Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 9 Gorffennaf 2013
Tuesday, 9 July 2013

Cynnwys
Contents

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

Dr Martin Duerden	Cyfarwyddwr Meddygol dros dro, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Acting Medical Director, Betsi Cadwaldr University Local Health Board
Angela Hopkins	Cyfarwyddwr Gwasanaethau Nyrsio, Bydwreigiaeth a Chleifion, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Director of Nursing,Midwifery and Patient Services, Betsi Cadwladr University Local Health Board
Geoff Lang	Prif Weithredwr dros dro, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Acting Chief Executive Betsi Cadwaladr University Local Health Board
Helen Simpson	Cyfarwyddwr Cyllid, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Director of Finance, Betsi Cadwaldr University Local Health Board
Dave Thomas	Swyddfa Archwilio Cymru Wales Audit Office
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
Gareth Price	Clerc Clerk

Dechreuodd y cyfarfod am 9.04 a.m.
The meeting began at 9.04 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 exits. I also remind Members that the National Assembly for Wales is a bilingual institution, and that people should feel free to contribute to the meeting in English or Welsh as they see fit. Headsets are available for translation and amplification for anyone that requires it. I request that people switch off their mobile phones, BlackBerrys and pagers because they can interfere with the broadcasting and other equipment. We have not received any apologies for absence.

9.05 a.m.

Trefniadau Llywodraethu Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr
Governance Arrangements at Betsi Cadwaladr University Local Health Board

[2] **Darren Millar:** We begin our inquiry on governance arrangements at Betsi Cadwaladr University Local Health Board, and we will be taking evidence from the health board itself. Julie, you wanted to say something here.

[3] **Julie Morgan:** I just wanted to put on record that my daughter was part of the Public Health Wales NHS team that investigated the C. difficile outbreak.

[4] **Darren Millar:** Thank you for that. Of course, that does not prevent Julie from participating in today's proceedings or our inquiry.

[5] Just to refresh our memories, a joint review undertaken by Healthcare Inspectorate Wales and the Wales Audit Office on governance arrangements at the Betsi Cadwaladr University Local Health Board was published on 27 June. The report found that the health board's current governance arrangements and procedures do not adequately address the gap between the ward and the board; that routine governance arrangements within the health board have not paid sufficient attention to infection control; that the effectiveness of the board has been significantly compromised by a breakdown in working relationships between some senior leaders in the organisation; and that the board collectively lacked the capacity and capability to provide appropriate levels of scrutiny in relation to service delivery. There are wider concerns in that report about the stability and capacity of the executive team as it moves forward.

[6] I am pleased to welcome to the table today to support our inquiry Geoff Lang, acting chief executive at Betsi Cadwaladr LHB; Dr Martin Duerden, acting medical officer at the health board; Angela Hopkins, director of nursing, midwifery and patient services; and Helen Simpson, director of finance. I am grateful for your attendance; I know that it was quite short notice to be able to organise today, so I am grateful for your being here.

[7] Mr Lang, you have been at the board since its inception. What went wrong?

[8] **Mr Lang:** There are a number of issues that are important for the committee to bear in mind in terms of the context of the health board. These include the size and scale of the board, in terms of bringing together eight organisations into one, and then creating a new structure with an agenda that was clearly designed to set about achieving service change, bringing together services across the whole of north Wales to serve its population, and, within that, challenging some quite fundamental historic patterns of loyalties, associations and

service delivery. That is a huge challenge for the board. So, contextually, it is a difficult environment.

[9] We should also be mindful of the financial scenario within which the board has been created, and the challenges that it has faced. They are quite unprecedented in terms of recent years, and that is one of the themes that runs through the report. You will find, as you have read the report and looked at the issues, that there are major interconnections between the challenges of balancing finance, service pressure, governance and safety. That has been a huge challenge for the board.

[10] In terms of some of the difficulties, I have operated in a number of boards, and the difference between being involved in a previous local health board and NHS trust, and being a member of a board of the size and breadth of Betsi Cadwaladr health board, is huge. The challenge for independent members and executive directors is a great one, particularly in terms of being connected from the board to the ward, as the report refers to. That is not as simple as perhaps it is in other organisations.

[11] So, the board needed to be clear in its direction. It needed to focus on priorities, and it needed to have the right systems in place. The report identifies some areas where that has not been the case, and some risks and key issues have emerged that are rightly being drawn to our attention. In other reports, strengths are set out in terms of what the board has achieved in some of its governance arrangements for audit, finance and workforce issues.

[12] So, there are positives, but there are clear challenges that reflect the scale and scope of the challenge in front of the board, the cultural and service change issues that it is facing, the financial environment and the complexity of the organisation.

[13] **Darren Millar:** Do you accept the findings of the report?

[14] **Mr Lang:** Yes.

[15] **Darren Millar:** Was there anything in the report that you did not already know?

[16] **Mr Lang:** There was nothing new in terms of content and issues. There are points of emphasis in the report where I might comment and portray things slightly differently in terms of the work that has been ongoing and the current status of where we are with some of those challenges. Hopefully, we might get the opportunity to share some of that with the committee this morning.

[17] However, when we sat down and discussed it as executive directors, we recognised a picture of a board that is challenged, a board that has to be clear about its priorities, that has to align and give strong leadership, and ensure that the governance throughout our organisation is fit for purpose. There are question marks in this report about elements of that governance, and we are firmly aware that those need to be attended to.

[18] A similar position and response pertained when the board met in full in confidential session on the day that the report was received. There was no sense of denial or trying to avoid the issues in the report. There was a clear sense of concern that the board had not made the progress it had set itself and which others expected. There was a clear resolve to attend to those matters in good time.

[19] **Darren Millar:** You referred to the size of the board. Do you think that the board is too big? There is not a recommendation in the report about this.

[20] **Mr Lang:** I do not necessarily think that it is too big. The board, given its size, needs

to be aware—and we need to have conversations with the organisations that we work with such as the WAO and HIW about this—of how a board of that size is governed, what is a reasonable expectation of independent members in the way that they work and engage in a board of that size and spread, and how we connect from board to staff. Those arrangements might be different in a very large, complex board such as ours than how they may have been in the past in smaller organisations. I do not pretend that we have got that right; there is more that we need to do. So, I do not necessarily think that the board is too big, but it presents different challenges and we need to address those.

[21] **Darren Millar:** You indicated that the findings of this report did not really come as a surprise to you. That is, of course, because many of the issues identified had been brought to the attention of the board in previous Wales Audit Office reports and by Healthcare Inspectorate Wales. Why were these not already being tackled by board members?

[22] **Mr Lang:** As you rightly say, a number of the issues had emerged through the structured review work that was presented to us last autumn by the Wales Audit Office, or through some of the work and the immediate feedback that we had with HIW in terms of its governance reports. Some significant immediate steps were taken in terms of those reports. Attention was paid to the way in which the board did its business and the structure and frequency of its meetings. There was immediate work to look at the balance between certain committees; for example, the overlap between finance and performance, and quality and safety, and to realign those. That happened earlier this year.

[23] The board was in the process of looking at structures, and has concluded a consultation on executive structure and clinical programme group structure, which is alluded to in the report and which is progressing. There are a number of other areas where the board has started to implement the changes. The report, in places, alludes to that, but does not fully take account of all those issues. That is understandable given the nature of the report. However, actions were taken that have changed the way in which we work, and there is undoubtedly more in the report that we need to do.

[24] **Darren Millar:** In terms of the Welsh Government's role in supporting change in the board, what was it doing when these problems were identified last year?

[25] **Mr Lang:** We have a regular dialogue with Welsh Government in terms of the performance of the report. That occurs at chief executive level, chair level and at individual professional level, so my finance director colleague would have a close relationship with the finance officer, and discussions have been ongoing and the challenges have been recognised. I am aware that there were ongoing conversations between the chair and chief executive and the director general and the Minister. I was not party to those, so I cannot share their detail.

[26] So, there was an ongoing dialogue about what needed to be done. Some of the initiatives were on reviewing the structure, focusing on planning for the year ahead and getting a more structured approach to what we were doing, as a part of that conversation. Those conversations have continued since the publication of the report, in terms of how we work with Welsh Government and how Welsh Government can support us to deliver what we need to do—putting right some of the issues in this report and putting the board on a firmer footing.

[27] **Darren Millar:** How would you describe relationships within the board between executives and other board members?

9.15 a.m.

[28] **Mr Lang:** There are different levels. At an individual level, there are some strong

relationships between executives and lead independent members in terms of certain functions within the board. There is positive working at a committee level within the board. When you get to the overall board level, there are tensions, and, from my perspective, those tensions are more born of frustration regarding the delivery of the board and having clear plans as to how we address our financial problems, service challenges and governance issues that the whole board is signed up to and aligned with. There have been difficulties in getting to that point. That is work in progress and there is no doubt that, when things are not going well, there will be tensions, and there have been tensions in our board.

[29] **Darren Millar:** Do the board members have the right skill sets and the knowledge to be able to hold the executive team to account?

[30] **Mr Lang:** We have a broad range of skill sets in our board. We have people with very good knowledge of clinical services. We have people who have had executive and non-executive director roles previously and experience. We have people who are well connected to their community and the third sector. So, I think that we have a broad range of skills. Independent members do challenge executives and hold them to account. There is a strong skill base there on which to build. As with all boards, whether it be executive or independent members, at some time a refresh is helpful and beneficial, and I am sure that the changes that are taking place at the moment will have an impact on the board and will allow an opportunity for a fresh focus.

[31] **Darren Millar:** A number of Members want to come in now, so I will bring in Mike, Aled and then Sandy.

[32] **Mike Hedges:** You talked about having discussions with senior staff and civil servants of Welsh Government, from Cardiff, I assume. How often would the head of health visit to have these face-to-face discussions with the chief executive? How many times in the last 12 months up to April 2013 would Mr Sissling have made his way up there to talk? How often would the finance director from the civil service have gone up to north Wales to engage in face-to-face discussions in that 12 months up to April 2013?

[33] **Mr Lang:** I cannot give you a precise number. There are very regular meetings. There are monthly meetings where we engage regularly. The chief executive has regular phone calls and dialogue. Mr Sissling has visited on a number of occasions in the last 12 months to talk with clinicians and to talk with the executive directors. Helen may be able to comment on finance. I cannot give you a number, but I can check that and respond to you in detail.

