioner, collectively, across the system. We've got some work ongoing so we can understand the new model, what that means in terms of what capacity we need to meet the demand. So, we're in a period of change, but a positive one I think.

[438] **David Rees**: Altaf.

[439] **Altaf Hussain**: Thank you very much. I'll take you to the first question

about a five-step model and its application in our aging population. Age-related illnesses, especially dementia—what's your opinion?

[440] **Ms Myhill:** I think the new model—

[441] **Altaf Hussain:** Is it applicable to them as well?

[442] **Ms Myhill:** Yes, absolutely.

[443] **Altaf Hussain:** Or are you adding any steps? Because we know, with most of them, there'll be dementia, there'll be other age-related illnesses, and they may not be able to communicate with you what you want in those five steps.

[444] **Ms Myhill:** I think the five-step model and the new clinical response model will make us much more sensitive to those issues. And I talked just a minute ago about the workforce, and how we're going to develop the workforce. Our workforce needs to develop new skills as well, because the population age, as you said, more dementia and co-morbidities, is a different skill set for us. So, this gets us into that.

[445] **Altaf Hussain:** Does that mean that you'll be adding a few more steps into these five steps? It doesn't say that it will be fit enough for those patients.

[446] **Ms Myhill:** I don't think it means that we need to add more steps into the five steps, although what we are trying to do with the five steps is elongate those to the whole system. So, we're working with health boards, social services, local authorities—there are probably 10 steps, of which five are related to us, so there will be—. It's not ambulance specifically, but, across the system, we will be looking to join up, because there are the other parts of the system that will contribute.

[447] **David Rees:** Okay? Time has caught us up. Thank you very much for your time this morning and the evidence we've received. You will receive a transcript for any factual inaccuracies that you can spot. Please let us know if there are any as soon as possible. So, once again, thank you very much, and we look forward to the figures coming out in January to see the outputs as well, which is critical, I think, to the way in which we now move ahead.

[448] **Ms Myhill:** Thank you very much.

[449] **David Rees:** As the witnesses leave, if we move on to the next item on the agenda, which is papers to note.

12:36

Papurau i'w Nodi
Papers to Note

[450] **David Rees:** Are Members content to note the following papers? The minutes of the meetings held on 19 and 25 November, the correspondence from the Finance Committee on the fourth Assembly committee legacy, and the correspondence from the Petitions Committee in relation to specialised neuromuscular services in Wales: are Members content to note those papers? Thank you.

12:37

Cynnig o dan Reol Sefydlog 17.42(vi) a (ix) i Benderfynu Gwahardd y Cyhoedd
Motion under Standing Order 17.42(vi) and (ix) to Resolve to Exclude the Public

Cynnig:	*Motion:*
bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod ac ar gyfer eitem 1 o'r cyfarfod ar 14 Ionawr 2016 yn unol â Rheol Sefydlog 17.42(vi) ac (ix).	*that the committee resolves to exclude the public from the remainder of the meeting and for item 1 of the meeting on 14 January 2016 in accordance with Standing Order 17.42(vi) and (ix).*

Cynigiwyd y cynnig.
Motion moved.

[451] **David Rees:** I propose, in accordance with Standing Order 17.42(vi) and (ix) that the committee resolves to meet in private for the remainder of this meeting and for item 1 of the meeting on 14 January 2016. Are all Members content? Thank you very much. Then we now move into private session.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 12:37.
The public part of the meeting ended at 12:37.