Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 2 Gorffennaf 2013
Tuesday, 2 July 2013

Cynnwys
Contents

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

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

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

Eraill yn bresennol
Others in attendance

Kate Chamberlain	Prif Weithredwr, Arolygiaeth Gofal Iechyd Cymru Chief Executive, Healthcare Inspectorate Wales
Mandy Collins	Arolygiaeth Gofal Iechyd Cymru Healthcare Inspectorate Wales
Dave Thomas	Swyddfa Archwilio Cymru Wales Audit Office
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales
Mike Usher	Swyddfa Archwilio Cymru Wales Audit Office

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

Dan Collier	Dirprwy Glerc Deputy Clerk
Joanest Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser
Tom Jackson	Clerc Clerk

Dechreuodd y cyfarfod am 9.00 a.m.
The meeting began at 9.00 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Darren Millar:** Good morning, everybody, and welcome to today's meeting of the Public Accounts Committee. I remind everyone that in the event of an emergency, we should follow the instructions of the ushers who will guide us to the nearest safe exit. We have headsets available for amplification and translation. Everyone should be aware that they can contribute to the proceedings of the National Assembly for Wales in English or Welsh, as they see fit; the National Assembly is, of course, a bilingual institution. I remind everybody to switch off their mobile phones, telephones and pagers, because they can interfere with the broadcasting equipment. We have not received any apologies.

9.00 a.m.

Trosolwg o Drefniadau Llywodraethu Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr: Sesiwn Friffio ar yr Adolygiad ar y cyd gan Arolygiaeth Gofal Iechyd Cymru a Swyddfa Archwilio Cymru
An Overview of Governance Arrangements of Betsi Cadwaladr University Local Health Board: Briefing on the Joint Review by Healthcare Inspectorate Wales and the Wales Audit Office

[2] **Darren Millar:** We are going to have a joint briefing this morning from Health Inspectorate Wales and the Wales Audit Office on the report that they published last week on the governance arrangements at Betsi Cadwaladr University Local Health Board. I think it is fair to say that it was quite an alarming read, and Members are taking a keen interest in this issue.

[3] I welcome to the committee today, from the Wales Audit Office, Huw Vaughan Thomas, Auditor General for Wales, Mike Usher and Dave Thomas, and, from Healthcare Inspectorate Wales, Kate Chamberlain, chief executive, and Mandy Collins, deputy chief executive. We appreciate you joining us today, and we are looking forward to having an overview of the report, and to asking you some questions to help us with our scrutiny of it.

[4] I have asked the auditor general to speak for five minutes, just to give us an overview of the report. We will then go over to Kate Chamberlain for five minutes, before Members ask questions as they see fit. So, Huw, over to you.

[5] **Mr H. Thomas:** Thank you, Chair. The report that HIW and the Wales Audit Office published on the Betsi Cadwaladr University Local Health Board last Thursday represents the culmination of growing concerns that our organisations have had about the collective ability of the board to address a number of challenges that we and others have previously highlighted. The challenges relate to the way in which the board and its sub-committees operate, the fitness-of-purpose of the clinical programme groups-based organisational structure, particularly in ensuring that issues at individual hospital sites are appropriately managed, the ability to establish clear lines of accountability, robust performance management arrangements within the organisational structure, and also the ability to design and implement future models for service delivery, which are financially and clinically sustainable.

[6] In December of last year, our organisations separately reported on these issues—the WAO through our structured assessment of governance arrangements, and HIW through its work on patient care at Ysbyty Glan Clwyd. We articulated our concerns clearly to the health board, and shared them with the Welsh Government in a series of meetings with David Sissling and his officials. Such concerns were further reflected in a quality and safety review

that HIW began in late 2012. Its primary findings were reported to the health board in March 2013, and they are incorporated in the report that you have.

[7] During the early part of 2013, we kept a close watching brief on the pace at which the issues that we had identified were being tackled by the health board. However, rather than seeing the improvements that we expected, we instead saw additional, ongoing challenges arising from sick leave and turnover at the executive level, together with a culture of managing the message, and a breakdown in the working relationship between the chair and chief executive of the health board. Our concerns were such that our organisations felt it necessary to bring together the different strands of our work to undertake an urgent piece of work that provided a single, consolidated overview of the governance arrangements in the health board, and to report that in a public fashion to the Public Accounts Committee.

[8] The fieldwork was undertaken during May, and in line with the usual practice, interim feedback was given to the health board immediately after the fieldwork. The joint report that we published last week is the first of its kind in Wales, and illustrates the magnitude of our concerns. The problems associated with C. difficile came to light during our fieldwork, and were a clear illustration of the challenges that the board faces. The weaknesses in the reporting of C. difficile outbreaks and related deaths are extremely worrying, and are currently being urgently examined by an external expert. We have indicated to the board that this review must be appropriately wide-ranging and the results shared fully with the public.

[9] Fundamental issues need to be addressed in relation to the way in which concerns are raised and escalated within the health board. We are concerned that the gap between the ward and the board is not being bridged. We are concerned about the arrangements for escalating issues within CPGs through to the quality and safety committee and, if necessary, to the board. The board and, in particular, the executive must drive the changes that are necessary. The changes to senior leadership that were announced last week are important, but it is vital that urgent action is taken to improve the way that executives and independent members work together with each other and collectively on the board; that they implement revised internal structures that support good clinical leadership and clear accountabilities; and that they develop and agree an affordable and clinically sustainable acute services strategy.

[10] In short, transformational rather than piecemeal changes are needed, so that the health board can restore its reputation and public confidence. Indeed, I might go so far as to suggest that perhaps the board needs to think about how it presents itself and the whole image of the board to the public of north Wales, and whether the term ‘Betsi Cadwaladr’ is helpful or unhelpful in terms of saying on the can what the board does. More widely, I think that the review that we have carried out has highlighted the need to have a clearer understanding of the triggers that should prompt intervention by the Welsh Government when concerns at an NHS body become apparent. We and HIW have agreed to work with the Welsh Government to establish that clarity, and that bit of work was started straight away.

[11] **Darren Millar:** For the benefit of members of the public who might be watching, CPG means clinical programme group.

[12] **Mr H. Thomas:** My apologies, yes.

[13] **Ms Chamberlain:** As a joint author of the report, obviously, I would echo much and certainly most of what the auditor general said there. The thing that I would probably come back to most is that this is the culmination of a period during which we have been raising these issues to the board, and our concerns come from a lack of progress and a lack of pace in terms of responding to those. Particularly from the perspective of Healthcare Inspectorate Wales, I would highlight the challenges that need to be addressed fairly promptly in terms of making sure that the clinical leadership that is in place is appropriate, but also is balanced by

the right sort of accountabilities at a geographical and a site level to make sure that issues are being identified and addressed at the most appropriate level. I think that that is an area where we need to see quick progress.

[14] Again, going back to the issues around patient safety and the quality of services, we have highlighted that we are not convinced, in any way, that the right information is being escalated to the board at the right level in order for it to take assurance that it is clearly aware of all the issues that may be existing within the health board area. That is something, again, that needs to be looked at very quickly to make sure that the quality and safety committee is working effectively and that the information is being collected and reported consistently across the whole health board area. That is certainly an area where we are going to be continuing to work with the health board, and we have a meeting set up to start talking to it about the actions that it will be taking in that area.

[15] **Darren Millar:** You said that both of your organisations have been raising concerns for some time and that they have been going unchecked or unaddressed by the board. Have you been raising those directly with board members or just the executive team in the organisation?

[16] **Mr H. Thomas:** Our report, particularly our structured assessment, is to the board as a whole.

[17] **Darren Millar:** To the board as a whole. That would be the same for HIW—

[18] **Ms Chamberlain:** Our published reports are placed in the public domain and would be reported to the board. The interim feedback that we give tends to go directly back to the board members whom we deal with.