[34] **Mike Hedges:** That would be helpful.

[35] **Ms Simpson:** I can confirm that Martin Sollis, not too long after his appointment to his position in the Welsh Government as director of finance, came up with one of his senior team to meet not just me, but my senior team, and he spent the day with us in Wrexham. Also, Martin Sollis has been in regular contact with me; during the last quarter of the financial year into this year, we had almost weekly conversations on the phone.

[36] **Mike Hedges:** Would it be possible for you to also provide a note on how many times he has visited you in north Wales?

[37] **Ms Simpson:** He has been with me once, but he has been appointed only recently and he came up as soon as he could after he was appointed.

[38] **Mike Hedges:** What about his predecessor?

[39] **Ms Simpson:** Yes, Chris Hurst was the first director of finance shortly after I was appointed. He came up to north Wales a number of times. I cannot remember the specific number of times, but I am happy to provide that detail to the committee.

[40] **Aled Roberts:** Rwy'n derbyn nad oeddech chi'n bresennol yn ystod y cyfarfodydd rhwng swyddogion y Llywodraeth, y prif weithredwr a'r cadeirydd, ond, er mwyn y cofnodion, ers pryd rydych chi'n brif weithredwr gweithredol ac ar sawl achlysur ydych chi wedi cyfarfod â swyddogion y Llywodraeth?

Aled Roberts: I accept that you were not present in the meetings between the Government officials, the chief executive and the chair, but, for the record, since you became acting chief executive, on how many occasions have you met Government officials?

[41] **Mr Lang:** In this period of acting chief executive, I have had numerous phone calls. I am trying to think of how many face-to-face meetings I have had. I think that I have had three face-to-face meetings with David Sissling, but I would need to check that. Some of those were specifically arranged for this purpose. Immediately, when I became acting chief executive, David Sissling visited the health board the next week to talk in detail with me and the chairman about the issues and challenges that faced us. I have very regular, almost daily, dialogue with David Sissling about the issues and challenges and the responses of the health board to dealing with these issues.

[42] **Darren Millar:** You alluded earlier to meetings between the previous chief executive and Mr Sissling, but you seem to suggest that feedback did not always come back to—

[43] **Mr Lang:** Sorry, Chairman, I did not mean to imply that feedback did not come back. The reason that I am aware of the dialogue is that Mary Burrows used to regularly report to executive directors the key messages that were coming back from those meetings. What I was not party to was the actual dialogue and the detail of it.

[44] **Darren Millar:** Fair enough. Thank you for the clarification. Sandy is next.

[45] **Sandy Mewies:** Good morning. One of the issues raised in the report was training for members. However, it seems to me that—well, perhaps you can tell us whether there was real clarity among the independent and executive members on their roles and how they related to each other. In particular, was there any joint training or any sort of programme for them to work together to understand where they sat in meetings, what their purpose was, and how they should join together to scrutinise?

[46] **Mr Lang:** At the time that the health board was created, there was a very structured programme for independent members. That ran across Wales and that briefed independent members about the role of their board, their unique contribution and their expectation of executive directors. As a health board, we had some development time early on in the establishment of the board, where we discussed our joint responsibilities and how we needed to work together as a board. In terms of the depth of that and the continuity of that to build a cohesive board, I would have to say that there was not a great deal of further work in that regard. One of the issues, about the board's focus and cohesion, would no doubt be aided by such a programme. That is something that we have initiated as a result of the concerns in the autumn. We started with independent member training and knowledge-base building, and we are just at the beginning of implementing a board development programme, which will be a structured programme that will be externally facilitated and will concentrate on precisely those issues: the collective challenge of the board, the individual responsibilities, the challenge between, and the need for alignment in terms of joint purpose. That is a programme that we are about to go through as a board.

[47] **Darren Millar:** Is that happening in other boards, do you know?

[48] **Mr Lang:** That is something that we have commissioned as a result of the structured assessment report in the autumn as a bespoke piece of work for Betsi Cadwaladr.

[49] **Darren Millar:** So, it is not happening in other boards, as far as you aware.

[50] **Mr Lang:** Not to my knowledge, Chairman. It may well be, but that particular work is local to us.

[51] **Darren Millar:** Okay. Oscar is next.

[52] **Mohammad Asghar:** Thank you very much, Chair. My question is for Mr Lang. Why is it that executive directors are failing to work cohesively as a team, and what steps are being taken to create more stability and collegiate working in that top team?

[53] **Mr Lang:** The report draws attention to instances where the board, particularly independent members, have been concerned that the executive has not perhaps presented a wholly cohesive view. There have been instances and difficulties and tensions in that way and, in one regard, having executive directors who are prepared to disagree with each other and present their own perspectives on issues is a key strength. That can become detrimental if it becomes too divisive, and the board does need a corporate sense of direction from the executive.

[54] In terms of the current executive group, we are quite clear about our role and that our role is a collective one. There have been difficulties in the past 12 to 18 months and my perspective on that is that it is very much as a result of the pressure that the board has been under and the pressure to deliver on a range of fronts. Depending on the individual roles, perspectives and the professional duties of those executive directors, then different perspectives have been presented. So, the balance of quality and safety, access and finance are real challenges. When a board is struggling to balance its books—we know that that is a huge priority and we must deliver on it—and is also faced with increasing patient demand and quality and safety issues, that brings tensions into the executive team. Those tensions are healthy. What we have not been able to do consistently—although we have done it on many occasions—is to present a very united picture to the board and a clear direction. In some instances, we have not been able to get to that point. That has led to difficulty. The way forward on that is for us to be very clear about our three-year plans, about finances and service, and invest in that joint sense of direction, because the absence of that picture of where we are heading to and the journey has caused, I believe, the focus to be at times on the short-term issues and the short-term positions, which people have a professional duty to report and bring to the attention of the board. If you are an independent member looking at that, you could view that as a division that is not helpful or healthy in directing the board forward. However, it really reflects the difficult choices that the board has to make.

[55] **Mohammad Asghar:** Any one of you can answer my next question. Why were the board papers on key business issues circulated late or on the day? Was this just administrative incompetence, or was it a more deliberate attempt to manage the board's agenda and avoid scrutiny?

[56] **Mr Lang:** Perhaps I could make a comment, and then Helen may want to comment on the budget example that is given, and Martin may want to comment on the recruitment of medical posts. If you look at our board papers, the volume of business that we do, and the preparation of the papers, they are, by and large, very thorough and sent out in advance in accordance with the timescales. There were one or two examples of papers on important issues—I do not underestimate the importance of those issues—where that was not the case. I

do not believe that it was incompetence, and I do not believe that it was meant to mislead or to manoeuvre the board in any way. It was a reflection of, in finance, a planned approach, and, in terms of medical posts, an urgent pressure that we were managing in a very short time and very dynamically leading up to a board meeting.

[57] So, I do not think that it was either of the assertions in terms of being misleading or incompetence—it was a reflection of the issues that we were dealing with. However, I acknowledge that it is not good practice, and that it puts the board members in a difficult position. I will ask Helen to give the context on the budget paper, because that was a planned process.

[58] **Ms Simpson:** Absolutely. The budget paper had been through detailed discussion and scrutiny, not just by the executive team, but also by the finance and performance committee and the quality and safety committee, which had come together at key points during the financial year. I totally support what Geoff said: it was about a willingness to get everyone joined up before that paper was presented, rather than present something where the i's had not been dotted and the t's had not been crossed.

[59] A good example of that was on the medical workforce issues. It is well known that medical recruitment in parts of north Wales is a significant challenge for us. It has presented a significant financial pressure for us, because we have had to rely on locum and agency senior medical staff to ensure that we can deliver our services locally and to the standard that we want to provide. Again, those issues were challenging for us, and Martin and I worked closely together to make sure that those papers were owned before they went to the board.

[60] **Dr Duerden:** The issue about the recruitment of medical staff really came out of discussions that we had with the deanery. Although we were aware that the deanery wished to change the training configuration and, quite rightly, wanted us to provide the right training environment for trainees coming in and to make it attractive for trainees in Wales, the deanery set a timescale fairly suddenly, which made it very difficult for us to see how we could meet our medical workforce requirements come August and September, when the training allocations change.

[61] The paper that we took in April was to advise the board of that and really just to seek its approval to consider going out for further recruitment, in the eventuality that that particular set of circumstances created by the deanery would play out by August and September. As things worked out—and we thought that this could happen—further discussion with the deanery about our acute services reviews and how we did not want the training placements to drive service configuration, allowed the deanery to relent on the process. So, we did not have to go out for as many doctors as we thought that we might in terms of recruitment, but it was, in effect, a crisis at that point in time. We knew that we needed to start the recruitment process for August and September, and April and May were crucial times to enable that process.

9.30 a.m.

[62] The other thing that I must say is that the recruitment that we have needed to do—and we have needed to place around 30 middle grade doctors and three consultants—has been highly successful. So, despite some of the misgivings about whether it was possible to achieve those placements, we have been quite successful in the process.

[63] **Mohammad Asghar:** Thank you very much, Mr Lang, for teaching me some new words: 'healthy tension'. With regard to the role of board secretary managing the papers for the board's meetings, should that person, in liaising with the Chair, have put ground rules in place that would prevent late or on-the-day submission of the papers?

[64] **Mr Lang:** There are clear rules in our standing orders about the normal issuing of papers—seven days before a meeting takes place—and, as I say, that is, by and large, the pattern that is followed and adhered to in terms of the way we work. There are no specific references to late papers, and discussions that we have had with the chairman and the board secretary since the issues that you refer to have arisen were that we may well need to amend our standing orders to be very clear about the chair's jurisdiction in terms of determining whether a paper has been submitted sufficiently in advance, and with sufficient detail, to allow the board to come to a fair consideration of the matters. I think that that is something that we should formally amend within our standing orders and procedures so that it is very clear in future reference what the process is and what the chair's role is in determining that. Having said that, they should be very, very rare occurrences.

[65] **Darren Millar:** A number of Members want to come in here, so I ask people to be brief.

