# Cynulliad Cenedlaethol Cymru
# The National Assembly for Wales

## Y Pwyllgor Cyfrifon Cyhoeddus
## The Public Accounts Committee

## Dydd Iau, 18 Gorffennaf 2013
## Thursday, 18 July 2013

**Cynnwys**
**Contents**



Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir

trawsgrifiad o'r cyfieithu ar y pryd.

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

**Aelodau'r pwyllgor yn bresennol**
**Committee members in attendance**

| | |
|---|---|
| Mohammad Asghar | Ceidwadwyr Cymreig<br>Welsh Conservatives |
| Christine Chapman | Llafur (yn dirprwyo ar ran Sandy Mewies)<br>Labour (substitute for Sandy Mewies) |
| Jocelyn Davies | Plaid Cymru<br>The Party of Wales |
| Mike Hedges | Llafur<br>Labour |
| Sandy Mewies | Llafur<br>Labour |
| Darren Millar | Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor)<br>Welsh Conservatives (Committee Chair) |
| Julie Morgan | Llafur<br>Labour |
| Jenny Rathbone | Llafur<br>Labour |
| Aled Roberts | Democratiaid Rhyddfrydol Cymru<br>Welsh Liberal Democrats |

**Eraill yn bresennol**
**Others in attendance**

| | |
|---|---|
| Y Athro/Professor Merfyn Jones | Cadeirydd sy'n Ymadael, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr<br>Outgoing Chairman, Betsi Cadwaladr University Local Health Board |
| Dr Ruth Hussey | Prif Swyddog Feddygol, Llywodraeth Cymru<br>Chief Medical Officer, Welsh Government |
| Grace Lewis-Parry | Cyfarwyddwr Llywodraethu a Chyfathrebu ac Ysgrifennydd y Bwrdd, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr<br>Director of Governance and Communications and Secretary to the Board, Betsi Cadwaladr University Local Health Board |
| Keith McDonogh | Cadeirydd y Pwyllgor Cyllid a Pherfformiad, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr<br>Chair of Finance and Performance Committee, Betsi Cadwaladr University Local Health Board |
| Dr Lyndon Miles | Is-gadeirydd sy'n Ymadael, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr<br>Vice-Chair, Betsi Cadwaladr University Local Health Board |
| Matthew Mortlock | Swyddfa Archwilydd Cyffredinol Cymru<br>Office of the Auditor General for Wales |
| David Sissling | Cyfarwyddwr Cyffredinol, Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cymru<br>Director General, Health and Social Services, Welsh Government |
| Martin Sollis | Cyfarwyddwr Cyllid, Llywodraeth Cymru<br>Director of Finance, Welsh Government |

| | |
|---|---|
| Dave Thomas | Swyddfa Archwilio Cymru<br>Wales Audit Office |
| Huw Vaughan Thomas | Archwilydd Cyffredinol Cymru<br>Auditor General for Wales |
| Mike Usher | Swyddfa Archwilio Cymru<br>Wales Audit Office |

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

| | |
|---|---|
| Dan Collier | Dirprwy Glerc<br>Deputy Clerk |
| Joanest Jackson | Uwch-gynghorydd Cyfreithiol<br>Senior Legal Adviser |
| Gareth Price | Clerc<br>Clerk |

*Dechreuodd y cyfarfod am 9.05 a.m.*
*The meeting began at 9.05 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. We have a full house in terms of our attendance today. I remind everyone, including witnesses, that the National Assembly for Wales is a bilingual institution, and that people should feel free to contribute to the proceedings of this meeting through Welsh or English as they see fit. Another housekeeping rule is for us all to ensure that our BlackBerry devices, mobile phones and other technology are switched off, because they can interefere with the broadcasting and other equipment. If there is an emergency, we should follow the instructions of the ushers. We have not received any apologies today, but, Julie Morgan, you wanted to put something on the record.

[2] **Julie Morgan:** I just wanted to put on the record that my daughter was part of the public health team that prepared the C. difficile report.

[3] **Darren Millar:** Thank you, Julie. I should have noted that Sandy Mewies is not here today, and that Christine Chapman is substituting for her. I do apologise, Christine; welcome. Before I go into item 2 today, I just want the committee to note that this afternoon's session with Mary Burrows will not be taking place. Mary has indicated that she is unable to attend this afternoon, but a written submission will be given to the committee for us to consider. The questions that the committee had hoped to ask will be relayed to Mary. I am sure that her non-attendance will be a disappointment to committee members, but, under the circumstances, it is important that we get a written submission for us to consider as part of the evidence for this particular inquiry that we are undertaking. So, without further ado, we will move on to item 2 on the agenda.

9.07 a.m.

## Trefniadau Llywodraethu Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr: Tystiolaeth gan Fwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr
## Governance Arrangements at Betsi Cadwaladr University Local Health Board: Evidence from Betsi Cadwaladr University Local Health Board

[4] **Darren Millar:** I welcome Merfyn Jones, outgoing chairman of the Betsi Cadwaladr University Local Health Board; Dr Lyndon Miles, outgoing vice-chair of the Betsi Cadwaladr University Local Health Board; Grace Lewis-Parry, director of governance and communications, and secretary to the board at Betsi Cadwaladr UHB; and Keith McDonogh, chair of the finance and performance committee at the health board. I am very grateful for your attendance today, particularly at relatively short notice. So, we appreciate your attendance.

[5] We all know why we are here. A pretty damning report was published by the Wales Audit Office and Healthcare Inspectorate Wales into the governance arrangements at your health board. It was the first report of its kind in England and Wales, as far as we understand, and it is perhaps one of the most awful reports into the conduct of a health board in Wales since their establishment. What do you have to say for yourselves? Mr Jones?

[6] **Professor Jones:** It is indeed an extremely serious, deeply concerning and sobering report. As soon as I became aware of its contents, as you know, I wrote to the Minister for Health and Social Services to offer to stand down, because it is the role of the chair to take responsibility for the issues raised by the report. I think that it is fair to say that much of what was in the report was recognised by me and other members of the board, and that there had been attempts to address those issues, perhaps not all of them, but certainly some of them. In light of the report, one has to say that that was not sufficiently successful and probably not conducted with sufficient pace. However, I certainly took responsibility for, as you say, the deeply worrying and sobering report that the WAO and HIW produced.

[7] **Darren Millar:** You referred in your media response to the report to very deep-seated issues at the board. You described the problems as ‘structural’ rather than being as a result of a crisis in personal relationships. The WAO and HIW joint report seemed to suggest that there had been a problem with communications at the top of the organisation. Can you elaborate on that?

[8] **Professor Jones:** Indeed, there were, and perhaps we can touch upon that later. However, there are structural or systemic issues to do with the board, and I think that it was very succinctly—I shall not repeat the words here now—summed up by the auditor general in his opening evidence to you two or three weeks ago. He referred to the clinical programme group structure, site management, and a whole series of issues: individual hospital site management, clear lines of accountability, robust performance management arrangements, and the ability to design and implement future models for service delivery that are financially and clinically sustainable. I recognise those as deep-seated structural, systemic issues that the board faces.

[9] **Darren Millar:** Was there a problem in the relationship between you and the chief executive, Mr Jones?

[10] **Professor Jones:** Indeed. In recent months, there have been difficulties. Over the last two years, there have not been.

[11] **Darren Millar:** What were those difficulties? Was it a personality clash or professional differences because you—

[12] **Professor Jones:** There was absolutely no personality clash between any of the people on the executive or the board; I think there were clear differences of opinion as to policy.

[13] **Darren Millar:** Some of the executive team came to give us evidence last week. They described tensions between independent board members and executive members. Can you describe what those tensions were like?

[14] **Professor Jones:** I am not sure that there was a clear split; one sometimes finds on boards that there is a clear split between the executive and the non-executive members. That was not the case, and is not the case, at the board. I think one-to-one relationships between independent members—perhaps my colleagues could comment on this issue—are very good. There was clearly a difference of emphasis and different solutions. The board, after all, was under immense pressure over the last year or so, not only due to the financial constraints, which are clearly present in the report and within which we have to operate, because we have a statutory duty to balance the books, but also because of the tension between that and performance, output and patient care.

[15] There were also, as you are aware, issues of turnover and sickness at the executive level over the last 12 months or so, which, again, was highlighted in the report. There have been five interim positions at executive level, including the chief executive position. All of that is going ahead against the backdrop of the service review changes in terms of community hospitals, vascular, older people's mental health and neonatal intensive care services. As members of the committee will be well aware, that attracted huge publicity and controversy. So, the board was also subject to those pressures.

[16] However, in terms of working relations, on the whole, people on the board got on reasonably well. That would be my view.

[17] **Darren Millar:** You said that there was a difference of emphasis between independent members and executive members. What do you mean by that?

[18] **Professor Jones:** No, Chair, I do not think that there necessarily was between independent members as a block and executives as a block. I do not think that that has ever been an issue. There were issues that arose, which Geoff Lang described when he was here. He called it 'a healthy tension'; there were tensions about how you balance the financial constraints against performance and against service review. Clearly, there were professional views also being expressed by executive members. I think that there were times when independent members found it frustrating that, occasionally, issues that they felt should have been sorted out at executive level were coming to board sub-committees to be sorted out.

9.15 a.m.

[19] **Darren Millar:** I have just a very brief question, before I bring Jocelyn Davies in. Do you think that the Welsh Government's response so far to what can only be described as a crisis at your board has been sufficient?

[20] **Professor Jones:** My own view—others may have a different view—is that the Welsh Government responded in a very active way. Up until last September, I had regular meetings with senior officials and with the Minister, but those were routine meetings. From September onwards, in the autumn, I had a number of meetings, both with the Minister and with David Sissling, in which they expressed their concern. I know that David Sissling was in regular contact with the chief executive expressing concern. There was concern about a whole series of issues. One of them was an issue that exercised me particularly and I had been very worried about since June/July, and that was the—let us call it A&E, although one is supposed

to call it the emergency department—A&E performance, particularly at Glan Clwyd Hospital. I thought that was deeply worrying, and I asked for weekly reports on that. The Welsh Government shared my concern about that and about financial planning, the forecast deficit, and a number of other issues.

[21] Since January, I have met the new Minister and spoken to him a number of times, and I have to say that I have been in very regular contact with David Sissling—quite often on a daily basis.

[22] **Darren Millar:** Can you just clarify something? You say that the Welsh Government recognised problems as far back as September. This report was obviously published much more recently than that. They were governance problems that the Welsh Government recognised at that time, were they?

[23] **Professor Jones:** I think that they were performance issues, primarily, but the Government officials may wish to elaborate on that when you speak to them later today.

[24] **Jocelyn Davies:** At the outset, you said that, because of your position, you were aware of all the problems that are outlined in this report. However, when you became aware of the content, when it was published, that is when you decided to stand down. If you were aware before the publication of the content, why was it that, when it was in the public domain, you felt that that was the moment to stand down?

[25] **Professor Jones:** It is a very good question.

[26] **Jocelyn Davies:** We are supposed to ask very good questions.

[27] **Professor Jones:** It is a very good question. I shall, no doubt, have more time to reflect on the nature of that decision in the months to come. It was clear to me that we had been trying to address many of these problems. It seemed to me that if one is to take regulators seriously—and here was a joint report from two regulators—then, as soon as this report was published, the proper and right thing for a chair to do was to take responsibility and to stand down.

[28] **Jocelyn Davies:** I can see why you would take responsibility, because it is your responsibility. I can see that, but I am just asking: if you were aware of all the problems outlined in this report, why did it have to be written down by somebody else and published in the public domain before you stood aside? It is quite obvious from the report that the board as a whole was dysfunctional and the board was not up to it. Would you say that was a fair reflection?

[29] **Professor Jones:** Well, as I have just explained, I think there were deep-seated structural and systemic problems. The board consists of some very able people. We could elaborate on many of the changes that were being introduced—some of them as a result of earlier reports, such as the Health Inspectorate Wales report on Glan Clwyd and the structured assessment of the Wales Audit Office. We were attempting to address those issues. Clearly, it seemed to me that we were not doing it with sufficient pace and had not succeeded.

[30] **Jocelyn Davies:** So, when did you become aware that the board as a whole—I am not blaming any individual—was dysfunctional?

[31] **Professor Jones:** If you came to one of our board meetings, I do not think you would walk away with the feeling that this was a dysfunctional board.

[32] **Jocelyn Davies:** So, you were not aware that the board was dysfunctional.

[33] **Professor Jones:** I was aware that there were serious problems in the way in which the board ran its business.

[34] **Darren Millar:** Dr Miles, it took you a week before your decision to step down. Why was there such a delayed reaction? Why did you feel it necessary to resign?

[35] **Dr Miles:** I felt it was the proper thing to do as vice-chair to accept responsibility for the system failure that existed. I did carefully consider the position. I considered the fact that we had been, and I had personally been, attempting for some time to address nearly all of the issues that were in the report, and I came to the conclusion that the right and proper thing to do was to stand down. I do not actually think it was a week. I resigned on the Sunday after the report, and I think the report came out on the Thursday.

[36] **Darren Millar:** Yes. It was announced on the following Tuesday, I think it is fair to say. I have another couple of Members who want to come in: Julie, Jenny, and then Mike.

[37] **Julie Morgan:** I can understand why a report does trigger a resignation, but, obviously, you were struggling with these issues for a long time before, and I do not really understand why, if the board was aware of the issues and wanted to address them, the structural problems stopped that from happening. Did the executive members of the board go away and do what the board decided? Was there any other structural element that got in the way?

[38] **Professor Jones:** I think the problem was that, as the auditor general said in his comments, many of the problems were structural in terms of the internal organisation of the whole health board. The problem in creating one organisation out of eight—one should not underestimate the scale of the challenge in doing that, particularly over a very wide geographical area, with a population of almost 700,000 people, and three major hospitals, all with their own cultures and ways of doing things. In order to achieve that—and I think that is what the WAO was getting at here, and HIW in some of its reports—you need some kind of horizontal structure that captures people and clinicians right across the area. Otherwise, people will just operate within their own local sphere. However, of course, things happen in places, and, where you do have local cultures, you also need vertical lines. It is at that point, I think, that the board had difficulties in managing the change that was necessary, because, again, to quote the auditor general, he raises the issue of

[39] ‘clear lines of accountability, robust performance management arrangements’,

[40] and so on, within the organisational structure. So there were, as it were, structural and systems issues that we were trying to resolve. So, this major issue of the clinical programme group structure and there being a separate board of directors to the board had been addressed by the review that Lyndon chaired, and which came up with certain conclusions about quite radical change—change that we have not yet been able to implement.

[41] **Julie Morgan:** The change was to ensure that there were clear lines of accountability, was it?

[42] **Professor Jones:** That is part of it. It was more complex than that, but that was certainly part of it, yes.

[43] **Julie Morgan:** That is a very key point.

[44] **Professor Jones:** It is. I think it is a key point.

[45] **Julie Morgan:** Is there anything, Dr Miles, that you could add to that?

[46] **Dr Miles:** Yes. I thought we would have an opportunity to discuss the review that we undertook. There are a number of issues that led us to undertake that review, some of which is about ward-to-board distance. Some of it is about lines of accountability, but there were other issues borne out of the matrix structure that we had, in a sense, in that we had clinical programme groups fitting into what is a locality arrangement in terms of hospitals and community localities. So, there were a number of tensions in there that we tried to drive through in terms of the review, which, hopefully, we will have an opportunity to discuss today.

[47] **Jenny Rathbone:** Professor Jones, when you took on the role of chairing this new board, clearly there were going to be some structural problems to address, because you had eight organisations going into one. What action did you take to make people feel that they were now part of a single body, all singing from the same hymn sheet, and bringing their protocols together? What actually did you do beyond realising that the report from the auditor general and HIW reflected the problems that you had been facing? I am struggling to understand why you, as the chair of the board, did not take more action to address these structural problems that the board was experiencing.

[48] **Professor Jones:** The board was created back in 2009, and I only became chair two years ago, so it was well established by the time I became chair. I had earlier been a member of the board, so I had some acquaintance with it, but as a university representative. To be fair, I think the whole of the board was remarkably committed to a north Wales vision, to trying to create a spirit of a north Wales health board, and to trying to break down, as much as possible, local cultures. I think that everybody was very active in pushing that message. Whenever I spoke to staff or to stakeholders, particularly at the regional leadership board, with local authorities and so on—and there are six local authorities across north Wales—I was always at great pains to argue that we were in this together, this was a north Wales project, and that we should not see it in terms of central, east and west. Indeed, we had far more in common across north Wales than the things people have traditionally thought separate us.

[49] I think that the whole board shared that vision, but it was extremely difficult. Those of you who know north Wales well will know that deep-seated views are held. I have lived in north-east and in north-west Wales, and even though they are actually remarkably similar, people think that they are different. There are different cultures, and there is of course far easier access from the north east to facilities over the border, and that is another consideration in creating an all-north-Wales body. I noted with interest that the auditor general in his evidence raised the issue of the name of the health board, and I have reflected over the years as to whether that name has actually helped to create a north Wales identity of not.

[50] **Darren Millar:** And has it, do you feel?

[51] **Professor Jones:** My own view is that it should be the ‘north Wales health board’.

[52] **Darren Millar:** The ‘north Wales university health board’. Thank you. Mike is next—

[53] **Jenny Rathbone:** But you did not bring in outside consultants to force people to work together more effectively, given that you had these silos or fiefdoms in the different geographical areas.

[54] **Professor Jones:** As I say, I honestly believe that everybody on the executive, and independent members, were totally committed to an all-north-Wales vision. It was remarkably free of the kind of localism that one might have expected to find. I think that there was a

genuine commitment at board level to planning on an all-north-Wales basis. It is the only way to do it. We have to do it, because we cannot sustain the services right across north Wales. There has to be a degree of centralisation, whether it be in one hospital or in three or two—that is a matter for strategic debate. However, there has to be, I think, planning across north Wales.

[55] **Darren Millar:** I am keen to pick up the pace now, and I have a few Members who want to come in: Mike, then Aled, then Christine Chapman.

[56] **Mike Hedges:** I have two very brief questions. From what you have said, and what other people have said, would it be true to say that the three large general hospitals did not buy in to the fact that it was a north Wales health board, the Betsi Cadwaladr health board, and they wished to continue as they had previously? While you at board level and at senior levels, with the executive directors, might have bought into an all-north-Wales structure, it was not bought into by those who were effectively running the three general hospitals. Secondly, Mr Sissling, you, the chief executive and others were talking for a very long time, yet—correct me if I am wrong—nothing much seems to have happened, despite all these long discussions since last July, when I think you said they started. There have been long discussions with the senior medical staff in the Welsh Government, yet nothing seems to have happened until the auditor general popped along with others and wrote a report.

9.30 a.m.

[57] **Professor Jones:** On the first part, perhaps other colleagues could comment on that as well. I think it was probably mixed: some people did buy in and some perhaps were more sceptical. That is certainly the impression that one got, and, clearly, institutions such as hospitals are very concerned if there is any suggestion that they might lose a service in order to centralise it somewhere else. So, one would expect that sort of response. So, I suspect that it was mixed, in that, actually, there was a degree of buy-in. However, whether it has been sufficient is questionable.

[58] On the second issue, an awful lot did happen as a result of pressure, either from the Welsh Government or from the board. To take the issue that I mentioned earlier, which was the A&E performance at Glan Clwyd, that was addressed in the autumn and it did improve considerably, having been at a very worrying level, although I remain concerned about A&E performance. The board also conducted a review of the clinical programme groups and of management structures. It is in the process of appointing a chief operating officer. There is now a commitment to reducing the number of CPGs over time. There are other examples as well, but things have happened, and it is partly as a result of the initiatives taken by the board, but often in collaboration with, or with the support of, the Welsh Government.

[59] **Aled Roberts:** Rhaid i mi gytuno, i ryw raddau, â'r hyn y mae Mike Hedges newydd ei ddweud. Mae'r sefyllfa hon yn mynd yn ôl rhyw ddwy flynedd erbyn hyn; roedd adroddiad ym mis Ebrill 2012 gan Chris Hurst yn sôn am yr anawsterau o fewn y bwrdd. Fe gomisiynodd Llywodraeth Cymru adroddiad gan Allegra ym mis Rhagfyr 2012, ac, i ryw raddau, yr hyn a ddywedodd yr archwilydd cyffredinol yr wythnos diwethaf oedd bod rhywfaint o rwystredigaeth o ran y rheoleiddwyr oherwydd nad oedd llawer yn digwydd. Roedd adolygiadau yn cymryd lle, ond nid

**Aled Roberts:** I must agree, to some extent, with what Mike Hedges has just said. This situation goes back some two years by now; a report by Chris Hurst in April 2012 talked about the difficulties within the board. The Welsh Government also commissioned a report by Allegra in December 2012, and, to some extent, what was said by the auditor general last week was that there was some frustration in terms of the regulators because there was not much happening. Reviews were taking place, but there was not much changing. I am very eager to know, aside from these daily phone calls between David

oedd llawer yn newid. Rwy'n awyddus iawn i wybod, heblaw am y galwadau ffôn dyddiol hyn rhwng David Sissling ac uwch-swyddogion o fewn y bwrdd iechyd, beth yn union wnaeth Llywodraeth Cymru?

Sissling and the senior officials in the health board, what exactly did the Welsh Government do?

[60] **Yr Athro Jones:** Mi wnaeth gomisiynu'r ddau adroddiad—nid adroddiad yw un Chris Hurst; mae'n fwy o nodyn i'r prif weithredwr. Fodd bynnag, adroddiad yw'r ail un a ddaeth allan jest cyn y Nadolig y llynedd, felly mae'n un diweddar iawn ac yn rhan o'r broses hon o newid. Rwy'n credu bod hynny wedi bwydo i mewn i'r adolygiad o'r grwpiau rhaglenni clinigol. Rwy'n credu bod Llywodraeth Cymru wedi atgoffa'r bwrdd o'i gyfrifoldebau yn ariannol ac yn nhermau perfformiad. Roedd yn gefnogol i mi fel y cadeirydd, ac i eraill, wrth geisio newid y system.

**Professor Jones:** It commissioned both reports—Chris Hurst's is not a report; it is more of a note to the chief executive. However, the second one is a report that was published just before Christmas of last year, so that is very recent and is part of this process of change. I believe that that did feed into the review of the clinical programme groups. I believe that the Welsh Government did remind the board of its responsibilities, financially and in terms of performance. It was supportive of me as chair, and of others, as we attempted to change the system.

[61] **Aled Roberts:** A ddaeth unrhyw swyddogion i fyny o Gaerdydd i weithio yn ddyddiol o fewn y bwrdd iechyd i sicrhau bod hynny'n digwydd?

**Aled Roberts:** Did any officials come up from Cardiff to work on a daily basis within the health board to make sure of what was going on?

[62] **Yr Athro Jones:** Naddo, nid yn ddyddiol, hyd y cofiaf.

**Professor Jones:** No, not on a daily basis, as far as I remember.

[63] **Aled Roberts:** Yn rheolaidd?

**Aled Roberts:** Regularly?

[64] **Yr Athro Jones:** Yn y cyfnod diwethaf hwn, mae David Sissling wedi bod yn dod yn weddol reolaidd.

**Professor Jones:** In this last period, David Sissling has been coming up fairly regularly.

[65] **Aled Roberts:** A pha mor rheolaidd yw rheolaidd?

**Aled Roberts:** How regular is regularly?

[66] **Yr Athro Jones:** Gallwn roi gwybod i chi yr union nifer o weithiau y mae ef wedi ymweld, ond mae ef wedi ymweld pedair neu bum gwaith eleni.

**Professor Jones:** I could let you know the exact number of times he visited, but he has been about four or five times this year.

[67] **Aled Roberts:** Nid yn fisol, felly.

**Aled Roberts:** Not on a monthly basis, then.

[68] **Yr Athro Jones:** Na, nid wyf yn credu.

**Professor Jones:** No, I do not believe so.

[69] **Christine Chapman:** Professor Jones, you talked a lot about the fact that the board has to deal with different cultures. I think that that happens in any organisation, whether it is in health, local government or any other organisation. Are there particular problems and challenges with the north Wales area compared with other parts of Wales that may be facing the challenges of change? Are there particular problems on top of the pressures that others are experiencing?

[70] **Professor Jones:** The obvious one is scale, in terms of the population—because the board has the largest population of any health board—and budget. However, I suppose that what confronts you immediately is geography. It is a very difficult geography in north Wales. When I drive from Bangor to Wrexham, it can take me two hours to get from one hospital to the other. It may not take that long, but you leave yourself two hours to get there. That is a long way. One of my frustrations over the last two years was that even though Bangor was the designated headquarters of the board, there was no central administrative hub where all the executives could meet and work. So, you had a dispersed executive across north Wales; some people were working in Bangor, some in Glan Clwyd and some in Wrexham. I personally do not think that that is or ever was a sustainable model.

[71] So, I may be contradicting myself here by saying that you have this huge geography, but you really need to bring executives together; otherwise they are going to spend an awful lot of time in the car. Of course, they did meet regularly and people travelled lengthy distances. However, it is about the geography and the fact that the three major hospitals are along the north Wales coast on the A55. You then have a major rural hinterland with a low population overall, yet with health needs. We have had issues in south Gwynedd recently. South Gwynedd is two hours' drive from Bangor. It is very difficult to ensure equity in access to healthcare when distance is such a crucial factor. I now live in Eifionydd, and I have to recognise that if I go to hospital, it is going to take me an hour.