[19] **Darren Millar:** I was surprised at just how serious those failings in governance were when I read the report, but one of the issues that you pick up on is the failure of the executives to share information with the board and this breakdown between the people at the top of the organisation and the board. Do you want to elaborate on that? What was the evidence, other than this difficulty in sharing information and perhaps trying to 'manage the message', which I think you said, auditor general? Can you elaborate on the relationship breakdown? Was it a personality clash or was it more—

[20] **Mr H. Thomas:** May I ask Dave, as the person who led on our structured assessment work, to answer?

[21] **Mr D. Thomas:** I think that it was the frustrations on the part of both the independent members and the executive, and a vicious circle was building up whereby the independent members were feeling that they were getting important information very late in the day—sometimes on the day of the board meeting—and that obviously was prompting them to ask for more information and delaying the process. That frustrated the executives, who felt that the process was not being taken through quickly enough. There was this ongoing spiral of poor board working, really. It is difficult to say whether it is down to personality. I think that the board got itself into a professional situation where things had not happened quickly enough and it was trying to play catch up. That was then prompting a very rapid turnover of important papers going through to the board, but missing the important issue of independent members having to have the right information at the right time to properly absorb that information and ask questions. It was quite clear that they were going to ask more questions when they were getting stuff on the day. I am concerned that they were not perhaps getting a full consensus picture from the executives. You will not always get total consensus amongst the executives, but it is important that the independent members get assurance that issues are being debated and validated amongst the executive officers before it comes to board. They

were not getting that assurance and that compounded the frustration.

[22] **Ms Collins:** One of the fundamental issues for me was the framework and structure around the working of the board and how it was planning what needed to come to the board at what point in time, so that sufficient time would be given to that item by board members. That it one of the recommendations in our report, that to get a board working well and cohesively, and to have trust in the executive, you have to have a well-planned agenda for your board.

[23] **Darren Millar:** Who would be responsible for planning that agenda? I assume that it was the chair.

[24] **Ms Collins:** It would be the chair, together with the board secretary supporting him.

[25] **Darren Millar:** Was that the critical relationship that had broken down, between the chair and the board secretary?

[26] **Ms Collins:** As Dave and the auditor general have mentioned, there were numerous failings in relationships, but for me, in terms of the working of your board and the timeliness of your board's agenda items, that is one of the key relationships that need to be in place and working well.

[27] **Darren Millar:** Was there any explanation as to why papers were being provided very late in the day or on the same day, particularly with some of the critical issues that were being discussed?

[28] **Ms Collins:** No explanation was given, but certainly one of our findings was the lack of planning of the board agenda and timetabling. So, for example, if you have a key issue around changing your services, you should know that that needs to come to the board well in advance of when those changes need to be implemented. We did not see any evidence of that level of planning.

[29] **Darren Millar:** Where was the Welsh Government in all of this? The Welsh Government was obviously aware of the concerns that you had been expressing in the reports that you had been preparing and the issues that you were flagging up with the board, but was it supporting the board in making the changes that were necessary? What was its influence on what was going on?

[30] **Mr H. Thomas:** Certainly, as you said, we had been alerting the Welsh Government, and the Welsh Government had, as I understand it, been talking both to the chief executive and the chair in order to try to improve the position in Betsi Cadwaladr. It also commissioned some parallel work, which we have heard about, in terms of the work from Allegra. There was, if you like, a growing awareness that there was an issue that needed tackling, but the responsibility in the end rests with the board in order to ensure that this is done. The Welsh Government was clearly trying to get the board to address issues.

[31] **Darren Millar:** Okay. I have a few Members who want to come in now. I will bring you in in a second, Jenny. Mike, then Sandy and then Jenny.

[32] **Mike Hedges:** I have two questions. I speak as somebody who used to be an independent member of Swansea NHS trust. I remember two things: first, if something was difficult, three and a half hours into a meeting was a good time to address it, preferably as the food was arriving; secondly, individual members at that time—I do not know if they are now—were appointed by a group, which included the chair, and the asking of difficult questions, which I engaged in, was the quickest way of being removed at the next possible opportunity. Are chairs still involved in the appointment of independent members? If they are,

that is something that needs to be changed, as it creates problems for independent members who try to ask questions. Were those really difficult issues pushed towards the back of the agenda as people were getting hungry and tired?

[33] **Mr H. Thomas:** On the first one, it is normal for the chair of the health boards to be involved in the selection process of their independent members.

[34] **Mike Hedges:** The danger then is that for any independent member who shows independence or opposition to the chair their chances of being reappointed rapidly decrease.

[35] **Mr H. Thomas:** The appointment is not the chair's to make; it is that of the Welsh Government. In any board situation, whether it is health or elsewhere, you would normally expect the chair to have a voice. You would also expect the chair to carry out an appraisal of the performance of board members. I accept your proposition that, in a sense, that might be seen as compromising the ability of the independent members, but it is normal, and it is part of good governance.

9.15 a.m.

[36] **Mike Hedges:** I wish to come back to the auditor general. Yes, it is an appointment that is made by the Welsh Government, but it is made on the recommendation of the committee, of which the chair of the board is an important member, possibly chairing the selection committee. Consequently, the Government is under huge pressure to appoint whoever is recommended by that committee, and by that board, is it not?

[37] **Mr H. Thomas:** I would hope that the Welsh Government has its own sources of information as to the selection process, the strength of the candidates, and so on. However, I accept the point that you are making that the chair is an essential part of the recruitment process.

[38] **Mike Hedges:** That is an opinion. [*Laughter*.]

[39] **Darren Millar:** Sandy has the next questions.

[40] **Sandy Mewies:** One thing that struck me when reading your report—which was most helpful—was the complexity of the structures that were involved. You have staff officers, chief medical officers, chief staff officers, independent members, executives and non-executives—indeed, all sorts of people—involved in this. I have read that the training process had not been completed for those who needed training. Do you think that that contributed to this whirligig that you describe, of things not being done quite right, resentment occurring, and nobody doing anything about it? It sounds as though it went round and round and that nobody was prepared to say, 'Time to stop'. Is that the impression that you got?

[41] **Mr D. Thomas:** Yes, partly. I think that there are two separate things in the scenario that you paint. The first issue is the structure—the operational structure, if you like—where you have your clinical programme groups, with a chief of staff heading them. That is like a matrix arrangement because, alongside that, you have the hospital site management, and that is the area that we were struggling to understand, as to how that worked internally. Where is the accountability between the chiefs of staff, who lead the clinical programme groups, and the assistant medical directors, who have accountability for the hospital site work? That is not clear, and we think that it needs to be made much clearer.

[42] The second issue to which you refer is the independent members. Yes, quite a few of them had joined after the initial induction had taken place, so they missed the first round of training. Therefore, an opportunity was missed, if you like, to get them all to the same level of

understanding of what an effective board should do. I believe that that has certainly contributed. Therefore, it is a combination of issues. There should be clarity as to what the role of the board is, and how the operational side of the organisation will work, and how the two interface. What you have is a complicated structure, which might have worked fine in a smaller organisation, but when you get to an organisation the size of Betsi Cadwaladr, which covers three acute hospital sites across north Wales, it becomes a very complex internal organisation with, as the report says, problems identified in terms of accountabilities and issues falling between the gaps.

[43] **Sandy Mewies:** One thing that happened was that hospital site managers were appointed. I am not clear where that suggestion came from, and I would be interested to know that. I think that you have hit the nail on the head when you say that there is this clinical side and this bureaucratic side. Can you clarify how they communicated with each other? Surely, if they had communicated, someone would have said, 'This is our responsibility'. The governance, or the board secretary, or someone should have said, and noted, that resentment was building up, and it should have been nipped in the bud.

[44] **Mr D. Thomas:** That is a fair point. Our understanding was that each of the chiefs of staff for the clinical programme groups was accountable to a named executive director, so that should have made the linkage into the executive and board structure. We were given examples of where some of those lines of accountability were not always observed, and perhaps some bypassing of that, so maybe direct lines of communication between the chiefs of staff to the chief executive that would have circumvented the structure that they had put in place. So, clearly, the structure itself was complicated, but it was also not working in the way that they had intended, so there were two problems there. I think that that is at the heart of it. My colleagues may want to add comments to that, but that was my understanding.

