AUDIT COMMITTEE

Tuesday 22 February 2000
(*Afternoon*)

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AUDIT COMMITTEE
3rd Meeting 2000, Session 1

CONVENER

*Mr Andrew Welsh (Angus) (SNP)

DEPUTY CONVENER

*Nick Johnston (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*Brian Adam (North-East Scotland) (SNP)
*Scott Barrie (Dunfermline West) (Lab)
*Cathie Craigie (Cumbernauld and Kilsyth) (Lab)
*Miss Annabel Goldie (West of Scotland) (Con)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*Lewis Macdonald (Aberdeen Central) (Lab)
*Paul Martin (Glasgow Springburn) (Lab)
*Euan Robson (Roxburgh and Berwickshire) (LD)
Andrew Wilson (Central Scotland) (SNP)

*attended

WITNESSES

Dr Eric Baijal (Highland Health Board)
Mr Tim Brett (Tayside Health Board)
Mr Derek Leslie (Highland Health Board)
Dr Bill Morrison (Tayside University Hospitals NHS Trust)
Mr Chris Spry (Greater Glasgow Health Board)

CLERK TEAM LEADER

Sarah Davidson

ASSISTANT CLERK

Sean Wixted

LOCATION

Committee Room 2

Scottish Parliament

Audit Committee

Tuesday 22 February 2000

(*Afternoon*)

[THE CONVENER *opened the meeting in private at 14:00]*

15:11

Meeting continued in public.

The Convener (Mr Andrew Welsh): We will start the public session of this meeting before our guests arrive.

I thank Alastair Macfie, who was our assistant clerk. I wish him well in his new role on the Transport and the Environment Committee. I welcome Sean Wixted, our new assistant clerk.

Public Finance and Accountability (Scotland) Act 2000 (Transitional, Transitory and Saving Provisions) (No 1) Order 2000 (SSI 2000/11)

The Convener: This statutory instrument, consideration of which forms agenda item 2, is enacted under the Public Finance and Accountability (Scotland) Act 2000. It deals with the making of transitory, transitional and saving provisions for and in connection with the coming into force of the act, the Auditor General of Scotland, and the establishment of Audit Scotland and the Scottish Commission for Public Audit.

I refer members to the explanatory note. I remind members that this is a negative instrument that came into force on 1 February. Under standing orders, the instrument has been laid after being made and is in force unless, within 40 days after the date on which it was laid, Parliament passes a resolution that nothing further be done. Are we agreed that we have no recommendations to make?

Members *indicated agreement.*

Scottish Ambulance Service

The Convener: I welcome our witnesses.

Mr Chris Spry is the chief executive of Greater Glasgow Health Board and Dr Eric Baijal is the general manager of Highland Health Board. Mr Derek Leslie is the director of service planning and development for Highland Health Board. Mr Tim Brett, who is the chief executive of Tayside Health Board, is accompanied by Dr Bill Morrison, a consultant in accident and emergency medicine for Tayside University Hospitals NHS Trust at Ninewells hospital in Dundee.

This is the first of two main sessions in which the Audit Committee will take evidence on the performance of the emergency ambulance service in Scotland. Our work will be based on the recent report by the National Audit Office. In light of the evidence that we hear, we will present our own findings, conclusions and recommendations.

I remind everyone that the objective of today's discussion is to seek informed third-party views from those who work in partnership with the ambulance service to provide emergency health care. We will question our witnesses about the performance of the ambulance service and how it affects their patients.

In today's session, we will ask questions on three main areas: performance against emergency response time targets, the scope for improved planning and development of operational ambulances, and how the service can improve the way in which it addresses the clinical and health issues that underlie its work.

All today's questions will be asked on behalf of the whole committee. We will start with control rooms' performance in answering telephone calls. Paragraph 2.4 of the NAO's report indicates that the service does not meet most of the required targets. How satisfied are you with that aspect of the service's performance?

15:15

Mr Derek Leslie (Highland Health Board): Highland Health Board is in the upper range of performance, therefore we are relatively satisfied with the ambulance service's responses. However, I recognise that my colleagues may have a different slant on that.

Mr Tim Brett (Tayside Health Board): By and large, Tayside Health Board comes out reasonably well in the report. Obviously, there are differences between response times in urban and rural areas that must be taken into account when one examines the figures. Members will be aware that Tayside has a range of urban and rural locations.

Rural areas may have only a single ambulance so, although the ambulance service will always send the nearest available vehicle, one must accept that there will be delays.

Mr Chris Spry (Greater Glasgow Health Board): There are several paradoxes, one of which is that while missing target times by a minute or two may not seem a lot—the difficulty of judging the clinical impact of such a delay will come out in our evidence—it is an awful long time for the patient or relative who is waiting for an ambulance to arrive. The answer to the question "Are we satisfied?", therefore, is no. How can we be satisfied if well-established targets are not being met?

We could have another debate about whether the targets are right or clinically appropriate, but the targets are set and the public expects us to meet them. When ambulances do not meet them, that causes distress at the very least to patients.

The Convener: What are the consequences of missed targets? Could lives be at risk?

Mr Spry: That is difficult to say. In 1998, we did a survey of one week's attendances at all accident and emergency departments in Glasgow. In that week, there were something like 4,580 attendances at A and E departments, of which about one third arrived by ambulance. Of those 4,580 attendances, 11 patients died in A and E departments. From the data, we do not know how many patients died subsequently in hospital for reasons that may or may not be attributable to ambulance delays, or how many would have died without entering the A and E department. My clinical colleagues will be able to say something later about the state in which patients arrive in the department. The data are lacking.

Dr Bill Morrison (Tayside University Hospitals NHS Trust): It is difficult to say whether patients would die. The standards are set arbitrarily, and are standards to aim for. Anecdotal evidence that I have heard suggests that we make very good responses and that patients would not come to harm or die if standards slipped slightly, which is inevitable at times of peak demand. The die is cast, if you like. Missing the standards by the times that we tend to miss them by will not make a great deal of difference.

The Convener: Is it true that no data are collected? How difficult would it be to collect such information?

Dr Morrison: It would be very difficult and an element of subjectivity would be involved. Deaths within the hospital are all recorded, but the committee must bear in mind that death may be pronounced in the hospital in cases when the patient died at home but attempts at resuscitation continued until the patient reached hospital, where death was declared. On very few occasions can the ambulance crews say that someone is dead and take him or her to a mortuary.