[66] **Jocelyn Davies:** Mr Lang, you have given evidence to the committee before and I have always been very impressed with your evidence. However, I have to say that, today, I think that you are underplaying incredibly the seriousness and the reality of this situation. To amend your standing orders is not the conclusion that I would have come to after reading that report. There is mention of some instances of difficulties, challenges and tension—it appears to me that it was completely dysfunctional, and you do not seem to be acknowledging that. Are you now prepared to face the reality of the seriousness of the situation that you are in?

[67] **Mr Lang:** If I have given the impression that I do not see this as a particularly grave report, in terms of the way in which the organisation is operating and fulfilling its duties, then I apologise for that; that is not my intention—

[68] **Jocelyn Davies:** I would not describe it as 'not particularly great'; I would say that this is a damning indictment.

[69] **Mr Lang:** 'Grave' not 'great'. I said grave report.

[70] **Jocelyn Davies:** Sorry. It is a grave report

[71] **Mr Lang:** There are grave issues in this report. They need to be attended to. I am very clear that, in terms of the governance arrangements and some of the changes that are required, that demands urgent action and very focused action for the board and its functioning and our relationships. That needs to be improved. Some of the quality and safety issues require very urgent attention. We have started work on some of those issues, and Angela, no doubt, will touch on that later in evidence to the committee. If I have given the impression that I do not believe that these are grave matters, then I apologise.

[72] **Jocelyn Davies:** It is the language that you are using. I was writing it down—'one or two instances', 'in some instances', 'difficulties', 'challenges', 'tensions'. To us, reading the report, it seemed completely dysfunctional, but you do not seem to be acknowledging that in the way you are answering us this morning—so far.

[73] **Jenny Rathbone:** I just want to probe a little further on this. You said that there were robust discussions in the board, which is always important, to ensure that you get to the right decision. However, would it be right to say that the board was not great at arriving at a decision and then uniting behind that decision? Did people continue to play out the fight after a decision, in principle, had been reached by the board?

[74] **Mr Lang:** I think that we have had examples where the tensions behind, for example,

how we would finance and make savings to deal with certain issues, are ongoing pressures for the board, in terms of making a decision that we need to attend to a safety issue. The implication of that is that we have to work very hard to save resources in other areas to do it, which is a very clear responsibility. That means that those pressures carry on beyond the meeting. In terms of aligning to deliver things, I would not say that the board has been comprehensively aligned on those matters; there have been issues that have remained as concerns for independent members and some executive directors because of that balance, and that has been a difficulty for the board. When those concerns continue, the sorts of messages about the tensions, which have been picked up in conversation with colleagues in the Wales Audit Office, become exacerbated. So, we have had examples where decisions have been taken that not everybody was comfortable with, and because of the ongoing ramifications of those decisions, some aspects have been returned to and have caused ongoing tension.

[75] **Jenny Rathbone:** So, that sense of corporate responsibility has never really been established.

[76] **Mr Lang:** I would not say that. I think that there are clear examples of difficult decisions being taken by the board. I will use the example of some of the service review decisions, where there were some varied views among the board about how we might progress with that. There were very difficult public issues in terms of pressure and response, and the board took a united stand in coming to a consensus about what should be done, sticking with that and moving forward. So, I think that we have some clear examples of the board being cohesive in quite difficult circumstances. However, there are other issues where tensions have remained.

[77] **Julie Morgan:** I am concerned about the issue you raised about the relationship with the deanery and the fact that the proposal for 72 new clinicians was only tabled on the day of the meeting. Could you explain how it happened that you suddenly had to put a paper in for 72 clinicians? You might have successfully recruited 30 since that, but it does indicate confusion and a lack of communication.

[78] **Dr Duerden:** With hindsight, I think that that was the wrong way to do it. The paper was quite explicit. It said, 'This is the worst case scenario. If we do not have change in terms of the current training allocation, we will need that number of clinicians to meet the shortfall. Therefore, we are in a pickle and we need to do something about it. We need to start making plans in case that worst-case scenario pans out.' That is how the paper was phrased: that this might happen and that we needed to start thinking about what we do about it. If we did not do anything at that point, in a few months' time, we would be very short of staff. What would then happen is that you would have a service configuration created out of emergency and we did not want to be in that position.

[79] Subsequently, what has happened is that we have established quite a healthy, useful and informative dialogue with the deanery and there have been discussions about how we can have a phased process to enable that type of training environment. I totally agree with the deanery that we have to have a training set of circumstances that is highly attractive to people we bring into north Wales, so that they wish to remain. One of the difficulties that we have is in making ourselves attractive; we have to have a better environment and a better set of training than what is provided in England.

[80] **Julie Morgan:** So, what is the position now, if you have recruited 30?

[81] **Dr Duerden:** We have managed, effectively, to delay those standards in terms of training. To say 'delay those standards' is probably the wrong expression, but we have managed to delay the change that has been required to achieve that type of training environment for a year, and that enables us to play through our acute services review. So,

specifically around paediatrics, obstetrics and gynaecology, the requirement to have that training in place and set up in that way from August and September has now been delayed for a year. That allows us to work through our acute services review. That review will need to be set up in a way that allows us to provide the services that we wish to provide, and it enables us to provide a very good and secure training environment.

[82] **Darren Millar:** I am keen to pick up the pace of our session now. So, Aled is next and then we will come on to Sandy.

[83] **Aled Roberts:** I want to pick up on this lack of communication and workforce planning. I was present at a meeting about 12 months ago in Rhyl, where we were discussing the neonatal review. A consultant stood up and challenged one of the executives that the removal of level 3 provision would mean that junior doctors were not trained in north Wales. That executive said that he was unaware of the situation and would check it. Discussions had been ongoing with the deanery for months at that stage, so either that executive was unaware of other people who had been down there, or there was a lack of transparency with regard to the situation. It is also the case that, when the board has been challenged with regard to its recruitment policies, in some instances, it has not been about a failure to recruit, but a failure to advertise.

[84] **Dr Duerden:** I have heard those types of descriptions. My view is that that is not the case. I think that there is an active dialogue with the deanery on how we provide for these trading posts. It is not set in stone. The issue around neonates is just one component of this.

[85] One of the issues related to that is that the acute services review is the thing that enables us, if you like, to maintain a paediatric training environment, and, therefore, as part of the acute services review, we have to look very closely at what will be required to ensure that we meet training needs. It is a slight paradox, because healthcare training in north Wales was set up around community services and our service configuration at that time, and part of the concern about that was the issue of intensive care in neonatal care, which itself has set up a Royal College of Paediatrics and Child Health review, which is delaying the process of acute services.

[86] **Aled Roberts:** I am not on about the review; I am on about the fact that an executive was either unaware of it or was unwilling to disclose it at a public meeting, and that surely affects the confidence that members of the public have in that executive body.

[87] **Dr Duerden:** I find that very difficult to accept. I was not at that meeting, but I am sure that there was no deliberate act of failure of transparency.

[88] **Darren Millar:** You have made your point now, Aled. Sandy is next, then Jenny.

[89] **Sandy Mewies:** There were 11 clinical programme groups at the end of 2012. Enough concerns have surfaced—for a variety of reasons and shortcomings—that that should be reduced. Then there were two short reviews, and a proposal was put to the chief executive to reduce the number to six. That went before the board, but the chief executive then took a proposal for an additional one, making 12, to the board, which refused to consider that, because it did not think that it was part of the remit that it had been sent. Can you tell me the reasons given for that?

[90] On the same theme, there seems to be general consensus on the fact that the health board's organisational structure is not functioning properly everywhere. Are you clear that just changing your CPG-based model will produce the right results, or should there be a more fundamental review? If you go ahead with the CPG plan, how confident are you that the six groups will work, and what are the timescales for taking that preferred model forward?

[91] Lastly, how do you plan to review and evaluate the effectiveness of the new model, whatever that settles into?

[92] **Mr Lang:** In terms of the review itself, as you say, there was a short review. A small task group, chaired by the vice-chair, gave recommendations to the chief executive. The chief executive was part of that group. The chief executive then consulted on a proposed amendment to the structure, which would see the number of CPGs move from 11 to six, and, importantly within that, to bring about the separation of community services and primary care from hospital services, to give a higher profile to those within the board.

[93] The feedback from the consultation, which was undertaken with all staff across the organisation, was mixed. There were some strong points, particularly around the emphasis on things like hospital site management and bringing in a local management presence that would provide more cohesion at the hospital level, but there were mixed views on the number of clinical programme groups, and on the wisdom of reorganising that aspect at a time when we were under great pressure for other service issues, and all of that was fed back to the chief executive as part of that process.

[94] The paper that you referred to that outlined 12 CPGs effectively proposed to implement the separation of community and primary care, to give it more profile and more focus within the organisation, but not to change the other 11. As you rightly say, that did not progress to discussion with the board, as it did not meet the board's requirements for sustainability and deliverability and therefore it was reworked. The proposal for six is what the board adopted in May and that is the direction of travel that we are now working to. The reasons for the 12 reflect some of the feedback in the consultation.

9.45 a.m.

[95] In terms of the functioning and connection of CPGs and whether that will be effective in the new structure, there are two elements to the new structure that are hugely beneficial in terms of giving a greater sense of coherence and alignment within the structure. The first is the changes to the executive director structure with the implementation of a chief operating officer. That will mean a single focal point of accountability and delivery for clinical programme group services, which, hitherto, has not been the case—it has been with a number of executives and there have been observations that that, perhaps, has meant inconsistency and has not given the strength and clarity of accountability that was required. So, I think that that is a positive move.

[96] The other aspect in terms of the structure, which is very positive and has been very well received, is a move to establish stronger site management. In terms of the dealings between clinical programme groups—because, regardless of what organisational structure you go for, there are always overlaps and boundaries to navigate—the role of the hospital site manager is seen as quite important in ensuring functionality of hospital services and delivering the day-to-day needs of patients. So, the ability to act with authority and influence, to bring CPGs together to tackle issues, will be there in that structure.

[97] So, it is about having the chief operating officer element, the focal point and the single line of accountability together with a stronger site management support and a reduced number of CPGs. The importance of having a reduced number of CPGs, from my perspective, is that it allows us to spread our management resource and our supporting systems—whether they be systems of governance or systems of management, such as nurse management—in a more even way across the organisation. It also allows us to be clearer about the requirements and about holding people to account on a common set of big issues that need to be dealt with. This relates very well, I think, to some of the concerns about quality and safety. There are real

indicators of quality and safety in the board, and with a smaller number of organisational entities, with a greater consistency, I think we have the potential for stronger accountability.