[45] **Ms Collins:** One comment that I would make is on the chiefs of staff. Having clinical leadership within a health board is, in principle, a really good thing. It very much comes back to your point about how you then tie it into accountability and scrutiny arrangements and ensure that people understand fully how it links in, particularly to the scrutiny arrangements of an organisation.

[46] **Mr H. Thomas:** I would also add that the clinical programme groups were an essential part of the way in which the financial governance was exercised at Betsi Cadwaladr. What we found was that, in a sense, at the beginning of the year, there was reluctance by some chiefs of staff to accept their budgets. They said, 'We'll sign up to this budget, provided that A, B, C and D is in there'. That is not the way to have a healthy financial discipline. So, the problem with how the clinical programme groups fitted in with the overall structure is something of which the board was aware and had been grappling with for a while, particularly the interrelationship between those groups and hospital managements.

[47] **Darren Millar:** We will explore some of these issues in a bit more detail as the meeting progresses. Julie, you wanted to come in briefly.

[48] **Julie Morgan:** I just wanted to ask the auditor general about a comment that he made. I think that you said that what was needed was something transformational rather than piecemeal. I think that you made that comment, did you? Somebody made that comment anyway.

[49] **Mr H. Thomas:** Yes, I did.

[50] **Julie Morgan:** Did you ask whether the term 'Betsi Cadwaladr' was helpful? Could you explain what you meant by that?

[51] **Mr H. Thomas:** What I meant is that we have had a series of problems with a board and it needs to transform itself. It needs to position itself so that it sets off in a new direction, one which commands widespread confidence. The normal way in which some organisations do that is to name change. I am not suggesting that one does a massive exercise, but I wondered whether the strapline 'Betsi Cadwaladr, the north Wales health board' would help it to position itself better. I have to say, to the outside world, where is Betsi Cadwaladr? If it is trying to recruit—where is it? We have a shortage of staff in north Wales. Would it be helped by having a name that makes it much clearer where the board is, geographically?

[52] On Welsh history and so on, I think I can hold my own in terms of knowledge, but on this one, I would argue that perhaps these are times in which we need to think about how we present the health service of Wales in a way that allows it to pull in the necessary experts from outside.

[53] **Julie Morgan:** I accept that point, but I think that it is something that needs to be debated a bit more.

[54] **Mr H. Thomas:** Absolutely.

[55] **Julie Morgan:** She was a famous Welsh nurse.

[56] **Mr H. Thomas:** I am not making a point about that. I am making the point that it is part of a transformation that needs to take place.

[57] **Julie Morgan:** I accept that.

[58] **Jenny Rathbone:** Before I go back to local governance, and sticking with the board for a moment, what did the independent members do when the annual income and expenditure budget for 2012-13 was presented to them the night before the board meeting? Did they complain to the chair? If so, what did the chair do?

[59] **Mr Usher:** In terms of the detail of the discussions, one of the issues that we had in looking at the operation of the board was the adequacy of minutes of discussions; they tended to be a little on the brief side. So, in terms of detailed substance of concerns being raised, the minutes tended to be fairly anodyne. From discussions with some independent members, it is clear that they had a number of concerns about the late submission of papers. Very often, that, in turn, led to the deferral of decisions until a following meeting. Taking the 2012-13 budget, for instance, it was not until the end of April—into the financial year itself—that the draft budget was approved. That sort of thing should certainly be happening before the start of the financial year. That is part of the issue around the operation of the board and its agenda and papers, which leads to those sorts of delays, and, to some extent, a breakdown of trust. Dave referred earlier to that spiral of challenge. I think that the financial arrangements were part of that.

[60] **Jenny Rathbone:** Was the chair not capable of insisting that the budget needed to be with the board before the beginning of the financial year—you are absolutely right—so that a meeting could occur in March to approve the budget? Where was the chair? Were the board members just passive recipients of these late papers?

[61] **Mr Usher:** No, I certainly would not characterise the chairman as being 'passive', but at the end of the day, the responsibility for the production of papers sits with the executive team, and there is only so much that a board member can do in terms of saying, 'We need this by a particular date', if it doesn't then happen. I think that there is certainly considerable concern, but in terms of the effectiveness of that, you have to look at what was delivered and when. The only conclusion that you can draw is that, to the extent that there were

interventions and challenge, that was largely unproductive or ineffective; it was not working because things were not being delivered on time, with sufficient time in advance of a meeting for members to consider issues. To what extent intervention was taking place is almost a moot point. The key thing is that whatever was being done was not enough because it simply was not working.

[62] **Jenny Rathbone:** So, the chair was aware that the independent members were dissatisfied at the late production of papers, but he was incapable of getting the executive members to change their ways.

[63] **Mr Usher:** In our work we have not sought to personalise individual issues to individuals within the organisation, but we would say that this is a collective failure of the board, which is clearly led by the chair. I think that we would see this as a collective breakdown in terms of board effectiveness.

[64] **Jenny Rathbone:** I understand that; it is just that the chair has the role of ensuring that the agenda is fit for purpose on a particular day.

[65] **Mr Usher:** Absolutely.

[66] **Jenny Rathbone:** If the papers are not there, either the papers will have to be produced a week in advance or the items will have to be deferred for another meeting.

[67] **Darren Millar:** Before Jenny moves on, I wish to ask about the chair. You mentioned independent member training. Did the chair receive any specific training in such an important role? Is there evidence of that?

[68] **Mr D. Thomas:** That is a good question. The honest answer is that we do not know. It might be worth asking the board that question when it comes before you. He certainly would have joined after the first induction, but I am not entirely sure.

[69] **Darren Millar:** I have one final question on the chair. We talked a little about the appointment of independent members. Who interviews the chair for his post?

[70] **Mr H. Thomas:** It is the Welsh Government.

[71] **Darren Millar:** So, that would be an entirely Welsh Government-only appointment.

[72] **Mr H. Thomas:** I imagine that there would also be an independent person engaged. However, it is a Welsh Government appointment.

[73] **Darren Millar:** Okay. We come back to you, Jenny.

[74] **Jenny Rathbone:** Just moving on to the appointment of these hospital site managers, whose idea was that? Was it a board decision or was it an executive decision? What was the purpose of these hospital site managers?

[75] **Mr D. Thomas:** Our understanding is that that was an executive decision taken in response to the concerns that we and others had raised. Clearly, there was a very worrying scenario of a lack of drive, I understand, in terms of what has happened at the hospital site within this matrix structure that we described earlier. The hospital site manager roles were identified as a solution to that problem—by the executive, we think—

[76] **Jenny Rathbone:** We think, but we do not know.

[77] **Mr D. Thomas:** To be perfectly honest, we did not ask that direct question. Our concern was to look at the response that had been put in place to the concern identified. The response was to have hospital site managers. The bit that we identify in the report as being more of a concern is that, accepting that there was an urgent need to push on quickly with those appointments, there were no job descriptions in place. They were interim three-month secondments. To expedite the process is fine, but given the problems that we are identifying with lines of accountability and authority, we felt that it was really important that there was clarity on what the exact lines of accountability and authority that those hospital managers had.

[78] **Jenny Rathbone:** Absolutely. I appreciate that it needed to be done in a hurry, but it takes fewer than 24 hours to write a job description. Ultimately, that must be the role of the chief executive; whether she delegates it or not is another matter. Surely, the chief executive must write the job descriptions for the hospital site managers, otherwise we would have no idea whether their role included infection control, in terms of the C. difficile problem, or whether it included sorting out the clinical protocols to make sure that everyone was operating according to the best evidence in the particular disciplines. So, to this day, we have no idea as to what their remit was.