Mr Spry: The other difficulty is linkage of records. I am not familiar with the detail of the Scottish Ambulance Service's record-keeping systems, but they tend to be paper-driven. The crew files a report after it has taken the patient to A and E. On some occasions those reports are done contemporaneously, while on others there is a slight delay because the ambulance has to respond to another call.

One cannot always be sure of the accuracy of every element of the data set. Another problem is that A and E departments, certainly in Glasgow, do not have sophisticated data systems that are capable of manipulating data. When we wanted to find out what was going on, we had to mount a special exercise—which was, in essence, paper driven—for a week. That made it difficult to get linkage between what happened in A and E and what happened once A and E patients became hospital in-patients, for whom we have computerised record keeping.

We would have to invest an awful lot in data systems that would track patients all the way through. We would also require a means of capturing data—through light-pens or bar codes—that required much less effort from ambulance crews, who are often hard pressed when they are expected to do their record keeping.

The Convener: So is it more of an information technology problem than a clinical problem?

Mr Spry: It is a bit of both. We would also need to get consistency of definition right.

The Convener: The evidence on ambulance response time targets shows that the service's performance has not improved greatly in recent years, while the performance of the least responsive division has worsened. What is your assessment of the wide gap in the service's performance between different parts of Scotland, and between different stations that operate within the same health board area?

Mr Leslie: The rural nature of the Highland Health Board area has a major impact on the response times that crews are able to achieve. For example, ambulances in Inverness may respond to a major trauma in Inverness and reach Raigmore hospital, also in Inverness, in a matter of minutes. However, a patient may require an A and E response from the village of Bettyhill, in the far north of Scotland, where the road infrastructure and weather conditions can mean that it sometimes takes three and a half hours for the patient to reach Inverness from the point of uplift. We have other A and E units, but Raigmore is used in cases of major trauma.

The rural nature of our area has a significant impact on getting people to Inverness. It also has a significant impact on the ability of the ambulance to get from the place where it is ordered to the patient. Those of you who are familiar with the Sutherland district will know just what that means.

Mr Brett: The report points out that, in the past five years, there has been a 28 per cent increase in the number of 999 calls; I cannot speculate on the reasons for that. In Tayside, the ambulance service has been able to absorb that increase through greater efficiency.

The health board receives local reports on how well the ambulance service is performing, which are discussed by middle managers; the reports are also sent to the board. We want to keep that under review. In some areas, there are issues on which we are keeping in touch with the ambulance service, but, by and large, we are pretty satisfied with the response times that are achieved when crews are dealing with 999 calls.

The Convener: How can you square such performance gaps with the overall goal of providing equality of access for national health service patients throughout Scotland?

Mr Brett: The report highlights the fact that the ambulance service staffs at average demand. We might all want to staff at peak demand, but the reality is that we cannot afford to do so. Occasions will arise on which there will be delays, but I understand that the ambulance service will send the nearest vehicle to the incident. That vehicle will respond immediately, but there may be some delay: in an urban area, vehicles are normally available, but in a rural area a vehicle may have to come from further afield.

I suspect that we will never be able to staff and equip at peak demand, as that would mean that vehicles would not be used at all for significant periods of time. In some rural areas, some of the accident and emergency crews also provide a patient transport service, but by and large we aim to provide a dedicated 999 crew.

Mr Spry: The issue is one of equity of access. It would not be possible to have a single measure; urban-rural differences would make that impractical. I can speak only for the service in an urban environment, but we should expect that whatever criterion is established nationally—50 per cent within seven minutes or 50 per cent within eight minutes—that standard should be met in Scotland's towns and cities. That seems to be a reasonable aspiration.

There are different considerations in rural settings, where the issue is one of being confident that the training and equipment of ambulance personnel are up to standard, so that the best possible support will be available for the patient at the scene and, subsequently, during the journey to the nearest hospital.

Mr Brett: More support may be received from a local general practitioner in a rural area than in an urban situation. Dr Morrison may want to comment on that. For instance, when a patient in an urban situation suffers a myocardial infarction, the priority is to get them to hospital as quickly as possible. In a rural situation, support may be provided by the local GP, who can begin treatment sooner. It is not a case of one size fits all.

We do not know whether any other initiatives, such as the introduction of helplines, will provide an alternative for some patients. I am not suggesting that they could provide an alternative to a 999 ambulance, but if the patient wants to speak to a nurse simply to get advice, such initiatives may be able to provide that service.

15:30

Dr Morrison: The ambulance service in my area makes good use of resources. If an ambulance in a rural area is off station, an urban vehicle will cover for it and vice versa. That leaves gaps at times, but is a reasonable way to do things, and it is the best that can be done in the circumstances.

There are, as Mr Brett said, differences in demand between rural and urban areas. GPs are called for emergencies more frequently in rural areas than they are in the city, where there is more of a culture of dialling 999 and going straight to hospital.

The Convener: Before I invite my colleagues to ask questions, I have one further question. The quality and efficiency of the ambulance service is crucial to your work in health boards and trusts. What contact, therefore, do you have with the Scottish Ambulance Service and what priority do you give to including that service in planning?

Mr Leslie: The involvement of the ambulance service is seen as fundamental in the Highland Council area, because—as a result of sparsity—it plays such an important part in the provision of care in the community. We had a good relationship with the service during the internal market period, as we have in the new health service. The ambulance service is involved in our health improvement programme planning process. It has adopted that programme this year and it has been consulting the health board while it plans its programme.

Mr Brett: We have a similar relationship with the ambulance service and we have a member of staff who liaises between the health board and the ambulance service. On planning, we are in the middle of an important acute services review and a group is examining transport issues as part of

that review; the ambulance service is a key member of that group.

Mr Spry: Our experience is that over the years there has been a lot of contact between middle-ranking people in Greater Glasgow Health Board and people in the ambulance service divisional headquarters in Glasgow. More senior contact has not been common until recently. In the mid-1990s contact was the result of contract negotiations, but the important bigger picture probably was not seen. With the recent change in divisional management arrangements there is now greater prospect of the contact at senior level that is needed.

The Scottish Ambulance Service is, however, a national organisation with only one chief executive. It is very difficult for that person to engage with all the other chief executives of trusts and health boards in Scotland. There are, sometimes, issues that call for engagement between chief executives and that can be difficult for the ambulance service. That is why the divisional structure is important and why recent improvements are encouraging.