[72] **Christine Chapman:** Are there other factors apart from geography that may make things more problematic?

[73] **Professor Jones:** There are others, but geography is linked to many of them. The other issue, of course, is the huge cross-border flow. We commission a huge amount of health work from outside of Wales, and we have traditionally done so in north Wales. In terms of medical training and recruitment, north Wales has always had very close links with Liverpool and Manchester until quite recently. Some people in north-east Wales, in areas such as Deeside, look not to Wrexham for their local hospital, but to Chester. That also creates an issue for us.

[74] There is also the aging population. Areas along the north Wales coast have some of the highest, if not the highest, concentrations of elderly people anywhere in the United Kingdom because of the—

[75] **Christine Chapman:** Is that exceptional? Lots of parts of Wales have an aging population.

[76] **Professor Jones:** It is exceptional.

[77] **Christine Chapman:** We are examining how the board has reacted to these extra factors.

[78] **Professor Jones:** On top of that—I think that we understand the demography of age reasonably well, and can foresee the demand due to the seriousness of conditions among the aged. However, I am not sure that we have a proper grip on the huge waves of people who come into north Wales every weekend and populate areas that would otherwise be absolutely unpopulated, and the health demands that they then create. Of course, there should be reciprocal arrangements and so on, but this can, at times, put great stress on the health service. So, that is an additional issue. In cultural terms, I do not think that the fact the north-west is largely Welsh-speaking and the north-east is largely English-speaking is an issue at all.

[79] **Darren Millar:** That begs the question: do you think that the health board is too big, due to the geographical challenges that it poses? Obviously, there is a health board of a

similar size in south Wales—the Cardiff and Vale University Local Health Board—in terms of population scale, but it has nothing like the geography that Betsi Cadwaladr has to cover. Is it too big, and is that one of the fundamental problems at the board? It is not alluded to in the WAO and HIW report, but is the sheer scale of the organisation something that you felt was difficult to manage? Do you think that it should have been smaller when it was created? Do you think that there should have been two boards in north Wales?

[80] **Professor Jones:** There is such a view, and one can see why people think that.

[81] **Darren Millar:** What do you think?

[82] **Professor Jones:** I think that you have to plan services on an all-north-Wales basis. Yes, that is hugely challenging, but I do not think that there is an alternative to having a north Wales vision for health. However, you are quite right to say that the scale of the operation is very challenging.

[83] **Darren Millar:** In terms of the impact of visitors, does the Welsh Government recognise that within the funding formula and the resources that you receive? Is it sufficiently recognised, if at all? You are the chair of the finance committee, Mr McDonogh; do you wish to give a view?

[84] **Mr McDonogh:** I cannot say that it is reflected in the activity plan.

[85] **Darren Millar:** Is it not?

[86] **Mr McDonogh:** I cannot say that it is reflected in the activity plan, which I have seen.

[87] **Darren Millar:** Have you ever made a plea, as a board, for recognition of this pressure within the financial resources that you receive from the Welsh Government?

[88] **Mr McDonogh:** It is not an area on which we have sought explicit information or support. However, there is a regular report to Welsh Government about performance figures. Clearly, any exceptional additional work would have been included in that performance report.

[89] **Darren Millar:** So, this is a pressure that the board recognises, but you, as chairman of the board committee responsible for finances, have never made a plea to the Welsh Government for that to be recognised in the financial settlement that your board receives. I find that astonishing.

[90] **Mr McDonogh:** No, but I would need to clarify with the finance team whether, in terms of the internal preparations for the accounts and budget-setting, there is some line that recognises that particular pressure.

[91] **Professor Jones:** There are reciprocal arrangements whereby the health authorities of patients from elsewhere are billed for treatment.

[92] **Jenny Rathbone:** How effective are you at recharging for visitors who come in from other health areas?

[93] **Professor Jones:** The systems are there to recharge, and, on the whole—

[94] **Jenny Rathbone:** Are they carried out? This is a board that has struggled with its finances. Are you telling us that you have not been recharging people in Liverpool and

Manchester?

[95] **Professor Jones:** It is absolutely the case that there is recharging. However, I suspect—though I could not confirm—that some people have slipped through the net.

[96] **Jenny Rathbone:** Could we have a note on how effective you are at recharging for visitors?

[97] **Professor Jones:** Yes, certainly. There is a huge amount of recharging that goes on.

[98] **Mr McDonogh:** I am aware of recharging under certain categories, and there will certainly be a note forthcoming with some detail on those categories and the amounts that have been recouped.

[99] **Darren Millar:** Is that something that the board has monitored?

[100] **Mr McDonogh:** It is something that we are aware of, and—

[101] **Darren Millar:** Do you monitor it? I am not asking whether you are aware of it; I am asking whether you monitor it. Do you hold the executive team to account for the delivery of the income that is due to the board?

[102] **Mr McDonogh:** Certain aspects of recovery are reported regularly as part of the conformance report to the audit committee.

[103] **Darren Millar:** Do you ask questions about them?

[104] **Mr McDonogh:** Yes, on a regular basis.

[105] **Darren Millar:** I cannot see any questions in the board minutes. We will come to some of those issues in a moment. I now bring in Mike Hedges.

[106] **Mike Hedges:** There was one question that I wanted to ask, and another leading on from that. You are, of course, a net payer into England. Apart from Powys, which covers certain specialities, you pay substantially more into the English health service than any other board in Wales. I therefore assume that you do a netting-off process, rather than you charging them and them charging you.

9.45 a.m.

[107] However, the question that I was going to ask was in relation to places that I, based in Swansea, think of as being in north Wales, geographically, such as Welshpool and Newtown. Those places happen to be part of the health board in Powys, which is less than half the size of that of north Wales. In that case, geography was taken into account in deciding on the health board. Do you think that the same should have happened in north Wales?

[108] **Professor Jones:** I am not quite sure that I understand the question.

[109] **Mike Hedges:** Which one—the first or the second?

[110] **Professor Jones:** The second.

[111] **Mike Hedges:** Powys Teaching Local Health Board is less than half the size of Betsi Cadwaladr University Local Health Board. If you had a Gwynedd health board and a Clwyd health board—to use the old-fashioned county names—they would still be bigger than the

health board in Powys. The geographical size of Powys was taken into account when the health board was created, so should the same thing have been done when the health board in north Wales was created?

[112] **Professor Jones:** In many respects, the geography of Powys is even more challenging and rural, is it not? As I say, there are people who believe that the health board in north Wales is too big and that there should be two boards. However, my view is that it was correct to have north Wales as one health board, partly because of what does not exist in Powys and, in fact, does not exist anywhere else, other than along the southern coast, which is a major road. The A55 links east and west in north Wales. What it does not do is tie you into the rural hinterland. However, I recognise the point that you are making.

[113] **Darren Millar:** We are going to have to move on. I want to pick up the pace—we move on to Oscar and then back to Christine.

[114] **Mohammad Asghar:** Will you allow me one supplementary question first, Chair?

[115] **Darren Millar:** Yes; I will.

[116] **Mohammad Asghar:** Mr Jones, you have been saying a few words very regularly, like ‘excess’, ‘geography’, ‘distance’ and ‘cultural issues’. I personally think that you are hiding something there that is more than serious. In 2010, when you took over the job, what steps did you take straight away? Did these concerns come to you in due course, or were you well aware of them before you took over? Did you take the necessary steps straight away, or did you leave it too late?

[117] **Professor Jones:** I think that one was aware of the general points about geography and so on, as most people in north Wales will be. I had briefly been a member of the board, so I had some acquaintance with it. I think that it is probably true to say that it took me two months—I have only been in the post just over two years—to recognise the scale of the problems that we faced. However, after that—certainly from the end of 2011—I think that we took a number of steps to try to address the issues.

[118] **Mohammad Asghar:** The report gives examples of board papers on key business issues being circulated late or on the day of the board meeting. Why was that allowed to happen and how did independent members challenge that practice?

[119] **Professor Jones:** I think that the first point to make is that it did not happen very often. Most board papers were presented in the way that you would expect—that is, an agenda would have been agreed and papers produced a week beforehand for all board members. That would go for the vast majority of papers going to boards and sub-committees. However, there were occasions, which are quoted in the report, when that did not happen. As chair, that caused me considerable concern; the independent members and I were deeply unhappy about that. Sometimes, there were good reasons for it, but that still does not change the situation—we were still very unhappy about it. To take the most recent case about the budget paper and the request for 72 or 74 new medical appointments, we have a finance and performance committee that meets just before the board. The executive and the finance and performance committee had scrutinised that paper thoroughly and it came, naturally, to the board. It would have been better if it had come earlier, but that was in the nature of the routine of the business. Perhaps Keith can elaborate on that later. The other paper, on recruiting all these medics, was being presented because it was argued that, if we did not take a decision, we might not have enough doctors this coming August. So, it was a sort of emergency. I think that a chair should be able to agree to receive an emergency paper. However, on that occasion, I allowed discussion on that paper, but I refused to allow the board to make a decision and to commit large amounts of money in response to a paper that I had not even

been able to read, as I was chairing the meeting. I refused to allow the board to come to a decision on that.

[120] **Mohammad Asghar:** My next question is to Grace. As the person with board secretary responsibilities, what was your role in ensuring that board members received papers in a timely manner?

[121] **Ms Lewis-Parry:** As the chairman has said, we routinely make sure that papers are provided in good time, seven days in advance of the public board meeting. That happens most of the time. However, there were some notable exceptions that were commented on in the report. As Merfyn has said, the one that was not appropriate was when a paper was tabled requesting an urgent decision. Merfyn allowed discussion, but no decision, and the board reconvened a week later to take proper consideration of the issues that were in that report. So, we do have arrangements for receipt of late papers. Those are set out in our standing orders, as they are in all the health boards, and that is at the discretion of the chair.

[122] **Darren Millar:** May I just clarify this, Mr Jones? It was your discretion as to whether to allow a paper to be presented late. You have, in common with all organisations, the opportunity to call additional meetings where necessary, so you could convene one a week later if you wanted to, in order to allow people proper time to digest the contents of a report. Yet on these two occasions, you allowed discussion to take place without allowing the members around the table to have sight of the report sufficiently in advance to digest the contents.

[123] **Professor Jones:** I can see why—

[124] **Darren Millar:** It is very odd, is it not?

[125] **Professor Jones:** It is not best practice, no. I agree. It seemed, though, that this was an emergency. The medical director wished to talk through the paper, but, as I said, I did not think that it was good governance, or indeed any kind of governance, to expect independent members and others to make a decision on it. So, we had another meeting a week later.

[126] **Darren Millar:** What was your advice to the chair, then, Grace Lewis-Parry?

[127] **Ms Lewis-Parry:** That it is quite clear that discussion can take place, but that it is not appropriate, if an important paper is tabled, that people do not have proper time to consider the issues in it. That is not good governance. You cannot expect board members to make reasonable or rational decisions if they have not had time to properly consider the information.

[128] **Darren Millar:** I have a couple of Members who want to come in before I come back to you, Oscar. We will move to Julie and then Aled.

[129] **Julie Morgan:** Professor Jones, on this paper about the extra doctors needed, did you say that you only saw that on the day it was presented?

[130] **Professor Jones:** Yes.

[131] **Julie Morgan:** So, was there no indication given to you, as the chair, before the board meeting that something so big was coming up?

[132] **Professor Jones:** No.

[133] **Julie Morgan:** That just seems an extraordinary situation. What caused that? Why

did that happen? In most organisations, I think that you would have to accept that, if you were the chair of a board and there was going to be an important paper, somebody would have phoned you or had a discussion and said, 'This is an emergency'. Why did that happen?

[134] **Professor Jones:** I am not sure why it happened that way. I think that it was partly because those working on this plan were in a shifting situation, in negotiations with the deanery, and they found themselves suddenly feeling that they had to take some action. So, they brought a paper to the board. However, as I say, I did not think that it was good practice.

[135] **Julie Morgan:** So they brought it on the day for you as well, as the chair?

[136] **Professor Jones:** Yes and, because I was chairing the meeting, I was not in a position to read it.

[137] **Julie Morgan:** So, perhaps this is a sign of some of the problems that existed—as you say, the medical director brought it.

[138] **Professor Jones:** Yes, along with senior clinicians.

[139] **Julie Morgan:** Yes; a sign of the lack of communication or building of relationships, which seems to be one of the key things in all of this.

[140] **Professor Jones:** I think that it was the urgency of events, actually. People were very desperate to get the thing sorted.

[141] **Julie Morgan:** If they were so desperate to get it sorted, surely there would have been a means of communication other than an actual board meeting to start off the process. It must have been written and prepared, presumably. Was it written the night before? Do we have any of those details?

[142] **Professor Jones:** It was written shortly before the meeting, as I understand it. We were aware, of course, of the negotiations with the deanery. We were aware of the impact that changes in training junior doctors and so on would have on our own requirements for GPs. Timing was extremely unfortunate also, because we were beginning to review our acute services and there was a danger that acting in this sort of urgent, emergency manner might affect the long-term decisions of service redesign. I believe that that was not the way to do it.

[143] **Aled Roberts:** Is there a working group that deals with workforce planning issues and is involved in communication with the deanery? This appears to be indicative of management by crisis, really. It seems unbelievable given that, during the neonatal review, for example, we were told that discussions had been ongoing with the deanery for 12 months at that stage, that you actually come to a situation where there is a paper produced at short notice to the board suggesting that some 70 doctors are employed. Is there no working group that actually deals with workforce planning and reports regularly to the board?

[144] **Professor Jones:** It is the office of the medical director that is responsible for medical recruitment. There is a group that deals with workforce planning, which I chair. The Wales Audit Office, in its assessment published in December, thought that it worked quite well.

[145] **Aled Roberts:** So, you are chair of that working group.

[146] **Professor Jones:** Yes. It is a sub-committee of the board.

[147] **Aled Roberts:** So, you are chair of the sub-committee, but there had been no

discussion regarding this urgent need for doctors within that working group before this paper was presented to the board.

[148] **Professor Jones:** There had been a discussion about it, but this was the first time that such a hard proposal had emerged.

[149] **Jocelyn Davies:** I want to expand on this point. You were aware of the context in which this paper was going to be produced, and members of the board, including you, would have known that this issue was an issue. However, on the day, that is, when you discovered the extent of it, although you would have been aware that there was an issue in relation to vacancies that needed to be filled in the months leading up to April. So, again, you were aware of the context and the content, but you did not actually have it in writing.

[150] **Professor Jones:** Yes.

[151] **Jocelyn Davies:** I can understand why you did not want a decision made when the ink was not yet dry on the paper—and people do need to think—but the board did know that this was coming at some point.

[152] **Professor Jones:** The board was certainly aware that this was an issue, that discussions were going on with the deanery, and that there could be a very serious impact on training places.

[153] **Jocelyn Davies:** It was the magnitude that you did not know.

[154] **Professor Jones:** No.

[155] **Jocelyn Davies:** So, were there any preparations in place, even though you did not know the magnitude at all, to deal with the issue of vacancies, where you might have thought, 'We know that there is this problem, but we don't quite know what the magnitude is. We'll wait until we know the magnitude before we do anything'? Is that the—

10.00 a.m.

[156] **Dr Miles:** It is my understanding that the board was aware of the longer term direction of training rotas—this is what we are talking about—with junior doctors on a 1:8 or a 1:11 training rota. My understanding was that the board was aware that we were heading towards a 1:11 training rota in due course. However, the change that meant that the issue needed to be urgently presented to the board was the understanding among executives that the deanery required a 1:11 rota from this August on. So, it was imperative to make a decision. It was—

[157] **Jocelyn Davies:** You knew that it was coming, though.

[158] **Dr Miles:** We knew that it was coming. My understanding was that it was expected to come next year.

[159] **Jocelyn Davies:** Okay.

[160] **Aled Roberts:** How regular are these reports from the deanery? We had this issue with the neonatal review, in that, during a public meeting, consultants challenged board members on decisions that the consultants were aware of, but which were not reported to the public with regard to rota changes. Those discussions had been taking place for 12 months, and board members claimed to be unaware of the situation. So, were these discussions with the deanery actually reported regularly to the board?

[161] **Dr Miles:** I have not been part of those discussions, so I do not know.

[162] **Aled Roberts:** Well, you are a part of the board, though. I asked whether they had been reported to the board.

[163] **Dr Miles:** Right. I do not know whether they have all been reported to the board, because I have not been part of the contact between the deanery and the clinical trainers in north Wales. There will be a regular contract for each specialty with those. All I can tell you is that some reports have come through, and we have had a number of discussions about how we handle and how we manage the increased number of trainees that we would need to fill those rotas. However, I cannot tell you whether every meeting that has been held with the deanery has been reported to the board, because I doubt that that will happen, to be honest.

[164] **Professor Jones:** I think that meetings with the deanery are a continuous process. People at the sharp end of this are in continuous negotiation and discussion with the deanery.

[165] **Mike Hedges:** I have two very brief questions. I take it from your answers that you were not shown a first draft of all reports prior to them coming to the board. I think that it is a fairly normal thing for the chair to see first drafts, to express a view. I take it that you were not shown a first draft, so do you not think that you should have been?

[166] Secondly, did the board not have 'key issues' discussions in private, at which issues coming up were there to be discussed? Surely, some of these issues should have come out as part of these 'key issues'. I just cannot believe that the chair was not shown the first draft of reports.

[167] **Professor Jones:** This was an emergency paper that came directly to the board. Normally, the board secretary and I would discuss all the reports that come to the board.

[168] **Mike Hedges:** Do you mean to say that there was no first draft of this report, but that it was produced overnight, as if from nowhere? I find it very difficult to believe that, within the health service, there were not consultations with more than one person and that it was not just one person writing the report and then putting it—there would have been consultations, and a first draft; the first draft would be circulated in order for people to be consulted on it, and, after the first draft, a second draft would exist, and a third draft would probably be the one that would come to the meeting. That is how I would expect it to happen. You are saying that that did not happen, but that there was just one draft, one report, and it was just plonked down.

[169] **Professor Jones:** I am sure that it did happen, but it happened among the group of people who were dealing with the problem. It was not shared with the board.

[170] **Mike Hedges:** But surely, you, as chair, should have seen a copy of it.

[171] **Professor Jones:** I agree.

[172] **Darren Millar:** Mrs Lewis-Parry, I still do not understand, given the key role that you have as an interface between the executive members and the independent board members, especially the chair, why the information did not appear to be flowing freely. Were you aware of this proposal in advance of the meeting, before the chair became aware of it? If so, how far in advance were you aware of it?

[173] **Ms Lewis-Parry:** As we have said already, it is not an issue that we did not know was coming. What we did not have in front of us, though, was a firm proposal for the board to

consider until the day of the meeting. The issue was that that was not well handled, and it should not have come in that way. As Mr Hedges has said, there should have been prior discussion and agreement. So, when it was tabled in that way, the chair took the appropriate action, which was to say that—

[174] **Darren Millar:** You are not answering my question. You are repeating the answer that we have previously had. I am asking you: when did you become aware of this paper? Could it have been circulated sooner? That is the point that I am making.

[175] **Ms Lewis-Parry:** I was aware that there were discussions, in the days leading up to the meeting, of a paper being prepared.

[176] **Darren Millar:** Did you not alert the chair at that time that there was likely to be an emergency paper tabled?

[177] **Ms Lewis-Parry:** I do not think that I did.

[178] **Darren Millar:** Was there any reason for that? I mean, you should have a close relationship with the chair, should you not?

[179] **Ms Lewis-Parry:** Yes.

[180] **Darren Millar:** But you cannot give us any reason for why you did not do that.

[181] **Ms Lewis-Parry:** I cannot. I should have done.

[182] **Darren Millar:** Okay. We—

[183] **Jocelyn Davies:** Did the chief executive know that this paper was coming?

[184] **Ms Lewis-Parry:** Yes.

[185] **Jocelyn Davies:** And the chief executive did not talk to you. You were not in the loop, as the chair.

[186] **Darren Millar:** Mr McDonogh, there was reference as well to the finance paper. Budget planning processes are long, drawn out and protracted, particularly in the biggest public sector organisation in Wales, I would expect. Why on earth could you not get your ducks in a row as a committee to make sure that the papers were available to the full board well in advance of the board meeting?

[187] **Mr McDonogh:** The budget-setting process is quite a lengthy one, with papers being submitted to the finance and performance committee, and then reported to the board two days later, at various stages in that process. One of the reasons there can be late tabling to the board of certain finance papers is that the latest iteration of that plan might have been considered by the FP committee two days before the actual board meeting. So, the finalisation of some of the last details may not have been subject to recommendation from the committee that I chair until two days before the board.

[188] **Darren Millar:** Why not hold your meetings beforehand, then? Why hold them so close before the main board meeting, where you have to sign the thing off?

[189] **Mr McDonogh:** This has been a matter of review, Chairman. One of the reasons the FP committee has to meet fairly late after the middle of the month is the availability of the current figures for the previous month, when the ledger has closed for that month.

[190] **Darren Millar:** Okay, I accept that. It is a timing issue in terms of the management accountants within the board preparing financial data and making sure that it is sufficiently robust for you to be able to test them. I understand that. However, why not then just change the programme in terms of the dates of meetings, et cetera, to make sure that they are available? Did you ever receive any advice from the board secretary?

[191] **Mr McDonogh:** It is a matter that we have discussed with the board secretary, and it is under review.

[192] **Darren Millar:** It is an obvious decision to make. When you say that it is under review, you could make the decision around the table now, could you not? When you say that it is under review, how long is it going to take you to just use common sense and make sure that the board has sufficient time to be able to digest the decisions and the recommendations of your committee before making formal decisions on what is a pretty important subject—the budget? Would you not agree?

[193] **Mr McDonogh:** I do agree, Chairman.

[194] **Darren Millar:** So, why is it under consideration? Why are you not making a decision?

[195] **Mr McDonogh:** It is because there is a mid-point in that month when all of the performance information and all of the financial information are robust enough for the committee to scrutinise. As I say, we are discussing, in terms of the board calendar, what would be the most appropriate time to ensure that reliable information and timely reporting to the board can be lined up earlier in the month.

[196] **Jocelyn Davies:** Has this been the case since 2009?

[197] **Darren Millar:** Mrs Lewis-Parry, you will be able to tell us that. Is this—

[198] **Jocelyn Davies:** Has it been the case since 2009?

[199] **Ms Lewis-Parry:** The programme of meetings was relooked at in 2011, and some changes were made then. We reset the dates for board meetings back in May this year; we put a new programme together to try to accommodate this issue, because we want to get the balance to make sure that the most up-to-date information is with the board and in the public domain, but not arriving late. So, the rescheduling of the board meetings has now been set to accommodate that.

[200] **Jocelyn Davies:** Mr Jones, your board is being bounced into making decisions. It is perfectly obvious. What did you do to ensure that that did not happen? I cannot believe that you would allow your board to be bounced into making decisions of this nature.

[201] **Professor Jones:** Well, I did not allow the board to be bounced into making a number of decisions. However, on the budget, I was reassured that the finance and performance committee, on which a considerable number of board members sit, had scrutinised the budget and the planning to a suitable level. I take the point about the timing, and I think that we need to reconcile those things.

[202] **Darren Millar:** We have a very brief supplementary question from Mike.

[203] **Mike Hedges:** The timing may not be a problem, as long as two things happen. One is that the finance committee papers go to all board members. Did that happen? The other is

that all board members are allowed to view the finance meeting. So, effectively, all board members get a second go at it. Did either of those things occur?

[204] The third thing is this: why worry so much about the budget? From what we have been told so far, the final budget was just a negotiating point for senior physicians to come back.

[205] **Ms Lewis-Parry:** The finance and performance committee did not have all the board members on it, but it did have most of them—

[206] **Mike Hedges:** Did others attend?

[207] **Ms Lewis-Parry:** Others do attend, yes.

[208] **Mike Hedges:** Did everybody have the papers?

[209] **Ms Lewis-Parry:** Not routinely, no.

[210] **Mike Hedges:** Why?

[211] **Ms Lewis-Parry:** That was not a system that we put in place.

[212] **Mike Hedges:** Why?

[213] **Ms Lewis-Parry:** It was because the remaining board members had them two days later.

[214] **Mike Hedges:** Why did you think that was a good idea?

[215] **Ms Lewis-Parry:** It is clear that, in retrospect, we should have done it differently.

[216] **Mike Hedges:** You had four year of retrospect; why are we retrospecting now?

[217] **Darren Millar:** You have a dual role within the organisation, Mrs Lewis-Parry, do you not? You are the director of governance and the communications director, as well as being board secretary.

[218] **Ms Lewis-Parry:** Yes.

[219] **Darren Millar:** Did that make your life difficult in any way? Was there a tension between the two roles?

[220] **Ms Lewis-Parry:** What I would say is that when the role was designed that I was appointed to back in 2009, by the then board when it was established, it was an unusual role. It is not the same as in other health boards in Wales—

[221] **Darren Millar:** So, yours was unique to this health board.