[79] **Mr D. Thomas:** We understand that personalised objectives were discussed between presumably the acting chief executive at the time and the hospital site managers, but there were no written job descriptions, so we had nothing to look at that clearly stated, 'This is the role of those site managers'.

[80] **Ms Collins:** The real issue for me when we were doing this was the fact that, by the very fact that there were no clear job descriptions from the start, instead of helping, something that could be really useful in terms of driving quality within a particular hospital, could have muddied the waters further in terms of accountability arrangements.

[81] **Jenny Rathbone:** In the context of these different clinical programme groups all doing their own thing—it would appear—presumably, without a clear remit, the hospital site managers had no chance. Presumably, the clinical programme group said, 'That's not what you do. That's what we do.'

9.30 a.m.

[82] **Mr D. Thomas:** That is the risk. Most people we spoke to said that they were positive about the roles and we consider that a step forward. It was just that that final bit of cement and the exact clarity of what the authority was when something went wrong was missing. You need to know what authority you have and what you can do if you need to change something.

[83] **Jenny Rathbone:** Do these people without job descriptions still exist? Are they still in post?

[84] **Mr D. Thomas:** They are. We understand that they are going to make those posts permanent. One assumes that the job descriptions will follow from that.

[85] **Darren Millar:** I have a few Members who want to come in with some brief supplementary questions. Jocelyn and then Aled.

[86] **Jocelyn Davies:** From everything that you have told us, I cannot work out whether the executive board was incapable or unwilling to produce those papers, whether the secretary did not have the papers or refused to send them out, or whether it was the chair. I cannot work out from what you have told us so far whether this was deliberate or whether it was down to

incompetence.

[87] **Mr H. Thomas:** What is certainly clear is that the executives lack clarity as to the responsibilities. You might say that any organisation looks difficult from the outside, but you would expect those within it to understand how it works and who has responsibility for particular areas. As we highlight in the report, there was a discussion about the numbers of CPGs taking place—was it six or more? You would have expected some clarity out of that and some clarity on the role of the hospital managers. There is also the fact that there has been change within the health board's executive over a period. People have left, there has been sickness, there has been a turnover, and, at the same time, there has been the continued absence of the main person on the board who should be responsible on the medical side for clinical leadership. You have a sense of an executive that is a bit at sea about who does what.

[88] **Aled Roberts:** I have two very brief questions. Did any of these independent members approach anyone in Government or in any of the regulators or inspectorates to express concerns regarding these failings?

[89] **Mr Usher:** Yes. I was approached in August of last year by two independent members and the director of finance who wanted to raise concerns with the Wales Audit Office about their perspective of what was happening at the health board. That, coupled with our own views as to what was happening, led us to start to escalate our own concerns about operations at Betsi Cadwaladr, and that got us into the dialogue with the chief executive of NHS Wales, which began in the autumn and worked through.

[90] **Aled Roberts:** Did it come as a surprise to the chief executive of NHS Wales? From the outside, in terms of an organisation that is responsible for a budget of over £1.2 billion, I have never come across a situation where a budget is not agreed. I was certainly astounded to read in the report that certain groups within the organisations were still arguing over their budgets at the end of September. Did NHS Wales not have any oversight of this?

[91] **Mr H. Thomas:** When we raised this with NHS Wales last year, it was said that budgets had been agreed in Betsi Cadwaladr, but I pointed out that I did not consider that getting sheets of paper saying, 'I agree this budget subject to A, B, C and D; and by the way, that bit isn't my responsibility', is not, to my mind, a balanced budget. It was at that stage that we started drilling down much more into what was happening. The chief executive of NHS Wales started to increase his dialogue with the Betsi Cadwaladr board.

[92] **Sandy Mewies:** Quite a few of the points that I was going to raise have been raised. I understand that there was a long-term absence of the medical director. Is that post still not filled?

[93] **Ms Collins:** The medical director has been absent due to sickness; interim arrangements were made, but, to this day, they are still interim arrangements.

[94] **Sandy Mewies:** Thank you. I think that the site managers were appointed in May, on temporary three-month contracts. We are into July now. Are you aware of any evaluation of the work that they have done? Given that they do not have job descriptions, has the board carried out any monitoring, any looking at results, any outcomes?

[95] **Mr D. Thomas:** I think that when they respond to our report we will be saying, 'Three months in, if you are making them permanent, what have you learned from the three months that is actually going to help you to make these roles clearer?'

[96] **Sandy Mewies:** Do you have a date for that? You know that it is three months. You know that they are talking about making the roles permanent. I think that you had a very

serious concern about this shoring up the governance really. How long will you wait now before you ask and look for answers?

[97] **Mr D. Thomas:** We will ask straight away for a response; there will be a request straight away. I think that the board considered our report at the end of last week, so now is appropriate for them to tell us how they intend to respond to our recommendations.

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

[99] **Jenny Rathbone:** What are these interim arrangement for the medical director? Why is there not an interim or an acting medical director?

[100] **Mr D. Thomas:** There is.

[101] **Ms Collins:** The interim arrangement is an acting director. The issue is that since the post holder is on sick leave, it is a difficult issue to manage.

[102] **Jenny Rathbone:** I understand that, but as you have an acting medical director, surely that person has the capacity to do everything that the medical director would do, were they not on sick leave.

[103] **Ms Collins:** I think that you are absolutely right. The roles and responsibilities of the medical director have been delegated to somebody else. I have not had the discussion with the person as to whether they feel that they have the responsibility to take major change within the organisation forward, when they are in those interim arrangements.

[104] **Darren Millar:** In my experience, there are two sorts of interim directors that come into an organisation—one who turns everything upside down and one who acts as a caretaker and does as little as possible in terms of change. Of course, this is a critical time for the organisation, needing to make transformational change on the ground happen in order to meet its financial commitments and improve clinical outcomes. You criticise how sluggish that has been in the report, so can we take it that the medical director's post being interim has contributed to the sluggishness? Is that a fair comment?

[105] **Mr H. Thomas:** I think that it is fair. You have a post holder on very long-term sick leave. You have people coming in, not sure whether they are going to be there long enough to actually make the change. They are coming not from outside, as they are actually internal people who have been moved up to do this role. So, the issues of authority do bite. I would ask why the board has tolerated someone in such a crucial post being on sick leave for such a length of time without doing full replacement action.

[106] **Darren Millar:** Yes, given the uncertainty about whether someone is returning to work or not. Okay.

[107] **Sandy Mewies:** I assume that this is one of the things that you will be going back to visit, or not, given that the medical director is at the peak of the clinical side, and that that is where there are weaknesses as well.

[108] **Ms Chamberlain:** I think that it is worth saying that we are going to be meeting the health board next week, to look at how it is addressing some of this. If we go back to some of the other issues that we have highlighted, such as the volume of information coming to the quality and safety committee, the manner in which clinical programme groups are, or are not, being scrutinised in the level of detail that you might want by the quality and safety committee, and the way in which the clinical programme groups themselves are managing the quality and the safety of the services that they are responsible for, then these are certainly

things that we want to talk to the board about in a great deal more detail. We do have a meeting that we are putting in the diary for next week as we speak.

[109] **Sandy Mewies:** Thank you. It might be useful, Chair, for us to have an idea of the timeline of what happens next in some detail. Turning to the clinical programme groups, following the issues that were raised by both organisations, I think, there was a suggestion that they should be reduced from 11 to six. When it went to the board, it was recommended by the chief executive that there should be 12—an extra one rather than a reduction of one. Are you able to explain what the thinking or the reasoning was behind that? The board would not discuss it because it was not what they had been asked to do. What was the thinking?

[110] **Mr D. Thomas:** We are not sure; it is as simple as that.

[111] **Sandy Mewies:** Right, okay.