Brian Adam (North-East Scotland) (SNP): The survey that was done in Glasgow is interesting; I note that it was based on accident and emergency data and not particularly on ambulance service data. Are you aware of any work that has been done by health authorities and the ambulance service on whether response times have any effect on outcome?

Mr Spry: No.

Dr Eric Baijal (Highland Health Board): There are a number of areas in which there is scope for significant meaningful research, and a research agenda is unfolding from today's discussion. That research is necessary before decisions can be made about the most effective way in which to manage the service in the future.

Brian Adam: So can you see an opportunity for a series of collaborative clinical audit projects?

Dr Baijal: Yes.

Dr Morrison: On an operational level, we have regular communication with the ambulance service. We interface with the paramedics and technicians and with the divisional officers. Those links are important, and I would like them to be much closer. It has always struck me as slightly strange that ambulance depots are not situated in or next to hospitals, but tend to be quite distant from them. I am not sure why that is the case. In the American system, emergency vehicles operate out of hospitals or emergency departments, which has many advantages. It certainly makes communication a lot easier. At the moment we are conducting a study on the passage of information between the pre-hospital and hospital arenas. We have found that neither we nor the ambulance crews are happy with the situation. The hand-over is always one of the most difficult parts of a patient's journey, because it involves getting information across to hospital staff.

Brian Adam: We have already touched on the rural-urban divide. In paragraph 2.9 of page 27 we are told that the average response time for a 999 call in a sparsely populated remote area is 20 minutes, compared with 10 minutes elsewhere. Obviously, there are resource constraints, but what else do you think the service could do to encourage equality? Mr Spry used the word "equity", but this is an issue of fairness. What can be done to achieve equality of access for patients who live in sparsely populated areas? Does not that require lateral thinking?

Dr Baijal: An aspect of equality that we have not yet addressed this afternoon is clinical need. There will be cases in which it will not matter whether there is a delay in an ambulance attending. In such cases, we might question whether an ambulance is the appropriate intervention. There are two issues here: the so-called priority dispatch of crews and vehicles, and the need to consider other kinds of intervention to deal with some types of emergency call.

Brian Adam: You have given us examples of other kinds of intervention. Other suggestions have also been made to us, some of which would have implications for the health board. How would you feel about people who are employed in other sectors of the health service in remote or rural areas doubling up or working part-time? That might allow additional cover. Are traditional ambulances always required, and do we need ambulances based in formal ambulance stations?

Mr Leslie: In the Highland Council area we are already fairly flexible in our deployment of ambulances. Some of the stations or bases that are mentioned in the report are the residences of ambulance service staff. That is because in some of the communities from which they must operate there are no suitable premises. The report makes it clear, from the perspective of the Scottish Ambulance Service as well as that of the health service, that there is scope to explore how trained and valuable personnel, such as paramedics, could be used better in the community. Likewise, at the other end of the scale, one might—as Mr Adam suggests—consider how to use resources that are already in the community.

Training people will be difficult, as will ensuring that they make the best use of their time, given that one does not know from one minute to the next when a 999 call will come. I come from a rural community where the fire service must rely on people running from all over the area to jump in

the fire engine. A balance must be struck between a static trained force and a supplementary force in a flexible system such as that which you suggest.

Mr Brett: I would like to make a point that relates more to a previous question. I am not sure whether the report highlights this, but there is an urgent category of patient who would also be moved by 999 vehicles if the family doctor saw them at home and wanted to have them admitted to hospital. The general practitioner will normally advise the ambulance service that he or she would like the patient to be in hospital in one hour, two hours or four hours. That is an example of another independent doctor saying what the priorities should be. There are concerns, however—sometimes the target time is not met. At least the ambulance service can go back to the doctor and say, "We can't make in two hours—can you wait another hour?" There can then be a dialogue about the priority, which, for most other calls, does not exist.

Dr Morrison: There is some difficulty regarding the skills that are required. I understand what is being suggested, and it is a good idea. We have been considering a tiered emergency service with units—or whatever you wish to call them—in more rural areas. I am thinking along the lines of minor injuries units that could be based in cottage hospitals and, possibly, run by nurses. It would make sense for such units to be adaptable so that they could be used in the most appropriate way.

It could be argued that the need for paramedics is greater in rural areas, where people are further away from the main centres. However, in that case the disadvantages are that it is likely that paramedics' skills would be used less and it would be difficult for them to keep their skills up to date. There would need to be a kind of exchange whereby paramedics would be brought into the main centres frequently—not for retraining, but for updating skills.

Dr Baijal: I would like to reinforce the point about multi-skilling. The example that I am most familiar with relates to nurses, not to paramedics. A difficulty in the remoter parts of the Highland Council area is that the work load is not sufficient to maintain the critical skills of nurses who are trying to act as district nurses, midwives and practice nurses. So-called triple-duty nurses are becoming a thing of the past, simply because the work load is not sufficient for them to maintain their expertise. That is a serious issue when it comes to paramedics.

Cathie Craigie (Cumbernauld and Kilsyth) (Lab): Paragraph 2.23 on page 34 of the NAO report explains how the response time targets were set some 25 years ago. Those targets for 999 calls are based not on clinical need, but on a first-come-first-served basis. In the times that we now live in, is that acceptable? Should we review the way in which we measure the performance of the service?

Dr Baijal: We all agree that there is no clear evidence at the moment on which to make such a decision. Logically, one could argue that targets for dispatch that were based on an assessment of need would be more effective and efficient, but we are aware of no research evidence to support that. However, as I think your question suggests, there must be some unfortunate individuals who are receiving less efficient care than they should because of the current dispatch system.

Mr Spry: In our case, as demonstrated by a survey conducted in Glasgow, about 60 per cent of patients—quite a large number—who arrive at accident and emergency in a 999 ambulance are referred for admission to hospital and should be considered to be seriously ill.

One hears many stories about inappropriate calls and so on, such as in the work that has been published on the allegedly high levels of inappropriate calls that are made in London. However, the evidence seems to be mixed. For example, a survey conducted at the Southern General hospital accident and emergency department showed that the number of patients who did not require significant treatment or investigation after a 999 call might be as low as 8 per cent.

In trying to design some sort of priority-based dispatch service or to rejig standards, one should bear it in mind that a large percentage of patients might still require a quick response. Indeed, my accident and emergency consultants tell me that the seven-minute or eight-minute standard—it varies across the UK—is extremely important. Therefore, one might end up finding that the standards are not adjusted by much.