[222] **Ms Lewis-Parry:** It was unique to BCU. There are a number of roles and functions within one post and within one team. I think that there were issues in terms of challenges and tensions, but it was seen to be a reasonable fit at the time when the organisation was set up. That was not my decision; that was a decision for the board. When that was tested out over the years, through the Wales Audit Office structured assessment, and other reviews, it was seen to be acceptable, until really the last 12 months, when the chief executive and I, together with the auditors, were saying that we needed a better separation of these duties. We needed

to make sure that we looked at the fact that the board needed more support, the board needed more attention paid to the routine and core governance processes and systems, and we needed to separate out those responsibilities. So, discussions were ongoing. However, in the midst of this, in the last 12 months, we had five acting posts within the executive team. So, it was a question of everybody who was still there trying to make sure that priority was given to issues. The board has now confirmed its intention to move the board secretary role to a separate full-time post, with accountability to the chairman, and not have this broader group of responsibilities as currently configured within the post that I hold.

[223] **Darren Millar:** Is that something that you suggested? Did you ever raise concerns about this?

[224] **Ms Lewis-Parry:** Yes. This is something that I was discussing with Mary, as chief executive, over the last six to eight months, which she was mindful of, and we were committed to doing. I very much welcome what is stated in the regulators' report because that will serve the board better.

[225] **Darren Millar:** Did you ever raise this tension with the chair?

[226] **Ms Lewis-Parry:** We recognised that there was a real area of competing priorities that were being dealt with within one function that would be better dealt with separately, as had been managed in other health boards. I think that it is now agreed that that is the way that the board will go.

[227] **Darren Millar:** On the one hand, you have a duty towards the executive team, and on the other hand, to the independent board members who you want to challenge the executive team et cetera. Very briefly, in terms of supporting them in that role—and we are going to extend this session to 11.00 a.m., by the way—and the support that you gave to independent members to enable them to challenge the executive team, what training or induction programme was in place for new members? You would be responsible for giving them that support.

[228] **Ms Lewis-Parry:** That is right. Between 2009 and 2011, we had a series of induction and development programmes as a collective board that was externally facilitated and we had support nationally to do that. That was seen to be working quite well. Following on from that, and up to the period of 2013, we have had over 27 separate board development sessions collectively as a board, looking at things like good decision making; scrutiny and challenge; the role of public health; making sure that people were familiar with their statutory duties around the Mental Health Act 2007, for example; child protection; and, health and safety. Also, we made sure, with the chair, that all the independent members came for their annual appraisals, and those were documented and their individual training needs identified through that process.

10.15 a.m.

[229] When new members were appointed after 2011, they had some one-to-one induction, but they did not, perhaps, enjoy the more collective board effectiveness programme to which the first wave of appointed members had been party. In May, at board, we agreed a new programme of board development as a collective, and that is under way.

[230] **Darren Millar:** However, your arrangements, even post 2011, would have been similar to those in other health boards in Wales, would they not?

[231] **Ms Lewis-Parry:** Each board does different things. Through my contacts, I am aware that some have done some additional more collective board development, while others have

not. It is a local arrangement.

[232] **Darren Millar:** So, at no time were independent members craving more training or support from you. They were not requesting specifically your support or—

[233] **Ms Lewis-Parry:** When those specific requests came up, they were—

[234] **Darren Millar:** So, there were specific requests, were there?

[235] **Ms Lewis-Parry:** Yes, for people to go to certain things; for example, the chair of the audit committee wanted more training on managing the audit committee, and that was done specifically for him. However, I think that, particularly as we move forward as a board, it will be really important to do collective board development to make sure that the board that remains can be as effective as it can be.

[236] **Darren Millar:** Do you think that there ought to be a national programme, determined by the Welsh Government, of board development opportunities and inductions, so that there is a statutory requirement, perhaps, or a requirement of some sort, for board members to attend? Would you welcome more guidance from the Welsh Government on this?

[237] **Ms Lewis-Parry:** Yes. In previous arrangements, some very well-received and high-calibre training and development was offered nationally for the then non-executive members and the now independent members. As we move through this, perhaps that should be something that we could work collectively on across Wales.

[238] **Darren Millar:** How about you, Mr Jones, as chair of the organisation? When you took on that responsibility, were you given specific training to equip you in that post? Your background had not been health focused in terms of your own professional experience.

[239] **Professor Jones:** Yes, I was certainly given a great deal of support. Grace spent a considerable amount of time with me going through a huge amount of documentation. The chief executive explained a great deal about health as well. I had some experience in health. I had a lot of experience on other boards, and that highlighted some of the issues that you have just been raising, Chair.

[240] **Jocelyn Davies:** On that point, you said earlier that you were the university representative on the board. Of course, when you sit on a board you are a member of that board—you are not representing another organisation.

[241] **Professor Jones:** Yes, that is right.

[242] **Jocelyn Davies:** Do other members of the board feel the same, that they are actually representing something else when they are there? You did say that earlier on.

[243] **Professor Jones:** I did say that, yes; you are quite right to pick that up. I think that board members are fully aware that they are board members; I certainly was when I was there. However, I was also aware that I was there because the board has ‘university’ in its title, and that there were particular responsibilities toward the university. As you know, there is a staff-side member who is a full member of the board, and we now have a member of the board who represents the voluntary sector. I understand the point that you are making very well; they are full members of the board, but they have special links. They do not have constituencies—they have special links. Local government is the other one; we now have a person from that sector, too.

[244] **Jocelyn Davies:** I know that I understand the point; I just wondered whether you did,

because that is how you described it.

[245] **Professor Jones:** I know; I think that there may have been some ambivalence there.

[246] **Darren Millar:** It is very important that we start to move on now.

[247] **Julie Morgan:** Very swiftly, did you, as a whole board, meet to look at the way that you worked?

[248] **Ms Lewis-Parry:** Yes; we did.

[249] **Julie Morgan:** How many times?

[250] **Ms Lewis-Parry:** In what period? Certainly between 2009 and 2011, there were several occasions when we met as a board to try to look at our effectiveness as a function. We received feedback and then had a development plan that came from that, for individuals and for the board collectively.

[251] **Christine Chapman:** I want to understand better how the management and clinical leadership structures worked. How effective did you feel that they were, and where were the problems? I know that we have touched on this, but the original structure had 11 clinical programme groups. We know that there were problems with those, such as no obvious connectivity to geographical sites. I know that Professor Jones has highlighted some of those. Bearing in mind those sorts of problems, should the board not have recognised the risks with this structure at the very outset? I am thinking of the timing issue. Everybody recognises them now, but how quickly were these difficulties picked up, and did you seek assurances on how they were going to be managed?

[252] **Dr Miles:** The board adopted and accepted the model that was put forward by the chief executive at the outset for very good reasons. One of these was that the clinical programme group model spanned north Wales, and we saw that as a solution to some of the cultural problems that we have discussed this morning. The second was that we were very keen on, and supportive of, the principle of clinical leadership, and this was a model of clinical leadership and of empowering clinicians. That was the reason that we adopted the model. One could debate the size and shape of the various groups, but that was the model put forward by the chief executive that the board accepted.

[253] In terms of when difficulties started being recognised by the board, I guess that board members might give different opinions on that. Certainly, from my perspective, there were some concerns that I recognised, perhaps within a year of its establishment, particularly with regard to community services. Part of my portfolio is to have accountability for community-based services, and I could see problems developing out of that. Then, there were some issues around board-to-ward distance that cropped up. Following that, there were some concerns about the transparency of the holding-to-account and financial-rigour process. So, this developed over the past 18 months or so.

[254] I had a discussion with the chief executive this time last year—we had had a number of discussions—on the need to progress what would, in essence, be a review. Her opinion, which I respected, was that, at this time last year, we were in the middle of the acute services review, or at least those elements that we took to the public, and that it was not a good time to do it. She requested that we postpone it until the end of the year, which is what we did. We then undertook a review. There was a discussion between independent members, the chairman and the chief executive. We established a panel, which I chaired on behalf of the chairman, which looked at a number of issues. Some of these were structural, but they were mainly functional issues relating to the workings of the executives, the CPGs and the board.

[255] **Christine Chapman:** So, you were recommending having six CPGs—moving from 12 to six.

[256] **Dr Miles:** Understandably, people focus on the number of CPGs that the panel recommended. I have to say that we were more focused on the functions that existed, the transparency of the process and dealing with issues such as doctor management, and so on, rather than the number. My personal opinion was that it was very important that we establish a community CPG, and that was one of the ultimate proposals. Beyond that, the numbers were not a particular issue for me. However, we did have a discussion as to the benefits and disadvantages of having a large number with a very flat management structure, which would make clinical leadership easier, but would make management functions more difficult, or whether we should have a small number, which would make clinical leadership more difficult, but would make management easier. What actually happened was that, before the conclusion of the review, the executive, under the leadership of the chief executive, made a recommendation that there would be six. That was presented to the board before the CPG review was completed. I was very happy—and the panel that we had was very happy—with that conclusion.

[257] **Christine Chapman:** In hindsight, could the proposals and consultation been handled differently? Or, do you think that it was about right, in relation to all of these changes?

[258] **Dr Miles:** Are you asking about the structural changes?

[259] **Christine Chapman:** Yes.

[260] **Dr Miles:** If one makes structural change, there is a requirement to engage with the staff members involved. I think that that was done correctly. With the benefit of hindsight, I personally wish that I had pushed this harder a year ago.

[261] **Christine Chapman:** I now have a question for Mrs Grace Lewis-Parry. What was the response from the wider staff body to the consultation that the chief executive undertook to move to the six-group model? Could you explain that?

[262] **Ms Lewis-Parry:** The consultation went out internally to all staff in the health board for them to comment on. A small but significant number of responses were received. From memory—I do not have the numbers here—there were between 40 and 60. That is off the top of my head. There was a variety of views expressed—

[263] **Christine Chapman:** Sorry, 40 and 60 responses.

[264] **Ms Lewis-Parry:** Between 40 and 60 responses. So, only a small number of responses.

[265] **Christine Chapman:** Out of how many would that be?

[266] **Ms Lewis-Parry:** How many staff?

[267] **Christine Chapman:** Yes. Is it a very small percentage?

[268] **Ms Lewis-Parry:** It is. I do not know what the percentage is. We have about 16,500 staff, so it is a very small percentage. Some of those responses came from groups and fora rather than individuals, so they would be—

[269] **Christine Chapman:** Would you say that that was a low number?

[270] **Ms Lewis-Parry:** Yes.

[271] **Christine Chapman:** Were you disappointed? Did you wonder why there was such a low response?

[272] **Ms Lewis-Parry:** I think that the senior teams who perhaps would be more directly affected by these issues did get involved in the discussion, debate and feedback. For front-line staff, their focus is their patient and what is happening day to day in their ward or in their community. For them, perhaps, the issue is around whether they have the skills and time to deliver the care that they want to deliver for their patients, rather than some of the other changes that they see that they may not particularly want to contribute to. However, I do think that, through all of this, it is clear that we have to do more as a board to communicate with staff effectively and to give staff a voice. That has come through loud and clear in the report.

[273] **Christine Chapman:** I want to go back to the response. Although it was low, what was the actual response? Was it in favour?

[274] **Dr Miles:** My understanding is that there were in the order of 65 responses; half about the executive element and half about the CPG element. If I remember correctly, there were 16 responses not in favour of the CPG number changes and 10 in favour. So, it was relatively balanced, but it was a very small number of responses.

[275] **Christine Chapman:** Moving on, how do you think that the six-CPG model will now be managed? How do you feel that will work, bearing in mind all the things that have gone on?

[276] **Dr Miles:** Having undertaken the review and looked at, as I said earlier, functions more than numbers, I would hope, having made the recommendation, that the model will be a better model. However, I think that it is more on the basis of the functional change, rather than the numbers game.

[277] **Darren Millar:** We have two people who want to ask some supplementary questions. Then I will come to Jenny, because we need to move on. Be very brief, Aled and Mike. Then the witnesses can answer after both questions have been asked.

[278] **Aled Roberts:** Rwyf eisiau deall y broses, yn hytrach na'r nifer. Dywedwyd gennych fod cynnig wedi mynd gerbron y bwrdd i gael chwe grŵp cyn i'r panel adolygu gyflawni ei waith. Roddwn i'n meddwl bod y panel wedi argymell y dylai fod 6 grŵp, ac eto roedd y prif weithredwr wedi mynd at y bwrdd ac wedi awgrymu bod y nifer yn mynd i fyny i 12. Nid wyf yn sôn am y nifer, ond sut mae panel yn gallu gwneud yr holl waith hwn, a dod i fyny gydag argymhelliad, a'r munud nesaf mae'r brif weithredwraig yn mynd at y bwrdd ac yn newid yr holl beth? Beth oedd pwrpas y panel adolygu?

**Aled Roberts:** I want to understand the process, rather than the number. You said that there was a proposal before the board to have six groups before the review panel did its work. I thought that the panel had recommended that there should be six groups, and yet the chief executive went to the board and suggested that the number should go up to 12. I am not talking about the number, but how can a panel do all of that work and come up with a recommendation, and the next minute the chief executive goes to the board and changes the whole thing? What was the point of the review panel?

[279] **Darren Millar:** You can answer in a second. Mike, please ask your question.

[280] **Mike Hedges:** Mine was along similar lines. From what I have heard so far, the people who were not responding believed that the board's decision was at best advisory and, at worst, just an idea that was being floated out in there, but the decision was being made somewhere else, so it was pointless to respond to the board.

[281] **Darren Millar:** Do you want to respond to that? Then we will move on to Jenny.

10.30 a.m.

[282] **Dr Miles:** The timeline was that the panel started work in December and completed at the end of February. In the board meeting during February, the chief executive made the announcements to the board that there would be six. The panel had not concluded at that time. The panel's recommendation went to the board for initial consideration in March. The engagement happened shortly after that—that probably would be about April—and the chief executive's recommendation to go to 12 was subsequent to that. That was the timeline.

[283] **Aled Roberts:** What was the justification given for that?

[284] **Dr Miles:** It would probably be best if you asked Mrs Burrows that, but my understanding was that there were some concerns about pressures on change and reorganising the organisation at a time of stress.

[285] **Aled Roberts:** Did you challenge the change in recommendation?

[286] **Dr Miles:** Yes, I did.

[287] **Darren Millar:** We will move on now. Jenny is next.

[288] **Jenny Rathbone:** Picking up on that point, of the six, 11 or 12 clinical groups, only one focused on primary care, where 90% of people's experience of the health service occurs. Is that right?

[289] **Dr Miles:** That is not quite correct, because the intention of the community CPG would be to have primary and community, which is currently part of primary and community specialist medicine, together with therapies and medicines management in the community. So, all of those would have formed one CPG. The other CPGs still had reach out into the community. So, paediatrics, for example, had a community element.

[290] **Jenny Rathbone:** Okay, so they were working together. In May 2013, it was suddenly decided to create hospital site manager posts. What was the involvement of the board in that decision?

[291] **Dr Miles:** That was considered by the review panel and it was one of the elements. I think that we had about six elements and site management was one of the issues. This is part of the matrix of tension that we mentioned earlier; that we have an all-north Wales clinical programme group structure, but we clearly have site delivery areas. There is, inevitably, tension between the north Wales management structure and what needs to be delivered on the site. The view of the panel was that we did not quite have that balance right and that we needed to strengthen the site management. So, that was discussed between December and February. It was not a suddenly implemented process.

[292] **Jenny Rathbone:** Okay. So, between December and February, the board discussed and agreed this proposal.

[293] **Dr Miles:** The panel did. The panel was made up of two non-officers, of whom I was

one, the chief executive, the medical director and two chiefs of staff. So, the panel debated and agreed that there needed to be stronger site management and that then went to the board and to engagement and then came back to the board.

[294] **Jenny Rathbone:** So, how was it that these posts were created on three-month secondments without any job description having been written? You had been discussing it since December, but no job description was attached to these posts.

[295] **Dr Miles:** That is a largely operational matter, but my view—

[296] **Jenny Rathbone:** Why is it an operational matter? If people did not know what the remit was of these post holders, how could they interact with them?

[297] **Dr Miles:** In my judgment, it is an operational delivery matter, rather than a strategic issue that a non-officer would get heavily involved in, but I take your point. My understanding was that it was considered that we needed to make urgent progress, because of the pressures in the system, and to appoint people on a temporary basis, and decisions were made to appoint people who had done the role before, as they were there and available and could be established in post, and, subsequently, a proper work-up of an appointments process would be conducted.

[298] **Jenny Rathbone:** How long does it take to write a job description? Whatever the situation, you still need a job description to know what the extent of your remit is. So, how did that happen?

[299] **Dr Miles:** I do not know.

[300] **Jenny Rathbone:** So, the board would not have needed to know exactly what the remit of these site managers was.

[301] **Dr Miles:** The board, I have to say, would not normally have sight of job descriptions of managers at that level.

[302] **Darren Millar:** The review panel must have had an indication as to what it wanted these site managers to do.

[303] **Dr Miles:** Yes, it did.

[304] **Darren Millar:** It did?

[305] **Dr Miles:** Yes. I cannot remember the detail of what was in the recommendation, but there was a reasonably good understanding of what the role of site management was about. So, I do not think that there is any doubt about that, but, clearly, it was not put down on paper in terms of a formal job description.

[306] **Jenny Rathbone:** Given that there were three site managers, how did the board expect to be able to compare and contrast the competencies of these three individuals across the three sites and to know that they were all singing from the same hymn sheet and all getting on with the same remit?

[307] **Dr Miles:** I do accept the point. There does need to be a job description, there do need to be objectives, and there needs to be performance management against those objectives. I accept all of that. However, it was my understanding that the chief executive, with the executive team, made a decision to put these people in post very quickly, because of the pressures in the system.

[308] **Jenny Rathbone:** It was not quick; you have been discussing it since December. Grace, as board secretary, what advice, if any, did you give about the governance arrangements around these hospital site manager posts?

[309] **Ms Lewis-Parry:** As Lyndon and the chairman has said, the issue of hospital site management as needing attention had come up through the Wales Audit Office report through the structured assessment and through the CPG review; so, you are quite right to say that this had been something that had needed to be done or attended to for some time. My memory is that it came to a head at a certain point in time, and there were significant pressures on the hospitals where the patient flow through the hospitals was causing risks. The decision of the chief executive, with the executive team, at that time and on that day was to say, 'We must attend to this patient risk today'. You are quite right to say that we probably should have attended to that sooner, but the decision was that, using our collective knowledge of the skills of the senior managers that we have in our teams, there was a decision made collectively by the executive team about who would be most appropriate to put in with immediate effect to deal with patient safety and patient flow issues, literally within a day or two, that they would be given clear objectives on the first day but that they started on the following Monday, which is what happened, and they are short-term interim—

[310] **Jenny Rathbone:** Were these objectives that were written down?

[311] **Ms Lewis-Parry:** That is my understanding—between the executive director and themselves. However, you are right that, once they became substantive posts—and they will become substantive posts—there will be formal job descriptions and a formal appointment and selection process, as you would expect. However, there was an urgent clinical safety issue.

[312] **Jenny Rathbone:** Okay. Would you accept that it was an absolute failure of the board to ask what the remit was of these site managers, given that it was a very important role? I accept that.

[313] **Ms Lewis-Parry:** I think that the board knew what it wanted out of that function, because it had discussed it broadly through the feedback on the annual audit letter, through the Wales Audit Office report and through the CPG review panel. The decision of the executive, with the chief executive, on that day was, 'There is an immediate patient safety issue. We must attend to this now'.

[314] **Jenny Rathbone:** But no-one was capable of immortalising these thoughts into a job description. It is extraordinary.

[315] **Darren Millar:** I think that we have exhausted that one. Jocelyn is next.

[316] **Jocelyn Davies:** You have mentioned several times today the interim positions that have been held by a number of people, and you have said that today in relation to explaining to us the challenges that you were all facing. The medical director is a key post, of course, if you want to drive service modernisation. Do you believe that someone holding an interim position can command the authority to drive through significant change?

[317] **Professor Jones:** I think that it raises difficulties. I took over an interim job some years ago. I know the difficulties that one faces in terms of transformational change in particular. So, I would recognise that that is not the ideal solution. However, there were, according to the procedures and expectations, and because of ill health, I was assured that the appointment was of an extremely capable interim medical director who would do a very good job for the board.

[318] **Jocelyn Davies:** I would not question the capability of the individual, but does the interim position—you will know from your own experience—command the authority to drive through change, because it is about how you are seen in the eyes of others, not your capability? What did the board do to manage the risk that this presented?

[319] **Professor Jones:** I think that the board was aware that—. At one stage, we had not only an interim medical director, but also an interim nursing director at the same time. I was acutely aware that this was not a situation that was sustainable, and that we needed to move quickly to make permanent appointments. We did succeed in making an excellent permanent appointment to the director of nursing post—

[320] **Jocelyn Davies:** I am not talking about the director of nursing post. Although I understand what you are saying there, I am just wondering—because the assistant medical director was also on long-term sick leave—what the board did to manage the risks around this very key position of medical director, held, as you say, by somebody very capable in terms of driving through significant change. Was the board able to do anything other than seek assurances from the chief executive that this was a capable individual?

[321] **Professor Jones:** That was the primary route—to seek assurances from the chief executive, and those assurances were given.

[322] **Jocelyn Davies:** Looking at the report, we know that progress has been made to turn around management capacity and bring some in. Has the board been involved to any extent in that?

[323] **Professor Jones:** Yes, the board has been very involved, and in particular the finance performance committee. Perhaps Keith will want to comment on that.

[324] **Mr McDonogh:** Turnaround arrangements were referred to virtually from the start of the last financial year, and if you look at the Chris Hurst report and the Allegra report, you will see references there to the need for that additional support.

[325] **Jocelyn Davies:** Have we been given that?

[326] **Darren Millar:** We have not been supplied with copies of those reports. We did ask for them last week, and we believe that they are on their way.

[327] **Jocelyn Davies:** I will take your advice if ever it does come across my desk—I will look for that particular reference.

[328] **Mr McDonogh:** Those arrangements are referred to and therefore the initial implementation of the arrangements was the creation of the delivery programme board at the beginning of the last financial year, which then became a recovery board in September with the chief executive taking responsibility for that. The subsequent identification of an internal executive who would take up the turnaround role, which happened in the late autumn, and then the recommendation to the board in the budget report for 2013-14 that, as well as the appointment of a chief operating officer, which has been discussed, specific arrangements will be required to provide turnaround support to two of the CPGs in particular, and interim transitional support for a further CPG. Those appointments have been progressing over the last couple of months.

[329] **Jocelyn Davies:** Okay. So, other than progressing, and saying ‘We’re going to get around to this’, or whatever, has any turnaround capacity been brought in that has made any difference? Merfyn, do you know?

[330] **Professor Jones:** I believe that the appointment of an internal turnaround officer did have a major impact on the savings programme in the autumn. Indeed, at the end of the day, we actually made larger savings than any other health board in Wales.

[331] **Darren Millar:** Can I just clarify something? We have not seen these reports, but why were they commissioned in the first place? Was it about finance or governance issues that were of concern—what was it? What drove the commissioning of the Chris Hurst report and the Allegra report? Whose decision was that to commission? Was it your decision?

[332] **Professor Jones:** No. It was the Welsh Government's decision.

[333] **Darren Millar:** It was the Welsh Government. So, what concerns did it identify that made it commission those reports?

[334] **Professor Jones:** I think the major concern was financial management.

[335] **Darren Millar:** So, it was driven by money rather than—

[336] **Professor Jones:** And the impact that then has on performance.

[337] **Darren Millar:** But it was money. Money was the driver.

[338] **Professor Jones:** I think that you need to probably—

[339] **Darren Millar:** I am just asking what your impression is.

[340] **Professor Jones:** My impression is that financial management was certainly one of the key issues that it addresses, but it does address other management issues as well.

[341] **Darren Millar:** Was that the major concern? That is what I am trying to get at.

[342] **Professor Jones:** Yes.

[343] **Darren Millar:** That was the major concern. Okay.

[344] **Mr McDonogh:** Chair, if I may, I had to give evidence to Chris Hurst when he did the review last April. He was concerned about the long-term financial viability, given the pressures that the health board faced, but he was also concerned about structural arrangements, particularly the CPGs, which we have already discussed, and he was also concerned that the capacity of the executive team risked being overstretched without additional support in terms of some of the long-term aspirations. So, it was a combination of those things; not just the financial imperative.

10.45 a.m.

[345] **Darren Millar:** Okay, but—

[346] **Jocelyn Davies:** Can I just ask if it was a priority for the board in terms of its turnaround capacity? That is, in terms of finance.

[347] **Mr McDonogh:** In terms of the turnaround support for the CPGs, we are looking for financial management and clinical governance support in respect of that support that is needed.

[348] **Jocelyn Davies:** Yes, but it is needed; it is not done, is it? It is not there. The impression that I am getting from what you are saying is, 'We will be getting this'.

[349] **Mr McDonogh:** No, I think it is probably fair to say, Chairman, that two appointments have been made in the last week.

[350] **Jocelyn Davies:** In the last week? Okay.

[351] **Darren Millar:** Okay. We are going to move on. We have a quarter of an hour left, so I would ask Members and witnesses to be succinct. Aled?