[98] **Sandy Mewies:** Have you planned your evaluation, your monitoring and your evaluation? Is that in place?

[99] **Mr Lang:** We have not set that out in detail as we have not begun to implement that process yet. I think that that will link in to a lot of the issues in the report, in terms of what the priorities are, what the things that the board needs assurance on are, and what the delivery that will define success for the health board is. For me, those will be some of the parameters, linked with a very strong connection with our staff and their feedback, because we know from the staff survey that there are major issues there. So, we need to connect and make sure that the contribution of staff is positive and that they feel that the structure is delivering for them as well as for patients.

[100] **Darren Millar:** Did you set out what success looked like before you tinkered around with the clinical programme groups? You talk about staff as well. May I draw your attention to a letter that has been received by the committee from the Gwynedd consultants and specialists committee? The letter outlines its lack of confidence in the board and the executive to manage with appropriate speed the changes necessary to sustain good healthcare in north Wales. It also notes that the consultant body does not believe that the current internal structures of the health board, that is the clinical programme groups, are fit for purpose, and says that there needs to be a fundamental shift on the emphasis to locality-based management with locality-based clinical input. The committee clearly does not have confidence that the current structures are fit for purpose or are going to improve patient care. In fact, it is worried about the patient care, is it not? So, if you are not able to take the consultants with you, who is going to be with you in terms of being able to give support to these structures that you say are going to deliver change, but you have not defined what that change is as yet?

[101] **Mr Lang:** There are a few things in terms of the change: the change is what is set out in our three-year plan for clinical services, which is to change the way that services are delivered across north Wales, change to address the balance of hospital care and primary and community care, and a change in terms of looking at the acute services review issues, which we no doubt will come on to. Those are the long-term goals and aims, and any structure must be able to deliver that effectively. The issues that I was pointing to in terms of accountability and delivery will be the steps along the journey. That is how we will assess. The consultants who were present at the meeting have expressed a view. I met with those consultants on Tuesday to talk about the report in great detail. They do have concerns. They have concerns about the connection with the clinical programme group structure, and the connection in terms of their influence in their hospital, as they see it, and how it works. Some of the elements within our proposals will attend to that. I think that site management will support that and a greater profile for our hospital management teams will support that.

[102] One could always look at a different approach in terms of structure. The important thing about the clinical programme group structure is not that they are clinical programme groups; it is that they span north Wales to deliver the strategic agenda that is referred to in the governance report. The transformation of services across north Wales to be safe and sustainable has to be looked at on a platform that is broader than individual hospitals and communities, and we have to build confidence that those two bits can work together. That is a challenge. There is no doubt that there is concern, but I believe that both things can work together. If we put in a local site-based model, we then have the challenge of how we deliver strategic change across north Wales. So, it is about how we balance those two things. We need to work very closely with our consultants to build assurance that that can happen.

[103] **Darren Millar:** However, you have got these hospital site managers in place—I

know that we have some questions that we want to come to on that—and they are still unhappy, are they not? So, how are they going to be confident that they are going to be able to deliver high-quality, safe care that patients can have confidence in and that they can have satisfaction in delivering under the current structures? They are clearly not feeling that they are able to do that at the moment and, from what you are saying, it seems that there is going to be little change in the structure to be able to deliver anything that is going to give them more confidence in the future.

[104] **Mr Lang:** I think that the key issues are the way that people operate within the structure and the relationships within that, and those can improve. The site management is not referenced there. When I talked to them on Tuesday, they were extremely positive about site management. They saw that as having real potential to bring people closer together and to deliver more effectively at hospital level. We have only just started on that journey—there is more to do with that, and I think that that has a great part to play.

[105] **Darren Millar:** We will come on to that in a second. Sandy, you wanted to come back, and then we will come to Jenny.

[106] **Sandy Mewies:** I just wanted to get clarification, really. Are they saying that six groups are not enough or too many, or that they are not the right sort? What are they criticising? Is it the old structure or the one that is proposed? Given that there have been some concerns raised across the board about communication—and you have had one meeting, you said, with the consultants—is that going to be part of a continuing and transparent dialogue?

[107] **Mr Lang:** There are two elements to this. On the part that they are not particularly content with, I think that the real concern of the consultants whom I met—and Martin was with me in that meeting in Bangor—was that they do not feel, at the moment, that they have the influence that, as clinical leaders in their own right, they should have on the way that services are developed, and they would prefer to see a return to a local model, which is, essentially, a geographically based model of management within the health board. In terms of the dialogue, that is a dialogue that takes place regularly in terms of the medical director and chief executive attending senior medical staff committees across the board. That will continue, and, as part of our response to this document, we will be very much connecting the messages in here about the board and the executive, and their connection to the organisation, with the staff survey and having far more communication face to face with staff on the issues and the challenges that they see, as well as the more formal written communications.

[108] **Jenny Rathbone:** Just before we move on to hospital site managers, the key for me is that hospitals are always able to get their views known, but 90% of all consultations take place in the community. In this squabble about the size or the framework for the CPGs, have you managed to strengthen the voice of the community services? Hospitals will always suck in all the resources that are going, leaving the poor relation struggling to provide a service to the vast majority of the population.

[109] **Mr Lang:** There are two points, I think, to that, which are quite important. One is this: the clinical programme structure, as it is designed, is intended to embrace everything from primary care right through to specialist services in their clinical programmes. So, of itself, it seeks to address some of that balance between hospital and primary care. There has been a view and concern within the board that core primary and community services have not got enough of a profile and, therefore, the proposal is to take them out of a clinical programme group that, traditionally, has included acute medicine and to put them in their own group to give them more profile, more scope and more visibility, if you like, within the health board to make sure that we maximise their contribution.

[110] **Jenny Rathbone:** That still would not stop all the money going into the hospitals.

Angela, what is your view on whether community services are going to get an adequate voice in all this?

[111] **Ms Hopkins:** The challenge across Wales is to get the voice in the community services. We have heard mention before about the locality areas as well, and I think that we do have to have a focus, because we are very clear in our direction of travel for Wales, and that, in setting the direction, we want to take care closer to home.

[112] As Geoff alluded to during the morning, it is always a challenge and a tension, but, realistically, that has to be a key focus for us going forward. I can only bring the benefit of five weeks' view, as I have only just arrived in the organisation, but I would say that I have seen a commitment within the board for that direction of travel to be a key focus going forward.

[113] **Jenny Rathbone:** Okay. All power to your elbow.

[114] Moving back to hospital site managers, Mr Lang, do you think that you could just describe to us how the proposal for new hospital site managers was put forward, and why, given the propensity to declare the UDI of certain hospitals, there was no job description making it absolutely clear exactly what their responsibilities were?

[115] **Mr Lang:** Why did we implement site managers? There are a number of reasons. One was that our experience through the winter, and what staff were telling us, was that there was a lack of cohesion in clinical programme groups working together to deliver day-to-day services and care to patients. So, there was a real need to put in a focal point that would focus on flow in the hospital and making sure that patients got the right service in the right place. We have touched on clinical engagement and the degree to which consultants and other clinical staff on the ground felt that they had a point of contact and somebody who was actually interested in managing the hospital that they worked in, and in helping them to deliver what they wanted to achieve, and cracking some practical problems.

[116] There were also some issues in relation to our working with social services and having a clear point of contact between hospital activity and social services, and our local authority colleagues—that is, a single point of contact that could deal with difficult issues around delays in discharges and things of that nature. There was also a clear desire to strengthen the identity and influence of our hospital management teams, which draw together clinicians and managers on site. Those were the issues that we were dealing with, and that is why we took an interim step to put in place hospital site managers to attend to those issues. They have been very well received on those sites. There are already some signs of improvement in the way that services are delivering for patients. Communication is improved, and feedback from consultants and other colleagues is very positive. We did not go through the process of writing a detailed job description and then going through all the HR processes in terms of banding et cetera, because we wanted to move quickly. You will know the difficulties we had in the winter, along with the rest of the NHS. We needed to get ourselves to a better place, so we identified people who had credibility and experience, and who knew the site and knew the clinicians they were going to work with, to go in on an interim basis and establish those roles. We are now in the process of formalising them.

[117] **Jenny Rathbone:** Fine. I have no difficulty with you appointing people on an interim basis without going out to open competition, but I am still struggling with why you never had a clear job description, given the problems you had with clinicians who are having difficulty working under the Betsi Cadwaladr corporate governance. The auditor general told us that, when signing off the budget for the previous year, clinicians would be minded to say, 'I'll go along with this, so long as I have x, y and z'. Surely, it was absolutely crucial that everybody in the hospital knew exactly what the remit of these hospital site managers was. We still do

not know, but did they have a remit for clinical governance, or administration and relations with social services et cetera?

[118] **Mr Lang:** I acknowledge that having a job description would have been helpful in terms of communicating to people the precise, detailed parameters of the role. The parameters were those that I described, and the implementation of site managers was communicated to people, and the site managers then went out to establish that communication and to tackle those specific issues. That was their focus. It was not all-embracing and comprehensive; it was very clear that there were a number of issues that we needed to attend to, safe in the knowledge that if that role proved to be beneficial—and I believe that it is and that it has been very well received—they would then formalise it in the light of that experience and in understanding the issue, which is tangible and real, that, until those people are on the site and start to deal with the issues and understand the concerns coming back, the breadth of the role is quite difficult to define.

10.00 a.m.

[119] We now know more about what site management requires in our board, given that we have clinical programme groups and other structures, than we did before. We have attended to, and focused on, some key issues. We have learnt in that period, now that we are two and half months in, and we will reflect that learning in defining a substantive job description. However, it has been a beneficial measure and it was the right thing to do, and we will consolidate that fully, in terms of the roles as they move forward.

[120] **Jenny Rathbone:** Do those roles include clinical protocols?

[121] **Mr Lang:** They include, for example, co-ordinating clinical site management. So, the clinical site managers who liaise between emergency departments and the wards and discharge to make sure that things are working when emergency departments are under pressure, escalating to get other specialties involved to attend to some of those problems, are central to that working. They are central to the effective functioning of the hospitals.

[122] **Jenny Rathbone:** You have three hospitals, and one has heard that they are not all operating under the same clinical protocols, necessarily. Would that be the job of the hospital site managers to ensure that everybody was singing from the same hymn sheet?