There is an issue about the cases that are manifestly not urgent, but the trick is in how to sift out those cases without causing further delay to those that require urgent responses.

15:45

Dr Morrison: There is no evidence one way or the other, as the matter has not been investigated in sufficient detail. Any changes must be compared with the system that is in place. On the face of it, it seems entirely sensible that a priority-based service is better than a first-come-first-served service. That seems so evident that it is not worth commenting on.

We all practise some form of prioritisation in the health service, from prioritisation of finance or funding, to the general practitioner deciding which calls to make first. In my service we practice triage

at the front desk, in order to treat first those patients who are in greatest need. Although we lack evidence, it seems that the present, first-come-first-served system is not the right one. We must improve it in some way.

Mr Spry: Figure 9, on page 29, is one of the most interesting graphs in the report. That graph illustrates the profile of response times for Glasgow central ambulance station alongside the profile for Dundee ambulance station. Several interesting and important issues arise from that graph. First, we do not know what caused response times of 17 and 18 minutes or more, but it is pretty unacceptable by any standard for people to wait that long when one does not know what is wrong with them. Secondly, if one concentrates on the seven-minute standard, one should examine how many patients fall just outside that standard, because many do.

If one is trying to improve that profile, to what extent are more resources required for the local service? Some of the evidence from London, on attempts to tackle that problem, shows that significant resources were required to make such improvements. Alternatively, if one is trying to be more efficient by deploying ambulances to cases in greatest need, one must do that in such a way that one does not spend a long time working out whether the case is urgent. There is not much of a margin for getting it right.

The Convener: We will now consider deployment priorities.

Lewis Macdonald (Aberdeen Central) (Lab): I would like to follow up on some of the comments that have been made. A number of witnesses have commented on the pros and cons of priority dispatch, on which it is quite clear that there are different views—we would expect that.

I was struck by Mr Spry's comments about the Southern General hospital and other hospitals. It occurred to me that his comments dealt with the arrival of patients, rather than 999 calls, which is an important distinction. Members of the committee who went on visits that were arranged to help our report have seen evidence that a significant number of the calls that are received by the ambulance service are bogus, unnecessary and often do not get as far as the accident and emergency department.

I was also struck by Dr Morrison's comment that the case for priority dispatch was so evident as to be barely worth mentioning. Much of the section of the report between pages 34 and 40 concentrates on the issue of priority dispatch. In general terms, there is an expectation that getting to the sickest patients more quickly would not only save time but would help to reduce subsequent illness and the cost of care.

Would witnesses comment on the conditions in which the service would have the greatest impact through early attendance and what sort of benefits priority dispatch would provide in those cases?

Dr Morrison: In a way, there is a priority dispatch system. A general practitioner—especially one in an urban area—who receives a call from a patient who describes the symptoms of a heart attack or myocardial infarction, will tell that patient to call 999 immediately. The patient will be taken to the accident and emergency department. There is unquestionable medical evidence that if that patient receives thrombolytic or clot-busting drugs early, the heart attack's symptoms can be reversed almost entirely. Although that might not be called priority dispatch, the system ensures that the person gets to hospital rapidly. Also, the message is getting across to patients that they should dial 999 at the first sign of the symptoms of heart attack. There are proven medical benefits of the early treatment of certain conditions.

Miss Annabel Goldie (West of Scotland) (Con): Page 39 of the report shows that, in a survey of clinicians and others concerned with the emergency ambulance service, more than 90 per cent supported the concept of priority dispatch. Most respondents also favoured varying response-time targets to reflect patients' varying needs. Does that mean that there is a need for consultation with patients and other health care partners in framing any proposals to move to a system of call prioritisation? Would that system give rise to any insuperable moral considerations?

Dr Morrison: It seems obvious that priority dispatch is the way to go. The question must be what the correct form for that is. I do not pretend to know what that would be—we do not have sufficient data. We need to discuss the correct form with various agencies, general practitioners and patient groups. It is not for me to force my opinion on anyone.

Miss Goldie: I would welcome your opinion as a clinician.

Dr Morrison: There must be brief questioning to ascertain symptoms; that cannot be done by an untrained person. However, NHS Direct is an out-of-hours telephone advice and information service in which nurses ask and answer questions and decide what course of action the caller should take—that might serve as a model. The questioning session should not be long and should not be stressful for the patient.

Miss Goldie asked about insuperable moral problems. There are downsides and there will be occasions when people make mistakes. That is inevitable but the question is whether such a system would be better than the current one.

I have studied 999 calls and there are many that

should never have been made. Ensuring that such calls are given low priority, while serious illnesses are given high priority, requires a lot of work. However, the problems are not insurmountable.

Mr Spry: I have not yet seen an evaluation of the English experience of criteria-based dispatch. However, I have talked to accident and emergency consultants in Glasgow about the issue—they support the principle of criteria-based dispatch and are extremely thoughtful about the practicalities. Their reading of the English experience is that there is significant under-detection of critical illness. What is meant by significant? I do not know—I have not seen the data. However, there is concern, which means that questions must be pitched carefully, and care should be taken over the ways in which questions are connected to the protocols for action that the dispatcher then pursues in dealing with the call.

I vividly remember a programme on television in 1996 about priority-based dispatch, which considered the experience in Amsterdam, where that was being used. The person who ran the control centre in Amsterdam was asked what happened if a caller did not elucidate what was wrong. The controller said, with, I thought, a rather defensive air, "They die." Although that was a bit of journalism, the reality is that if priority-based dispatch is introduced, people will die. The question is whether more or fewer of them die than under the present arrangement. The trouble is that we do not know, because the area is so under-researched. People will die as a result of priority-based dispatch and, therefore, people will "blame" that system, even though they have nothing to compare it with.

Miss Goldie: Is the obverse of that, that if we fail to adopt the priority-based dispatch system, another moral consideration lurks, which is that lives might be being lost through abuse of the ambulance service?

Mr Brett: Probably. The problem is that we do not know. It is, perhaps, more for Dr Morrison to say, but when somebody dies, it is difficult to determine whether they might have survived if somebody had got to them five minutes earlier. Dr Morrison and I discussed this on the way here. As others have said, given that we are prioritising in all other aspects of medicine, it is logical that we should be trying to do it in this matter, too. Like Chris Spry, I would like to see results from places where such a system has already been in operation, such as parts of England.