[352] **Aled Roberts:** A gaf eich herio yn gyntaf ar y chwyldroi hwn? Rydych yn dweud bod y chwyldroi wedi bod yn llwyddiannus a bod aelod mewnol o staff wedi cael ei benodi, ac mai mesur y llwyddiant hwnnw oedd bod arbedion wedi cael eu gwneud sy'n fwy nag unrhyw fwrdd iechyd arall. Er hynny, rydym hefyd wedi derbyn tystiolaeth mai'r prif reswm dros yr arbedion hynny oedd eich bod yn canslo triniaethau ac yn gweithredu yn erbyn rhestrau aros am dri mis olaf y flwyddyn. Nid chwyldroi yw hynny.

**Aled Roberts:** Can I just ask you first about the turnaround process? You say that the turnaround has been successful and that an internal member of staff has been appointed, and that the measure of that success is that the savings made were more than in any other health board. However, we have also had evidence that the main reason for the savings was that you were cancelling treatments and acting against waiting lists in the last three months of the year. That is not a turnaround.

[353] **Mr McDonogh:** First of all, to deal with the issue of the appointment of the interim arrangements last autumn, the turnaround director then did identify, with CPGs and the corporate services departments, a range of additional initiatives that could, potentially, generate further saving plans. The issue that you are raising about the elective surgery needs to be clarified. There was a commitment at the start of the financial year to £15 million of investment in RTT, and that programme was delivered—

[354] **Aled Roberts:** Sorry; what is RTT?

[355] **Mr McDonogh:** 'Referral to treatment', which is the measure by which the Welsh Government assesses clinical performance in certain specialist areas.

[356] So, that was delivered. Two things happened. The first thing that happened was that additional pressures were identified at the turn of the year, and the finance and performance committee, and then the full board, explored the tensions between delivering the performance targets as required by the Welsh Government and delivering the financial target as required by the Welsh Government. The finance and performance committee and the board subsequently resolved that they were not willing to pursue the payment of waiting-list initiatives for new referrals, except in the case of certain key specialisms, which were cancer on the one hand and glaucoma in ophthalmology on the other.

[357] The reason for cancelled appointments—which, I think, was explored last week—is, in the main, the impact and consequences of winter pressures on the emergency department, which are common across Wales. So, if there were cancellations there, it was because of increased bed pressure at that time, the presence of outliers in surgical beds and so on. It was not a direct consequence of the decision in respect of the additional investment.

[358] **Aled Roberts:** I have to say that that is not borne out in casework for Assembly Members in north Wales, but there we are.

[359] **Darren Millar:** It is also not borne out by the recent Wales Audit Office report published earlier this week. It demonstrated very clearly the link between the delayed elective surgery and the waiting-time initiatives and finance. So, you are telling us that finance had nothing to do with the decision to stop the waiting-time initiatives; it was all down to bed pressures.

[360] **Mr McDonogh:** No, I am not saying that, Chairman. I am saying that we were not able to make the additional investment in the new referrals at the turn of the year without compromising the ability to break even.

[361] **Darren Millar:** How many patients did this affect?

[362] **Mr McDonogh:** I could not say this morning.

[363] **Darren Millar:** So, you took a decision without knowing how many patients were affected.

[364] **Mr McDonough:** I could give you a note on that, Chair, subsequent to the meeting.

[365] **Darren Millar:** There is a patient safety issue here. How many patients did this impact on? Was there further pressure at the front door of the hospital as a result of people who were waiting for operations having a problem and then turning up in an emergency department? Were you compounding the emergency department problem?

[366] **Mr McDonogh:** That is a matter on which the finance and performance committee has asked for a detailed analysis, which we are expecting at the next meeting. The analysis will include how many of these delays were due to decisions made by the board in the early part of the financial year, how many of them related to productivity and efficiency and how many of them related to winter pressures. I am sure that the detail of that could be provided for you after the meeting.

[367] **Darren Millar:** I have to ask this question: this was obviously a planned and calculated decision to delay operations in terms of the initiatives that were in place, so did you communicate your decision to the patients that would have to wait much longer for their treatment, potentially in pain, and with a poor quality of life? If so, how was that communicated to patients?

[368] **Mr McDonogh:** I do not know.

[369] **Darren Millar:** The casework that I have received suggests that it was not communicated at all, frankly.

[370] **Mr McDonogh:** I do not know the internal arrangements for that, but I am sure that I could clarify that for you.

[371] **Darren Millar:** My casework suggests that people turned up to the hospital or were called on the same day and told that their operation was not going to take place. I find that unacceptable, given that this was a calculated decision taken a good period in advance of the time when people were due to have their operations.

[372] **Mike Hedges:** Did the board collectively decide and minute that you would reduce the number of elective procedures in the final weeks of 2012-13?

[373] **Mr McDonogh:** The board decided that it could not invest in the additional activity that had been identified unless we breached the financial duty.

[374] **Mike Hedges:** The information that I have—perhaps you can correct me if I am wrong—is that there was a reduction. It was not that you did not increase—there was an actual reduction. I know that Aled Roberts, among others, was talking about it at the time. I know that Aled did it publicly, but most north Wales AMs that I have talked to said—I am not sure how many did it privately and how many publicly—that they could see that there was a substantial reduction, not a non-increase, in activity taking place within Betsi Cadwaladr.

[375] **Mr McDonogh:** I would not be able to differentiate between the new referral issues, which were referred to earlier, and the impact of the winter pressures and other circumstances on the pathways through the waiting lists. It is a piece of work that we have asked for, so that we can clarify the reasons in respect of any patient delays that were identified.

[376] **Jocelyn Davies:** Surely, the decision was taken at a time when there would also be winter pressures. You knew that there would be winter pressures—it was winter.

[377] **Mr McDonogh:** The board has a winter plan that anticipates additional demand during the winter period. The fact that this winter was extraordinarily long and could not be anticipated compounded the situation. We also need to take account of the adverse weather at the end of the year, particularly the flooding, which, together with the snow, reduced the ability of some patients to turn up or to accept their appointments. So, there was a combination of factors, and we need to bottom out what the impact of each of those was in terms of the residual waiting list.

[378] **Darren Millar:** Okay. It is very important that we spend a little time in the time that we have remaining looking at the infection control, and quality and safety-related issues. Aled?

[379] **Aled Roberts:** Dr Miles, chi sy'n cadeirio'r pwyllgor ansawdd a diogelwch. Wrth i ni edrych ar yr adroddiadau hyn, a oedd gennych unrhyw bryderon fod y pwyllgor hwnnw yn cyflawni ei swyddogaeth?

**Aled Roberts:** Dr Miles, you chair the quality and safety committee. As we consider these reports, did you have any concerns that that committee was fulfilling its function?

[380] **Dr Miles:** In medicine, one can always say that one can do more. I am very happy to talk to you about the C. difficile issue if that is what you would like to talk about. In terms of the wider functions of the Q&S committee, Betsi Cadwaladr university health board is a massive organisation that provides a huge number of services, services that I am generally very proud of. The Q&S is an assurance committee, so it is not a committee that should be seen as driving standards. It is more about seeking assurances that standards are being delivered, which is a slightly different role. There is a massive challenge on the agenda for the Q&S committee. We are working regularly on that agenda to make sure that the most important issues are coming to the top. That will be an ongoing process and, whoever is in place and however long it lasts, that will continue to be an issue. One has to make a judgment before every meeting, at every time, as to what issues one should consider.

[381] **Aled Roberts:** On that, this joint report is quite critical and, in fact, it suggests that the important issues were not coming to the top because the agendas were too large and, because of that, the really important information was not coming to the top. The impression given was that there was so much information going forward that members of that committee would have been unable to identify what the real critical issues were as far as patient safety was concerned. Do you accept that judgment?

[382] **Dr Miles:** I accept that there was a big challenge on the committee in terms of the

agenda. I do believe that we have acted appropriately with regard to trying to identify the high-risk issues, and we have processes and discussions in place. We have a regular cycle of business and we have been proactive in terms of putting other items on the agenda to ensure delivery. I can give you examples, from when clinicians have approached me, or through other mechanisms; we have had concerns about endoscopy waiting times for example, or unscheduled care issues. We have elevated those issues to sometimes a regular standing item on the committee, until we have had assurance that they are being dealt with. Whether we have actually missed issues that we ought to have discussed is a matter of judgment. We have done our best to identify those issues that are of most importance. I believe that we have done that reasonably. I am not sure of any areas of significant risk that we have not discussed; I would like to know what they are. However, it is a big agenda and it is something that we try to address each month.

[383] **Aled Roberts:** Mae nifer ohonom wedi derbyn llythyron—rhai yn ddi-enw—am fisoedd nawr, gan bobl yn y bwrdd iechyd yn sôn am eu pryderon. Wrth gwrs, yn ystod y pythefnos olaf hwn, mae nifer o grwpiau o fewn yr ysbytai wedi datgan yn gyhoeddus y ffaith nad ydynt yn gallu codi pryderon o fewn strwythur y bwrdd iechyd ac, o achos hynny, nad oedd ganddynt hyder yn rheolwyr y gwasanaeth iechyd yn y gogledd. Mae hynny siŵr o fod yn creu pryder i chi fel aelodau'r bwrdd. A yw hwnnw'n ddarlun yr ydych chi yn ei gydnabod ac, os felly, beth yn union mae'r bwrdd wedi ei wneud ynghylch hynny dros y flwyddyn olaf hon?

**Aled Roberts:** A number of us have been receiving letters—some anonymous—for months now, from people within the health board talking about their concerns. Of course, during this last fortnight, a number of groups within the hospitals have stated publicly the fact that they cannot raise concerns within the structure of the health board and, because of that, that they had no confidence in the managers of the NHS in north Wales. That must surely be a cause for concern for you as members of the board. Is that a picture that you recognise and, if so, what exactly has the board done about it over this past year?

[384] **Dr Miles:** I accept that issue. There are concerns. I think that there is very good practice in many areas, and more challenging practice in other areas. That refers to the much wider responsibilities about quality and safety and the alerts mechanism when issues come up. Clearly, just to close off the quality and safety committee first, it is an assurance committee rather than a committee that drives responsibilities and standards. I am a clinician as well, and, in my clinical practice, never in my life have I thought to myself that I have to deliver x treatment for a patient because of an assurance mechanism by a committee somewhere else in the system. What drives me as a clinician is personal standards and revalidation, and I have a responsibility to keep up-to-date and so on, and if I see issues, then I escalate those appropriately. That responsibility lies with clinicians, and that is something that the committee and the review felt very strongly we should enshrine with all clinicians, be they doctors or otherwise, in the board.

[385] Lying on top of that will be a whole raft of accountabilities and management structures to ensure that the standards are met. Some of the concerns that have been expressed to you—and I know that consultants in Ysbyty Gwynedd in particular were concerned about some of the structures—reflect some of the difficulties in some parts of the system. I have mentioned the clinical programme groups and, in my judgment, everybody who is working in the CPGs is working hard, with good intention. They want to improve the system, but, sometimes, the structure has gotten in the way. For some of those clinical programme groups, there has been some tension and, perhaps, a gap between the management structure and the front line.

11.00 a.m.

[386] **Aled Roberts:** Hoffwn symud **Aled Roberts:** I want to move on to C.

ymlaen at C. difficile, a gofyn i chi, fel cadeirydd y pwyllgor ansawdd a diogelwch, a hefyd i'r Athro Jones, fel cadeirydd y bwrdd, pryd y daethoch yn ymwybodol, yn y lle cyntaf, fod problem yn Ysbyty Glan Clwyd.

difficile, and ask you, as chair of the quality and safety committee, and Professor Jones, as chair of the board, when you became aware, in the first place, that there was a problem at Ysbyty Glan Clwyd.

[387] **Dr Miles:** C. difficile has been mentioned. First of all, I say that hospital-acquired infection is a major focus for us as a board. It is our top risk on the risk register. We have a sub-committee of the quality and safety committee specifically to look at the prevention and improvement of infection control. It is a major issue for us. There have been some reports about C. difficile in some of the minutes of that sub-committee that come to the quality and safety committee; it will have been mentioned for many months.

[388] I think that it is fair to say that we were aware that the incidence of C. difficile was higher in the centre. However, we had a focused set of minutes that we discussed at the quality and safety committee—in January of this year, I believe—when we received assurances. The sub-committee is chaired by the executive director of nursing and has microbiologists and clinicians on board, and it has been looking in a focused way at C. difficile. We had an assurance that root-cause analysis was conducted for every death. We know that every death is unfortunate, but, unfortunately, not every death from C. difficile can be prevented, I regret to say. There was a root-cause analysis to look at whether there were any factors that might have improved the outcome for a particular patient. As a result, there were weekly meetings looking at that root-cause analysis, and there was an intention of having an action plan that would be presented to the board in due course. We would have been expecting to receive that action plan at about this sort of time.

[389] **Aled Roberts:** When you say that there have been minutes going back months, what would be your estimate of when this was first flagged up as an issue?

[390] **Dr Miles:** I honestly could not—[*Interruption*.]

[391] **Aled Roberts:** Could you give us a note on that, if you cannot confirm that information this morning?

[392] **Dr Miles:** Yes; certainly.

[393] **Darren Millar:** Can you remind us of when the Public Health Wales report, which was recently published, identified the problem with C. difficile as having started? I seem to remember it being many months before January of this year.

[394] **Dr Miles:** My recollection about the incidence of C. difficile in the centre—that is, the number of cases of C. difficile—is that it has been higher in the centre. I do know whether anybody understands that. We know that 3% of the population has C. difficile. If those people become ill, and they are given antibiotics, which are life-saving antibiotics, they are more likely to suffer with the illness of Clostridium difficile. We are waiting for Professor Duerden's report on this; I do not know whether we understand exactly why the level of incidence is higher, although there are some factors that will influence that.

[395] **Darren Millar:** However, you say that this is at the top of your risk register. I think that the committee would like to see a copy of that register, as I think that it would be interesting for us to see; so, if you could provide that, it would be very helpful. However, the Public Health Wales report alludes to the fact that the number of infection control nurses had fallen and that the clinical groups that are supposed to look at these issues had been disestablished. That does not strike me as you taking this risk very seriously, given that it was the highest risk on your risk register. Why was the decision taken to reduce the number of

infection control nurses, and to disband and disestablish the clinical groups that had been set up, because that must have been a board decision?

[396] **Dr Miles:** It was not a board decision. I do not know why that happened.

[397] **Darren Millar:** Did you not ask?

[398] **Dr Miles:** I was not aware that the numbers had been reduced.

[399] **Darren Millar:** You were not aware, even though you were chair of the quality and safety committee.

[400] **Dr Miles:** The quality and safety committee receives the minutes of the sub-committee, which is the infection control committee that is chaired by the executive director of nursing.

[401] **Darren Millar:** Are there independent members on that committee?

[402] **Dr Miles:** No.

[403] **Darren Millar:** There are no independent members at all.

[404] **Dr Miles:** No. It was an operations group, so operational decisions were made with regard to the staffing numbers. I was not aware at all of the reduction, if there was one.

[405] **Darren Millar:** Mrs Lewis-Parry, these were critical decisions that were presumably being taken by the group that did not have any independent board members on it. Given that this was the highest risk on the risk register, as has been suggested, why was the board or its sub-committee not made aware of these staffing reductions?

[406] **Ms Lewis-Parry:** I cannot answer that question. The sub-committee on improving infection prevention and control was a formal sub-committee of the quality and safety committee, and its full minutes came up to the quality and safety committee, month by month, together with issues of significance. That gave the executive nurse at the time the opportunity to raise issues of concern, bringing them formally to the attention of the full committee. If you go back through the notes, it is clear that we were concerned about infection control. However, it is absolutely clear that the committee and the board did not understand, until April, the full extent and impact of the C. difficile outbreak at Glan Clwyd Hospital.

[407] **Darren Millar:** I need to clarify this. In the minutes that were presented to the quality and safety committee, was there a note of the decision to reduce the infection control staffing and to disband the clinical groups that were responsible for managing infection control on the different hospital sites?

[408] **Ms Lewis-Parry:** Without going to look at the minutes, I do not know. That would have been a decision that was taken some years ago.

[409] **Professor Jones:** My understanding is that those groups were disbanded quite a few years ago, in order to create the all-north-Wales infection control committee.

[410] **Aled Roberts:** Do you have any observation on paragraph 52 of the report, which says:

[411] ‘We note that a Quality and Safety Lead Officers Group has been created to support and help manage the Quality and Safety Committee’s business. However, several

interviewees expressed concern to us that the QSLOG was not operating effectively and that its remit, role and membership could usefully be re-examined.'

[412] **Ms Lewis-Parry:** It is a group that is chaired by the executive nurse. It is where the three clinical executives come together, and they are provided with information about the key issues, risks and themes that have come up through concerns, complaints and incidents. What is reflected in the report, quite rightly, is that, in the preceding months, due to the changeover in executives, many of whom had been in acting or interim roles, that group had lost direction and focus. The new executive nurse now in post is starting a new piece of work to ensure that the group reviews its terms of reference, is clear about its reporting lines and is clear about what it is supposed to cover.

[413] **Aled Roberts:** Was the fact that this group was not operating effectively and was tasked with patient safety reported to the board at all?

[414] **Ms Lewis-Parry:** There was awareness that the quality and safety lead officers group reported issues of significance formally; that is minuted. It was clear that more work needed to be done.

[415] **Darren Millar:** That is not quite—

[416] **Aled Roberts:** I asked whether it was brought to the board's attention that that group was not operating effectively. What about the people of north Wales, if that group does not operate effectively and your structures depend on that group to feed into the quality and safety committee?

[417] **Darren Millar:** It would have been your job to draw the attention of the board to this problem, as board secretary, would it not?

[418] **Ms Lewis-Parry:** The quality and safety lead officers group is just one group. It is not a formal sub-committee of the quality and safety committee. It is an officers group that is trying to ensure that some of that information is pulled together in a way that is more manageable for the quality and safety committee.

[419] **Mike Hedges:** There are a lot of committees and sub-committees.

[420] **Ms Lewis-Parry:** Yes, there are.

[421] **Mike Hedges:** What seems to be lacking is the ability for someone to go and tell the chair: 'These are our key issues and our key problems.' Professor Jones, do you feel that, as chair, you were kept adequately informed? If you were not kept adequately informed, how could you keep the rest of the board adequately informed? A number of people here have held senior posts in a lot of different organisations. There are two rules that most people have gone by: 'no surprises' and, 'if there is anything serious, tell me first'. Those are the two rules by which most big organisations work. That does not seem to have happened in your case.

[422] **Professor Jones:** It is true to say that I was certainly shocked to hear of the outbreak of C. difficile at Glan Clwyd at a later stage than I believe I should have been told.

[423] **Mike Hedges:** It was not just the C. difficile, but the general issue of 'no surprises'—you were being surprised by lots of things and not being kept informed of the key issues. You do not want to know the minutiae, but, if there is a reduction in staff and nurses in a certain area, you, as chair, should know what is going on. You are, under the structure we have for health, the board, nominally, making a decision. I understand, from what I have heard so far, that you might have been mildly advisory in your role, but other people made the decisions.

[424] **Professor Jones:** No, I do not think so.

[425] **Darren Millar:** I think the big question here that is probably in all of our minds is: given that this was top of your risk register, why were you not asking these questions anyway about infection control rates at each of the three main hospital sites? Were you asking those questions, Dr Miles? Was that a question you were asking each time your quality and safety committee met? Was it a question that the wider board was then asking?

[426] **Professor Jones:** On the wider board—

[427] **Darren Millar:** It is top of your risk register.

[428] **Professor Jones:** Absolutely. The wider board actually had a paper on C. difficile at its February board meeting.

[429] **Darren Millar:** Was it not something that you returned to on a more regular basis than once a year, however? Dr Miles, this, presumably, is something you should have been asking about every single time you met as a quality and safety committee. What are the infection rates? What is the hospital-acquired infections rate? It is a massive public priority, a huge Welsh Government priority and at the top of your risk register, yet you were relying on a group that included no board members at all—it was an officers' group, you just said—to report information to you and you were just accepting that at face value without any challenge.

[430] **Dr Miles:** Well, there was discussion and there was challenge—

[431] **Darren Millar:** What challenge?

[432] **Dr Miles:** For example—

[433] **Darren Millar:** Did you ask every month what the hospital-acquired infection rates were in each hospital?

[434] **Dr Miles:** The infection rates went to the board every month, rather than to Q&S. It was part of the integrated quality and safety report that was developed by Q&S. Did we ask every month for the infection rates? The answer is 'no'. Did we discuss and challenge? The answer is 'yes'. With regard to the aetiology of C. difficile infection, one of the issues is about antibiotic prescribing. There were issues about compliance, and whether doctors would be complying with guidance. None of us complies all the time with guidance. We challenged on that issue, and we had assurance from the medical director that, when there was resistance to follow guidance, that that would be dealt with through the office of the medical director. There was discussion about deep hospital cleaning and the new vaporising system for deep ward cleaning, there was quite a lot of discussion going on—

[435] **Darren Millar:** But you did not ask what the infection rates were on a monthly basis.

[436] **Dr Miles:** On a monthly basis, I cannot honestly say—

[437] **Darren Millar:** Okay, thank you. That is all we need to know.

[438] **Jocelyn Davies:** The idea of a risk register is not just to tell you what your greatest risk is, because other boards will not have C. difficile as their No. 1 risk. They would have something else, because that is their greatest risk. So, the idea of the risk register is that you identify your greatest risk. It will also state on the register why it is your greatest risk and

what you ought to do make it go down your risk register so that something else comes at the top. It will be interesting to see the risk register to see what was being identified to get it down the bottom of your risk register, because it will not be the top of the register for everybody else. So, it was your No. 1 thing that could go wrong, because it had been identified at some point that there was a high risk of this happening—not that it was a bad thing if it happened, but that, in your case, there was a high risk that it would happen. That is what that risk register is for.

[439] **Darren Millar:** I am going to bring Jenny in to ask a very brief question, and then I will ask a question, and then you can answer them together.

[440] **Jenny Rathbone:** Did any of the independent board members visit Glan Clwyd to inspect the regime that was supposed to be tackling this infection?

[441] **Darren Millar:** Go on and answer that question, because I wanted to raise a slightly different issue.

[442] **Professor Jones:** I cannot specifically answer it, but there are certainly regular visits by independent board members on walkabouts and visits to hospitals.

[443] **Jenny Rathbone:** Okay, but on this specific one, 'no', as far as you are aware.

[444] **Professor Jones:** I could not answer. It may well be the case—

11.15 a.m.

[445] **Darren Millar:** I have a further question on quality and safety. You alluded to comments that had been made by the consultant body at Ysbyty Gwynedd. Its comments suggested that the risk adjusted mortality index rate—the death rate, to put it more bluntly—at that hospital had increased recently to a rate of 122. I think that that was the figure reported in the media. That was confirmed last week by your executives. That is obviously a very worrying death rate for a main hospital site; it is higher than any other that I have seen reported in Wales. What action are you taking to address that particular problem, and how often do you look at those risk adjusted mortality index rates for each of the three hospital sites at your quality and safety committee, Dr Miles?

[446] **Dr Miles:** At every meeting. They are discussed in detail. We take the figures very seriously. There is a trend in Ysbyty Gwynedd over a number of months. The trend in total has not amounted to a big rise, but it has been a persistent trend for some time. I am advised that the average result peer group in Wales—the Wales average—is 120, so, if we have gone to 122, we are only just above the average. Most of the figures that have been reported to us have put us at better than the Welsh peer, but considerably worse than the English peer, because of differences in the ways of collecting data.

[447] **Darren Millar:** Sorry, but may I interrupt you? The Welsh Government publishes these figures on a quarterly basis in arrears. The last available figures that we have that are published are for up to March, and none of them is as high as 120, so, you would expect, if 120 was the average, there to be lots of hospitals above that figure and a good number of hospitals below it in order to get that average of 120. I do not recall seeing on those reports any other hospitals at higher than 120, or, indeed, 122. So, on what basis have you got this average of 120?

[448] **Dr Miles:** Well, on the basis of information given to us by health analysts—

[449] **Darren Millar:** Is that recent information?

[450] **Dr Miles:** Yes, that is recent information. My recollection—

[451] **Darren Millar:** So, the trend must be increasing across Wales.

[452] **Dr Miles:** No, I do not think that it is. In fact, I do not know, to be honest. My recollection, Mr Millar, is that there are hospitals in Wales with a RAMI greater than 120. I cannot be certain about that; we would need to check it, but my recollection is that there were some considerably higher than that.

[453] I also have to say that, despite the fact that we take this extremely seriously and we have had very detailed discussions about it—these are important issues and I do not want to make excuses—there is limited statistical and clinical credibility in some of these statistics, because the results of hospital performance will vary on the particular statistic that you wish to choose. If you look at the crude mortality rate or RAMI or the standardised hospital mortality ratio—and there is another one that I cannot remember—they give varying answers for the same hospital. So, we do look at it very seriously, but we have to, I think, look at it through a different lens and come at it in a different way.

[454] It seems to me that the most important way, possibly, is to look at the deaths retrospectively, and look at the case notes to see whether there is anything better that one could do in order to make sure that we are delivering the service that we want to. We did that for emergency department deaths. We were concerned, and it was one of the proactive issues that we brought up in Q&S on the basis of the Mid Staffordshire NHS Foundation Trust experience that building work had been going on in the emergency department there. Clearly, we have building work going on in Ysbyty Glan Clwyd at the moment and we will have building work going on in Ysbyty Gwynedd, so we specifically employed a clinician to go through the deaths of patients in the ED to see whether there was anything that we could have done better. I am pleased to say that the result was that there was not anything that we could have done better. So, the RAMI, although it is important, is but one lens on performance.

