Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 4 Tachwedd 2014
Tuesday, 4 November 2014

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

William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Mike Hedges	Llafur Labour
Alun Ffred Jones	Plaid Cymru The Party of Wales
Sandy Mewies	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Julie Morgan	Llafur Labour
Jenny Rathbone	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Yr Athro/Professor Andrew Davies	Cadeirydd, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Chair, Abertawe Bro Morgannwg University Local Health Board
Simon Dean	Dirprwy Brif Weithredwr GIG Cymru, Llywodraeth Cymru Deputy Chief Executive NHS Wales, Welsh Government
Rory Farrelly	Cyfarwyddwr Nyrsio a Phrofiad Cleifion, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Director of Nursing and Patient Experience, Abertawe Bro Morgannwg University Local Health Board
Dr Andrew Goodall	Cyfarwyddwr Cyffredinol, Iechyd a Gwasanaethau Cymdeithasol a Phrif Weithredwr GIG Cymru, Llywodraeth Cymru Director General, Health and Social Services and Chief Executive of NHS Wales, Welsh Government
Dr Ruth Hussey	Prif Swyddog Meddygol Cymru Chief Medical Officer for Wales
Mr Hamish Laing	Cyfarwyddwr Meddygol, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Medical Director, Abertawe Bro Morgannwg University Local Health Board
Paul Roberts	Prif Weithredwr, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Chief Executive, Abertawe Bro Morgannwg University Local Health Board
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales

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

Claire Griffiths	Dirprwy Glerc Deputy Clerk
Michael Kay	Clerc Clerk

Joanest Varney-Jackson — Uwch-gynghorydd Cyfreithiol
Senior Legal Adviser

Dechreuodd y cyfarfod am 09:03.
The meeting began at 09:03.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Darren Millar:** Good morning, everybody, and welcome to today's meeting of the Public Accounts Committee. I will just make the usual notices and explain that this is a bilingual meeting, as are all meetings in the National Assembly for Wales, and that Members and witnesses who attend today's committee should feel free to use either English or Welsh as they see fit. There are headsets available for amplification and translation purposes. I encourage everybody to switch their mobile phones on to silent mode and remind everybody that the microphones operate independently and that you do not need to touch any buttons. In the event of a fire alarm, we should follow the instructions of the ushers, who will guide us to the nearest safe exit. We have not received any apologies for absence today, so we will go straight into item 2 on our agenda.

09:04

Papurau i'w Nodi
Papers to Note

[2] **Darren Millar:** We have a number of papers to note, including a letter from James Price in respect of the intra-Wales Cardiff to Anglesey air service, and a note on the scrutiny of commissioners' accounts, which is a response from the Public Service Ombudsman for Wales on the pension arrangements and provisions. We have also had a copy of a letter to the auditor general on the Well-being of Future Generations (Wales) Bill, which confirms our agreement for the auditor general to proceed to undertake some work. We have also had a response from Nick Capaldi on our scrutiny session of the Arts Council for Wales, with some information on the collectorplan scheme. I have also written to Nick Capaldi just raising a few additional questions, effectively those that we did not manage to cover during our evidence session. We have had an update letter from Sir Derek Jones, the Permanent Secretary, on the EU structural funds. It would appear now that the postponement of funds flowing back in to Wales has ceased and that they have overcome the barrier in terms of the interruption of the structural funds. Also, we have had a letter as a follow-up to our grants management session with Sir Derek with a few of the lessons that have been drawn from the All Wales Ethnic Minority Association case. I take it that those papers are noted. Excellent.

09:05

Llywodraethiant Byrddau Iechyd GIG Cymru
NHS Wales Health Boards' Governance

[3] **Darren Millar:** We move straight into item 3 on our agenda, on the governance arrangements at the Betsi Cadwaladr University Local Health Board. I am very pleased to be able to welcome Andrew Goodall to his first appearance before this Public Accounts Committee in his new capacity as director general of health and social services and chief executive of NHS Wales. Welcome to you, Andrew.

[4] **Dr Goodall:** Good morning. Bore da.

[5] **Darren Millar:** There is a welcome also to Ruth Hussey, the chief medical officer, and to Simon Dean, deputy chief executive of NHS Wales.