[123] **Mr Lang:** In elements within their remit, yes. They are already collaborating across the three sites. The three managers are working together and are developing single solutions that can be applied across the health board. So, they would be doing that, but they would not have oversight of all the clinical protocols. A lot of that would sit under governance and with Angela's portfolio or within individual clinical programme groups, if it is speciality specific. The areas that stitch the hospital together and the common protocols and pathways that everybody needs to adhere to, to make the hospital efficient and effective, is the territory for those hospital managers, and they would have influence in changing that.

[124] **Jenny Rathbone:** With the benefit of hindsight, do you think that it would have been better to write a job description for these three individuals?

[125] **Mr Lang:** It may have helped to give a little bit more clarity. I do not think that it would have changed the impact or what they had focused on in their first couple of months.

[126] **Jenny Rathbone:** There was no uniformity, with each hospital site manager operating according to a grand plan.

[127] **Mr Lang:** No, but I think that we have to remember that, in the short term, we were

trying to intervene to improve rapidly some issues of performance. We know—and, if you look around Wales, you will find the same—that every hospital is different. There are elements of uniformity, but there are quirks. For example, Bangor is a different place to Wrexham; it functions differently and the clinical relationships are different, and the site manager has to engage with that. So, finding the elements of commonality is important and finding the standards that should be applied across the board is important, but starting with that and going out with it, I suggest, is not always the best solution, because we need to understand exactly what the consultants in Bangor have said. We know our place best and we know how to make it work, and the manager is about dovetailing with that and making sure that the standards are common but that there is flexibility locally.

[128] **Darren Millar:** I am conscious of the time. I will extend this oral evidence session because I think that it is important that we get to the other issues that we want to address in the report. I will bring Jocelyn Davies in next. I remind Members and witnesses to be brief in their questions and answers. I think that one question is important as a supplementary to Jenny's though, and that is whether it is a common feature of the appointments process that you appoint people to interim posts without full job descriptions, or is this the first time that it has been done?

[129] **Mr Lang:** I could not say that it is the first time, but it is not routine practice. This was an expedient to attend to service issues. So, it is not routine practice.

[130] **Jocelyn Davies:** In terms of the interim medical director's post, do you think that being an interim medical director meant that you were not able to drive forward the changes needed to transform the services across north Wales that Mr Lang spoke of earlier?

[131] **Dr Duerden:** I do not think that that is the case. It has been a difficult task to take over as an interim or acting medical director. In particular, the medical director went off on sick leave and one of our assistant medical directors was off on sick leave. Therefore, within the office of the medical directorate, we were really struggling for capacity and we had to bring in extra people to do sessions. Bringing in people to do sessions who are able to get up and running and to do a difficult and quite a complex job is not easy in itself. Therefore, there is a struggle, if you like, around that. In terms of my role, healthcare in north Wales is changing and, in relation to service configuration, I have been quite strong and made some specific recommendations and supported the process.

[132] **Jocelyn Davies:** So, the fact that it was an interim position made no difference. You still feel that you were able to drive forward those transformational changes. Would you like to outline what some of the changes that you have been able to drive forward are, even though you have been in an interim position?

[133] **Dr Duerden:** There are quite a few things in terms of the success that I have had. Service configuration, having got through very difficult consultation and a lot of concern that healthcare in north Wales is changing, is now progressing and we are seeing those service changes occurring. I have been part of that process.

[134] **Jocelyn Davies:** So, apart from the initial getting up to speed, you do not think the fact that you were in an interim position made any difference. Or, do you?

[135] **Dr Duerden:** I did not say that.

[136] **Jocelyn Davies:** I am sorry.

[137] **Dr Duerden:** I said that the uncertainty made it difficult, and I accept that maybe the strength behind that has been less than it might have been, because of that difficulty. I think

that that is acceptable in those circumstances. It is a very unusual set of circumstances that have come together to make that difficult, and we have to work through that.

[138] **Jocelyn Davies:** Yes. If you have a key person who goes off on long-term sick leave at a very important moment, it is bound to be difficult. Can anybody tell us why that long-term sickness was left unattended and not confronted for so long at such an important time?

[139] **Mr Lang:** It is really important to say that it has not been unattended; it has been carefully managed in accordance with our sickness policies and procedures as a health board. As you will appreciate, it is about the health of an individual, which would be inappropriate to talk about. It has been properly and actively managed in line with our policies as a health board.

[140] **Jocelyn Davies:** What is the position now?

[141] **Mr Lang:** The medical director remains off sick as we speak today.

[142] **Jocelyn Davies:** Will there be some point when that post is filled on a permanent basis?

[143] **Mr Lang:** We are working through that, and will hopefully get to a point of clarity when we can be clear about the substantive medical director.

[144] **Jocelyn Davies:** It would be nice to get to that point. So, how long has that been ongoing?

[145] **Mr Lang:** Last October was when the sickness period started.

[146] **Jocelyn Davies:** Okay. The external capacity has been important; the report makes that point and it has been agreed that you need external capacity. How many people have been brought in?

[147] **Mr Lang:** We are interviewing tomorrow for two individuals. Those are turnaround support roles. The closing date was yesterday for an interim chief operating officer, so, as soon as we have been through that process, we will be interviewing. Angela is bringing in infection control nursing expertise next week. We are also looking to commission and procure financial and planning support to refresh our three-year financial plan, and that will happen in the next month.

[148] **Jocelyn Davies:** I see. So, you have not brought anybody in yet, but there are—

[149] **Mr Lang:** Nobody has come in yet, but there are clear actions, and obviously there are lead times with these things, but we have moved swiftly to advertise and bring those to a point where we can interview and appoint and get that capacity into the organisation.

[150] **Jocelyn Davies:** Are they permanent positions?

[151] **Mr Lang:** They are interim positions. The chief operating officer is an interim position, until we have certainty about the chief executive role and the roles of others. There are knock-on implications within that. So, there are interim positions at this point and, as I say, we are interviewing tomorrow, and in a couple of weeks' time for a chief operating officer. After tomorrow, I think that we will be able to fill the turnaround roles and I hope that we will be able to appoint an interim chief operating officer.

[152] **Darren Millar:** Do they have job descriptions?

[153] **Mr Lang:** They have full job descriptions and person specifications.

[154] **Darren Millar:** Clear lines of accountability.

[155] **Mr Lang:** Yes, they also have clear lines of accountability.

[156] **Darren Millar:** Everybody knows what their jobs will be when they come in.

[157] **Mr Lang:** Absolutely.

[158] **Darren Millar:** Okay. That is very helpful. Aled is next.

[159] **Aled Roberts:** Hoffwn droi at y problemau ynglŷn â chofnodi heintiau C. difficile. Mae'r adroddiad yn dweud bod problemau ynghylch dealltwriaeth staff am sut i gyfeirio pryderon i lefel uwch. Mae hynny'n rhywbeth eithaf sylfaenol. Pam oedd hynny'n amlwg yn y bwrdd iechyd?

Aled Roberts: I would like to turn to the problems with recording C. difficile infections. The report says that there are problems around staff's understanding of how to refer concerns to a higher level. That is something quite basic. Why was that the case in the health board?

[160] **Ms Hopkins:** I speak with the benefit of having only five weeks in the health board, so my position is that I have been reviewing what has been in place, and I am looking forward to what we will need to put in place in the future.

[161] In terms of lines of reporting, we now have in place clear mechanisms for staff to report up. Some of those were in place before, but the challenge is that we have not necessarily seen the whole context brought forward in terms of where the C. difficile individual cases sit within a much broader context of the underlying number for the health board, as compared with the rest of Wales.

[162] So, in terms of the reporting arrangements, we have been very clear with the medical staff, nursing staff and the health board about how we report through to Welsh Government. We have already had some external support, as the question was posed before, from Tracey Gauci, who is the lead for infection prevention and control in Welsh Government. She has been working with us to look at the way in which we report effectively going forward, and also to support the review around what has been happening in the past.

[163] **Aled Roberts:** Ynglŷn â'r adolygiad, pryd fydd yr adroddiad yn cael ei gyhoeddi gan y panel allanol?

Aled Roberts: In terms of the review, when will the report be published by the external panel?

[164] **Ms Hopkins:** Professor Brian Duerden, our external expert, has indicated to us that by the end of this month, he will have the early draft of his review. We will then have an opportunity to look at that. It is fair to say that we have had very clear terms of reference for Professor Duerden in terms of that review. That has also been clarified with the chief medical officer, and she has requested that other matters are also included within that review, so they have been incorporated within it. By the end of this month, we expect to have the first draft from Professor Duerden.

[165] **Aled Roberts:** A oes unrhyw dystiolaeth y bu'r bwrdd iechyd yn cwtogi ar adnoddau a oedd yn cael eu neilltuo ar gyfer rheoli heintiau?

Aled Roberts: Is there any evidence that the health board has been cutting back on the resources allocated for infection control?

[166] **Ms Hopkins:** As part of my ongoing review, I will need to have a look at the make-up of the specialist team, because we have infection prevention and control teams across Wales. They tend to be small in number—they are the specialist groups, and they are made up of consultant microbiologists and the nurses who have had extensive training in infection prevention and control.

[167] However, I emphasise that infection prevention and control is the responsibility of every employee in the organisation, so we need to undertake a much broader review. Rather than just focusing on how many in number we have, it is around the expertise and skill, and the leadership of the infection prevention and control agenda, including things such as antibiotic prescribing. We know that that has a very significant impact, for example, on Clostridium difficile incidence.

[168] As Geoff alluded to, we have an expert coming in from a nursing perspective on 18 July to give us support around that review. Her expertise will be key in establishing the appropriate level of infection prevention and control nursing, with the expertise to support the organisation. Again, I emphasise, as we are always doing, that infection prevention and control is everybody's business—it is not just reliant on a very small specialist team.

[169] **Aled Roberts:** Rwy'n derbyn bod pob aelod o staff â chyfrifoldeb, ond beth yn union yw rôl y grŵp swyddogion arweiniol iechyd a diogelwch y cyfeirir ato yn yr adroddiad? Pam mae cymaint o broblemau ynghylch yr agenda sydd gan y pwyllgor ansawdd a diogelwch? Nid yw'r agenda yn gymedrol, ac mae'n amlwg bod y pwyllgor hwnnw wedi methu â chydnabod bod problemau ar un o'r safleoedd, ac awgrymwyd yr wythnos diwethaf fod hyn hefyd yn broblem ar draws nifer o safleoedd o fewn y bwrdd iechyd.