[455] **Darren Millar:** I appreciate that and, when the Mid Staffs situation developed, the mortality rates, albeit in a slightly different form in terms of the statistics, were used as the alarm bell that triggered the report that was published this week into a number of other hospitals, which found serious failings. So, while there can be statistical anomalies—I think that everybody would accept that—it does set alarm bells ringing when you see death rates at this level. A death rate of 122 means that you are 22% more likely to die, on that statistical basis, at Ysbyty Gwynedd than at other similar hospitals.

[456] **Dr Miles:** I am sorry, Mr Millar, but I do not think that that is correct, because—

[457] **Darren Millar:** Okay. Tell me why we should not conclude that that is correct, and why members of the public should not be concerned about the rising trend in death rates at Ysbyty Gwynedd. You have just told us that, over a long period of time, this has been creeping up.

[458] **Dr Miles:** There are two points to make there, if I may. The rising death rate in Ysbyty Gwynedd is something that we take very seriously, and we want to look into it. We want to analyse it. The second point is on whether the mortality is 20% higher in Wales, or in north Wales, than the average. I do not think that that is correct, because the 100% average that is quoted is based on England-and-Wales figures. In England, deaths in community hospitals are not included, so, the average, as I understand it, in Wales is 120, not 100. So, we are not—

[459] **Darren Millar:** That is not borne out by the figures that are published, Dr Miles. I

am sorry, but if you are really on top of this brief, you ought to have accurate figures at your fingertips. The average RAMI rate in Wales is not 120. I would suggest that you go away and prepare us a more responsible answer to the questions that we have raised on the death rates in Ysbyty Gwynedd.

[460] We will have to move on, I am afraid. Jenny has a question on the Chris Hurst report. We will then have one final question on the strategic vision and service reconfiguration.

[461] **Jenny Rathbone:** Professor Jones, you mentioned earlier that you did not feel that it was necessary for the board to see the Chris Hurst report, because you thought that it was a note to the chief executive. Given the weaknesses that the board had in managing the finances of the health board, could you explain why you did not allow the board to have access to this report that had been commissioned by the Welsh Government?

[462] **Professor Jones:** It is not that I did not allow it to happen. It was a note to the chief executive. It was explicitly directed towards the board of directors, as opposed to the board itself. It is my understanding that the contents of that document then informed much of what Keith and Lyndon have been talking about in terms of reviewing the CPG, the management structure and the financial management. So, it did—through the chief executive—impact on the issues and the priorities of the board.

[463] **Jenny Rathbone:** Okay. It is just that Geoff Lang told us last week that it was your decision not to circulate that report for discussion.

[464] **Professor Jones:** Well, we discussed it at that time.

[465] **Jenny Rathbone:** Who discussed it? The board as a whole?

[466] **Professor Jones:** I discussed it with the acting chief executive at the time. It was also just at the point when the chief executive was coming back into post.

[467] **Jenny Rathbone:** Okay, but I think that it is of concern that these reports that have been specifically commissioned to look at the weaknesses in the financial management of the health board were not then properly discussed by the board in order to improve your financial management.

[468] **Professor Jones:** Well, I think that the contents were fed in through officers, and through the chief executive, to the discussions of the board.

[469] **Jenny Rathbone:** Okay, but surely it is the board that should be making the decisions about how you improve our financial management, so that you are not setting our budget for next year when the year has already started.

[470] **Professor Jones:** Yes. Quite.

[471] **Aled Roberts:** I have a question I would like to ask you, because we dealt with this financial management situation last year and we were concerned that the budget had not been agreed until two weeks into the previous financial year and that certain CPGs had not signed up to the budgets until the end of September. Even more concerning is that we now understand that four of the 11 CPGs in this financial year have only signed up to their budgets with the same kind of level of caveats. This indicates that there are major problems with budget-setting within the health board. Would you agree?

[472] **Mr McDonogh:** I would not entirely agree, Mr Roberts. First of all, we are operating on a flat cash situation, and you explored that issue last week with the director of finance. The

budget strategy for 2012-13 was not in such a state by the finance and performance committee meeting in March that we were able to recommend a balanced, deliverable budget to the board. Rather than recommend to the board a budget that was undeliverable for the start of the new financial year, the director of finance proposed an interim budget arrangement to operate for one month. So, that deals, in a sense, with last year.

[473] The situation this year is that there has been additional support given to CPGs and to central service functions in respect of the planning arrangements for the new budget. All of the detail of that, and the basis on which the budget is being set, has also been shared with board members, either in the form of paper reports, month on month, or in terms of detailed briefings by the director of finance preceding the start of the financial year. So, I would say that board members are apprised of the issues, the detail and the challenges that need to be faced in producing and delivering a balanced budget.

[474] As far as 2013-14 is concerned, the position that we are in in July, after the June finance and performance meeting, is that a small number of the CPGs are not able to sign up to their budgets without adding notes about caveats, in terms, for example, of the recruitment of locums and so on. Clearly the expectation in a delegated situation is: the budget is the budget; that is something that I am used to operating in local government, with whatever constraints that may apply in terms of the planning arrangements. What we have, really, is two things: first of all, a clear set of escalation measures in terms of governance. The CPGs that are not able to sign up to their current-year budgets have been subject to a report this month to the audit committee, and that issue has been escalated to the appropriate executive, who has immediate accountability to the chief executive for those CPGs.

[475] **Aled Roberts:** These seem very cumbersome arrangements, with reports, reviews, committees et cetera; surely, in the current financial climate, the budget is the budget, and the CPG has to live within that budget.

[476] **Mr McDonogh:** I would not disagree with that, but the line of accountability in respect of the budget holder is through a named executive to the chief executive. There are escalation measures that need to be considered at both of those stages.

[477] **Jenny Rathbone:** But the impression—[*Inaudible.*]

[478] **Darren Millar:** May I ask Members to come through the Chair? Go ahead, Jenny; now that the microphone is on we can hear you.

[479] **Jenny Rathbone:** —as opposed to implementing the budget that they have been assigned by the board. The board should be setting the budget, surely; not individual CPGs.

[480] **Mr McDonogh:** I just want to reassure this committee that the board has set the budget within the confines of what is a cash-limited situation. Those budgets have been identified after discussion with the CPGs, and appropriate savings plans have either been identified or are being worked up for regular reporting through the finance and performance committee and subsequently to the board, in full. We have a series of control measures that are capable of being introduced progressively, month on month, should there be a shortfall in the delivery of those plans. It is not the planning that is at question here; it is the delivery of agreed plans.

[481] **Darren Millar:** Two very brief questions are going to be asked now, and then we will have a brief answer before our final question from Julie Morgan. Very brief, Oscar.

[482] **Mohammad Asghar:** I will ask this question to everybody. In every NHS board, there are some rules to follow and integrated governance principles to be observed. You have

totally failed in that part. Why?

[483] **Darren Millar:** Okay, that was your question. Mike, you are next. You can answer in a second.

[484] **Mike Hedges:** Do you know of any other organisation, including within the health service, where, after a budget has been set, it has to be agreed by the people who are the budget holders?

[485] **Darren Millar:** Okay, if you could answer those two questions: why do the ordinary procedures not appear to have been working or implemented, and can you think of any other organisation where the delegated budget holder has to be asked permission, effectively.

[486] **Mike Hedges:** To receive it.

[487] **Darren Millar:** To receive a budget.

[488] **Mohammad Asghar:** Integrated governance should work together and I think it is not about—

[489] **Darren Millar:** Okay. Mr McDonogh, do you want to answer?

[490] **Mr McDonogh:** The question of sign-off is the sign-off on a budget that they have clearly been involved in formulating with their CPG accountants, monitored by the senior finance team. The clear expectation would be that they would simply sign it off.

11.30 a.m.

[491] **Mike Hedges:** My question was really specific: do you know of any other organisations, in the health service or otherwise, where a budget is set by the board and it then has to be signed off by the recipients?

[492] **Mr McDonogh:** No.

[493] **Mike Hedges:** Thank you.

[494] **Julie Morgan:** I will finish off with the future for acute services in north Wales. There have obviously been delays in working out the development of the acute services strategy. Could you tell us what you have done as board members to try to accelerate the process?

[495] **Professor Jones:** As you know, when the service review plans were discussed in June last year, there were major areas where we decided that we would continue on three sites, but the CPGs responsible were tasked, indeed, challenged, to demonstrate that that was sustainable in the long run. They were involved in that process, but, of course, once we started discussing one medical speciality, that had interdependencies with others and it became clear that there was a need for a review of the whole of acute services, led by clinicians and assessed by clinicians. That process is going ahead, I think, and it will now report in September.

[496] **Ms Lewis-Parry:** October.

[497] **Professor Jones:** It is October now. Okay. There has been some slippage, partly as a result of the review that the First Minister has called for. Clearly, if neonatal is brought back into north Wales, that will have a major impact on other services. So, I think that there is a

quite understandable issue there. I think that it is fair to say that the independent members would have wished to have seen this process move more quickly and that we had service plans clearly delineated, because that should be the basis, the foundation, for any planning. You cannot do financial planning and you cannot do workforce planning unless you have a serious service plan. When the plan is produced, it will obviously have to go out to consultation, and there will be considerable public debate about it, but I think that I am not alone in wishing that the process could have been abbreviated.

[498] **Julie Morgan:** What did you do to try to move it on more quickly?

[499] **Professor Jones:** As a board, we raised the issue in confidence, in private session and with officers, but this is a clinically led review, and it is not easy. Clinicians are finding it difficult on a whole range of issues to arrive at a consensus, perhaps for the reasons that we discussed earlier. This is not easy stuff, and if it is to be clinically led, as it should be, then I think that, despite our impatience, we have to let the clinicians come up with what is the right solution.

[500] **Julie Morgan:** Do you feel that the strengths and capabilities are there in the board to enable this to happen? You must have some role in this. It is the clinicians who will come up with something, but it is your role to drive it forward, it is not?

[501] **Professor Jones:** Yes. Well, it is being driven forward, and, clearly, the role of the chief executive is critical in that regard. However, if you are asking me about the capacity of the board, it seems to me clear that, in part, given the interim nature of so many of the posts, and, also in part, the huge demands on individuals, and given the geography of north Wales, added capacity is needed at management level and at executive level, and I am glad to say that that is now happening.

[502] **Julie Morgan:** Thank you.

[503] **Darren Millar:** On that note, that brings us to the end of this evidence session. We are very grateful, Mr Jones, Grace Lewis-Parry, Lyndon Miles, and Keith McDonogh, for your attendance today. You will be sent a note from the clerks in terms of the additional information that you have agreed to forward to the committee for our consideration. Also, you will be sent a copy of the transcript of today's proceedings so that you can correct any inaccuracies.

[504] Diolch yn fawr iawn i chi. Thank you very much.

[505] The committee will now take a break. We will reconvene at 1 p.m., when we will hear evidence from the Welsh Government. Thank you.

*Gohiriwyd y cyfarfod rhwng 11.35 a.m. a 1.15 p.m.*
*The meeting adjourned between 11.35 a.m. and 1.15 p.m.*

## Trefniadau Llywodraethu Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr: Tystiolaeth gan Lywodraeth Cymru
## Governance Arrangements at Betsi Cadwaladr University Local Health Board: Evidence from the Welsh Government

[506] **Darren Millar:** Good afternoon, everybody, and welcome to the second part of the meeting of the Public Accounts Committee, continuing with our inquiry into the governance arrangements at the Betsi Cadwaladr University Local Health Board, this time taking oral evidence from the Welsh Government. I am very pleased to be able to welcome to the table

David Sissling, the director general of health and social care in the Welsh Government; Dr Ruth Hussey, chief medical officer at the Welsh Government; and Martin Sollis, director of finance at the Welsh Government. Thank you very much for your attendance today. We appreciate that it was at rather short notice, but we appreciate your being able to come to give us some evidence on this very important inquiry. Thank you also for the letter, which has been circulated to committee members prior to this afternoon.

[507] Mr Sissling, can you tell us when you first became aware of the problems at Betsi Cadwaladr?

[508] **Mr Sissling:** The first thing that I want to say—and I should put it on the record—is how significant and serious we see the position. I wanted to say that in my opening remarks. The position with all health boards is that we are always in performance management mode, to an extent. With Betsi, the position was no different, but it became more serious, particularly during the course of 2012. I will pick up on four areas to highlight our concerns.

[509] First, there was unscheduled care, particularly at Glan Clwyd Hospital. That reflected difficulties that the health board was experiencing in the flow of patients through the hospital, and was also associated with some intelligence that we had about some strained relationships within that hospital. We reached a position where we had to raise those formally with the organisation—with the chief executive—and seek assurances about the actions that it was taking, particularly about quality and safety issues. So, the first issue, throughout 2012, was concern about unscheduled care at Glan Clwyd.

[510] The second issue, which became known to us in September, was particularly about finance. There are a couple of things there. First, it was prompted by an approach—you have heard about this before—by non-officers and the director of finance to the Wales Audit Office, which was clearly a matter of concern. It was not a conventional way for concerns to be addressed. We became aware of that. However, more significantly, I suppose, was the fact that its year-end forecast at that time—for September turn to October turn—went from break even to a projected deficit of £19 million. Clearly, we would be concerned about that, and concerned about what it said about weaknesses in the planning, monitoring and forecasting arrangements.

[511] Concerns developed further—I am trying to paint a picture through this—in December, when I think that we became particularly concerned about the capacity of the executive team. We drew that to the attention of, particularly, the chief executive, recommending the appointment of a chief operating officer and the need to resolve with urgency the CPG issue. I am sure that you have heard about that. There was a review in place and we urged them to take that to a conclusion, and sought reassurance that there were appropriate processes of board development in place.

[512] I think that my final point—my fourth point—would be about board governance. I suppose that the timing of when we became concerned about that, in terms of detail, was when we received from the board a copy of the structured assessment that the Wales Audit Office had provided. We received it in February from the board, with a very clear responsive action plan about what it was doing to address those points.

[513] I hope that that gives you a picture of the cumulative issues through 2012. I suppose that if there was a point at which those concerns became particularly serious, it would perhaps be around September or October, when they moved into a different zone of seriousness and concern from our point of view.

[514] **Darren Millar continues:** What sort of action did you take when you became aware of the concerns back in the early part of 2012?

[515] **Mr Sissling:** We did a number of things. We formally raised the concerns and asked for responsive action.

[516] **Darren Millar:** Was that done in writing?

[517] **Mr Sissling:** Yes; there is quite a considerable weight of formal written correspondence. I must say that, to an extent, it was increasingly formal, with the tone becoming increasingly brisk.

[518] **Darren Millar:** Was that sent to the chair or just to the chief executive?

[519] **Mr Sissling:** It would have been sent to the chief executive. My approach would always be chief executive to chief executive. There was a point in the escalation of concerns where I copied in the chair, because I felt that it was important that the chair was aware of the nature, scale and gravity of the concerns. First, we formally brought the level of my concerns to the attention of the chief executive, along with the formality of those concerns, seeking actions and responsive plans to ensure that we saw commensurate action in terms of the action plans.

[520] The delivery and support unit is a resource that we, as the Welsh Government, can deploy to organisations when they are in difficulty in terms of areas of performance. We deployed the unit to Betsi Cadwaladr University Local Health Board. At any point in the last 12 months, it has been working on unscheduled care, elective care, stroke, cancer and mental health. It has provided diagnostic support, clinical insight and facilitation to allow the health board to develop plans. It has not done it for the board; we have sent in a team of people that can support the board to do so.

[521] We were also, at this point, meeting with the Wales Audit Office and Healthcare Inspectorate Wales to share intelligence and ensure that those bodies that have responsibility for oversight—supervision, if you like—were co-ordinated in their actions and in terms of our complementary roles in this system. We commissioned external exercises, for example the Allegra review, to provide us with an independent point of reassurance. That was very much triggered by the concerns about finance. We also escalated the matter; we have a delivery framework that has an escalation of action and interaction according to the concerns raised. In February, the health board was placed at level 4, which is the highest level of escalation; there is a formality to that. Kevin Flynn, who is the director of delivery, oversees that. At that point, due particularly to the difficulty with finance, as well as one or two other things, the board was moved into the highest level of escalation.

[522] I suppose that the final thing that I should say is that this is an organisation that is clearly going through a process that is difficult in all kinds of contexts. I would like to think that we provided support to it, and that we continue to do so. It is fine being at the end of a letter, and it is fine to send in a team, but I, and others, have certainly spent more time in the organisation since the problems developed, because I think that that is part of the role—to ensure that we are available, that we can provide the board with support and that we can be seen to offer whatever guidance is helpful.

[523] **Darren Millar:** You mention that you had engaged in correspondence with the chief executive and then, at a later date, that you had copied in the chair. Can you tell us what the initial response of the chief executive was when you began raising concerns about governance, unscheduled care, performance issues and finance issues?

[524] **Mr Sissling:** The response was to very quickly respond—in writing, of course—with letters setting out the health board's positions and plans. It would not be the kind of

correspondence where there would be a detailed improvement action plan; that would be done much more in correspondence between Kevin Flynn, as director of delivery, and other colleagues—other executive directors. We received assurance from the chief executive about how seriously she took it—or how seriously he took it, because, at times, the correspondence was with the interim chief executive—and we received particular assurance about quality and safety issues.

[525] When I raised concerns about unscheduled care at Glan Clwyd, for example, it was not just about targets; it was also about what unscheduled care represents in terms of the risk to quality and safety. The assurance that I got back—I got this three times, I think—was that the health board was paying attention to matters such as the RAMI in that particular hospital; at that time, it was at level 97. Other matters included fundamentals of care, using a safety dashboard, using nursing metrics, reviewing nurse staffing levels and basically providing reassurance about the things that I think should define our relationship, namely matters of quality and safety. So, it was about getting assurances that this was being taken seriously and assurances that action would follow. In some cases, it was about me pushing for time frames, asking when this and that would be done by. That was the basis on which we could monitor the action and the improvement that was necessary.

[526] **Darren Millar:** At what point did you bring the chair into the frame, as it were, by copying him in on the correspondence?

[527] **Mr Sissling:** That would probably have been in September or October. Previously, the matter was predominantly between me and the chief executive. In September and October, the concerns escalated, and the board seemed to be brought into it. The director of finance and two committee chairs had sought a meeting with the Wales Audit Office. I felt that, at that point, I needed to copy the chair into that correspondence and to talk to him. Aside from just the executives, this was more an expression of the way in which the board was functioning.

[528] **Darren Millar:** I just want to be clear on this. We took evidence this morning from the outgoing chair, the vice-chair and the chair of the finance committee from the board, and the board secretary. They suggested that the driver for most of the contact was the financial situation rather than other performance issues. While other performance issues were important, they suggested that the main driver was finance. Is that a fair reflection?

[529] **Mr Sissling:** No, I do not think that it is. Finance was there, but it is also about what finance represents, in terms of the ability of the board to plan and conduct its affairs in an appropriate way. Finance was clearly one of the issues, but there were concerns about waiting list times and continuing concerns about unscheduled care, particularly because of what it represents in terms of risks to quality and safety. So, I would not agree that it was entirely, exclusively or narrowly based on finance, although that was clearly one of the issues that we were concerned about. As I said at the beginning, there were probably four things that we were particularly bothered about.

[530] **Darren Millar:** You made reference to death rates—the RAMI rates, as you called them earlier. Is it a concern to you that, this morning, the vice-chair of the board, who is responsible for the quality and safety committee at the Betsi Cadwaladr health board, did not know what the average hospital RAMI score was in Wales? He suggested that the average RAMI score for Welsh hospitals was 120. Is that a concern to you?

[531] **Mr Sissling:** I have not heard what he said. I would expect the committee chair who takes responsibility for quality and safety—as I would expect the responsible executives—to have a good insight into the mortality rates for their own organisation, and to have an understanding of the comparative benchmarks that they might want to utilise, accepting that mortality rates and RAMI rates are complex. I would expect that.

[532] **Darren Millar:** Okay, thank you. I am now going to bring in Aled, and then Sandy.

[533] **Aled Roberts:** Rwyf am ofyn fy nghwestiwn yn y Gymraeg. Rydym wedi cael tystiolaeth ysgrifenedig gan Mary Burrows. Hoffwn ichi egluro'r hyn a ddywedoch, sef mai'r sefyllfa ariannol oedd un o'r materion a oedd o bwys i chi. Mae hi'n dweud hyn:

**Aled Roberts:** I wish to ask my question in Welsh. We have had written evidence from Mary Burrows. I would like you to explain what you said, namely that the financial situation was one of the issues that was important to you. She says this:

[534] 'In my professional opinion, financial balance became the main priority for the health board. Documentation from officials during 2012-13 stated that financial balance must be achieved and that there could be consequences if this did not happen. Tensions continued to grow.'

[535] So, there is no reference in the opening statement regarding any of the other issues that you alluded to, other than the fact that financial balance was the main priority, in her opinion, and that that was what was creating the tensions within the board.

1.30 p.m.

[536] **Mr Sissling:** I would disagree that that was the main or only issue that we were raising. Throughout 2012-13, the volume of concern was raised about unscheduled care, and the concerns about finance developed later in September and October. However, unscheduled care continued to be a matter of concern. We also raised issues about the capacity of the health board at the executive level. So, I would not agree that it became a single issue. The support, as I mentioned before, was on a number of issues. We were interested in the health board as a whole. We were interested in infections and a whole series of things. That is not to say that we did not have a keen interest in finance, as you would expect us to have.

[537] **Darren Millar:** In terms of the consequences if financial balance was not achieved, what consequences do you think that Mrs Burrows might be referring to there? In the quote that Aled just read out, she states:

[538] 'Documentation from officials during 2012-13 stated that financial balance must be achieved and that there could be consequences if this did not happen. Tensions continued to grow.'

[539] What were those consequences that chief executives were told there would be?

[540] **Mr Sissling:** The requirement on any organisation is to break even financially. We have a delivery framework, which has a series of escalations within it. On the consequence of failing to do that, there would have to be some reflection on the particular circumstances, but clearly it would be wrong for us to say that, in terms of the accountability arrangements and the performance management arrangements, there is no consequence of a failure to deliver a particular important target. I would be surprised if anyone suggests that. The consequence is difficult to forecast, but I think, at a point where the delivery of financial balance has emerged as a particularly serious issue for the board, as it did for all health boards in Wales, and a health board that was struggling with its forecasting and was not, from our point of view, quite in sufficient control as we would want it to be, it was quite appropriate that we drew their attention to the necessity of delivering financial balance and to clearly say that there will be consequences. There is no algorithmic equation that says what they would be, but, equally, we were making points. It will be in correspondence that they would need to improve unscheduled care. If there were concerns about any particular issues, we would have been drawing attention to the requirement to improve.

[541] **Mike Hedges:** When did you become aware that the budget as set by Betsi Cadwaladr and given out to budget holders could then be agreed or not agreed by those budget holders? Really, the final budget was not a final budget; it was a final budget out for negotiation. When did you discover that?

[542] **Mr Sissling:** I will make an opening remark, but then I will ask Martin to talk in a bit more detail. In terms of 2012-13, we received assurances in April that the board had agreed a balanced budget at organisational level. That is the important thing to say. Martin, do you want to say a bit more?

[543] **Mr Sollis:** The requirement to get budgets signed off is at board level. It is not something that I would naturally see—if individual budget managers were not signing off the budget—being escalated to our level. There is no mention in any monetary returns of budgets not being agreed. As David has said, it is stated that the financial budget strategy was agreed and that the budget was agreed in April.

[544] In terms of the budget holders, we issue guidance—standing financial instructions—that tells you what you should do if those budgets are not signed off by managers, as well as the requirement to have those budgets signed. The delegation of budgets is usually a good financial management practice, and it is making sure that you have engagement throughout the organisation in terms of making sure that you have people on board in terms of the budgets that they have been allocated, and that they act accordingly. If the budgets are not signed off, then there is recourse where the director of finance and the board secretary are supposed to raise that with the audit committee and take advice. That is not something that would normally come to us. We set the SFIs, which are on a standard basis across Welsh LHBs.

[545] **Mike Hedges:** Is it normal for health service budgets to be signed off in this way? When did that happen? I used to serve on an NHS trust board back in the early and mid-2000s. When we agreed a budget, people were told, 'This is your budget; here you are'. They did not have to agree it. The board agreed it, they accepted it—they may not have liked it, but they accepted it. When did you change the rules so that budget holders could then decide that they were not happy and that it would go back to further negotiation?

[546] **Mr Sollis:** I do not think that it is the case that people can, if you like—. The issue for me is around engagement. It is a clinically driven service. There are spending plans and issues that need to be agreed across the whole organisation, therefore, you want engagement across the whole organisation. Therefore, you would want your organisation, on a co-production basis with staff, to have agreed to those actions in spending plans and to make sure that you can deliver them. That engagement is absolutely fundamental. I cannot comment on—. I have only just come back to health after a long period of absence, but, in terms of the LHBs since they have been set up, each LHB has signed off standing orders and standing financial instructions that have been signed off by their boards, which agree to those practices. It is good practice to make sure that those delegations are owned by people, so that the actions are there and spending plans are delivered.