Mr Spry: I am afraid that I am getting anecdotal here, but part of the difficulty is that abuse of the 999 system is sometimes associated with people drinking or being on drugs. It might be obvious to whoever is receiving the call that the person on the other end is under the influence of drink or drugs, but that does not necessarily mean that there is not an issue that needs to be addressed. In fact, it becomes more difficult to work out whether the call really is urgent. It becomes even more difficult at times when more people are likely to be under the influence of drink. Friday and Saturday nights, for example, are when priority-based dispatch is most needed, yet that is when it would probably be difficult to handle with the confidence that we would like.

Mr Leslie: My comment relates to Miss Goldie's question. The users of the service have, if you like, voted by their views, however scientifically those views were taken.

Under the direction of "Designed to Care", we are trying to develop patient and user-centred services. In spite of the difficulties and challenges that we are suggesting, there is an opportunity for the ambulance service to explore an alternative way of setting out a dispatch system that will address users' concerns.

16:00

Dr Morrison: In answer to your question—and I am afraid that any evidence would have to be anecdotal—people have died through abuse of the 999 system: there is no doubt about that whatever. The issue of drink and drugs is an important one that will not go away, but will cause difficulties. It causes me difficulties on Friday and Saturday nights as well. I do not presume, just because somebody comes into the department intoxicated or on drugs, that that is their problem. That must be taken into consideration; it is not easy, but we must work round it.

The Convener: Is it possible for you to quantify your anecdotal statement that people have died through abuse of the system? Are you talking about a large or small number of people? Can you give us even a rough figure?

Dr Morrison: That would reduce the issue to my personal experience. I know of cases in which people have died. I also know of someone who dialled 999 because they took the head off a plook while they were shaving in the morning. There is evidence that the best thing for patients who have a cardiac arrest is electricity—defibrillation—which must be provided quickly. If an ambulance is tied up attending someone who has a minor problem, it will not attend the person who requires resuscitation.

I appreciate that you would like evidence, and I could regale you with interesting anecdotes all afternoon.

The Convener: No, you could not.

Dr Morrison: I could not give any names, obviously. However, that is my perception of the

situation.

Cathie Craigie: The evidence that we heard from Mr Spry, of cases in Glasgow, was interesting. I was not surprised by the figures for 999 calls that he quoted for the Southern General, given its reputation for dealing with head injuries. I might be making an assumption that is not right, but I imagine that quite a large number of cases at that emergency unit would come from 999 calls.

I would like to return to the issue of response times and the question whether we should prioritise them. I understand the need for research, as evidence is patchy. However, if the ambulance service is to consider a priority dispatch service that would be able to provide greater care and attention to 999 patients, what areas should we be addressing and where would the start be?

Mr Leslie: I would guess that we need to start where the response will have an evidence-based outcome. That is easy for me to say, as I am not the clinician. We are trying to design a health service that is evidence based and patient centred, and two or three issues need to be pulled together. We must look for evidence, and research must be undertaken. People such as Dr Morrison can inform that process.

Those who are involved in primary care and general practice will have a view—particularly in a rural setting, where they are the first-line response—as they are often delighted to see the ambulance coming over the hill to join them. I hate to use bureaucratic terms such as working group and steering group, but you must begin to engage with all those who have an interest in the issue, including those who have voted or made their views known. Even with a limited amount of knowledge, people in the street are saying that there must be some kind of priority dispatch service. The professionals must inform service users, so that they can enter the debate and share in the process of deciding whether to introduce a priority dispatch system.

The Convener: Which areas do the clinicians think that we should manage with greatest care?

Dr Morrison: There is some evidence from pilots in certain areas of England, but there is very little. That must be the starting point. It is all very well for us to say that there is no evidence; somebody must find it. It may as well be from a group from our country. We should get together with the ambulance service to consider the best way of instituting a system, perhaps on a trial basis in a limited area, so that we can see how it could be developed.

Mr Spry: That is the starting point. Quite a few systems are in operation around the world, including some in England. Most, if not all, of them will have undergone some sort of evaluation. I would start by examining what is already in operation and seeing what the evaluation of the system tells us. Either the system will be acceptable or, if it is not, we can consider how to build on the best to take art and science forward in the interests of Scotland.

The Convener: I note that you say that you would start by examining the systems. I take it that no one is doing that yet.

Mr Brett: I would assume that the systems are being evaluated. When the committee sees the ambulance service next week, I imagine that it will have more information. I want to raise one small point. The system will probably not work in rural areas where there is only a single vehicle, so the system will not be universally applicable.

Nick Johnston (Mid Scotland and Fife) (Con): A number of points have been well made, but I want to draw things together. Page 38 of the report says that

"90 per cent of . . . users of the Service supported the concept of priority dispatch."

I will not bore you with the rest of the paragraph.

My question is not to the clinicians, but to the individual health board managers. What do you think about setting up priority dispatch? What handicaps might you encounter? Where will you find the resources? The report suggests that £500,000 is to be devoted to a study in Lothian and Borders for training, hardware and software. Will health service resources need to be reallocated from health boards to the ambulance service to enable priority dispatch to be set up?

Mr Leslie: That is a difficult question, but I know that we are here to provide some answers. The Scottish Ambulance Service is now its own special health board. As director of Highland Health Board, I would expect it to find its own resources, but I doubt that the chief executive of the national health service would thank me for saying that.

We would need to consider the benefits—care pathways and outcomes at the end of journeys—to decide whether priority dispatch is effective and worthy of investment. If the health service in Scotland in general thought that priority dispatch was the way to deliver better services for patients, we would need to find ways of resourcing it, whether by redirecting resources or by lobbying the Scottish Parliament for more resources.

Dr Baijal: One of the issues for me—this goes back to Miss Goldie's comment about moral problems—is the need to be convinced and to be able to demonstrate to the public that what is proposed is better than what exists. I am therefore in favour of a pilot of the system or action research. If we are convinced that it will be better, the most efficient way to resource it might be to

tackle it as a national initiative.

The Convener: Highland Health Board, therefore, does not have a policy for or against the system.

Mr Spry: I would not expect an individual health board to have a policy on the matter. Either the system is put in place for the whole country or it is not. You cannot have priority-based dispatch in place A and not in place B. The country needs to decide.