[112] **Mr D. Thomas:** We just described what really was a rather strange set of circumstances. You convened a process to review the CPGs, which was good and there was an appropriately broad range and remit for that review. You had a panel that included independent members, which was good, and that panel came up with proposals to reduce the number of CPGs from 11 to six. There was a degree of logic to that. There was no clear process for how they would get there but, nonetheless, there was logic to the numbers. There was then, as we understand, a form of consultation. The chief executive took that proposal away and, ultimately, a paper went back to the board after that process with 12 CPGs as the suggested model. That was not even considered by the board. In fairness to the board, it put it to one side and said, 'No, that clearly does not meet the remit of the review, and is probably not financially or clinically sustainable'.

[113] **Sandy Mewies:** Okay. So, they have moved to the six groupings now. I do not know where they are on that but, again, is it the case that, when you revisit this, you will be checking?

[114] **Mr D. Thomas:** Yes, at the point of this report, they were still going through that process. So we will get the update, as part of—

[115] **Sandy Mewies:** I am sure that you will be, but I just wanted to tick the box. [*Laughter*.]

[116] **Mr D. Thomas:** Absolutely.

[117] **Darren Millar:** You said that that issue was not even considered by the board, so was this proposal for 12 CPGs tabled to the board?

[118] **Mr D. Thomas:** Yes.

[119] **Darren Millar:** It was.

[120] **Mr D. Thomas:** Yes, I am sorry; I should have been clearer. It was looked at straight away and the board said, 'We are not even going to bother debating this, because it does not meet the remit'. So, the board received it but, in effect, set it aside and asked the chief executive to go back and reconsider.

[121] **Darren Millar:** There must have been some discussion at the board.

[122] **Mr D. Thomas:** Yes.

[123] **Darren Millar:** So, there was discussion at the board about that proposal, but it was set to one side and they were told to go away, think again and come back.

[124] **Mr D. Thomas:** Yes.

[125] **Darren Millar:** Thank you for that. Jocelyn is next.

[126] **Jocelyn Davies:** The questions that I was going to ask about the medical director have been covered, Chair.

[127] **Darren Millar:** Okay. We will turn to Aled.

[128] **Aled Roberts:** May I ask about the C. difficile situation? It is clear from the report that there was under-reporting of serious incidents, and it makes reference to the rather informal arrangements when issues were identified at hospital site level and the way in which they were escalated up, usually by e-mail, with no real understanding with regard to how they would then be actioned. It seems strange that there was a quality and safety committee, and I think that your report says even that was not sighted on the C. difficile issue. I think that that was referred to. Were there no specific terms of reference for that quality and safety committee, so that you could expect it to have had a handle on the situation?

[129] **Ms Chamberlain:** May I go back to two points in the question that you asked? In terms of under-reporting, we believe that there was under-reporting, but that is still something that is being looked into. So, we have been quite careful in terms of the language that we have used, because we do not want to pre-empt the outcome of the external review that is being undertaken. You have also referred to the informality of reporting. What comes through in terms of some of the early findings that we have seen is something about inconsistencies in identification and reporting, which means that you are getting different types and levels of information. So, informality might be overstating part of it—

[130] **Aled Roberts:** I am actually quoting the report, though.

[131] **Ms Chamberlain:** That is in particular instances, but not across the board. There are certainly other reporting processes that are in place and it was about inconsistencies and application. In terms of the quality and safety committee, Mandy, do you want to add anything?

[132] **Ms Collins:** It did have terms of reference. The major issue that we are talking about in terms of under-reporting is a lack of clarity and understanding as to what should be reported to that committee and when. There were issues where information was not being escalated up in the right way and in a timely way. Certainly, in our view, quite often, information can be reported, but unless somebody takes time to analyse and look at the trends, sometimes you will miss some fundamental and key issues. So, it sometimes comes back to piecemeal reporting to that committee, rather than somebody looking, analysing and pulling information together over a period of time.

[133] **Aled Roberts:** Many of us in north Wales are often told that part of the legacy that Betsi Cadwaladr LHB inherited was that there were three trusts with three very different management regimes. Is there now a uniformity of purpose between the three areas? It is a bit worrying that the hospital management team, perhaps, which you would expect to have responsibility for the safe operation of its site, does not even have job descriptions three months in, so what reassurance do we have that there is that uniformity of purpose and clear understanding regarding one regime being in place?

9.45 a.m.

[134] **Ms Collins:** I think this is a major issue that has been raised in the report, and this is where we refer to the pace of change. One of the key areas where we feel that the pace of change has not been fast enough is the bringing together of one organisation with consistent and clear approaches right across that organisation. There is still some evidence of there being very localised procedures and protocols in place, which do go back historically to the old organisations.

[135] **Aled Roberts:** Have any steps been taken since your organisation started looking at the situation in autumn of last year? Do we have any reassurance that, nine months on, the board is more aware of the need to address these issues?

[136] **Mr H. Thomas:** The fact that we have had to bring a report to the Public Accounts Committee reflects the fact that we feel that the board has not adequately been addressing these concerns since we first raised them.

[137] **Darren Millar:** I will just ask about the infection control issue. This is on the back of another report, which was published just a few weeks ago, about the situation at Ysbyty Glan Clwyd on the infection control measures there, and the piece of work that Public Health Wales is doing. You say that you identified significant under-reporting. You do not talk about the scale of that, but you use the word 'significant'. By what margin are we talking? Is this confined to the one site where we know there has been an issue, or is it across three sites? Is it just infection control, or are there other matters that are not being reported to the quality and safety group?

[138] **Ms Collins:** It is across all sites. When you look at historic trends, there are fundamental issues that need to be addressed, and are being addressed. We use the word 'significant', but we have not quoted numbers because, as Kate referred earlier, the report is an interim report and more work needs to be done. I think we would have misled the public if we had started to quote numbers in this report. The organisation has a new nurse executive, and I know from my discussions with her that her fundamental priority is to get under the skin of what has been happening around the wider infection control arrangements of that organisation. Her first piece of key work will be to put that right. Our report refers to there being insignificant resources around infection control in the organisation.

[139] **Darren Millar:** One of the very concerning parts of the Public Health Wales report was this issue of C. difficile being cited on seven death certificates. That is something that is easy to measure, so have you looked at that at all for the three hospital sites?

[140] **Ms Collins:** There is a lot of work being taken forward in looking at not just rates of C. difficile, but mortality rates linked to C. difficile. As you have said, we need to unpick the information and the work that has been taken forward. On death certificates, as you know, you can have it as a contributory factor, or you can have it as a main factor. The aim of the piece of work that the health board has commissioned is to look at and go into some detail as to what deaths are of which type. Certainly, as we know, older people in the community who may have been on antibiotics can be admitted into hospital with C. difficile. So, it is a complex picture that needs to be unpicked if we are going to put things right for the future.

[141] **Darren Millar:** You do not have those figures per se, to be able to give those—

[142] **Ms Collins:** Not at the moment; that work is ongoing. The report that the health board has commissioned will be in the public domain and will go into a lot of detail around this. I know that the Welsh Government chief medical officer is taking a particular interest in this work and will be keeping a watching brief.

[143] **Darren Millar:** In terms of other areas that the quality and safety committee should have had sight of but did not have information on, what other risks that were not reported to the quality and safety committee? Are you aware of any other particular areas?

[144] **Ms Collins:** We are not aware of any particular areas. We cannot guarantee that there are no other areas. What we need to do, through the work that we will be taking forward with the health board, is to ensure that the quality and safety committee is getting the right information at the right time in order to react and respond in a timely fashion.

[145] **Darren Millar:** Infection control is a matter of significant public interest. The Welsh Government has indicated that this is a priority for the NHS. Rates have been reported as coming down in all health boards, including this one, funnily enough. Why were those independent board members not asking such questions as: where is the infection control information? How many C. difficile problems have we had, and in which hospitals? What are we doing to address them? They are simple, basic questions, are they not?

[146] **Ms Collins:** I think that it comes back to what we mentioned earlier, namely a lack of training for some independent members—

[147] **Darren Millar:** Do you really need training to be able to ask questions that are clearly a matter of public interest?

[148] **Ms Collins:** I do think that, sometimes, we need to equip people in the right way and support them to ask the right questions, and to know when they are not getting the right answers.