Aled Roberts: I accept that every member of staff has responsibility, but what exactly is the role of the health and safety lead officers group referred to in the report? Why are there so many problems regarding the agenda of the quality and safety committee? The agenda is not inconsiderable, and it is clear that that committee failed to recognise problems on one of the sites, and it was suggested last week that this is also a problem across a number of the health board's sites.

[170] **Ms Hopkins:** The quality and safety committee, which sits at a high level, is looking at a range of things. The very nature of that committee, and it is the same across all health boards, means that there is a great deal that that committee will need to assess in terms of its scrutiny, going forward, on all of the issues of importance to patient safety. The challenge for us, going forward, is how we assure ourselves and the public that we serve that the issues going to that quality and safety committee are the appropriate things.

10.15 a.m.

[171] You mentioned the lead officers group below that. Its function, as I understand it—once again, with the benefit of only five weeks—is that it was looking to pull forward the key issues to take forward to the quality and safety committee. It is fair to say that we are bringing in additional support to look at our clinical governance framework and our arrangements, which will include the committee structure, going forward. However, we started the morning by talking about ward to board; that will be one of the key components of looking at our clinical governance framework, because we have to have a good connection between the ward and the board, and the public and the board, and the clinical work that goes on. So, we are bringing in expertise—and that has already been agreed—to look at that framework with us. For me to just make a comment on a committee, it really narrows it down. It is much more about the CPGs that we talked about earlier, how the clinicians engage with the clinical work, going forward, and the way in which we connect the clinician, ward and the board, and make sure that we have a cohesive and sound clinical governance framework.

[172] **Mr Lang:** May I add a point about the lead officers group, as Angela is not familiar with that? The purpose of that group, as the report alludes to, was to act as a focal point for gathering information together and flagging issues to the quality and safety committee. One of the challenges that we have and one of the issues on which we have not been as successful as we could have been is being really clear about the key issues that need to be on the committee's agenda, which need to be brought very much to the fore, so that the committee can see right across the organisation how things are delivering.

[173] We have had, and we do have, very many quality and safety issues and initiatives running across the board, as do other health boards, and we have been guilty of trying to report everything all the while. In trying to report that, we have not given a focus from the board in terms of saying, 'If there are five or six indicators that this board wants to be absolutely confident are being delivered from top to bottom in this organisation, what are they and how do we know that they are coming through? That clarity is what we need to bring.

[174] The quality and safety lead officers group has done some good work. It has not achieved what it set out to achieve in making the quality and safety agenda a more focused, lighter agenda that allowed scrutiny of the real issues, but there have been some very important issues that it has identified and flagged as topics for the committee to follow up. So, it has fulfilled a role, but, organisationally—and this is a broader point, and it runs right through the quality and safety committee because of the breadth of the agenda—we have to determine the absolute priorities and be clear that there is a line of sight from the board right through to every service. The lead officers group has done some of that, but has more work to do. That will be refreshed. As part of our executive changes, Angela is taking clinical governance responsibility from the director of governance role. She will have a clinical lead on that and will be responsible for the entire infrastructure. Angela will review and refresh the lead officers group arrangements to make sure that they are fit for purpose, that they are focused and that they are delivering the right things to the committee to allow us to discharge that role.

[175] **Aled Roberts:** This health board has been in existence for four years. During those four years, was it ever identified that these agendas were so crowded that there was a danger that issues such as C. difficile were being drowned in agendas? Angela, I accept that you have been there for only five weeks, but how do the committee arrangements at Betsi, from what you have seen in that five-week period, compare with your experience at Cwm Taf Local Health Board?

[176] **Ms Hopkins:** I would say that Cwm Taf, in line with every other health board, is, not struggling, because that would be the wrong word, but we all have a challenge to make sure that we assess at our quality and safety committees the vast range—because healthcare is all about quality and safety. So, it is a challenge, and we know that, for example, the Deputy Minister for Social Services went around Wales last year looking at each of the committees and the way in which they function to try to bring forward some recommendations on how we could deliver that agenda more appropriately. So, it is a challenge for each of the health boards. In north Wales, it is a particular issue because of the sheer size of the organisation.

[177] As part of the wider review, we need to take the advice of experts. That is why we are bringing experts in to support us, namely to really clarify what are the points that really need to be on the agenda, but also how the committee functions underneath that as well, because there will be sub-committees there. We need to make sure that there is scrutiny and assurance at every level. So, at every board, I would expect there to be scrutiny of their local information and their outcomes so that they know that they are putting right the things which are within their gift. That then needs to go right the way up through the organisation, so that when we do eventually get to the quality and safety committee, we are looking at the key

points, which really gives those members on that committee the opportunity to scrutinise hard the things of key importance to the quality and safety of the health of the population.

[178] **Mr Lang:** I will just return to the point about whether the board did not reflect on the quality and safety committee. Yes, we did, and it was about 12 or 15 months ago, I think, that the chair of the committee changed and refreshed the committee, and we looked again at the agenda and priorities. The chair of that committee has been working diligently to get the right data set and information and to get the right indicators, and we have moved a long way. We met again last week in terms of quality and safety, and the reports that we are now getting, which are focusing on key issues, are far crisper and neater and will help the committee look at the issues that really matter. So, the board did recognise that it was a crowded agenda; it was not focused and it was not picking things up. The board did act to amend that and refresh the way in which the committee worked. That is work that still needs to be progressed further.

[179] **Darren Millar:** Does the Welsh Government not have a role in saying, 'These are the priorities that you ought to be looking at as a board' in terms of infection control or any other quality and safety issues?

[180] **Ms Hopkins:** There is a committee, which is the quality and safety committee, and which is chaired usually by the chief medical officer. You are quite correct that the natural flow is set from there, which does then inform your own agenda.

[181] **Darren Millar:** So, why is it so difficult for the health board to determine what its priorities are? Surely, infection control should be up there at the top of the list, should it not? It is in the public interest and it is a Welsh Government priority, and yet it was drowned out. You say that you were guilty of reporting everything, Mr Lang, but, actually, the Wales Audit Office and Health Inspectorate Wales report states that there was significant under-reporting of serious incidents. You were not reporting everything; you were not reporting some things that you should have been reporting and you were reporting other things that were spurious and not necessary. Is that right?

[182] **Mr Lang:** We were reporting a broad number of indicators. I would not say that they were spurious and not necessary. The Public Health Wales report, and this report, identified that, in one aspect of our reporting around infection control—a very important aspect—we did not have a robust system. We accept that and that needs to change. We were reporting infection control data and it was linked to the priorities and the targets that are set at a national level. One of the things that that did not adequately bring to focus for us is the absolute level of infection that was going on and the board's focus on a number of cases, as opposed to whether we were reducing or increasing. So, there is a real issue about refining those indicators and being clear about what they were. Some of that infection control information has been reported. There were weaknesses and they have been identified, and we would not pretend to suggest they were not there.

[183] **Darren Millar:** On this infection control rate, there was an interview today with Dr Tony Roberts today, which has been publicised in the media. He suggested that there were concerns about infection rates and untoward incidents not necessarily being recorded and reported properly, access to beds, and people in the wrong wards. He was very concerned about the risk-adjusted mortality index figures, the death rates as it were, in his hospital having shot up recently. Is the issue of death rates regularly reported to the board?

[184] **Dr Duerden:** We look at the RAMI figures and we are aware of a drift up in those numbers in Ysbyty Gwynedd.

[185] **Darren Millar:** Is that a problem particular to Ysbyty Gwynedd or across the board?

[186] **Dr Duerden:** We have seen a very slight rise in the last few months in Ysbyty Glan Clwyd. We are conducting an intensive forensic examination of why that might have occurred, and there are quite a few different reasons. One might be that, for various reasons, the care of patients has suffered, but there are other possible reasons why that could have occurred. For example, there are simple things like the way that we have coded the death within the system. We are in the process of examining that.

[187] **Darren Millar:** I am aware of the complexities around the risk-adjusted mortality index figures and that their validity, sometimes, can be questioned. However, these are figures relating to a hospital that has collected the figures in the same way, consistently over a period of time and they have suddenly shown an increase.

[188] **Dr Duerden:** There has been a change. I would not want to dismiss that change. There has been a change in the way that they have been recorded. This is partly because of the change in the case mix coming from Llandudno General Hospital, and that has altered the way that the figures are captured, and partly because of some of the issues around community hospitals and the way that the data is collected from them.

[189] **Darren Millar:** People will draw comparisons here between death rates at the Stafford hospital and death rates in north Wales. The figure quoted in the media this morning—I do not have the official figures I am afraid; it does not appear that they are available on the board's website.

[190] **Dr Duerden:** They are on the main website.

[191] **Darren Millar:** They are on the website, are they? Are they right up to date?

[192] **Dr Duerden:** Yes, they are.

[193] **Darren Millar:** Right. That is interesting. It is very intersting, because the figure is 122, which is as high as the figure in Stafford, as I understand it.

[194] **Dr Duerden:** You need to look at it relatively.

[195] **Darren Millar:** Please, explain to me why it should not be of concern to us.

[196] **Dr Duerden:** It is of significant concern. It is something that we are looking at and attempting to understand. Obviously, if there is a real issue around our increasing mortality—more than we would expect—we need to deal with that very firmly and swiftly.

[197] **Darren Millar:** Are these figures reported to the Welsh Government on a regular basis?

[198] **Dr Duerden:** They are reported to the Welsh Government.

[199] **Darren Millar:** What is the Welsh Government doing about the situation? Has it taken an interest? Has it asked you any questions about it?

[200] **Dr Duerden:** I have been discussing it with the Chief Medical Officer for Wales and her deputy, and they are fully aware of those changes. If you remember, much the same thing happened in Cardiff and the Vale last year, and that was also analysed. You need to be really careful in terms of understanding what that means and whether it is real. I am not denying that there is an issue, but we are investigating.

[201] **Darren Millar:** Mr Lang, on the availability of this RAMI information, you will be

aware of pesonal correspondence between us requesting figures in relation to the mortality rates. Why has that not been more quickly forthcoming, given that this information is, apparently, on your website and easy to access?