The NHS, in conjunction with the Parliament, would have to work out how a priority dispatch system would be funded. Whether the funding would come from existing resources or be a top-sliced investment for the NHS is a matter for detailed negotiation. The fundamental question is: do we want such a system? That depends on what is shown by evaluation of the existing systems and whether the benefits would be worth the extra money. There is a reference in the report to an estimated £515,000 for Lothian and Borders, so it would mean a significant sum for the country as a whole. If £500,000 was to be spent on improving the ambulance service, would a better return come from a priority dispatch system or from some other measure?

Mr Brett: I echo what Mr Spry said. Such a system would have to be considered alongside a range of other options and priorities. Off the top of my head, I reckon that it would cost £3 million plus to introduce a priority dispatch system for the whole country. I have no doubt that the ambulance service would say that some of the other problems in the report could be solved with that sort of money. However, the principle behind the response should be the same as in all other areas of health care, that one gets to the person in greatest need first if possible.

Nick Johnston: I take Mr Spry's point—it is a national rather than a health board problem. However, who should be initiating the studies or insisting that this is a priority?

Mr Brett: It is a matter for the Scottish Ambulance Service board in discussion with the NHS management executive. Health board general managers could comment if invited to do so.

Mr Spry: It would be a significant decision, in which a minister would want to be involved.

The Convener: Who made the decision in England?

Mr Spry: I am pretty sure that there was ministerial approval to pilot the system.

Lewis Macdonald: If we are talking about a possible national policy change, is there a case for piloting it in urban areas?

Mr Brett: Yes.

Dr Morrison: As far as I am aware, the decision was taken some time ago that this was the way to go. When I first arrived in Tayside, six or seven years ago, I was told by the ambulance service that it would be introducing a priority-based dispatch system in two years' time. That is the intention, but it has not happened yet.

Mr Leslie: If there is an urban pilot, it should include a rural area because, as Tim Brett said, priority dispatch might not be an issue in an area with only one ambulance. I support the idea of a pilot, but rural areas should be taken into account.

The Convener: We should now concentrate on Glasgow.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Section 2.11, on page 27 of the report, indicates that the response times for 999 calls in Glasgow are very poor compared with similarly populated areas in England. What has the service been doing to alleviate that difficulty?

Mr Spry: It has been doing a range of things. There has been a review of rosters, as one often finds that response times are poor because the rostering pattern does not match the demand pattern. There have also been attempts to tackle sickness levels, as high sickness levels blow a hole in rostering. At one point, we funded an additional ambulance on the south side, after we came to the conclusion that the only way of improving the situation was to put another vehicle on the road.

There has also been work on getting the balance between the patient transport system and the 999 ambulance service right. On occasions we found that 999 ambulances were being used for non-urgent transfers of patients between hospitals when a PTS vehicle would have done. There has been a great deal of discussion with individual hospitals about ensuring that the protocols for inter-hospital transfers do not distort demand for the accident and emergency service.

16:15

Margaret Jamieson: How do you track that? We have heard today that there is no evidence to support the information, but we have been told by those working in the service that it can take 90 minutes to transfer a patient because the patient is not at the door of the acute hospital. Has Greater Glasgow Health Board made any attempt to evaluate that?

Mr Spry: That is why discussions between senior ambulance managers and trust chief executives are so important. What you describe is a readily recognised problem—an arrangement is made for a patient to be transferred, but when the

crew arrives, the patient is not there. It is depressing how often that happens. High-level intervention is required in the trust to get that right.

Tracking the effect of the various changes is extremely difficult. If people are trying to improve rostering, to increase the number of vehicles on the road, to relieve the burden on A and E ambulances by getting the PTS side sorted out, and to talk to the ambulance service about what it is doing to improve activation times, it is hard to tell what impact each intervention has on response times. There is no doubt that response times in Glasgow now are better than they were, but they are not good enough. I know from experience elsewhere that if one is engaged in a campaign to improve response times significantly, an enormous amount of time and effort must be spent on achieving that. One has to look at shaving seconds off telephone-answering times, seconds off activation times and seconds off time spent by crews in hospital once they have deposited patients. The devil is often in the detail, which makes it difficult to track what is happening through data.

Margaret Jamieson: I appreciate what you are saying. However, given that in the new health service we have clinical governance, clinical audit and so on, response targets need to be tied to clinical outcome. We need to track what happens through the service from the moment that the call is made. Nobody today has said that we need to look at that big picture, which would indicate whether the targets that are set are correct or incorrect.

Mr Spry: Earlier I made a point about the lack of record linkage between the ambulance service, A and E departments and in-patient services. To achieve what you are suggesting, record linkage would be needed all the way through. That is a huge jump, as there are paper-based record-keeping systems in the ambulance service and a variety of not terribly good systems in A and E departments—that is certainly the case in Glasgow, but I cannot speak about Dundee. There are different in-patient systems in different hospitals.

Part of the matter is about getting a unique NHS number; there is a project on that. That should be an important enabler, because we could then construct electronic systems that were based on that number. We are not there yet, and to get the linkages right will require much investment and will require somebody to work out where the development of those improved data sits as a priority alongside the other improvements in NHS records that need to be made.

We are on another subject now, but NHS record systems are incredibly primitive compared with what we are used to in other areas of our everyday life.

Paul Martin (Glasgow Springburn) (Lab): I will ask Mr Spry this question, as it is about Glasgow. I refer him to paragraph 3(b) on page 11, which states:

"The Service should work with Greater Glasgow Health Board to assess the specific health risks of not meeting existing ambulance response targets in Glasgow".

What work is being carried out to deal with that matter? Have you examined that recommendation and considered the action that you will take in response?

Mr Spry: We have not considered that in detail since the report was published a couple of months ago. We have had conversations with A and E consultants along the lines of our discussions this afternoon. We recognise from those conversations that without adequate record linkage and the ability to audit, we can get so far on the issue but cannot make a decisive impact.

The approach must be to establish how we can get better record linkage and build clinical audit systems that would enable us to have a common clinical policy, which we could then monitor. That is a national rather than a local issue.

Paul Martin: The way in which hospital staff receive ambulance crews when they arrive at hospitals is not raised in detail in the National Audit Office report. During a fact-finding visit, members of an ambulance crew indicated that, in one instance, they spent 90 minutes in a hospital chasing round the corridors looking for staff to receive patients. What action has been taken to deal with that? Are you satisfied with the fact that ambulance crews sometimes spend 90 minutes in hospitals?