[547] **Mike Hedges:** Should that not happen before the budget is agreed, rather than afterwards?

[548] **Mr Sissling:** Yes, I agree.

[549] **Sandy Mewies:** May I go back to something that Mr Sissling said earlier? You said that one of the things that came to your attention and that worried you was unscheduled care, particularly in Glan Clwyd Hospital. You said that you had discovered some strange

relationships.

[550] **Mr Sissling:** I am sorry; I said ‘strained’ relationships.

[551] **Sandy Mewies:** Oh, ‘strained’. Well, good. That is a bit better. [*Laughter.*] But, what do you mean by ‘strained’? Was it in relation to the budget? What did you mean by that?

[552] **Mr Sissling:** No; I am sorry. The intelligence that we were getting from Glan Clwyd was that the relationships between different parts of the hospital were not always as coherent and harmonious as we would want. That might have been an issue in some of the problems. To an extent, we were also influenced in that by a HIW report on Glan Clwyd, which makes reference to the fact that there are some issues in that hospital in terms of some of the relationships. So, again, it is a demonstration of how we are working, of course, with the numbers, but at times you have intelligence that gives you some indications of the history. So, my request to the organisation’s chief executive was to provide me with a commentary on that.

[553] **Sandy Mewies:** Did you get it?

[554] **Mr Sissling:** Yes, of course.

[555] **Sandy Mewies:** I think that you also said that, towards the end of 2012, you had asked about CPGs and the appointment of a chief operating officer. I do not know whether these were the sorts of things that led to that recommendation. What was the immediate reaction to that? Did you get letters straight back? Was there an agreement, or a blocking? What was the tone?

[556] **Mr Sissling:** I think that I can remember the details without the actual date. It was a letter in mid December and then a response in January describing the actions that the board was taking, appropriately through the board, to consider changes to the executive team, including a chief operating officer—it might have been called clinical lead, or someone who would take responsibility for the CPGs. It also said that it was looking at some other posts, and gave an update on the review ongoing within the board on the CPGs—the clinical leadership structure—and some reassurance that the board was paying attention to board developments. I then wrote back to say, ‘Very good, thank you, but I would like some dates of when things would actually happen’, and I was told, for example, that a chief operating officer would be in place, as I recall, by April. So, that was the kind of interaction of discussion, formalising it in writing, a response, and me saying, ‘I would like to be precise and understand exactly when it is going to happen’ and then getting a date. Obviously, it is easier to clarify when things happen when you have a date and an outcome.

[557] **Sandy Mewies:** Did you get a timeline back?

[558] **Mr Sissling:** Yes, we got the date.

[559] **Sandy Mewies:** So, really, that was the action that you took in response to those concerns and it was something that the chair had explored with you. You did say that you clearly set out the improvements, I think, to the chair by letter. Did you say what was needed and when it was needed? Did you indicate any consequences that could occur if, in fact, you did not get that information back?

[560] **Mr Sissling:** Are you asking about my letter to the chief executive?

[561] **Sandy Mewies:** Yes, or to whomever you raised it, I suppose, because I am not quite clear about the changes in personnel. I am asking about whoever the person in authority was

with whom you raised it.

[562] **Mr Sissling:** As a general rule, I would write to the chief executive. That is the appropriate way for me to conduct business with the board. So, I would be writing to the accountable officer—the chief executive. I would, therefore, be directing my inquiries or making clear my expectations about improvements in defined time frames and copying those inquiries to the chair—and I may have copied things to the vice-chair on occasions—to make sure that they were aware of it, because that helps the board, through the board leadership, to conduct its business properly.

[563] **Sandy Mewies:** Did you, at any time, get to the point where you said, 'Look, I expected this by now and I haven't had it'? Did you say what you wanted to happen then?

[564] **Mr Sissling:** The general pattern that emerged was of me asking for reassurance and receiving it very promptly. There was no problem; we did not have to particularly chase it up. At times, there was not quite the pace in the consequential delivery, which became a matter of concern and a matter of inquiry for me, I suppose. To an extent, it seemed to be that the executive team was stretched, which is why my attention was then drawn to the capacity of the organisation, and particularly what seemed to be a need to resolve this issue between the clinical leadership structure and the executive leadership structure. The model that a number of health boards have successfully employed—and you need it, I think, in big organisations—is to have a chief operating officer who can appropriately manage the clinical leaders and provide a pan-health-board view of operational matters. That was one of the outcomes of that. Generally, we were getting reassurances of action, but quite often, it was not quite delivered with the pace and to the time frames that we would have wished for.

[565] **Sandy Mewies:** I understand that, and you seem to have recognised some tensions between the clinical and the executive—

[566] **Mr Sissling:** Yes.

[567] **Sandy Mewies:** Fine; thank you, Chair.

[568] **Darren Millar:** Something strikes me as a little bit strange here. You were worried about the capacity of the health board to deliver the financial savings that were required, and you knew that there were issues in terms of the budget not having been signed off in April because it is noted in Chris Hurst's report, yet you took on face value, and did not test the assertion, that a balanced budget had been agreed at the April board meeting, in spite of the fact that we have been told today that that was an interim budget for one month that had been agreed, because not all of the CPGs had signed off their particular parts of the budget, and the full budget strategy had not been agreed. I cannot understand where the challenge is from the Welsh Government here. Do you challenge the accuracy and authenticity of the assertions that are made to you, when you ask a health board about its financial position, and, if so, how? Why did you not do so in this case when you knew that there were already problems at the board?

[569] **Mr Sissling:** Just to clarify the opening remarks that you made about the insight into capacity, this was not just about finance. This was an organisation that was taking itself through a very challenging period. It had financial pressures, and it was also going through a major service reconfiguration.

[570] **Darren Millar:** Okay. I am just asking specifically about finance. Mr Sollis referred to the fact that you had received a response that indicated that a balanced budget had been agreed as a result of the April meeting, but you did not test that. You said that you accepted that on face value.

[571] **Mr Sollis:** I am sorry. I was not in post at that point in time. To repeat what I said, we get monitoring returns every month. I have looked back through the monitoring returns that we received all year and there is no indication in those monitoring returns, which go into a lot of depth on financial performance, that budgets had not been signed off by individual managers. What they did say was that certain spending plans still needed to be put in place, but that is a different issue because spending plans can cover wide-ranging themes that cover a multitude of budget managers. So, it is not just around budget managers.

[572] Perhaps I can just refer to the Chris Hurst issue. Again, just in terms of the Chris Hurst arrangement, as far as I am concerned, since I came in, no-one has been aware that that work was carried out in any official capacity on behalf of the Welsh Government. The issue for me in terms of that report, because I only received a copy in the last week and I have tried to chase it through in terms of the arrangements around that, is that it is my understanding that the report was done around 4 and 5 April, around a couple of brief discussions and observations to the board. It was making observations rather than actually commenting on the fact that budgets had not been signed off at that point in time.

1.45 p.m.

[573] I cannot refer to the conversation that you had this morning, but what I am saying is that the monitoring returns, and the spending plans that we get from organisations, have not indicated that individual budget managers have not signed off. Obviously, as the position moves forward throughout the year, there is a clear non-delivery against some of those plans, because the actual performance at months 1, 2 and 3 earlier in the year showed that expenditure was running higher than their spending plans and their approved budget. That came through and it ended up with a forecast in September of £19 million where—and again, I am sorry, because I was not in post—I could see that immediate action was taken. The Allegra review was undertaken.

[574] **Darren Millar:** I just want to clarify something. Betsi Cadwaladr University Local Health Board tells us that the Welsh Government commissioned the Chris Hurst review and the Allegra review. Can you tell us, and you were not in post, Mr Sollis, but did the Welsh Government commission the Chris Hurst review, and what was Chris Hurst's role within the Welsh Government at that time? Was he a Welsh Government employee, or had he been in the past?

[575] **Mr Sissling:** He had been, yes; he had been the director of finance. Again, I was not personally involved in this at all, so I am doing this second hand. He was available to do some work across health boards on a call-off basis, health boards were made aware of that and, at Betsi Cadwaladr, the acting chief executive decided that they wanted to take advantage of that. Chris spent some time—not a considerable amount of time—with Betsi Cadwaladr. He did not produce a report. If you look at it, it says that it is a brief, informal note. I have to say that, in my mind, it does not qualify as a report. It is what it says it is: a brief, informal note that was shared with the health board, not with Welsh Government. We did not receive a copy of it, and that is entirely right, in a sense. We made it available and it was something that the health board accepted and used internally in a way that, maybe in your previous evidence sessions, has become clarified to you.

[576] **Darren Millar:** It is not clear at all, actually. Betsi Cadwaladr tells us that you initiated this Chris Hurst review. The outcome of it is here. It is referred to as a report, which is why we are referring to it as a report, in the Wales Audit Office and HIW report. It took place while the acting chief executive was in post in the Betsi Cadwaladr health board. It has got quite a section on finance, yet you do not appear to have had sight of it. You obviously had a copy, because, Mr Sollis, you said that you have a copy.

[577] **Mr Sollis:** What I said was that, in the last week, I have received a copy. I asked for a copy. When the report was raised, and when the report was mentioned in a phone call that I received from the AGW, we chased up a copy of the report. I wanted to see what was in there, and what it said around the financial issues.

[578] **Darren Millar:** Yes, quite right.

[579] **Mr Sollis:** So, we have subsequently, in the last week, received a copy.

[580] **Darren Millar:** However, the Welsh Government did not have a copy and was not aware of a report or any informal note of any kind prior to the publication of the HIW and WAO report.

[581] **Mr Sissling:** I can only speak for myself. I think that I was aware that Chris might have been doing some work with Betsi, for Betsi—

[582] **Darren Millar:** So, you were aware. You were aware that some work was going on. Did you not ask for the outcome of that, Mr Sissling?

[583] **Mr Sissling:** I was not aware of the detail of it. I think that I was aware that there was some work going on, and it was for the health board, and it would have been for the health board to draw it to our attention if there was any reason to do so.

[584] **Darren Millar:** I am still not clear on this. You made health boards aware that this gentleman was available to do some work. Was that in the finance area? As he was a former director of finance, I assume that that was the case. You knew that he had been called in—or you are suggesting that he had been called in by Betsi Cadwaladr to do a piece of work—and you were aware of that, but you did not ask for the outcome.

[585] **Mr Sissling:** I did not, no, but I cannot talk on behalf of others in Welsh Government at that time. That is all that I can really say about this: this was an exercise that was done for Betsi Cadwaladr—

[586] **Darren Millar:** It was paid for by the health board, was it?

[587] **Mr Sissling:** In a sense, it was paid for by us. We made that available.

[588] **Darren Millar:** So, it was paid for by you, but you did not ask for the outcome of it, even though he was essentially commissioned by you to do this work on behalf of health boards.

[589] **Mr Sissling:** It depends on what you mean by 'commissioned'.

[590] **Darren Millar:** Well, you paid for it, did you not? You paid for it, at the end of the day. They were your purse strings.

[591] **Mr Sissling:** We paid for it, but we did not specify the work that would be involved.

[592] **Darren Millar:** That is pretty extraordinary, is it not? How are you going to test that it is worth your while paying for any work if you do not know what the outcome is?

[593] **Mr Sissling:** There are two parts to it. One is who paid for it, and then there is what work was involved, which is part of commissioning. The fact that we paid for it, yes, I accept that. The actual nature of it was specified between Chris Hurst and Betsi Cadwaladr, and the

work was presented to Betsi Cadwaladr. You are right—we did not have sight of the finished product.

[594] **Darren Millar:** Did you ask for sight of the finished product?

[595] **Mr Sissling:** I did not, no.

[596] **Darren Millar:** Did anyone in your department ask, up until last week?

[597] **Mr Sissling:** I honestly could not tell you.

[598] **Jocelyn Davies:** How much did it cost?

[599] **Mr Sissling:** I could not tell you, I am sorry.

[600] **Jocelyn Davies:** [*Inaudible.*]

[601] **Darren Millar:** Yes. Mr Sollis, do you want to add to that?

[602] **Mr Sollis:** We can provide that detail subsequently.

[603] **Aled Roberts:** May I just ask who the director general and finance director were between January 2012 and May 2012—within the Welsh Government?

[604] **Mr Sissling:** Sorry, the—?

[605] **Aled Roberts:** The director general of the NHS in Wales, and the finance director.

[606] **Mr Sissling:** Between which dates, sorry?

[607] **Aled Roberts:** January 2012 and June 2012.

[608] **Jocelyn Davies:** Last year.

[609] **Mr Sissling:** Last year, I was the director general. The director of finance, I think, at that point would have been Alan Brace, on an acting basis.

[610] **Aled Roberts:** Mary Burrows's evidence to us states that

[611] 'The 2012/13 budget setting process caused concern with the Director General and Finance Director at that time, Mr Hurst. The Director General did contact me during my period of absence from February to mid-May 2012 as to the initial shortfall being identified and concerns about financial forecasting and management. I was not in a position to respond, but did disclose the conversation with the Acting Chief Executive at the time. The concern prompted the Chris Hurst Review which the Acting Chief Executive received and acted upon.'

[612] So, there are discussions regarding concerns that the Welsh Government has. There is a suggestion here that the finance director at that time, presumably within the Welsh Government, was Mr Hurst.

[613] **Mr Sissling:** I would have to check at what point Chris Hurst left Welsh Government.

[614] **Aled Roberts:** However, the Welsh Government, given the levels of concern—which

caused Welsh Government officials to contact the chief executive, who was absent due to illness at the time—did not seem sufficiently concerned to ask for a copy of the report.

[615] **Mr Sissling:** Our concern was to look at the process of budgeting and to look at the reassurance we got about the plans that they had produced and the balanced budget that they had produced.

[616] **Aled Roberts:** You could not get that reassurance from what we had in the Wales Audit Office and Health Inspectorate Wales reports. You have not had that reassurance—we still have not had the reassurance. We still have clinical programme groups in Betsi Cadwaladr that have not signed off the 2013-14 budget.

[617] **Darren Millar:** Okay, I think that we will move on.

[618] **Mohammad Asghar:** My question is on the effectiveness of the board and its sub-committees. What assurances did you receive from the health board that the concerns were being effectively managed?

[619] **Mr Sissling:** Sorry, but could you say that again, please?

[620] **Mohammad Asghar:** You want to hear it again; okay. What assurances did you receive from the health board that the concerns were being effectively managed?

[621] **Mr Sissling:** We received written assurances that the concerns were being managed. We had action plans and we had an ability to test those out, either through me or through colleagues in the department with their counterparts in the health board. Obviously, our focus would be on the actions that were specified in the action plans, to make sure that they were delivered.

[622] **Mohammad Asghar:** Okay. Who were you seeking assurances from? Was it just the chief executive, or did you engage with other board members to get a balanced view?

[623] **Mr Sissling:** I interacted predominantly with the chief executive. However, there were interactions with other executive members. So, the director of finance in Welsh Government would be interacting with his counterpart. The director of delivery will be interacting with a number of executives. The chief medical officer will be interacting with medical directors. Our chief nursing officer will be interacting with the director of nursing, and so on. We have, twice a year, a joint executive meeting with the whole of the executive team. We draw on reports from HIW and WAO, which are relevant, and the ombudsman. We send in the delivery support unit, which is another source of assurance. Therefore, we are able to build a picture that our assurances are conveyed and demonstrated by action.

[624] **Mohammad Asghar:** Were you seeing sufficient improvements, and, if not, what were you doing to escalate matters?

[625] **Mr Sissling:** As I mentioned earlier, I think that it is fair to say that we were in some cases, but, in others, we were not satisfied with the improvement that we saw. I previously alluded to a process of escalation and the formality of that. The health board in our delivery framework was escalated to level 4 in February. So, action was taken when there was a failure to deliver. During the period from September onwards, we also had meetings with HIW and WAO about the way in which the system in a general way could respond to the position.

[626] **Mohammad Asghar:** How did you test the robustness of any assurances that you were being given?

[627] **Mr Sissling:** With regular follow-up meetings, looking at the data, the information, whether the trajectories were on track and whether the delivery of x was in line with the expectations that the board had created. We explicitly commissioned Allegra to do that in order to provide an external perspective. We had validation from the delivery support unit.

[628] **Mohammad Asghar:** In your earlier statements, you said that you were getting all these assurances from the chief executive. Were you not being a little bit slack or not taking responsibility, because you were ignoring the diversity of responsibilities among the board members and not getting the proper information from every corner of the board?

[629] **Mr Sissling:** While I understand the question, it could confuse matters if there is not a clear and consistent line of interaction and communication. I believe that it is right for me to operate through the chief executive in terms of all matters in the health board, and to ask others to interrelate with their functional counterparts. If I start having detailed discussions with other directors, that could confuse and dilute the relationships.

[630] **Jocelyn Davies:** Were you not having daily conversations with the chair? I believe that that is what he told us.

[631] **Darren Millar:** I ask Members to come through the Chair, if that is okay. It would help the committee to know exactly what the escalation process is. You have mentioned this level 4 a couple of times. What is level 1 and when was Betsi on it? When was it escalated to level 2, 3 and 4, and what was the rationale behind that? I will allow you to come in in a second, Jocelyn, but another couple of Members want to come in first.

[632] You also mentioned the interaction between you and the chief executive. Were there any discussions with the Minister about your concerns, and any encouragement for him to relay those concerns to the chair of the board? That would be the usual communication, would it not?

[633] **Mr Sissling:** Absolutely. As the situation was serious, I was briefing the Minister, who took a keen interest, was concerned, was interested to know about the responsive action, was periodically discussing the issues with the chair and was seeking assurances of improvement from the chair of the health board.

[634] **Darren Millar:** Was that very early on? How far back did the discussion between the Minister and the chair of the board about the problems go?

[635] **Mr Sissling:** I would say from late autumn/winter.

[636] **Darren Millar:** So, around September time.

[637] **Mr Sissling:** Probably a bit after that—probably October time.

[638] **Julie Morgan:** You say that the communication was chief executive to chief executive, and that that was your role. How, personally, were you involved? How many times did you meet the chief executive over the period of time that these problems started to emerge?

2.00 p.m.

[639] **Mr Sissling:** I could not give you an exact number, to be quite honest. However, very frequently I would be talking on the telephone, meeting in my offices or visiting Betsi Cadwaladr health board. Since March and by next week, I will have been up there six or seven times; I have visited about that number of times. However, we have an awful lot of

meetings in Cardiff that are opportunities to have face-to-face discussions. So, we have very regular contact.

[640] **Julie Morgan:** Were you meeting regularly before March, when these problems started to emerge?

[641] **Mr Sissling:** Yes. We talk to all chief executives quite regularly. We have meetings that are timetabled, but there are all kinds of meetings. It is difficult to describe it; it has a structured side, but there are also an awful lot of ad-hoc meetings or conversations about issues.

[642] **Julie Morgan:** Looking back, do you feel that your involvement could have been greater?

[643] **Mr Sissling:** No. I believe that, certainly since September, I have given this an enormous amount of personal attention, as I should, in terms of developing an understanding of the seriousness of the issue and spending time with executives. When I went up the week before last, for example, it was to see not just the acting chief executive, but the chair and vice-chair. I met the whole executive team, senior clinicians and the leader of the British Medical Association. It is important for me to meet colleagues beyond the chief executive. In previous meetings, I have, again, met all of the chiefs of staff and non-officer members. While I would interact through the chief executive in particular, there is also a network of contacts that develops.

[644] **Jenny Rathbone:** Would it be true to say that, because you had not seen the Hurst report, it was not until the Allegra report was on your desk that you were able to see that the assurances that you had been getting from the chief executive and acting chief executive were given promptly but were not an accurate picture of the extent of the problems that the board had? The Hurst report was very clear that there was really urgent need for action. As a result, the observations that Hurst was making were to be shared with the board of directors. As you did not see the report, you did not know that. It also meant that the board of directors may not have been aware just how serious the situation was. Is it not the case that you had prompt replies but that those replies were not tested for accuracy?

[645] **Mr Sissling:** I think that there were a number of things happening during that time. There were issues to do purely with finance, but there were also more general issues. With finance, for example, I would not agree that it was not until we got the Allegra report that we really became concerned. We became concerned in September in particular in the light of the events that I have described and the deterioration in financial performance, particularly the forecast. At that point, we commissioned the Allegra report, which responded quickly, but we had already taken action at the beginning of October, with an appointment agreed for an internal turnaround director. When the Allegra report was produced in early December, that action had already been taken. We were not waiting for external reports. External reports are helpful, but you cannot rely on them to take action. These were also pretty brief in-and-out reports. It was important, at any point, for us to take decisions based on our own insight in terms of the organisation, which is why we mobilised action in October, rather than waiting until we had the report—we cannot always be waiting for reports.

[646] **Jenny Rathbone:** Fair enough. However, it was not until September or October that you were really aware of the extent of the problem.

[647] **Mr Sissling:** In terms of finance, yes. In other areas, I think that we were aware previously, because we drilled down on unscheduled care.

[648] **Darren Millar:** On the Allegra report, it seems as though there may have been some

confusion as to who owns the ability to reproduce the report. We have been provided with a copy, fortunately, by the Betsi Cadwaladr health board, but written answers to Assembly Members have suggested that the Welsh Government could not share this report because of copyright issues. In fact, one of the requests for information has been treated as a freedom of information request. Is there any reluctance for you to share this?

[649] **Mr Sissling:** Not on our part, no.

[650] **Mr Sollis:** The only thing that I am aware of in terms of the Allegra report is that there was a disclaimer on there that said that we needed to go back to the individual—they were quite happy with that disclaimer—to notify them that we were making it available, because it could be in the public domain. That was the only aspect of it.

[651] **Darren Millar:** So, that is this line:

[652] 'They are provided for your information only and should not be copied, quoted or referred to without prior written consent.'

[653] Okay, I understand that.

[654] It is interesting that the report lists the issues for review, and at the top of that list is 'financial performance'. However, you are saying that financial performance was not a primary driver.

[655] **Mr Sissling:** No, the report was commissioned particularly in the context of financial problems, so its focus necessarily would have been on financial issues. That was the main thrust. That is really what it was there for. There was a request within it to comment on one or two other issues, but this was not a report on the broad range of challenges facing the health board. It was a very short, sharp report that we felt was necessary just to confirm some of the issues that we were concerned about.

[656] **Aled Roberts:** The Allegra report itself states that it was produced 'in accordance with terms of reference dated 12 October 2012' from the department of health in the Welsh Government. Would you be willing to share those terms of reference with us?

[657] **Mr Sissling:** Yes, absolutely.

[658] **Aled Roberts:** May I also ask who the responsible officer was within the Welsh Government who was the link officer as far as the preparation of this report was concerned? There are some worrying notations in the report, in point 5, with regard to the 'Effectiveness of organisational management structure', and in point 6, 'Governance structure and effectiveness'. The report has notations on both those paragraphs. On the effectiveness of organisational management structure, which talks about confused accountability around the clinically led structure, there is a note that says:

[659] 'Note: Limited review of this objective at request of CEO'.

[660] **Mr Sissling:** That is the chief executive officer.

[661] **Aled Roberts:** Of Betsi.

[662] **Mr Sissling:** Yes.

[663] **Aled Roberts:** If it is a report commissioned by the Welsh Government, which is supposedly looking at how effective the governance structures concerned are, why would the

chief executive officer determine what is within the scope of the review, if the terms of reference are provided by the Welsh Government?

[664] **Mr Sissling:** I would have to go back to the colleague, the director, who was responsible for setting the terms of reference, which were signed off between the reviewer and with the involvement of the chief executive, to understand why that was there.

[665] **Aled Roberts:** There is also, in point 6, an observation that formal governance processes were not 'fully effective'. The note there is this:

[666] 'Limited review of this objective as expected to be part of wider review by HIW'.

[667] **Mr Sissling:** Yes. That was making a connection with the review that had been agreed to look at matters of quality and safety in governance, which Healthcare Inspectorate Wales was undertaking.

[668] **Aled Roberts:** As far as the Hurst report and the Allegra report are concerned, was there any sharing of those reports, given that the Allegra report was commissioned by the Welsh Government and the Hurst review was paid for by the Welsh Government? Was the Allegra report shared with Betsi board members, and were both documents then shared with the WAO and HIW?

[669] **Mr Sissling:** I could not comment on whether they were shared with the Betsi board. My expectation was that they should have been.

[670] **Aled Roberts:** You did not require them to be.

[671] **Mr Sissilng:** No. My expectation was that they would have shared those with the board as a matter of good practice. As I said, it is difficult to talk about the Hurst review. That was not shared with HIW and the WAO. I think that we discussed the Allegra review at one of the meetings that we had, but I do not think that it was shared with HIW and the WAO.

[672] **Aled Roberts:** Why was that not shared, given the breadth of concerns outlined in the Allegra review?

[673] **Mr Sissling:** I could not tell you. That is probably something that we should have done.

[674] **Jocelyn Davies:** Before I come to my questions about the departure of the chief executive and the chair, just for clarification, Welsh Government made Mr Hurst available to local health boards at Welsh Government's expense. Is Mr Hurst still available at Welsh Government's expense to local health boards? If not, why has that stopped?