[149] **Darren Millar:** It just seems bizarre, really, that they were not asking those simple questions. So, what questions were they asking?

[150] **Ms Collins:** That is one of the issues behind why we have written the report. We want the board and the quality and safety committee to be asking the right questions at the right time in future.

[151] **Darren Millar:** This is my final question on this particular issue; I will then bring in Jenny. The Welsh Government relies on the quality of the data that are presented to it by the individual health boards. The First Minister and the Minister for Health and Social Services have both made statements about infection control, and they are satisfied that the rates are coming down, but they want to work towards even lower rates of infection outbreaks in hospitals. What confidence can we as Assembly Members have in the information that is being presented to us by the Welsh Government on its progress on infection control if the information, even within this board, is questionable? Can we have any confidence?

[152] **Ms Collins:** Kate and I had a discussion earlier about the role of HIW and how, as we go forward, in terms of some of our routine inspections, we can start to do work that will give better assurance around infection figures and rates. Certainly, over the last 12 months, we have been doing some development work, because at the moment, as you know, we undertake unannounced cleanliness and infection control spot checks. To be totally honest, they have very much focused in the past on cleanliness, and we need to move those into real, biting infection-control issues and questions. We need to be doing more of the testing at ward level and at service level, as well as asking some of the fundamental questions around information flows.

[153] **Darren Millar:** So, should we take everything that we are currently told with a pinch of salt?

[154] **Ms Collins:** I do not think that we should take it with a pinch of salt. I do think that we need to understand that we need to always question those data and ask the right questions of those data.

[155] **Darren Millar:** The Welsh Government should also be asking those questions.

[156] **Jenny Rathbone:** Are the cleaning staff directly employed or are they outsourced to an agency? Whether they are outsourced or directly employed, are they under the control of the infection prevention and control nurse staff?

[157] **Ms Collins:** I cannot answer the first question, because we did not look at those arrangements. It is certainly something that we need to look at as we move forward. In relation to it being under the direct control of infection control staff, the answer is 'no'.

[158] **Sandy Mewies:** Just as a reflection, I was wondering whether, when independent members and different people are trained, some input from your organisation would be helpful.

[159] **Darren Millar:** That is a fair point.

[160] **Mike Hedges:** Were Welsh Government officials aware of the emergency expenditure controls implemented by the health board in the final weeks of the 2012-13 financial year? Effectively, were financial targets given priority over treatment?

[161] **Mr Usher:** In terms of awareness, our understanding is that all of the health boards were facing financial pressures in 2012-13. The Department of Health chief executive and director of finance were having regular discussions, at least monthly if not more frequently, with each health board on financial performance and what was being done to address the deficits that were being forecast month on month through the financial year.

[162] In terms of BCU, at one point in the year it was forecasting a deficit of £19 million. That was the point at which the Welsh Government made additional funds available to each of the health boards during the year. BCU received £15 million and was told to put in place arrangements to bridge the remaining £4 million gap internally. That, I think, was quite a challenge to the health board, and even at the end of February—so, with one month to go in the financial year—it was still forecasting a deficit. At the end of the financial year, it achieved financial balance and we looked very carefully at that to establish how it had been done. We have identified that, in essence, the remaining gap in those last few weeks of the financial year was mainly dealt with through a cut back in the volume of service being delivered. That was largely in elective surgery. We have had assurances from the board that those decisions were clinically led, in terms of reduction, but I think that you would certainly want to be asking the board about how it made those sorts of prioritisation decisions in terms of who would continue to receive elective treatment prior to the end of the financial year, and those for whom treatment was postponed.

[163] **Darren Millar:** When you say that the elective stuff was stopped, how many patients are we talking about here? Is it a large number of patients? Is it a small number? How many elective procedures do they do?

[164] **Mr Usher:** I could not give you numbers on that, I am afraid, off the top of my head, but it would have to have been a fairly significant reduction in activity in order to have bridged a gap of the size that they had in the last four to six weeks of the year.

[165] **Mr H. Thomas:** I will be producing a report on health finances in, I think, about three weeks' time, in which we look at the impact of the decisions that all the health boards

took as part of their bridging the gap finances.

[166] **Sandy Mewies:** Could I come in at this point?

[167] **Darren Millar:** Yes. I have two who want to come in—Sandy and then Aled.

[168] **Sandy Mewies:** Has Julie finished, or Jenny?

[169] **Darren Millar:** It is Mike.

[170] **Sandy Mewies:** Or Mike—whoever. [*Laughter.*]

[171] **Darren Millar:** I will come back to you.

[172] **Mike Hedges:** I have two more questions.

[173] **Sandy Mewies:** If you want to carry on, I can come in at the end.

[174] **Mike Hedges:** Okay. I have two further questions. First, this committee and others have recommended three-year budgets for health boards. Do you think that that would help them to manage themselves better, or do you think that it would just create a huge problem at the end of year 3?

[175] **Mr Usher:** Yes, the committee made recommendations last year, after it considered the auditor general's previous report on health finances, and it recommended that the Welsh Government should look very seriously at moving away from simple annual expenditure controls, on the basis that they are a constraint that is inappropriate given the nature of health board operations. I know that the Welsh Government has been looking very actively at that. We have had some discussions with health department officials in the last six weeks on proposals that they are developing. My understanding—obviously, you will want to ask David Sissling about this—is that the Welsh Government intends to introduce legislation in pretty short order, to introduce a degree of flexibility to health finances, to move them away from the purely annual basis to something around a three-year funding model.

[176] **Mike Hedges:** My final question is this: it is a tradition in health boards that, in the first few months, they overspend, quite often massively—I had a report just yesterday that the Swansea board had gone over by £5 million in the first two months—and then they claw it back. If something is going to come out of this, we need a sustainable, flat service, so that expenditure is roughly the same, month on month, leaving aside the problems of peak pressures et cetera, so that we do not have spending at the end of April and May, cutbacks in February and March, and a repeat of the cycle the following year? What can be done to improve things and to have a more focused, robust, transparent and effective budgeting procedure?

[177] **Mr Usher:** You are absolutely right in characterising the situation. For BCU, at the end of May—just last month—it was already overspent by £5.1 million in-year, and it was forecasting a deficit of £29 million for this current financial year. So, it is back in the same position as previously. You are right; we do observe every health board, I think, being fairly slow in the early months of the financial year in getting up to speed in implementing savings schemes, thereby giving them less elapsed time to make those changes later in the year. Coming back to BCU, the late approval of a budget, well into the financial year, and other similar things, mean that they do not have a running start on 1 April; they are almost starting from stationary again, and have to build up speed and momentum, so that savings only really start to kick in in the latter months of the year. Again, I think that the auditor general's report in a few weeks' time will comment on this in terms of health finances more generally.

[178] **Mike Hedges:** If savings were sustainable, savings in the last month of the year would actually be good, because if you were saving 10% of your budget in the last month of the year, it should then flow through into the next year, which would make a substantial saving during the year. I do not want to steal Aled Roberts's thunder—I have no idea what he is going to say now—but some of these seem to be pretend savings, with things closed down for two months at the end of the year, before being opened up again, when the floodgates open and all the treatments that should have taken place in the last two months of the previous year take place in the first two months of the next, to be repeated the following year.

[179] **Mr Usher:** I think that, to some extent, that is what is happening. The issue of savings being, not only genuine savings, but something more than one-off savings, is about delivering recurring savings in future financial years. That is the key. To be honest, that can only really come from genuine service reconfiguration, which is the agenda that all health boards are grappling with. That is the only way of delivering long-term financial sustainability.

10.00 a.m.