Mr Spry: One could never be satisfied about that. In London, I spent time on a shift with an ambulance crew; the range of problems that crop up when the crew arrives in hospital is remarkable. The problems can range from searching for somebody to accept the patient—although that is rare, in my experience—to the more common experience of the crew needing to retrieve equipment that is attached to the patient, which can take time.

That brings us to a discussion about whether we should have stocks of equipment in hospital, so that crews do not have to wait for their kit to be released. There are difficulties about whether equipment has been properly replenished or, when a crew member tries to get the spare, they might discover that the stock has run out.

Sometimes the delay is because the crew—especially if the patient is seriously injured—is part of the team that is with the patient at the time of arrival; it is important that crew members continue

their hands-on care of the patient with the hospital doctors and nurses until it is appropriate for them to withdraw.

Crews are delayed for a range of reasons. The key way of dealing with delays would be to strengthen ambulance management presence in hospitals, so that the ambulance management could monitor crew arrivals, identify the problems and talk to the hospital management about how to deal with those problems.

The Convener: Can I make a plea for shorter answers? I notice that Mr Brett wants, courageously, to put a toe into the Glasgow water.

Mr Brett: I hesitate to do that, but ambulance crews taking patients all the way through to the admitting wards came up at Ninewells hospital. Dr Morrison might be able to say something about that, giving an example of how we try to tackle the issue in Dundee.

Dr Morrison: This is a hobby-horse of mine. I think that the ambulance service taking all patients to the accident and emergency department and leaving them there is archaic, unkind and unfair. If a GP has seen a patient and decides that they need to be admitted, they should be taken to a bed and not left on a trolley in a corridor.

Although that might seem to suggest that ambulance crews spend longer in the hospital, that has not appeared to be the case in Dundee, based on anecdotal evidence. The turnaround time for ambulance crews has been shorter for taking the patients to the wards there, because they do not indulge in the social aspects of mixing with A and E staff.

I cannot condone the system that most hospitals, particularly in the larger cities, operate, of taking all GP-referred patients to A and E departments and leaving them on trolleys in corridors.

Paul Martin: You have clarified the position that ambulance crews find themselves in, but can you clarify what action has been taken? We have learned that the amount of time ambulance crews are spending in hospitals—90 minutes—is unacceptable, and could result in fatalities. What action is being taken, has been taken and will be taken as a result of this issue repeatedly being raised?

Mr Spry: I cannot tell you what action is taken in individual hospitals; it is a matter between the ambulance management and the management of the trust. It is an operational matter that has to be addressed by the appropriate managers in the trust and the ambulance service.

The Convener: Can we now consider clinical direction and deployment?

Brian Adam: We heard some views on that earlier. I think it was Mr Leslie who referred to the health improvement programme and the involvement of the Scottish Ambulance Service with Highland Health Board. It would be interesting to have some elaboration of that and to know how your views on the most important needs of ambulance patients have been taken into account in the preparation of health programmes by the Scottish Ambulance Service. How can the service have the most beneficial impact on the needs of ambulance patients? What involvement has there been by the service helping you to prepare your health improvement plans?

Mr Spry: The honest answer to that is, until recently, not much. There are new divisional management arrangements in the ambulance service and we can now see that there is a prospect of fruitful, mutually supportive and helpful conversations between us and the service, to ensure that it contributes to our health improvement planning effectively, just as we are able to influence its. There was relatively little contact at that level, but a lot of contact at what I would describe as the old internal market contract negotiation stuff. That missed the big picture.

Mr Brett: When I knew who the new divisional director was for Tayside Health Board, Fife Health Board and Forth Valley Health Board, I made it my business to make early contact, so that the divisional director had access to me, so that I was aware of what the issues were for him, and so that he, likewise, was aware of our plans in Tayside as we consider our services.

There are different levels to consider. There are operational issues within the trusts, which are considering establishing a new day hospital. That would have a major transport impact on the ambulance service. As far as change to the bigger picture is concerned, we are considering changes in acute services, as the convener is aware. It is of major importance that we ensure that the ambulance service is fully aware of our thinking. The service can also be of influence, and might be able to identify the consequences of any proposals. We need to be aware of that just as much as we need to be aware of the consequences for other health professionals and members of the public.

16:30

Brian Adam: Paragraph 4.11 on page 64 of the National Audit Office report says that the service has no specific targets for health gains, although such targets might be useful. In view of that, what scope is there for the service to have a target relating to the Scottish Executive's target for the

NHS as a whole, to reduce the number of people dying from coronary heart disease by 2010? What are your views on the use of streptokinase by paramedics? When we were out and about, we heard a plea for that to be added to the list of drugs that they might be allowed to administer with appropriate training and supervision.

Dr Morrison: That is one way ahead. Early treatment is of proven benefit and, if it can be given early, streptokinase will have benefits. Who gives it is important—it should be the earliest medical person in attendance. The study in the Grampian area has shown that general practitioners giving thrombolysis has enormous benefits. There is no great advantage in the ambulance service giving streptokinase in urban areas, as it can get patients to hospital quickly. In isolated rural areas, however, that may be one of the ways ahead, but I am not sure how to square that with the general practitioners.

Brian Adam: Will you elaborate on two points? First, will moves to allow paramedics to use streptokinase be held back because of professional jealousies? I know that they exist, but they must be addressed. Secondly, are there other health gain targets, apart from coronary heart disease, to which the service might be able to contribute?

Dr Morrison: On professional jealousies, I have no problem whatever with paramedics administering streptokinase, but I do not know how that squares with the general practitioners. At the moment, paramedics are not trained in reading electrocardiograms, but if we had a link to the accident and emergency department with senior staff on hand 24 hours a day to help with interpretation, I would be happy for paramedics to go ahead with that.

I shall leave the second question to my colleague.

Mr Brett: I believe that I am right in saying that most ambulances now carry defibrillation equipment to administer electric shocks. That is the sort of thing that we should be able to audit. Information is being gathered, but I do not know whether anyone has had time to assess the impact that that has had. If we could do that, we could assess whether it has made a significant difference to saving lives. It is expensive to conduct that sort of study. All the time, we are balancing that with other needs.

Mr Spry: There is a drug—its name escapes me—that can be administered to someone who has taken an overdose—

Brian Adam: Naloxone.

Mr Spry: That is right.

The Convener: You asked the right person. [*Laughter.*]

Mr Spry: You obviously have experience of that drug, for some reason.