[675] **Mr Sissling:** It was a short-term arrangement that existed but has now elapsed.

[676] **Jocelyn Davies:** It has now elapsed. So, did you do a value for money evaluation on what he did?

[677] **Mr Sissling:** Not to the best of my knowledge.

[678] **Jocelyn Davies:** I guess that you would have found that pretty difficult when you did not see anything that he did. However, you did mention earlier that you knew that he spent a lot of time on this particular report. You said, 'I know that he spent a lot of time'. I wrote it down as you said it—we can check the transcript.

[679] **Mr Sissling:** If I did, that is not what—

[680] **Jocelyn Davies:** Perhaps I misheard you. So, you do not know how much time he spent on it.

[681] **Mr Sissling:** It is my understanding that he spent a relatively small amount of time on this—that is just from reading the report, which I have only done in the last week. It is my understanding that he did not spend a lot of time on this at all. So, that is just to correct that.

[682] **Jocelyn Davies:** All right. Perhaps I misheard you. So, during the time of the escalation, did you have daily conversations with the chair? Do you recall having daily conversations with the chair? I see that that did not happen.

[683] **Mr Sissling:** No. I spoke to the chair relatively frequently, and there have been times when I may have been talking to him on a daily basis. It would be wrong to say that, since the escalation, I have been talking to him on a daily basis. However, we had fairly frequent contact.

[684] **Jocelyn Davies:** Okay. In relation to the chief executive leaving, as indicated, what discussions has the Welsh Government had with the health board on the terms of the departure?

[685] **Mr Sissling:** Our role would be one as part of a process. We have had discussions that basically set out the process that needs to be put in place and matters of integrity of the process. We have a role in terms of oversight, but not in terms of detail.

[686] **Jocelyn Davies:** Okay. So, you do not know what terms have been agreed and you do not know the details.

[687] **Mr Sissling:** No.

[688] **Jocelyn Davies:** So, you cannot tell us then whether it will be strictly within the contractual arrangements?

[689] **Mr Sissling:** That is a matter for the board to resolve.

[690] **Jocelyn Davies:** I see. So, you take no interest in that at all.

[691] **Mr Sissling:** We would take an interest because there are circumstances in which we might have to approve arrangements. So, we have a governance role where there are certain circumstances that we would have to formally approve and sign off.

[692] **Jocelyn Davies:** If you are involved in that, if you have to sign something off, do you ensure—because we have heard of the BBC quite recently, for example—that pay-offs are strictly within the contractual obligation?

[693] **Mr Sissling:** We would look at a whole series of issues and we would take advice; we would look to make sure that there has been an appropriate process locally and that proper advice has been taken; we would look to ensure that the Wales Audit Office have been involved appropriately; we would make sure that the appropriate process has been pursued; and we would take a view on it, having made sure that all of the many steps have been put in place.

[694] **Jocelyn Davies:** So, they are not necessarily strictly within—. Taking all of those circumstances into consideration, they could possibly be outside the strict obligations.

[695] **Mr Sissling:** It is really difficult for me to comment on that. The guidance that we would normally want is that it should be within the conditions.

[696] **Jocelyn Davies:** Okay. What about the exit of the chair? Is there any package for a chair exiting?

[697] **Mr Sissling:** Not to the best of my knowledge.

[698] **Jocelyn Davies:** Perhaps you will have a look at that. When we talked earlier about consequences, and you mentioned the consequences that may very well occur if books were not balanced, you did not mention the Minister's stated threat of removing boards.

[699] **Mr Sissling:** No. That would be something for the Minister to comment on, really, in terms of the Minister's approach in that regard.

[700] **Jocelyn Davies:** So, the board would have been made aware that the Minister could, at some point—I heard her say it in Plenary. Would that have been pointed out to this board?

2.15 p.m.

[701] **Mr Sissling:** I would not be aware of that.

[702] **Jocelyn Davies:** So, not to your knowledge—

[703] **Mr Sissling:** I could not properly comment on what the Minister's position would be on that.

[704] **Darren Millar:** Can you just confirm that the terms of the chair's or chief executive's departure will allow them still to speak freely about their experiences at the health board and that there will not be any gagging clauses in the terms of departure? Can you also confirm for us—because this is not clear to date, as far as I can see in any public statement from the board itself—whether the departure of the chief executive was related to the publication of the report or was it in process or progress in any case?

[705] **Mr Sissling:** That is a difficult issue for me to comment on in this meeting, to be quite honest. That would be very difficult. The chief executive has decided that she wants to stand down, so I do not think that it is appropriate for me to go into the details.

[706] **Darren Millar:** The question that I am asking is this: was the decision, to the best of your knowledge, taken after the publication of the report or before its publication?

[707] **Mr Sissling:** I am not sure whether it is appropriate for me to answer that question.

[708] **Darren Millar:** Why?

[709] **Mr Sissling:** It is because—

[710] **Darren Millar:** I am just asking whether you were aware that the chief executive had the intention to leave before the publication of the report or afterwards, and whether it was as a result of the contents of the report.

[711] **Mr Sissling:** That is subject to processes within the health board and I think that it would be difficult for me to comment on that. I may offer a view that may not be accurate and I do not think that it should be subject to opinion—you are asking for my opinion on

something that is quite a sensitive, delicate issue.

[712] **Darren Millar:** Okay, that is fair enough. Thank you.

[713] **Jenny Rathbone:** I think that we have pretty much covered the Hurst report, although it would be interesting to know what other work Chris Hurst did for other health boards under these terms of engagement and what happened to that—did it go to your department or did it just go to the relevant health board? Moving on from that, there are some concerns in the Allegra report that highlight, particularly in relation to governance structures, the risk of agreed financial plans being undermined by perceived clinical needs and/or informal networks overriding formal controls. Looking at the written evidence that you have had from Mary Burrows, she tells us of several instances where she took executive power to recruit consultants and emergency nurse practitioners, to recruit to Birthrate Plus staffing levels, to recruit to 60 vacancies, mainly in nursing, to which she gave her personal authorisation. It would appear that the chief executive was not going back to the board to say that they needed to do 'x' because of clinical governance reasons, and that the chief executive was bypassing the board and running the show almost single-handedly. That is worrying in the context of the Allegra report. Could you comment on the extent to which the Welsh Government was on top of this situation?

[714] **Mr Sissling:** The position that you describe is clearly unsatisfactory—that the chief executive had to do that to allow appointments to be made. My understanding—which to an extent has developed through the visits that I have made to the board—is that there was the application of some vacancy controls, which required the chief executive to sign off vacancies personally. That was, at times, an understandable process, though I would question whether it was right for the chief executive to be signing off every single vacancy. In doing that, as to whether those were executive powers—I would not necessarily see it like that. Clearly, it would be inappropriate for every single vacancy to go to the board for approval. There would normally be a process by which vacancies can be considered with the involvement of clinicians to make sure that the right kind of decisions were taken. I have not been aware that Mary was working to that extent and feeling that degree of isolation in the way that she was working.

[715] **Jenny Rathbone:** It also means that the financial parameters set by the board—. There is no indication that the board was in charge of managing a balanced budget and taking the clinical decisions to enable it to do that.

[716] **Mr Sissling:** My expectation of the board in such circumstances is that it would set up processes and might well ask the chief executive to shape and maintain a process where there could be cognisance of the statutory financial duties. Equally there could be decisions taken to respond to necessary clinical requirements, which might be to do with recruitment. However, it could apply in a number of other areas. The chief executive would normally involve other colleagues in that process. So, trying to align, at difficult times, the financial and—above all—the clinical safety issues is something that all boards have to work their way through.

[717] **Jenny Rathbone:** Indeed, but it is not clear from the Allegra report whether the problems highlighted in the Allegra report and the risks were being followed through properly. Surely, it was the role of the Welsh Government, having commissioned this report, to ensure that these risks were then managed appropriately.

[718] **Mr Sissling:** The Allegra report did not just drop on their desks and then we said, 'That's it. Thank you very much'. There was follow-up action. We asked for assurance in terms of the various recommendations and worked closely with the board to make sure that it was giving attention to the various recommendations within that report. So, it was not as if it

was a report without action or enforcement.

[719] **Jenny Rathbone:** Okay. It is similarly unclear as to—

[720] **Darren Millar:** Just for the sake of clarity, the points that are being made are in a document that the committee was given this afternoon as evidence from Mrs Burrows. It refers to some discussions within the board with other officers of the board, if you like, and also to some correspondence with the chair of the finance and performance committee, the chairman of the board, and the quality and safety committee, about these appointments. Apparently, however, there is no acknowledgement from them of the concerns that are being raised, or acknowledgement of receipt of the correspondence at all. I am not quite sure why that was. Aled is next.

[721] **Aled Roberts:** On the Allegra report and the turnaround capacity, Mrs Burrows states that,

[722] 'External support for turnaround was discussed with Officials and previous to that Officials had suggested external financial support. This was not supported some Executives or in some cases IMs due to the costs it might incur. For turnaround this meant an existing Director took on this role for a short period of time.'

[723] She goes on to state,

[724] 'The lack of management capacity within the organisation has been a constraint compounded by direction to reduce management costs and a reluctance to overturn this position for financial reasons.'

[725] Can you tell us how much Betsi Cadwaladr spends on salary protection per annum?

[726] **Mr Sissling:** I could not tell you. I simply do not know that figure.

[727] **Aled Roberts:** Are you aware of the number of compromise agreements that Betsi Cadwaladr has entered into in the last three years with its staff?

[728] **Mr Sissling:** I would not have that figure.

[729] **Aled Roberts:** It is 313, at a cost of quite a few million pounds. It seems that it has money to spend on salary protection and on compromise agreements to gag staff, but not actually to put in external management support when its chief executive is clearly saying that it could not cope.

[730] **Mr Sissling:** From our point of view, as I said before, in October we supported it or asked it to identify some turnaround support, which it did internally. That was its decision. That was not a decision that was taken as an option against external support. It is my understanding that that was a very clear decision taken by the chief executive, as were other decisions at that point to deploy the executive team in certain ways. From December onwards, we were saying, 'You need to strengthen your executive team. You need to bring in a chief operating officer'. Over the following months, we developed that and said that it needed to bring in further support and to secure consultancy support to help it with planning, so, our view is that it is an organisation that, for a range of reasons, needed to extend and expand its management and leadership capacity.

[731] **Aled Roberts:** However, those requests were made to the board, and they were turned down, even though—Chair, I do not know whether we could be provided with a note as to how much Betsi Cadwaladr LHB spends on salary protection in any year to compare

with these requests for additional capacity that had been refused by the board.

[732] **Darren Millar:** Okay. Thank you, Aled. Mike is next.

[733] **Mike Hedges:** Can I go back to—this is probably for Mr Sollis—budget setting within the board? What I would expect to happen—tell me if I get anything wrong and stop me at any time—is for there to be a discussion with managers who hold budgets on cost pressures and on expected savings for the following year. I would then expect a draft budget to be produced that would only be shared among them, showing exactly where they thought that they were going to be during that time. At the end of that, I would expect further discussion with them and for some additional cost pressures and additional savings to be identified. I would expect, after that, for a final report to be taken to the finance committee, or whatever name it has, then I would expect that to be agreed, with amendment, by the finance committee. I would expect it to go to the main board and, after that, when the board had agreed it, I would expect that to be the final budget and the budget that people had to work to, although, during the year, there would be virements taking place. I would not expect, at the end of that process, when you have reached the stage of the budget being agreed by the board, somebody along the line to say, 'You haven't given me enough money; I am not prepared to accept it'. I do not see how any organisation could be run along those lines.

[734] **Mr Sollis:** I would agree. The only thing that I would say in response to that is that, inevitably, you will get changes that will occur that may lead you to adjust your plans. There is always going to have to be continuous improvement. There will always be a need, where some saving plans or budgetary issues are outside, for example, unscheduled care or other pressures that may exist. A plan is only as good as the time that you have got it in place. There are lots of factors that will require you to change that plan to reflect the current circumstances.

[735] **Mike Hedges:** That is why I talked about in-year virement, but, really, you cannot have—under the way that Betsi Cadwaladr worked, I cannot understand why anybody ever signed off on a budget, because you had an amount of money in the budget, but, if it is was not what you had in mind, you would negotiate to get some of somebody else's. I do not see how you could ever run a budget system that way; I do not understand how people here did not know that it was happening, and, if they knew that it was happening, why they did not put a stop to it. You are going to say that you were not in post; I accept that.

[736] **Mr Sollis:** No. Sorry, but, as I said to you, the issue for me is that budget management and the arrangements around those non sign-offs or engagements are matters for the board. I outlined what the measure was, which was that the director of finance and board secretary should be raising that with the audit committee, and the audit committee should be making recommendations to the board.

[737] **Mike Hedges:** Do you give advice—I do not mean personally, but the Welsh Government—to boards about a process not dissimilar to the one that I outlined there of how to go about setting a budget?

[738] **Mr Sollis:** A lot of that is set out in the standing financial instructions that are approved by the board.

[739] **Mike Hedges:** So, are we saying that Betsi Cadwaladr was working outside its board structure, if it was having negotiations post the final budget?

[740] **Mr Sollis:** The standing financial instructions set out the procedures that it should follow in agreeing budgets before the start of the year, that is true, and that is an issue that has been approved by the board, so it should have those arrangements in place. If I am honest, the

planning cycle needs to shift back and should have started a lot earlier, so that you have the budget in place for 1 April. As I said to you, thereafter, there will inevitably be arrangements that you need to accommodate.

[741] **Mike Hedges:** I have been brought up on a system where next year's budget starts the day after this year's budget has been agreed.

[742] **Mr Sollis:** Exactly.

[743] **Mike Hedges:** I think that a number of people recognise that. A final question on this: is the way that Betsi Cadwaladr did this the normal way that health boards do it, or do the other health boards have a final budget that they agree and then, at some stage, virements may have to take place, but that is the budget that people have to start off working to?

2.30 p.m.

[744] **Mr Sollis:** Everybody has the same arrangements through model standing financial instructions that they should operate. As I think was outlined in the NHS finances report that has just been published, this practice and this issue whereby they are still looking to develop saving plans during the year to accommodate changes is common across the board.

[745] **Mike Hedges:** It is a good answer, and the one that I expected. However, it is the answer to a different question. Yes, you expect changes. If I was told that I had £1 million to spend, and my budget is showing £1.1 million, I have got to find £100,000-worth of savings during the year. I understand that; I have set budgets like that, and I have put pressure on people to work to budgets like that. What I have not seen is this: you have given me £1 million, but my budget is £1.1 million, and I am not prepared to accept a penny less than £1.1 million, and I am not prepared to accept that budget until you raise it. That is the point that I am trying to get to.

[746] **Mr Sollis:** It should be agreed upfront.

[747] **Mike Hedges:** Thank you. That is me done, Chair.

[748] **Darren Millar:** Julie Morgan is next.

[749] **Julie Morgan:** Thank you. Would you agree that the health board broke even partly because it cut back on its elective surgery towards the end of the year?

[750] **Mr Sissling:** We have looked at this, not just in Betsi, but more generally, and I think that it is a very complicated and complex picture. The emerging picture that we are seeing is of a very significant increase in the demand for unscheduled care in all parts of Wales, including the Betsi area. The level of admissions, while remaining relatively constant, was associated with significantly increased lengths of stay. The occupied-bed days associated with that were very significantly increased. Health boards increased in bedded capacity, but the consequence was that patients who were admitted as emergency cases and as clinically urgent had to occupy beds that would normally be used for surgery cases, and that meant a very significant number of cancellations due to a lack of available beds across Wales in the last three months of 2012-13.

[751] Health boards did continue with elective work where they were able, particularly clinically urgent work. The health boards then had to take decisions as to whether they could reinstate the activity they had lost from scheduled care. Some health boards, including, to an extent, Betsi, did this by paying additional money over and above their core expectations—I think that, in Betsi, it did some for cataracts and cancer, and that was a clinically-driven

process that was overseen by, I think, the appropriate committee, the finance and performance committee. However, there was a point at which I think it felt that it could not reinstate all the activity, which would have been difficult, because the beds were still full, so it would have to have gone outside the organisation. It therefore took the decision to postpone some activity.

[752] So, the answer is that I think that it is a complicated issue that is emerging, and a complicated picture. The driver for it was unscheduled care. That was the reason that there was cancellation or postponement of elective care, rather than it being a case of simply saying, 'With beds empty and with theatres and surgeons waiting, we are not going to undertake this activity'. That is our analysis across Wales, and that is the information that I have received from chief executives across Wales, including in Betsi.

[753] **Julie Morgan:** So, you do not think that finance was a driver. Is that what you are saying?

[754] **Mr Sissling:** I think that finance was not the absolute driver for the cancellation. Looking at the number of cancellations across Wales, which is a significant number, the cancellations were made due to a lack of beds, and the evidence that we have is of health boards having to open additional beds—and spend money on additional beds—to accommodate non-elective demand. At times, they had to send patients out from medical areas into surgical areas. So, our analysis, the emerging analysis, is that that is the main driver, but, clearly, finance influenced decisions in terms of their ability to secure, possibly in the independent sector, possibly in other ways, activity that would compensate for that loss.

[755] **Julie Morgan:** Right, so you are saying that there was no conscious decision to cut down on elective activity.

[756] **Mr Sissling:** That is the emerging analysis. I think that we would—

[757] **Darren Millar:** May I read a line from the submission from Mrs Burrows? It says that she brought

[758] 'Constructive challenge to the Finance & Performance Committee when it was recommended to slip the additional planned activity to meet financial balance.'

[759] It is quite clear from the analysis of Mrs Burrows, as a chief executive—and you have said that you sought these assurances from chief executives—that the reason that the planned activity was being postponed, or 'slipped', as she puts it, is to meet financial balance. Do you disagree with that? Do you also disagree with the Wales Audit Office report on health finances, which suggests exactly the same thing?

[760] **Mr Sissling:** I am at a disadvantage because I have not, obviously, read that.

[761] **Darren Millar:** I have just read it to you.

[762] **Mr Sissling:** The word—[*Inaudible.*]—I thought, was there. I heard what the chief executive, Geoff Lang, said last week, that the core activity was compromised and that decisions were taken about additional activity. That is the distinction. As it says in the Wales Audit Office report, this was a complicated issue, with unscheduled care and decisions that were, to an extent, contextualised by financial positions. However, simply to say that routine operations across Wales were cancelled for financial reasons is not the picture that is emerging for me.

[763] **Darren Millar:** However, the patients themselves would have had dates booked and then subsequently cancelled as a result of this slipping of the additional planned activity

because of the financial balance situation. That would have been devastating for them, would it not?

[764] **Mr Sissling:** I agree. I am not making any comment as far as that is concerned.

[765] **Darren Millar:** As far as they are concerned, this is their operation delayed or postponed as a result of finances. You do not dispute that, do you?

[766] **Mr Sissling:** I think that it merits a very detailed analysis of the—

[767] **Darren Millar:** Were people's operations postponed or delayed because of finances? That is the question. Yes or no?

[768] **Mr Sissling:** I do not think that it is as easy to reduce it to a 'yes' or 'no' response. The reasons why the majority of operations were postponed or delayed was because of unscheduled care, not because of financial reasons. There were consequences.

[769] **Darren Millar:** So, you dispute the findings of the Wales Audit Office report that was published earlier this week that suggested a direct link between the financial pressures and the slippage leading to the postponing of appointments and delaying elective surgery.

[770] **Mr Sissling:** No, I am just stating the position as I see it. I am trying to explain the position to you. You have asked me a question, so I am trying to explain it. I am happy to go through it again. There were unscheduled care pressures, which caused a requirement to invest in additional capacity and additional beds. There were patients, medical patients, in surgical beds, and that caused the significant cancellation of planned, routine activity. The consequence of that was that some patients, very regrettably, had their operations cancelled, sometimes at the last minute. However, decisions had to be made about additional activity. That is where this plays into this, and then financial issues did play into it. I can only give you my analysis of it. That is what you would want me to give, surely.

[771] **Darren Millar:** It is, of course. It seems to me that you are not disputing the fact that the additional activity was driven by a financial decision, a decision to postpone the additional activity. That is all I wanted to know.

[772] **Mr Sissling:** It is the difference between the additional and the planned.

[773] **Darren Millar:** That is all I wanted to get on the record, Mr Sissling. I call Mike and then Aled.

[774] **Mike Hedges:** A lot of elective surgery is day surgery, which would not involve beds. Are you telling me that that would be flat? That is not a bed or a capacity problem. So, you are telling me that if they were doing 1,000 in Glan Clwyd in November, they would still be doing 1,000 in the last months of the financial year, because that would be unaffected. There is a very easy way of cutting costs by not filling cancellations. Some 10% of appointments are cancelled for one reason or another. If you do not fill those cancellations, you make a 10% reduction in the number of people you see, without cancelling anybody by just not filling cancellations. Traditionally, people have been offered dates and told, 'If you can come in tomorrow, you can be seen, because we have a cancellation'.

[775] **Mr Sissling:** I would like to make two points. You are absolutely right that day care capacity tends to be protected and day care activity would therefore be unaffected by unscheduled care pressures. The information that I have seen would indicate that that was not reduced and that day care activity was generally fairly stable. So, I would agree with your analysis.

[776] The second issue is that, with the cancellation of activity, the staff remain in post and the majority of our costs are staff. Why would we not want to use staff when they are available to be used? So, the economics of it also need to be tested. Hospitals and health boards and the clinicians within them, in my experience, are very keen to undertake activity. I may not understand the point that you are making.

[777] **Mike Hedges:** Say I wanted to save money in a health board such as Betsi Cadwaladr. I have this area, half a dozen nurses and a couple of doctors. If I have a cancellation, then I can redeploy the nurses within the hospital in such a way that I do not need to bring in agency staff to fill those posts, so I am saving agency costs by internal redeployment, rather than carrying out activity.

[778] **Mr Sissling:** I can understand the point, but I have nothing to tell me that that was happening.

[779] **Aled Roberts:** I accept the point that you make regarding Betsi deciding not to go ahead with the additional capacity, but are you able to provide us with a note regarding what you refer to as 'core capacity'? There is an issue in north Wales regarding the reduction in the number of beds, which means that, in fact, the additional capacity would have been replacing beds that had been taken out of the system anyway.

[780] **Mr Sissling:** I understand the point, and that is why I said that this merits careful analysis. I would be very happy to provide a granular picture of exactly what has happened in terms of bad capacity, surgical capacity, medical capacity and the way that the pressure on unscheduled care caused some of the capacity to be unavailable for operations, and then decisions—financially contextualised to an extent, and clinically driven—had to be taken. So, I understand the point.

[781] **Darren Millar:** Just for clarity, the health finances report from the Wales Audit Office, which was published earlier this week, says that some NHS bodies decided to significantly cut spending on waiting list initiatives, which involved paying hospital consultants premium rates for additional elective work, which is the point that you made. The report also says that some NHS bodies told the WAO that it took decisions to reduce elective activity in non-priority areas, based on clinical need, in order to reduce costs.

[782] **Mr Sissling:** To an extent, that confirms what I am saying about waiting list initiatives, which are very expensive.

[783] **Darren Millar:** Some of it is not: general elective activity is also referred to in the report.

[784] **Mr Sissling:** I will be seeking further details because, at the moment, I do not know where they are. If there are, it would be contradicting the assurance that I have had from individual chief executives. I will follow it up. I need to know where these places are, because I do not know at the minute which hospitals or health boards have been asserted as doing that. I have taken formal assurances from the chief executives, and I now need to get behind that because this cannot be left hanging—it is a really important issue.

[785] **Darren Millar:** I appreciate that you have not had sight of this report; we will send you a copy, as it is has literally just arrived on our desks. Another assertion from Mrs Burrows is that there is a massively increasing backlog of people waiting for follow-up appointments as a result of financial pressures; there has been an increase in Betsi Cadwaladr from 25,000 to 42,000. Is that a phenomenon that you are aware of?

[786] **Mr Sissling:** I think that we are aware of that. There is a point in this as to whether the chief executives of the health boards are aware of this. One would have to ask about responsibility for resolving these issues, and the displacement to Welsh Government. The knowledge and responsibility sit with the health board and the chief executive. That issue is one that I think that we are aware of in terms of follow-ups and the backlog.

[787] **Darren Millar:** It says that follow-up waiting lists are not being tracked by the Welsh Government, and that only a few health boards reported to you. Is that right? Dr Hussey, did you want to come in?

[788] **Dr Hussey:** I can confirm that we are investigating accounts that I have heard of, that there is a backlog in different specialties in different health boards. Work is under way to understand what has been happening, what the pattern is and seeking to identify what the health boards will be doing to correct the position. The work is ongoing—it has not been completed—but I am concerned to get to the bottom of it, and to ensure that people who need clinical priority are getting it. So, I am aware that this is an ongoing issue for us.

2.45 p.m.

[789] **Darren Millar:** Thanks for that reassurance. Sandy is next.

[790] **Sandy Mewies:** Thank you. I have been ticking off here, and I had lost my place, so please forgive me a moment.

[791] One of the things that is emerging, and I saw some of it this morning, and certainly last week, is the need to train independent members. There seemed to be some doubt as to whether all the independent members were present when training took place. It has definitely come out as an issue I think that it is fair to say. Has the Welsh Government considered whether an all-Wales programme of such support is necessary to help others to learn from the problems that have been experienced in Betsi Cadwaladr, and as part of the wider response to the Francis report on the Mid Staffordshire NHS Foundation Trust?