[180] **Sandy Mewies:** You have just got to where I was getting to. You have said so many times that it is 'one-off savings, one-off-savings, one-off savings' but that it has to be sustainable. It seems that the conclusion of saying that for you was that the strategy for reconfiguration had to have more clarity and move forward, because these savings cannot go on being one-offs, or it will just be a recyclable problem. Have I got that right? It is not a long report but there is an awful lot in it, so it is quite easy to come to conclusions that are not there. However, I felt that you were saying that about the reconfiguration process. I would like to know if I am wrong, because it is quite important. The reconfiguration process so that services are sustainable has to proceed, but perhaps with a bit more clarity about what is happening, and with a bit more level thrust over the period of time.

[181] **Mr H. Thomas:** What we highlight is the fact that we have yet to see what the acute reconfiguration is. Issues around neonatal care and so on have surfaced, but the strategy for the acute services has not surfaced. We have had proposals from Betsi Cadwaladr that are targeted towards the community and primary care end, but not towards secondary care. If you get to reconfiguration, you need the whole and you need it costed. It is that that we are missing for north Wales.

[182] **Mr Usher:** I should also add that, when we talk about sustainability, we should not just think about it as financial sustainability. Clinical sustainability is equally important. Both factors need to be taken into account, so that safe services are delivered for the future within a financially sustainable envelope. That is a tricky balance to be struck, but it is one that every health board has to address.

[183] **Aled Roberts:** Are the same arrangements in place for this financial year with regard to the sign-off required by the clinical programme groups as far as the budgets are concerned? If that is the case, have they signed them off?

[184] The report states that it is expected that the acute services review will be reporting back in the autumn. One thing that struck us with the previous reconfiguration plans was the total lack of information with regard to financial or clinical sustainability. If you ask members of the public who attended the board meetings, they would not need a report from your two organisations to say how little challenge there was by the board with regard to the lack of information upon which they were taking those decisions.

[185] **Mr H. Thomas:** I will ask Mike to answer on the CPG sign-off.

[186] **Mr Usher:** On the CPGs, I do not know the answer to that at the moment. I am going up to Bangor on Thursday for a meeting with them, and that is one of the questions that I have for them: have all the CPG budgets been signed-off without caveats? So, I do not know at the moment.

[187] **Mr H. Thomas:** On the issue of the costing, this is where we would have expected the board to drill into the proposals, to make sure that they are financially and clinically sustainable, and for the board to address those concerns. I am aware of the comments about the public meeting, but we are looking at how the board is currently managing. Those two tracks about the strong scrutiny of proposals are areas that we feel the board needs to do more in, particularly this autumn when it comes to look at the acute services. We would expect the board to show that it is in charge and grappling with the issues.

[188] **Aled Roberts:** Have the members of the board received any subsequent training, because it is the same board—apart from the two resignations—that will be expected to make these decisions in three months' time?

[189] **Mr H. Thomas:** Not in the last week, but, as the Wales Audit Office, we have tried to help the boards across the NHS to deal with governance issues, and that help is available. I would hope that the Welsh Government will be addressing some of these issues.

[190] **Ms Chamberlain:** The only thing that I can add to that is that this almost brings us back full circle to where we started the discussion, around the capacity of the board members, gaining consensus among the executives and making sure that there is sufficient executive capacity within the board to bring forward well-planned and well-thought-through proposals in an appropriate time for effective scrutiny. In terms of responding to the issues that we have highlighted in the report, the way in which future reconfiguration is taken forward will be a key test of how effective the arrangements that have been put in place have been.

[191] **Jocelyn Davies:** You seem to have described shambolic governance and weak clinical leadership. Under those circumstances, do you think that any organisation would be up to delivering a strategic vision and driving change in such a large organisation?

[192] **Mr H. Thomas:** That is why I said in my opening remarks that we are really after transformation. This is not a report where we say to an organisation, 'Well, you know, there are 24 recommendations, you address these and carry on'. The board needs to take stock and think about where it wants to drive in order to deliver a health service to north Wales that is sustainable for the future. Currently, we have grave doubts about the governance and the ability to do that driving. It needs a transformation agenda and new leadership, and, if you like, a new vision for the future.

[193] **Darren Millar:** Even with the reorganisation proposals, which are already on the table and in the process of being implemented, they do not give any assurances that money will be saved as a result of those measures at all. In fact, quite the opposite; they have made it quite clear that they will not save a bean. It is just about changing the way in which services are delivered to deliver better outcomes. Mike, do you want to comment on that? Then I will go over to Julie.

[194] **Mr Usher:** I was just about to pick up on that point, Chair. The consultation that has already gone out and come back in, mainly on community services, is quite explicitly not about financial savings. It is about reconfiguring services to make them clinically sustainable. On the financial savings, I think that the board's plan is that those have to come from the second stage consultation process on acute service delivery. So, that is where it is looking to drive through financial savings rather than from the stage 1 consultation. However, the board

has been quite explicit about that.

[195] **Julie Morgan:** Bearing in mind the discussion that we have had about the importance of driving ahead the acute service agenda, and the information that we had about the urgent need to recruit, we were told in the report that, in April 2013, the chief executive took a proposal to add 72 clinicians in time for the August 2013 rota, which obviously seemed to be very difficult to achieve. You were probably left thinking, 'Is this board going to be able to do any of these things?' What do you think is the next step that should be taken to ensure that something happens?

[196] **Mr H. Thomas:** First, there is an urgent need for the Welsh Government to help the board with interim leadership at both the non-executive and chair level and also by sending in interim support staff to strengthen what is in north Wales. That is absolutely essential. There is a need to look at the whole issue of the deanery and the proposal for the additional 72 clinicians, because the deanery was thinking of withdrawing, in a sense, the permissions for Betsi Cadwaladr to be able to have junior doctors working there. That is serious. So, there is a need for the clinical leadership to be strengthened, particularly. All of that requires extra resources to be devoted by the Welsh Government to the board.

[197] **Julie Morgan:** So, you think that perhaps the Welsh Government should send in a board.

[198] **Mr H. Thomas:** I think that it needs to work with the board to help it over the next few months. After all, on a favourable wind, it would take three to four months for a new chief executive to be appointed, although less for a chair. The board cannot afford to just mark time for that length of time.

[199] **Mohammad Asghar:** Before I ask my question, I will just say that I have been listening with great interest and it is a sad scenario. What is happening here is disgusting. I am not happy with what this health board is doing. Whether it is a board, an authority or a team, if the leadership is not together, teamwork never works; it is a failure. As a sportsman, I know; it is a total failure. This case is bizarre, as the Chair just said. We come here every week and every month. You must invent a red button, as the auditor general, for all these organisations once things start getting bad, not worse. You come in at a point when everything has gone beyond; we are under the portal, rather than getting in at the right time and getting these problems sorted out straight away, or within a short period so that we do not waste a lot of public money. So, there are a lot of problems, as we heard just now, and we are getting all these excuses. That was my first point.

[200] How quickly do you anticipate that you will be in a position to review arrangements for handling risks to service delivery or the organisational effectiveness of NHS bodies in Wales? What do you anticipate that such work will consist of?

[201] **Mr H. Thomas:** May I say that, because you asked about a red button, first of all, this report is a red button? It was because of the concerns that we and HIW had, which we felt were not being adequately addressed, that this report appeared. We left a recommendation in the report that we ought to consider intervention protocols with the Welsh Government to make sure that other boards are not allowed to drift into this position. I am glad that the Minister has accepted that recommendation, and we will be meeting with Welsh Government officials in order to draw up protocols for the future. As I said, this report breaks some ground in terms of bringing a joint report on a health body to you, but it is important that lessons from this are picked up by other bodies. It is not the case that we should simply be saying, 'There but for the grace of God', but 'Look and see whether there are lessons that apply to other bodies, or at least consider that'. It is the same issue in terms of Mid Staffordshire NHS Foundation Trust. Are there things that we should be doing in order to prevent us drifting into

that situation? More particularly, we want to have a protocol in place so that it is clear, when we have concerns, how they shall be escalated and the extent to which we will make them public.