[202] **Mr Lang:** The published data are, as Martin says, available. More up-to-date data are stuff that we have to work through ourselves from reports that we get from an information analysis company that does the work for us. We then have to present that and put the appropriate commentary and narrative with it. That is the local work that has to be done to respond to those questions.

[203] **Darren Millar:** So, how up-to-date is the information on the website, Dr Duerden?

[204] **Dr Duerden:** It is the most up-to-date information. We have information that goes beyond that, but the problem with RAMI data is that if you look at the last few months, you do not have the clear figure until you have done the data checks.

[205] **Darren Millar:** I am sorry, but I am a little bit confused. Mr Lang, you have told us that the up-to-date data are not on the website. Dr Duerden, you are saying that it is. What is on the website and how up-to-date is it? When do those figures telling us about the situation go up to?

[206] **Mr Lang:** The quality-assured data, as Martin refers to, where you can absolutely say that those are the figures, are on the website. There are further data that we have that are subject to quality assurance, which is what I was alluding to. As to which month is posted on the website, I could not tell you as we sit here. Martin may know that or we may have to clarify that outside the committee.

[207] **Dr Duerden:** It is up to March.

[208] **Darren Millar:** It is up to March; okay. So, it is a few months out of date. Aled did you want to ask any more questions? I see that you do not. We will turn to Mike.

[209] **Mike Hedges:** Was it reported and agreed by the board to reduce the number of elective procedures in the final weeks of 2012-13?

[210] **Mr Lang:** I will answer this, and Helen may want to add some information in terms of the delivery. The board did not agree to reduce its planned activity. What the board considered in the autumn and moving into the new year was the degree to which it could resource additional activity over and above the core work that goes on week in, week out in our hospitals. The board took a decision that, in balancing clinical and financial risks, there was an element of that work that could be done, which related to suspected cancer work, to patients on cancer pathways or to patients who had waited a long time where there might be an indication in a specialty that could have a cancer implication, and extra work was done in those specialties. However, in other specialites where, in previous years, we have undertaken additional work in the final quarter, that did not take place. That was the decision that the board took. Helen may want to add to that.

[211] **Ms Simpson:** At the beginning of the last financial year, we recognised as a health board that we needed to invest more in increasing elective capacity. As part of the budget that was set at that time, we set aside £15 million to deal with elective access in general surgery and a whole range of specialties, such as orthopaedics. Obviously, as we were going through the financial year, things were very pressured, and we were under financial challenge and also quality challenge. As we have talked about earlier, it is about making sure that we look at all the targets together and, obviously, safe services were always a priority.

10.30 a.m.

[212] In terms of getting to the year-end position, we spent very close to that £15 million—it was £15.4 million that we set aside—but what we did have to do was make decisions in terms of making sure that those absolutely urgent cancer treatments got through as quickly as possible, and there was absolutely no delay in decision making. We also had to, as part of the year-end process, pull back very hard on our corporate spend, as you would expect, because what we had to do was to protect front-line services. So, again, if you look at our board reports by the end of March, you will see that there were significant underspends on estates, planning, finance, workforce and organisational development—perhaps, with hindsight, it was those very areas that we should have put more investment into, recognising where we are now. However, decisions were made at that time, and they were made by the finance and performance committee, which has clinical executive directors as part of its membership. Also, where there were important decisions to be made, we brought together the finance and performance committee and the quality and safety committee, to make sure that we made informed decisions, always mindful of clinical issues.

[213] **Mike Hedges:** I think that that was a 'yes' in answer to the question. The next one is: you incurred a deficit of £5 million early this year, which is not unusual for health boards; is that because what was postponed last year has been done in the first quarter of this year? If not, what has caused that overspend in the first quarter?

[214] **Ms Simpson:** Again, it is a range of issues. As you are aware, the health board is in what is deemed a flat cash arrangement across Wales; we recognise that. However, we have had a decision to fund pay awards. We have to pay staff—if they have a pay award, we absolutely must make that pay award. We have had increases in the costs of our continuing healthcare packages and, again, we absolutely have to pay them. We have an increasing demand on our services because of our demographics; a higher proportion of our population in north Wales is aged over 75. So, we have a demand for an increased level of statins, other medication and hip and knee operations.

[215] We knew, going into the first quarter of this financial year, that we were very likely to overspend, but we have put plans in place now—our budget strategy went to a public board in March, and it outlines the methods by which we want to tackle that. We are taking a different approach to the approach that we took in previous years. We have learned, we have reflected and we have stratified how we are going to take those savings out. We recognise the Wales Audit Office report recommendation about the need to move forward and change and modernise our services to ensure that we get a transformational change, but that does not come quickly. So, we recognise that those savings will come out late in the year. As part of our budget strategy—again, we have learned from previous years—we have built into that that we will need external expertise to work with our clinical programme groups and the executive team to target where we can most quickly get those savings without impacting on quality.

[216] **Mike Hedges:** That leads me on to a question that I have never really understood about health, which perhaps you might resolve for me: if you are making savings in the third and fourth quarters, and if those savings are ongoing, why do you not get the full-year benefit of them in the following year?

[217] **Ms Simpson:** We do for a lot of them, but, as I said, there have been a lot of pressures that have happened this year that did not happen last year, for example. One example that I mentioned was the cost of the pay award. That has cost us an estimated £300,000 already this year. That is a lot to resource and we talk about the increasing demand for our services.

[218] **Mike Hedges:** It is £300,000 out of £5 million, so it is not really the major driver.

[219] **Ms Simpson:** Sorry, I should have said that that is just one example. I could give many examples.

[220] **Mike Hedges:** The other thing that I do not understand—and I used to serve on a health board, or the old Swansea NHS trust—is how you come to a budget, and then that becomes a negotiating position for people later on. People did not like the budgets that we set as a trust, but they accepted them, because that was the final decision. That happens all the time. The Assembly sets budgets, and people do not like them—even Members of the Assembly do not like them at times—but they are the budgets, and they are set, and that is what people work towards. I do not understand this system where you set the budget, and people say, 'Well, I am not happy with that; can I come back and negotiate with you?' Perhaps you could explain how that happens, and how you can stop it happening. Are you unique in allowing that to happen?

[221] **Ms Simpson:** We take the budget absolutely critically seriously, as you would expect. The board has responsibility to the public of north Wales to make sure that we get the best value for our patients. We started our budget-setting process back in the autumn, and it is in many respects how we work within that Welsh Government envelope. It is a set of discussions and a negotiation, because it would be wrong for the finance director to set the budget, or for my team to say, 'There is the budget'. In the run-up to the budget setting, it is negotiated. In fact, I would go further and say that it is very much co-produced by the executive team. As part of that, there is lots of debate and discussion. As you would expect, we also involve senior clinicians and chiefs of staff. What happened last financial year was that there were specific issues in some CPGs—we alluded to some of the issues earlier, around difficulties in recruiting senior medical staff—which made it difficult, in one example, for one CPG to say, 'Yes, I will sign off', because it might have had to recruit locums.

[222] The point for me was that we reported to the audit committee, in line with good governance, where budgets were not fully signed off. That included—and I felt it was important in terms of transparency—flagging to the audit committee where comments had been made by managers. However, those budget managers did take their budgets very seriously. They did not just sign it off and say, 'That is the budget; I'll overspend'. They were working with us, and we worked very hard with those chiefs of staff to bring the health board in line with its budget, as we did last year, and as we had done in previous years.

[223] **Mike Hedges:** From what I understand, you have all these discussions prior to the budget being set, which is how every organisation works—or every organisation that I have worked in. At some stage, a final decision is made at the board, and it says, 'We are going to spend this amount in one area'. Surely, at that stage, negotiations stop, but in your organisation, negotiations seem to carry on during the year, with people saying 'I am not happy with what has been decided'. I am used to local government, and when a budget is agreed, you might not like it, and you might not think that you have been given enough, but that is what you get. It does not go back to further negotiation, which appears to be how you run things.

[224] **Ms Simpson:** The context that I would put round that, if I may, is slightly different, because we were very mindful of the need to invest the £15 million in access, and we were very mindful of the need to ensure safety. The last thing that we would want is to have budget managers slashing and burning services in order to stay within a budget. For us, that was very important. In terms of budget ownership and sign-off, that was taken seriously by the board. We have put in place training going forward to support those managers. As I say, the audit committee has, this year, discussed removing budget responsibility from those budget managers who do not sign up to it, unless there is good reason for that. We have clear lines of

accountability in place to deal with that, going forward.

[225] **Mike Hedges:** Should not all these discussions and all these things be done before the final budget, rather than after it?

[226] **Ms Simpson:** Absolutely, and they did, but things cropped up during the year and we had to react to that.

[227] **Aled Roberts:** There is a difference between things cropping up in year, which all of us have experience of, and the suggestion in the report that there was not an agreed budget at board level at the start of the financial year, and that there were clinical programme groups that, in some instances, did not agree their budget with the board until September. Is there not a Welsh Government requirement that there is an agreed budget in place by the start of the financial year?

[228] **Ms Simpson:** In the last financial year, we decided as a health board to put in place an interim budget for one month only, and that was to take account of the issues that I have discussed. We put the annual budget in at the April board for the remainder of that year. In previous financial years, and in this financial year, the board has been fully signed up in advance of the financial year, but we fully recognise that it was important that there was a robust budget set by the health board, rather than one that was just, if you like, a budget in name only.

[229] **Aled Roberts:** The report states that, in the last three months, you reduced work to meet access targets and ceased the waiting list initiatives, which had a detrimental impact on patient waiting times. Are those waiting times still increasing, and are the decisions that you took not to allow referrals to some of the hospitals used historically over the border still in place?

[230] **Mr Lang:** In terms of the current position with waiting times in the first quarter of this year, those waiting time difficulties have got worse. In our finance and performance committee last month, and at the board discussion, we agreed a package of resources and a plan to recover that position, and that will start this month, in terms of bringing that back. In terms of our relationship with providers over the border, most of that relationship revolves around whether our changes mean delivering services more locally for patients in north Wales as opposed to a blanket decision to stop referrals to certain centres. There are local hospitals that support communities and we still have those flows. What we are trying to do within north Wales is to deliver as many services as we can locally, and if we can do that by repatriating that resource and investing it locally, then we try to do so.