[792] I would also be interested to know whether any thought has been given—this is a question that I posed last week—to what happens when you have a new board of any kind, whether it is a health board or any sort of board, and there are different types of members, such as executive members and directors, and here you also have the clinical direction, if you like, which is completely separate from the administration. Would the Welsh Government consider not only whether guidance and training specific to those members should be given, but whether some form of joint training would be suitable when new organisations like this come into being?

[793] **Mr Sissling:** It is a very good question. One thing that I should say in general terms is that there is an awful lot of learning in this for us. As much as I am in a position, it is important that we recognise that there is a scope for reflection for Welsh Government in a whole series of areas. One of the areas that I do think we need to strengthen is the board development and board training in the way that your question implies. There are systems in place at the moment. There were arrangements, which were very well received, when the boards were first established in 2009. There were subsequent opportunities that were taken up by boards in further years to develop both the executives and the non-officer members and then together. At the moment, different boards are implementing different development arrangements, including Betsi—they had a development session earlier this week. I do think that it is an area where, as Welsh Government, we could make sure that there was some core, appropriate and consistent development for boards as they are now, and certainly for new members. It is available now, but we could make sure that it is more consistently applied.

[794] On your second suggestion, to be thoughtful about how we can craft the right kinds of arrangements, I think that we will be pursuing that. I have already raised it with the chief executives earlier this week. We will be working with the Welsh NHS Confederation and others to shape such arrangements.

[795] **Sandy Mewies:** So, if you can encourage that sort of synergy, and then you go on with training, are you saying that the Welsh Government is now mindful that training happens, but that it has to keep happening?

[796] **Mr Sissling:** Yes, I could not agree more. The health boards have now been in existence for three and a half years, and all of them could show a track record, a catalogue of different training activities. I think that we should not just assume that that is taking place. We should make sure that there is the right kind of training and development for boards and that they share best practice between them much more consistently, and that we play the right kind of role in making that happen. I would completely concur. There needs to be much more regular training and consistent training.

[797] **Mike Hedges:** I have two questions and one statement. I can tell you that the fastest way for a member not to be re-appointed to a health board is to ask difficult questions. That is from the heart of personal experience. Should you be keeping—I do not mean you, personally. Should a list be kept of independent members, the number of questions that they have asked and their activity, in such a way that when they come up for re-appointment it is not, 'You've asked 200 questions, you must be good' and 'You've asked 20, so you are bad', but to actually get to grips with what people are trying to do? I think that we have chairs who hardly want to re-appoint people who have been difficult for the last four years.

[798] **Darren Millar:** In relation to that, can you also tell us a little bit about the appointments process of independent members for health boards and how that works? How do you test the competency of somebody before they are appointed?

[799] **Mr Sissling:** As a general point, we would want our independent members to be constructively challenging the executive in a way that, to an extent, this particular report exposed the board, through its independent members, to be holding the executive to account. To an extent, that is done through asking the right kind of questions, but it is also about having the right kind of arrangements, the right kind of information and the right kind of committee structures. It is also about boards being constructed in the right way in terms of their agendas, their meetings and other activities.

[800] I understand the implications of the question of whether we keep a log of every individual activity. It is something that the chair should be doing, and, at times, they should be bringing in external insight to allow appropriate reflection and feedback to individuals. Certainly, when I was on a health board, we had some quite soul-searching exercises on how people see themselves operating in board-time circumstances, which I think is necessary. It underlines the critical importance of boards and of the independent members.

[801] On the appointment processes, there is a set of competencies and personal capabilities that are tested through an interview process, which would involve appropriate external and public-body appointment colleagues. That is really important, as we know—recruitment, appointment and interview is the golden chance to get it right and to ensure that we appoint the right people and get the right balance. Boards need the right balance of skills and, at times, of geographies, perspectives and different qualities. The induction is then very important to provide new board members with the right introduction to the responsibilities of being an independent member. These are mighty tasks that we are asking people to do. They are huge organisations, in any sense, in terms of their costs and staff, but, perhaps most importantly, in terms of the patient care responsibilities.

[802] **Darren Millar:** In terms of the chairs of boards, there has always been this suggestion from some people that the appointments process for the chairs is not always necessarily related to their previous experience and the qualities that they bring to the job. What confidence can you give the committee that the decisions, in terms of the appointment of chairs, are always made because of the qualities that they bring to the job and not because of their political affiliation, for example?

[803] **Mr Sissling:** I sit on the panel, and it is a very searching merit-based approach, looking at the calibre of the candidates. It is about wanting long shortlists, if you know what I mean, to give a choice, and about making the decision about the best candidate who is able to satisfy the panel that he or she would lead an organisation in an appropriate way.

[804] **Darren Millar:** Were you on the panel that appointed Mr Jones as chair?

[805] **Mr Sissling:** I was not; that was prior to my taking up this post.

[806] **Darren Millar:** Okay; thank you.

[807] **Jocelyn Davies:** I am very reassured by some of the things that you have told us. However, in this case, we ended up with a dysfunctional board. There is something a bit more that needs to be done, is there not?

[808] **Mr Sissling:** Yes; it is a very—[*Interruption*.]

[809] **Jocelyn Davies:** I do not think that anybody could read that report and suggest that this board is not dysfunctional—it is.

[810] **Mr Sissling:** As always, there is a question of looking back or looking forward. We now need to provide the support to allow the board to reconstruct itself, in a sense. We need to be attentive to the appointment of the new chair. It is absolutely critical that that individual has the right qualities in a difficult situation. We are moving through the appointment process with pace, but we need to be absolutely sure and steady that we get the right person. Obviously, the vice chair will follow in a matter of two or three weeks after that. We then need to look at the board more generally, and it needs to develop the right capabilities and confidence, both as a board but, more generally, in terms of what the board represents.

[811] It is one of the reasons that, in my recent visits—I know that Ruth knows about this—we were paying particular attention to clinical engagement. This is not about 20 or 24 people meeting around a board table once a month. In the case of Betsi Cadwaladr LHB, it is about 17,000 or 18,000 people—predominantly clinicians. We see this as an opportunity to refresh and re-energise clinical engagement and be quite imaginative and bold. Boards do not work on their own; they do not work in a bubble. We want to make sure that there are connections. That is one of the things in the report—from the board to the ward. It must have the right clinical buy-in. We must get the clinical leadership structures aligned with that and the right site management structures and the right public patient involvement as well. That is where the attention is now. It is an opportunity to allow this board, with some pace but with some care, to develop a new reality for itself. I would agree entirely with the thrust of your question.

[812] **Julie Morgan:** How, in the future, will you be able to get in earlier to stop this sort of thing escalating? The reports that we have heard and the evidence that we have heard is that there should have been some mechanism to stop this getting to the stage it has reached. I know that you said that this has all given you food for thought in the Welsh Government. What is being planned so that there will be some sort of process in place to stop this sort of thing happening?

[813] **Mr Sissling:** First, it is a time for reflection, because it would be very easy to be defensive, and that would be wrong in the circumstances. One of the questions was whether we identified the problems on a timely basis and act. So, were we aware that unscheduled care problems were developing? Yes. Did we act? Yes. Were we aware that the finance problem was developing in a not particularly good position? Yes. Did we take action? Yes. Did we encourage action about the executive team? We did. Did we seek to force things through in a very complicated situation? The answer is 'yes'. So, without being defensive, I think that—

[814] **Julie Morgan:** But, it did not work.

[815] **Mr Sissling:** It has reached a point where we are where we are, are we not? This has not been going on for years. This was not something that started in 2006. This, arguably, started in mid to late 2012, although there may have been some warning signs. However, to put it in context, this was an organisation that had a reasonable pattern of delivery. It is one of only a couple of organisations that has broken even every year without the need for brokerage. It was always in the pack in terms of performance. Its style was somewhat distinctive, but it had a track record of delivery. As the year developed, we identified problems. In some cases, we acted quite swiftly and, in other cases, we could have acted a bit more quickly.

[816] There is also an issue we have identified and agreed on, which is that we would need to work in a slightly different way with HIW and WAO. We have a meeting in the next few weeks to pursue that, to make sure that our respective contributions are complementary. We are strengthening some of our surveillance work in terms of quality in particular. That has to be the driver. So, it has to be about not just the target, but the quality. We now have better metrics for quality in terms of how we can see the quality story unfolding. We will be looking again at some of our performance management arrangements to make sure that they are robust.

[817] We have an escalation process, which moved from September through to February in this situation from 0 to 4, which was quite rapid in a sense and shows a sort of impatience and an intolerance of poor performance. There is stuff to do and we are doing that. We will be working with Huw and HIW colleagues to make sure that we can define our respective roles. The key thing is what escalation means at a whole-system level and, when we work in different ways and escalate, that we should do so without creating an environment within which we do not allow health boards, which will at times go into trouble moments, an opportunity to gather themselves and move out of it with purpose.

[818] **Julie Morgan:** I have one last question. What about the CHC? How do you feel its role has been in this saga?

[819] **Mr Sissling:** The CHC, to an extent, I suspect, has been preoccupied with service change quite a bit. I think that its attention has been on that. Whether it should have had a role in identifying some of these issues is an interesting question. I had not really thought that through. The CHC would not, I think, have been aware of financial problems, and not to the extent that we should be and were. In terms of other issues, I am not sure that its members would necessarily be aware. Should a CHC that is alert have been signalling some concerns to the board or, alternatively, to a national arrangement or through to us? Possibly, but I think that there is a bit of food for reflection in that.

3.00 p.m.

[820] **Darren Millar:** I would just ask something before I bring Mike in, after which,

Jocelyn has some questions that she wants to ask about the Clostridium difficile situation. Did any independent members of the board ever flag up any concerns with the Welsh Government directly, because they were not satisfied with the functioning of the board? It is just that—

[821] **Mr Sissling:** No.

[822] **Darren Millar:** They did not. Thanks for clarifying that; it is just that we had correspondence that suggests that they had been aware of problems for a long time, but, for whatever reason, it does not appear that they flagged them up. So, that is just helpful for the sake of clarity.

[823] **Mike Hedges:** How would you respond to the statement that service change and budget have taken top priority, well above treatment?

[824] **Mr Sissling:** I might ask others to comment, but I would not agree with that. What I would say is that the environment that health bodies are working in at the moment is a challenging one, as they do have service change and they have financial pressures. However, they also have the fundamental responsibility for quality and safety, and we have been emphasising that at all stages. It has been our repetitive message: 'This is quality and safety; that is how we define ourselves'. So, I would not accept that. However, I do not know whether, Ruth, you would like to comment on it.

[825] **Ms Hussey:** I think that it is sometimes easy for people to say, 'Oh, it is targets. It is often scheduled care as a target.' I was quite clear throughout the winter that, for me, it was about quality. That is where it begins and ends, in the experience that people are receiving services when they are under pressure; so, unscheduled care is about quality. We were clear throughout the winter that that was at the heart of our concerns; it was not about a specific waiting time. Underpinning it is what mattered. So, we were conscious of looking right across the experience that people were getting, to keep looking at the quality measures underpinning that.

[826] A reflection, as we look forward, is how we can strengthen that, and there is a piece of work starting at the moment, which is to open up the conversation about how we monitor quality, use staff and patient feedback in a different way, and how it becomes relevant at the front line as to how we have a shared sense of the measures that we are going to follow through. So, I think that this is part of that move into a different type of focus on quality, but at the heart of it, throughout the winter, it was a clear focus that this was very much about whether people are getting the right care at the right time.

[827] **Darren Millar:** May I just put this point you? Again, it is a reference to a little comment in the transcript of something that Mary Burrows has sent in. If we accept what you are telling us, which is that you communicated to the chief executives that, yes, finance was important, but quality and safety were also paramount in all things, and that there was a dynamic tension between the two to make sure that the board was delivering and performing on all fronts, how effectively do you communicate that to the chairs of boards and other independent board members? Mary Burrows says this:

[828] 'When needed support came from other Chief Executive colleagues when I raised financial balance over safety become more prominent. On reflection my main regret is that I should have whistle blown upon my return in mid-May 2012 about the direction the Board was heading in regarding making finance its main priority and its increasing ineffectiveness in managing its overall obligations.'

[829] So, it appears that, while Mary was receiving this message, perhaps, that it was not just about finance, the board had that impression. Do you see the distinction that I am

making? That is, the board as a whole—the independent members—seemed to have the impression that finance was the fixation of the board. Is that something that you are seeking to overcome in the future, perhaps?

[830] **Mr Sissling:** I am in a really difficult position, because—

[831] **Darren Millar:** I appreciate that.

[832] **Mr Sissling:** —you are presenting me with this information. I am sure that if you were to put that to the board members, they would contest it. I am not sure that they would necessarily accept that. That is my first comment.

[833] Secondly, the message that has gone to chairs from me and the Minister is, I think, a very balanced one. It is the task of leadership to make sure that you can reconcile the tension, as you describe it, between the financial imperative and the quality and safety imperative. To an extent, we have seen it played out there. Certainly, from the executive point of view, we get together regularly as the whole executive of NHS Wales. We met recently in Swansea; we met in December in Llandudno. I suspect that we have not spoken about finance once in the last few meetings: we have spoken about quality, quality, quality. An ex-chair from Mid Staffordshire came to talk to us; people have talked to us about transformational change and quality. It is obsessively about quality: 1000 Lives Plus quality. The mood music is very much about quality, so, I have to say that I contest that. Non-executives have had a session as a group with chairs and people who had involvement in Mid Staffordshire. So, I must offer a different view from that particular statement. It is palpable and I am sure that, if you test it with others, you will find that there is a balance—which is not to say that we are saying money does not matter, because I am sure that we would be visiting you again in the future if we sent out that sort of message. We could do it, could we not? We could say that it is all about quality and safety, and that would be inappropriate. Our job as public servants, on behalf of Ministers, is to reconcile that tension. I am satisfied that, while it is difficult and, at any point, your concerns move from one area to another, we are paying sufficient and ever-increasing attention to matters of quality and safety.

[834] **Darren Millar:** I just wanted to allow you to respond to that point. Jenny is next, and then we will move on to the final issue.

[835] **Jenny Rathbone:** Obviously, we all agree that we want quality services, but how do you get people to change so that we can provide better quality with less money, which is an issue facing all public bodies, rather than just hiding behind, 'Oh, well, we cannot do this because it will affect quality'. It would appear that three of these 11 clinical programme groups were the ones that consistently overspent, whereas others were able to deliver quality services within the envelope with which they were provided. I think that that is the problem. It is all very well saying that, of course, we must have quality services, but, if people are not living in the real world of there being no more money, how do we get them to change?

[836] **Mr Sissling:** There are a number of starting points, so, rather than talking concepts, I think it is better to say what we are doing. I think that that is always better. First, we are paying attention to three-year plans and we recognise that the planning capability in Wales needs to be strengthened, so we are bringing in external support by four or five organisations. We will be using that, because it is not easy stuff to plan in such a complex environment for three years and take account of the workforce, clinical issues and financial constraints. Within that, we want to be absolutely explicit about matters of quality and safety. These are not afterthoughts: they are ingrained in the plan. No. 1 is getting planning right. No. 2 is something I mentioned earlier: we have to get our clinicians much more actively involved. That goes beyond positional involvement; it goes to a more extensive, inclusive approach. We need to use best practice and evidence of best practice much more thoroughly and rigorously.

I am sure that many share the frustration that what is good in Bangor does not, for some reason, easily transmit itself to be adopted in Bridgend and vice versa. Even between Bridgend and Neath Port Talbot, it is sometimes very difficult. We need to find ways to better get best practice adopted, because, if we could just get a significant proportion of the best practice that is currently in existence in Wales universally adopted, we would almost answer that question very quickly. There are some honest discussions that we need to have about the level of financial constraint and what austerity means on a sustained basis and some of the difficult choices that may need to be squared up to. I think that that was implicit in your question. We may not be able to carry on simply assuming that we can do everything that we have done in the past in the same way: there may need to be some tough decisions and to have the right conversation, which plays straight into your world, in terms of how those are sponsored and taken forward. So, that is just a personal view. I do not think that it is impossible. It probably is not just more of the same; it is not incremental development. It is probably a step change and a break from the past.

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

[838] **Jocelyn Davies:** I wanted to ask you about the C. difficile outbreak. What did the Welsh Government do when it heard about this in May?

[839] **Mr Sissling:** Do you mind if I ask the CMO to lead on that?

[840] **Dr Hussey:** The Welsh Government was first notified on 4 April that there was an outbreak at Ysbyty Glan Clwyd. There was an exchange of information and there were further updates a few days later. I was notified on 25 April that a number of serious incident reports had come in relating to deaths from Clostridium difficile. Within a matter of a couple of hours, I took steps to ask that Public Health Wales go to the health board to help, support and look into the circumstances. I immediately wanted assurance that it had the support that it needed and that all the steps were being taken to bring the outbreak under control.

[841] **Jocelyn Davies:** So, it requires you to ask Public Health Wales to intervene. Are health boards not able to do that directly?

[842] **Dr Hussey:** They can invite support. There is a team within Public Health Wales that is available and provides support on a day-to-day basis. I took the decision that I wanted the team to go in, to visit and to help to understand the detailed epidemiology beyond the day-to-day support and to particularly to look at the outbreak situation.

[843] **Jocelyn Davies:** So, you decided that yourself—there was not a request that came to you. You assessed the situation, and decided that. Before the outbreak became apparent, had you had any concerns about serious incident reporting from Betsi Cadwaladr?

[844] **Dr Hussey:** The health board does report serious incidents, generally. In fact, over recent years, you will know that we have created the expectation that people come forward and report serious incidents. It is important to encourage an environment of doing that. So, 'Putting Things Right' was all about bringing those incidents to the surface and discussing them. Looking back, there is evidence of increasing serious incident reporting by the health board throughout the year. There is no right answer. We encourage people to bring them forward, so, in a sense, it is pleasing to see that there was a growth in serious incident reporting, perverse though that sounds, as it means that people can then look into those issues.

[845] However, what this has highlighted for me—because, as soon as I started to question the fact that we had a number of notifications of deaths in relation to C. difficile, I did ask for a review of other health boards across Wales to make sure that we were getting the notifications in line with expectations on this particular issue, and I wrote out to health boards

in June, having discovered that it was inconsistent. So, it was not alone in not reporting every single one. I have taken steps to look at that, and I will be following it up, because I think that there is more work to be done to make sure that this information is being actively used on a day-to-day basis.

[846] **Jocelyn Davies:** So, you did not have any concerns prior to this particular outbreak and there was nothing different about Betsi Cadwaladr—or you had not noticed anything different.

[847] **Dr Hussey:** No. On serious incident reporting, as I said, it was reporting and showing signs of increasing its reporting. There is another element of reporting, which is to the national reporting and learning service. In that regard, again, it was reporting numbers. However, there was some evidence and suggestion that it was slower in putting the reports forward and slower in investigating and completing investigations. So, there were issues. They were discussed and Healthcare Inspectorate Wales was undertaking a review of elements of the handling of those issues, so it became part of the wider picture that Mr Sissling has talked about this afternoon.

[848] **Jocelyn Davies:** So, when there is an increase in reporting, that in itself does not flag anything up. You retrospectively looked at that and thought, 'Well, there may be two reasons for this. Either this is leading to something serious or I am pleased because the incidents that would have been happening anyway are now being reported.'

3.15 p.m.

[849] **Dr Hussey:** The team looks at them, looks at the categorisation of them and at the type of events. If it is what we call a never event, it elicits a different response. So, there is some consideration of the types of things. They are categorised, and they are followed up. Some are followed up on a short-term basis and some on a long-term basis. There is also follow-up as to whether investigation has happened. Clearly, the Welsh Government cannot go into every single one, but we try to ensure that boards are looking at them and learning from them. We have a quarterly quality and safety forum to which all the health boards come, and things are shared and reflected back. The last meeting was all about the Francis report, and examining the implications and sums. So, we take themes, look at issues and help the boards to consider issues such as that.

[850] **Jocelyn Davies:** However, clearly, you and the board—we know this from speaking to the board—were getting false assurance as to the extent of the infection control problems there. Would you agree with that?

[851] **Dr Hussey:** The information about numbers of infections and rates is produced regularly through Public Health Wales. That is a test that is done and then it feeds into a system. Those data were available, were known and were monitored. The historical picture across Wales is that the infection rates have been coming down over recent years; there has been a concerted effort to do that. So, that is all now in the public domain—it was all published last week, in fact, by the health board, and the picture is there.

[852] The issue about serious incident reporting is about this question of, if someone has Clostridium difficile on part 1 or part 2 of the death certificate, whether that is being flagged regularly and systematically to Welsh Government as a serious incident. Having seen what happened with the cases that we were coming in from Betsi Cadwaladr, I went back and double-checked that with the health boards. What is evident was that it was inconsistent, and I have taken steps to try to close that—

[853] **Jocelyn Davies:** So, lessons are being learned from what gone on here.

[854] **Dr Hussey:** Absolutely. It is paramount for me always to use this as an opportunity to ask, 'What can we all do together to keep a focus on issues of importance such as quality and safety?' We have already taken steps on one element of it, and we will continue to do that. Also, at the same time as asking Public Health Wales to help with the outbreak, I agreed with the health board that an independent expert would come in and have a look at the situation across north Wales. That report is due very soon. Again, that is an opportunity to look at what he has to say, and we will share the advice he may give and ensure that everyone else has a look at that. There is always an opportunity to learn.

[855] **Darren Millar:** Okay, thank you. I have three quick questions, and then I will ask Mohammad Asghar to ask a final question. These are very brief questions. Do you think that the name of the board needs to be changed? A number of witnesses have suggested that it ought to change to 'north Wales university health board', and that that might help to overcome some of the recruitment problems and the recognition in terms of where it is. Do you have a view on that? If not, that is fine. Secondly, do you think that the health board is too big? Some people have suggested that it is quite an unwieldy size because of the geography—even though other health boards serve similar populations in Wales, the geography of north Wales makes that a little bit awkward. Thirdly, we know that you have drafted in support from other NHS organisations in Wales to support them in north Wales. Are you confident that there are still arrangements in place in those health boards that now have those personnel drafted into the north to safeguard services there?

[856] **Mr Sissling:** With regard to the first question, I do not have a view, but I know that people do and maybe there is a debate that needs to start, particularly among the public. I do not think that the health board is too big, but we need to make sure that the management arrangements are sufficient in every regard to manage it. That would be my take on it. With regard to the support arrangements, this was not just about picking people out of organisations—this was agreed with chairs. I needed to be reassured that I was not addressing one problem and creating another, particularly in Abertawe Bro Morgannwg University Health Board, where the deputy that previously acted up when I moved on from there for a period of three or four months will be not acting up, but will be a point of strength in terms of ensuring that it has the right kind of executive leadership. Aneurin Bevan Local Health Board is being very supportive, and I have every confidence that its executive team is strong. I felt that it was important that NHS Wales, as well as asking Betsi to bring in some internal people, needed to show that some of our internal leadership capacity could support an organisation when it needed it.

[857] **Mike Hedges:** If you do not think that Betsi is too big, do you think that Powys Teaching Local Health Board is too small?

[858] **Mr Sissling:** No.

[859] **Darren Millar:** Thank you for that. The final question is from Oscar.

[860] **Mohammad Asghar:** Thank you very much, David. Wonderful—you have been very honest and straightforward with your answers, but I will ask you one very straight question now. Since 9 a.m., we have been listening to all of these different witnesses in relation to Betsi Cadwaladr. It shows that NHS Wales has virtually failed in its responsibilities for delivery and monitoring in certain areas. We have been told that there are constraints on finances, we have been told about the problems with the culture and geography. So, do you think, with your hand on your heart, that the NHS in its present form can deliver and is sustainable for the future? I believe that it is not and that there need to be many changes to give a quality service to this nation. The health of the nation should be the first law of the nation.

[861] **Mr Sissling:** Once again, it is a personal view. The test of any system is how it reacts when it runs into problems—and there will be problems in any system. You can look at any healthcare system in the east, west or north and you will find that they have problems at the organisational service level, and this happens in other public service. This is a problem that has been detected and there has been decisive action. We are now moving into a completely different era. Importantly, I have asked the chairs of every other board for an assurance by the end of August that they have looked at the recommendations of the report. They will formally send to me an explanation of how they are meeting those and sharing best practice. We will follow that up, and I suspect that that is the basis on which we should move ahead with confidence. There is a lot of good stuff happening in the NHS in Wales, including Betsi Cadwaladr. We should not, in any sense, take anything away from the thousands of people who work with enormous dedication and to very good effect in Betsi. This failure at the board level in terms of leadership has been addressed. We will now move on and ensure that that organisation continues to fulfil its ambitions and aspirations.

[862] **Darren Millar:** Okay. On that positive note, we will draw this session to its conclusion. Thank you, David Sissling, Martin Sollis and Dr Ruth Hussey, for your attendance.

3.22 p.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.

[863] **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).*

[864] Are all Members content? I see that you are and that there are no objections.

*Daeth rhan gyhoeddus y cyfarfod i ben am 3.23 p.m.*
*The public part of the meeting ended at 3.23 p.m.*