[202] **Aled Roberts:** O ran gwersi, mae diffygion o ran y bwrdd—mae'r rheini yn eithaf amlwg o'r adroddiad—ond un o'r cyrff eraill yn y gogledd sy'n ymwneud â chraffu ar waith y bwrdd iechyd yw'r cyngor iechyd cymunedol. A ydych wedi gwneud unrhyw waith ynglŷn â diffyg y corff hwnnw hefyd o ran yr holl broses hon, achos mae'r un feirniadaeth o'r corff hwnnw a'i rôl yn goruchwylio'r gwaith o ran y gwasanaeth iechyd y gogledd?

Aled Roberts: In terms of lessons, there are deficiencies with the board—those are quite evident from the report—but one of the other bodies in north Wales that is involved in scrutinising the health board's work is the community health council. Have you done any work on the failure of that body in terms of this whole process, because there is the same criticism of that organisation and of its role in overseeing the work in terms of the north Wales health service?

[203] **Mr H. Thomas:** Nid wyf wedi gwneud unrhyw waith ar y cynghorau iechyd ond, ar yr un pryd, rydym ni, ac yn enwedig HIW, yn siarad efo nhw yn ystod y flwyddyn, ac felly rydym yn tynnu rhan o'u gwybodaeth i mewn i'r farn rydym yn ei ffurfio am y bwrdd hwn.

Mr H. Thomas: I have not done any work on the CHCs but, at the same time, we, and especially HIW, talk with them throughout the year, and so we draw in some of their information into the opinion that we are forming of this board.

[204] **Ms Chamberlain:** We work quite closely with the CHCs, but the other thing that I would say is that Huw referred to us bringing together our concerns, and part of the way in which we bring together those concerns is through a process that we call 'summits', where we bring together those who have an oversight, scrutiny or regulatory interest in particular bodies. The CHCs were also part of that process. So, it was through a collective discussion of some of the issues that we had that we made the decision that we were going to escalate and take things forward on this joint basis.

[205] **Aled Roberts:** I think that the same criticisms regarding lack of challenge and lack of scrutiny could be levied at the community health council in the north as at the board of this particular organisation.

[206] **Ms Chamberlain:** That is certainly, in terms of our protocol for working with CHCs, is something that we are working through to strengthen at the moment.

[207] **Darren Millar:** May I ask about the intervention arrangements that you alluded to, Huw, and the possibility of drawing together a more formal process for Welsh Government intervention into boards, in the event that something similar might happen elsewhere in the future?

10.15 a.m.

[208] If this were a local education authority, I am pretty sure that responsibility for the management of education in that local authority area would have been completely withdrawn if these sorts of governance failings had been identified. If you look at the intervention by the Welsh Government in local education authorities across Wales or look at the intervention on Anglesey where the council was suspended completely because of the failures in its governance, why is there no speedy response to this in quite the same way from the Welsh Government? Have you had an explanation from the Welsh Government as to why it has not intervened, appointed commissioners or suspended the board completely while these problems are resolved?

[209] **Mr H. Thomas:** In local government, I have certain powers, particularly in carrying out inspections of local government to make statutory recommendations. The appointment of commissioners in Anglesey arose out of one of my statutory recommendations. In the same way, Estyn and the Care and Social Services Inspectorate Wales are actually able to highlight where they feel intervention should take place. We do not have such powers at present with the health boards, but I am hoping that, as a result of the protocol, that will be adopted.

[210] **Darren Millar:** Let us assume that you have those powers today. If we assume that those powers are available to you, would you be using them and recommending a statutory intervention in this particular health board with the suspension of the board and the appointment of commissioners?

[211] **Mr H. Thomas:** In a sense, what you have is the closest that we have been able to get to a statutory inspection. The—

[212] **Darren Millar:** That is not an answer. Would you be recommending the suspension of the board and the appointment of commissioners? Yes or no?

[213] **Mr H. Thomas:** If you press me, I think that I would say, under the current arrangements, I would certainly be recommending intervention by the Welsh Government. That is, in a sense, what is happening. Would it be that I would recommend that commissioners go in? I think that I would need to think very carefully about that recommendation. It is the nuclear option; it is the standing aside of a board. I would expect the Welsh Government and the board to be taking the report that we have jointly put to you, and into the public arena, seriously, now. I think that, in a sense, we have escalated concerns in such a way. I am not sure whether the appointment of commissioners is needed. What is certainly needed is a new direction for the board and a transformation of the leadership.

[214] **Darren Millar:** It is the same question to HIW. If you had these powers, what would you be recommending that the Welsh Government do?

[215] **Ms Chamberlain:** I think that part of the issue that we have is that we have discussed this quite closely before and I would probably reiterate what Huw has said. There is a point within our powers where we do have the powers to recommend something that is called ‘special measures’.

[216] **Darren Millar:** Right.

[217] **Ms Chamberlain:** One of the challenges that we have is that there are a number of ways of considering what special measures might be. Certainly, in some circumstances, special measures can be to do a significant report of this nature, making significant recommendations. In effect, you could argue that we have started to take steps in that way. Following on from that, there is routine monitoring, immediate monitoring, to consider whether the right actions are being taken at the right time in the right way. I think that it is important that there is some intervention from the Welsh Government to support the board in addressing the issues that we have highlighted to them. I would certainly have concerns about their capacity alone to be able to pick up and address with sufficient pace and urgency. I would certainly be recommending that the Welsh Government take steps to step in and assist.

[218] **Darren Millar:** Okay. Mike is next.

[219] **Mike Hedges:** I have two questions. Am I right that the Minister has the ability to remove all independent members at any one time? I know that the Welsh Office did in the past remove every independent member from one of the former trusts. How confident are you

that some or all of these problems do not exist in any of the other boards in Wales?

[220] **Mr H. Thomas:** On the first point, yes; having appointed a board, Ministers are able to suspend the board.

[221] **Mike Hedges:** 'Dismissal' was the word that I was using—they can remove them.

[222] **Mr H. Thomas:** Yes, 'dismiss them', if you wish. As to the problems that exist elsewhere, as I said earlier, I think that every board should read this report and consider whether there are things that they can do to make sure that they are not experiencing such problems. However, it is because of the unique and significant issues that we identified with Betsi Cadwaladr that we brought this report forward. We do not have another of the health boards or health bodies in our sights for such a report.

[223] **Darren Millar:** Okay. I have one final question, and then we will close this part of the meeting. This is the biggest public sector organisation in Wales—one of the biggest in Europe, in fact, in terms of its size. Is it too big? Is that part of the problem with this organisation?

[224] **Mr H. Thomas:** Cardiff and Vale University Local Health Board, in financial terms, is pretty close to the size of Betsi Cadwaladr LHB. Of course, it does not have the same geography. However, I would hesitate from recommending anything that is a further reorganisation. I do not think that the health service could take that. I think what is needed is to make the current organisation work, and work better.

[225] **Darren Millar:** Okay. Is there any view from HIW?

[226] **Ms Chamberlain:** The challenge that I would put back is that I do not recognise that size in and of itself should be a constraint on the ability of an organisation to operate effectively. What is important is that it puts arrangements in place that are fit for the purpose that it is trying to meet. That means having arrangements in place where accountability is clear and where it is addressing both the challenges of size and co-ordination.

[227] **Darren Millar:** Okay, thank you. On that note, we will close this item of business. We really appreciate your helping us to consider this matter.

10.21 a.m.

Papurau i'w Nodi
Papers to Note

[228] **Darren Millar:** We have the response from the Welsh Government to actions arising from the meeting on 6 June on 'A Picture of Public Services 2011', our work programme for the remainder of the summer term, and the minutes of the meeting on 25 June. I take it that those are noted.

Cynnig o dan Reol Sefydlog Rhif 17.42 i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod
Motion under Standing Order No. 17.42 to Resolve to Exclude the Public from the Remainder of the Meeting

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

the committee resolves to exclude the public from the remainder of the meeting in accordance

with Standing Order No. 17.42(vi).

[230] There are no objections.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10.21 a.m.
The public part of the meeting ended at 10.21 a.m.