Brian Adam: I knew that my toxicology would come in handy some day.

Mr Spry: I know that the ambulance service is pursuing that issue. The greater Glasgow drug action team is keen for the ambulance service to be able to use that drug, as it would help us to achieve earlier interventions that may avert some drug-related deaths.

Brian Adam: I believe that that happens in Tayside.

Nick Johnston: Paragraphs 4.14 and 4.15 on page 65, and figure 27 on page 66, cover skill levels in ambulance crews. It appears that paramedics are not always directed to the emergency services. What impact does that have on health care? Is there any way the service could improve the deployment of paramedics, which, as can be seen from the figure at the bottom of the page, varies widely across Scotland?

Dr Morrison: The answer would be to have a paramedic in every front-line ambulance, so that any ambulance attending an emergency would have a paramedic. It is difficult to use resources appropriately. You may well take a crew with a paramedic to deal with a certain case just because it is the closest crew, only for something for which a paramedic's skills were more needed to happen elsewhere. Perhaps making more appropriate use of available crews could tie in with the setting of dispatch priorities.

There is not a paramedic in every front-line ambulance. To fill that gap, there should be more use of pre-hospital support from the local A and E department. That was pioneered by Keith Little in Edinburgh; we are trying to do the same in Tayside. Paramedics have skills up to a certain level, but we can augment them. This is not professional jealousy. I do not want to tread on paramedics' toes. They are very good at what they do. In certain cases—although I do not want to go every call-out—we could add an extra dimension and offer help.

Mr Leslie: Rural issues rear their heads again. We have paramedics and ambulances that respond to all categories of call, because we need the cover throughout the Highlands. As Dr Baijal has already mentioned, we are concerned about how we can keep up the skills of paramedics and how we use those skills. It would be a bit of a lottery for us to remove paramedics from some of our ambulance stations or response units, because they would not know from one day to the next whether they were going to get a 999 call that required those skills.

Euan Robson (Roxburgh and Berwickshire) (LD): I was interested in the earlier exchanges about keeping skills levels up. What evidence is there that skills are lying dormant and that that is having an impact on patients? Has there been research into that, or is the evidence purely anecdotal? On one of our information-gathering visits, some paramedics said that they are not keeping up their skills because they do not see certain types of incident for several weeks at a time.

Dr Morrison: I know of research involving junior hospital doctors. It is now compulsory for all newly qualified doctors, when they begin their house jobs, to undergo a half-day training session in cardiopulmonary resuscitation. At the end of that session, they are extremely good at CPR, cardiac massage and managing an airway. Three months later, those skills have atrophied considerably. That is well known and has been documented. I do not think that it would be any different for paramedics.

Euan Robson: How can we address that problem? Is there any way hospitals can provide some training, refresher courses or assistance? Could paramedics go to an urban centre on exchange visits? Are any health service staff doing that sort of thing at the moment, to keep their skill levels up?

Dr Morrison: You are talking my language—that ties in with what I was saying about having better links between ambulance service staff and the staff of A and E departments. I would like there to be a much closer relationship, with paramedics spending time in A and E departments, where the requirement for CPR skills is greater. Whether there could be an exchange, with nurses also working in the ambulances, I do not know. I have spoken to our local divisional officer about this, and although our discussions are at the embryonic stage, I think that we could have paramedics spending time in A and E departments. We could also run a rolling course for them.

The Convener: Is that being replicated elsewhere?

Mr Leslie: The question about skills retention covers a wider range of medical and clinical services in a rural setting. It does not apply only to the ambulance paramedics. We have secondments out of the rural setting into the urban setting of Inverness. It might be interesting to raise the issue of those who work in urban areas coming to the Highlands and spending a few months up in Bettyhill.

Euan Robson: Is the system of secondments formalised?

Dr Baijal: It is formalised for certain categories of clinicians. General surgeons are seconded regularly, but I do not think that paramedics are often seconded.

Mr Brett: In Tayside, we second midwives from smaller units to bigger units.

Scott Barrie (Dunfermline West) (Lab): I am sorry to return to an issue that Mr Brett touched on more than an hour ago, but the nature of the wide-ranging discussion that we have had today has ensured that I must.

We have heard that partnerships exist between the Scottish Ambulance Service and GPs, particularly in rural areas. Paragraph 420, on page 68 of your submission, highlights the fact that health care professionals who work with the service saw scope for the service to improve communication and consultation on health care matters, particularly as regards pre-hospital time.

What benefits for patients would improved communications result in? How could that be evaluated?

Mr Brett: Now that there are new local health care co-operatives throughout Scotland, we have an opportunity to talk to groups of GPs and agree practice and ways in which certain issues can be handled. On the way down to Edinburgh, Dr Morrison told me that he is willing to discuss issues with GPs. In the past, it was more difficult to do that as GPs worked exclusively in their own practices and it was difficult to meet them, particularly if they worked in a rural area. I am stealing Dr Morrison's thunder, but I know that he regularly speaks to GPs to give them feedback on issues that have been raised by patients.

I am not sure that I have answered your question.

Scott Barrie: I asked what benefits would be achieved for patients. It is interesting to see that, since the evolution of the new partnerships, patients are seeing benefits.

Mr Brett: We might not be using the new mechanisms properly yet. The groups have been running only since April and they have had a lot to worry about. However, the forums are available and I encourage people to take issues to them.

Dr Morrison: GP basic schemes vary throughout the country. There happens to be a pocket of excellence in Perth and Kinross, where a number of interested GPs operate basic schemes that function well with the ambulance service. They are willing to go out to accident scenes to assist ambulance crews. Unfortunately, the situation is not uniform throughout Scotland. I am told that, since the advent of out-of-hours services, there is less enthusiasm for GP basic schemes.

Mr Leslie: I want to reassure you that there are also pockets of co-operation in the Highlands,

even though GPs, ambulance crews and district nurses often operate in remote circumstances.

There has been a trend in the ambulance service towards recognising the need to work in partnership with health agencies and others. Our new divisional officer in the Highlands is working in partnership with the local authority on non-emergency patient transport.

There is no doubt that working in partnership produces a better outcome for patients. We should promote that idea.

The Convener: This has been a long session and we have covered a detailed and important range of issues.

I thank all our witnesses for their attendance. I am sure that the evidence we have heard will be of great assistance to the committee.

16:46

Meeting continued in private until 17:01.

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