[231] **Aled Roberts:** Of course, where you already have waiting lists for those services in those local hospitals, all that you are doing is adding to the problem.

[232] **Mr Lang:** If a patient is on a waiting list in a hospital, they will have their surgery in that hospital. We are only dealing with new referrals in terms of changing our patterns. We do not change patients who are on waiting lists.

[233] **Darren Millar:** Just on a point of clarity, how many patients had their operations delayed as a result of the decision to reduce the number of elective procedures towards the end of the financial year?

[234] **Mr Lang:** I do not have that figure with me today.

[235] **Darren Millar:** Could you provide that figure?

[236] **Mr Lang:** It is difficult to say exactly how many patients, because the number of operations would depend upon the patients on the waiting list at any point in time to hit the Welsh Government standard, but we will show the movement in our performance standard and the number of patients implicated in that. We can provide you with a note on that.

[237] **Darren Millar:** That would be very useful indeed. Can you also tell us with any confidence whether the decision to postpone elective surgery for that cohort of patients had an impact on your emergency services, detrimentally or positively?

[238] **Mr Lang:** I could not comment on that. I do not think that we have any evidence to suggest—

[239] **Darren Millar:** Is there any evidence to suggest that people end up falling over et cetera and turn up at accident and emergency?

[240] **Mr Lang:** We have no evidence to suggest that, Chair.

[241] **Ms Simpson:** One thing that we can say is that there was pressure on our emergency services from December through to March, and that did have an impact on bed pressures and on our elective waiting lists. Obviously, we are taking account of that.

[242] **Darren Millar:** I have one final question on this issue. Was the Welsh Government aware of, and did it give it consent to, the decision to delay operations?

[243] **Mr Lang:** The Welsh Government was aware of our plans and trajectory. I think that it would be wrong to say that it gave permission or consent for us to do it. That was a decision that the board took, balancing its financial duties and its service duties. However, the Welsh Government was aware of our trajectory and the position that we were likely to be in.

[244] **Jenny Rathbone:** Turning back to the strategic issues, Betsi Cadwaladr has form in not being good at managing its finances. You featured along with Cardiff and Vale local health board in the auditor general's report on health finances as being the two health authorities that are taking decisions very late in the financial year about trying to come in on budget. So, some of the things that you are saying really underline that—everybody has to do more with less—the board is still not able to take strategic decisions to enable you to save money across the year.

10.45 a.m.

[245] You had two separate external reviews in 2012 around this very issue. The report into Betsi Cadwaladr board that we are looking at is not clear to the extent to which the board was aware of the findings of these two reports. Could you just tell us whether that is accurate as far as you were concerned, and how much that remains the problem—that is, that the board is simply not sufficiently clear about the strategic decisions that it needs to take?

[246] **Mr Lang:** I will comment in terms of the two reports. In terms of the financial track record, there are issues in terms of how we have achieved financial balance, but it is important to record that we have achieved financial balance, and not all boards have achieved that. So, that is one small point of credit. In terms of your points about strategic planning and needing to move to a far more medium-term view and a structured plan, we would wholeheartedly agree with that. Helen will comment on how we are approaching that in a moment. It is one of the areas where we are bringing external support to make sure that our preparations for 2014-15 and beyond are very clear in terms of service change and financial change.

[247] The two reports that you refer to did feature in our discussions. The reports themselves are quite high-level, but they contain some very important issues. However, they were not presented to the board as such. The first report from Mr Hurst, which came in April, discussed the need to sharpen our focus on the delivery of savings, to bring our financial and service planning together, and to be clear about our clinical leaders owning some of the financial issues. Out of that, we established a delivery board and changed some of the ways that we were working within the board. So, there was clear evidence of change around that, although the report itself was not presented. The later report, prepared by Alison Lord and published in December 2012, discussed turnaround a great deal, and it also discussed changing the structure and implementing the chief operating officer role. Furthermore, it discussed linking the acute services review with finance and accelerating movements on that. I think that, in some of our responses and in some of the comments in the auditor general report, you can connect those themes and see that there are significant actions ongoing now that were referenced in that report. There is a trail of things that we have put in place that are in that report. So, those themes are clear in the way that we are moving forward. We have addressed a number of the issues.

[248] **Jenny Rathbone:** Why was it not considered appropriate for the board to see these important reports, given that they discuss a strategic weakness in the board?

[249] **Mr Lang:** I cannot answer that. I do not know about that decision. The Hurst report came in at a time when I was covering the chief executive role, and I discussed with the chairman how we would respond to that role and to that report, and develop the plans. That was not taken to the board as a paper, but the proposals that came out of it went to the finance and performance committee. I was not particularly involved in the Alison Lord report, nor were colleagues, I do not think, so it is difficult for us to comment on that.

[250] **Jenny Rathbone:** Okay. We can obviously ask the outgoing chair next week. In terms of the Allegra report, you did actually appoint a turnaround director for a short time in 2012-13. Why was that then not continued if that was deemed to be effective?

[251] **Ms Simpson:** I think it was actually very effective—certainly in a few of the boards. It was something that we, as an executive team, were very keen to put in place. It was a crucial time, when we actually got to a financial balance in the end. Recognising the success of the turnaround director role, we, again as part of our budget-setting strategy, identified the need for not just one turnaround post but three as part of that budget at the start of the year. As Geoff has said, we are actually interviewing tomorrow morning to get them in place as quickly as we can in order to get that external expertise.

[252] **Jenny Rathbone:** That is still four months into the financial year.

[253] **Ms Simpson:** I totally accept that, but we are absolutely determined to get these people in place as quickly as possible.

[254] **Darren Millar:** Would you be able to provide us with a copy of the Chris Hurst and Allegra reports?

[255] **Ms Simpson:** Yes.

[256] **Mr Lang:** Indeed.

[257] **Darren Millar:** We would be very grateful for that. I call on Aled very briefly, and then I will then come to Julie for the last question.

[258] **Aled Roberts:** You have just asked the question that I was going to ask.

[259] **Julie Morgan:** Most of my questions have also been asked. [*Inaudible.*] However, what is actually happening at the moment and when will it be done?

[260] **Mr Lang:** Perhaps I could make a brief comment and then ask Martin to comment on the work that is ongoing at the moment. It is quite important to reflect that, in July last year, when the board considered proposals to consult, a significant amount of acute care work was included in the board's discussions of its preparatory work. It included obstetrics and paediatrics and work around non-elective surgery. The clear clinical view and the view from stakeholders, and people who were involved in our engagement process, was that there was a strong desire to continue to deliver those services on three sites across north Wales, because that is what was viewed as the right thing to do. The board took a very explicit decision to ask those clinical review groups that had been working on it to go away to test the feasibility and the sustainability of services on three sites. That work was done, and when we got to October and November, it became very clear that there were real question marks over whether that could be achieved. That was the stimulus for this phase of work that we now move into. Martin can comment on where we are with that.

[261] **Dr Duerden:** We have done a lot of work during the last few months. It has been slower than I would like, but I think that the necessity in this type of review process is to do it as thoroughly as you can and to come up with the right solutions. There are reasons why it has been delayed over the last few months. Basically, we have been looking at non-elective general surgery. We use that expression simply because when most patients are admitted for surgery, they get their operation, if they need it, a few days down the line. So, we call that 'non-elective general surgery'. Paediatrics, obstetrics, gynaecology, trauma services, mental health and acute medicine are all elements that interrelate, and so it is about working through how they interrelate and how you can provide a core set of services on three sites and how there might be specialities within that range of acute interventions. For example, if you have an acute myocardial infarction, the best way of treating you is to have a percutaneous intervention, and it would be better to go to a speciality centre to have that done. Likewise, if you need stroke services, it would be better for you to go to a specific centre where there is a particular set of kit that can provide the best treatment for you. So, it is about working through how those things interrelate and how you can provide a core set of services, plus speciality services around acute interventions.

[262] I mentioned earlier that the Royal College of Paediatrics and Child Health's review of our neonatal intensive care is ongoing, and the outcome of that has quite a significant impact on providing paediatric services as a whole. So, we need to work out how that will play into this. We will get the results of that in September. That work was requested by the First Minister.

[263] There is the issue of interaction between medicine and non-elective general surgery, and some of those debates about that interrelationship are very hot in college circles at the moment. So, we are waiting for clarity on how to designate an accident and emergency department, based on some of that inter-collegiate debate that is taking place. There is a lot happening in this environment that will alter some of the decisions that we make. So, the standards and the re-designation of emergency departments will all be fairly crucial to the recommendations that we come forward with.

[264] I have already alluded to the issue around how we provide the best training environment. The deanery is redefining some of its standards, particularly around acute medicine, and it is very vexed that we are struggling to recruit doctors that are keen to do acute medicine. In the past, it always used to be a glamorous thing to do because people found it exiting, but it is actually very difficult and challenging, and doctors have generally shrunk away from it. So, we need to find ways to encourage them and to make it a better option for

them. There are questions in terms of that debate, for example whether those doing training in acute medicine need to have access to other trainees who are doing things such as acute surgery. Therefore, they all interrelate, and as a result of that, we have been through one set of stakeholder meetings and we are going through another set of stakeholder meetings. We intend to take our recommendations to the board in September.

[265] **Julie Morgan:** There seems to be a lot of discussions going on and one discussion relates to another. Do you have an overall grip of moving towards a clear strategic plan?

[266] **Dr Duerden:** I do, and that is something that we need to work through in those future stakeholder events. That needs to be clarified, but I am not going to impose my particular view on others. It is a matter of giving people that vision and seeing whether they agree with it.

[267] **Darren Millar:** I am afraid that the clock has beaten us. Thank you very much, Geoff Lang, Martin Duerden, Angela Hopkins and Helen Simpson. We are very grateful for your attendance today. You will get a copy of the transcript of the proceedings from today's meetings to correct any factual inaccuracies, and we look forward to receiving the additional information that you promised to provide. The clerks will be in touch to check on those items with you.

10.55 a.m.

Papurau i'w Nodi
Papers to Note

[268] **Darren Millar:** There are several papers to note.

10.55 a.m.

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

[269] **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).

[270] There are no objections, so I ask for the public gallery to be cleared. Thank you.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10.55 a.m.
The public part of the meeting ended at 10.55 a.m.