[6] **Dr Hussey:** Chair, may I just remind the committee that, as we are discussing Betsi Cadwaladr, I have a declaration of interest in that I am related to the chair?

[7] **Darren Millar:** We will note your declaration of interest. Thank you for drawing the committee's attention to that.

[8] Obviously, the committee has agreed to maintain a watching brief on governance arrangements in the Betsi Cadwaladr University Local Health Board. We have received two reports over the years in respect of problems that have occurred at the board. Both of them were joint reports from the Wales Audit Office and Healthcare Inspectorate Wales. We have undertaken, previously to this particular evidence session, an update session with the board itself, where we received some feedback on the current situation at the board. It was in the very early days of the new chief executive's appointment. We very much hope that we can have an update from the Welsh Government's perspective on the situation at Betsi Cadwaladr this morning. In addition to that, I hope that we can cover some wider territory, looking at the NHS more widely in terms of the governance arrangements that are in place. I note for the record that we have received a letter this morning from Andrew Goodall in respect of the Betsi Cadwaladr University Local Health Board's escalation status. Perhaps, in a few opening remarks, Mr Goodall, you can just explain precisely what that letter means and where the board sits now in terms of the escalation scales that the Welsh Government has. It is over to you.

[9] **Dr Goodall:** Good morning, everyone. Bore da. Thank you for my first opportunity to see you in the Public Accounts Committee. I have obviously been frequently before—

[10] **Darren Millar:** It will not be your last.

[11] **Dr Goodall:** I think that I have a number of meetings ahead of me over the next few weeks and months. Thank you for the opportunity to come to talk to you, yes, of course, about governance arrangements at Betsi, but I absolutely accept that this will broaden out to the NHS in Wales more generally. I hope what we will be able to demonstrate is the seriousness around the original report, the progress that has been made, not least with Betsi itself—I know that you had your evidence session back in July—and, hopefully, that we can convey some of the broader learning and the way in which we discharge and deliver some of the general oversight within Wales, not least within boards, but obviously from a Welsh Government perspective as well.

[12] In respect of Betsi Cadwaladr as an organisation, we obviously keep a close surveillance on its own progress. It is reported to us in general terms, but through very specific progress as well. Just for the record, as you have indicated, Chair, I want to make reference to the letter that I sent to you this morning. Over the last couple of weeks or so, we have been liaising, not least as part of our escalation framework where there are concerns. Simon could probably outline some of that during the course of the questions at this stage about the precise detail. We had a meeting with regulators last Friday and that led to us increasing the escalation level for Betsi Cadwaladr around a number of fronts, allowing us to give some targeted intervention and support to what is a new team within Betsi Cadwaladr itself. So, that has emerged over recent weeks and months. There are a couple of reasons for it. Obviously, we have some general concerns on mental health services for the organisation. The board had declared a different financial position for the in-year performance, which I know had caused some concerns. We just felt that it was right that it moved up a level on the escalation scale and we had various choices. It has been on the enhanced monitoring level over recent weeks, along with some of the other organisations in Wales. The targeted

intervention did feel as though it was appropriate, not least for the needs of what is still a new team. You have referred to the fact that the chief executive has been in post only since June. It has had a finance director recently. It has had a chief operating officer recently, who has just joined. I do think that, as a team, it needs some particular support from us, from a Welsh Government perspective. However, I am happy to explore some of that detail as we go through the questions.

[13] **Darren Millar:** So, just for the sake of clarity, the targeted intervention that you refer to in your letter refers specifically to concerns around mental health and financial performance effectively.

[14] **Dr Goodall:** Yes, they are two of the main drivers. There will be some other broader issues as well. One of the other triggers for us was that because some capital issues have been raised over at Betsi as well, we felt that that fitted within the envelope. We have it under enhanced monitoring on some other particular measures around performance areas, but, at this stage, it is probably those two or three areas that were the link, at least in our liaison with regulators and auditors as well.

[15] **Darren Millar:** In terms of the escalation levels within the NHS delivery framework, which go from 0 to 4, whereabouts does the board fall now on those escalation levels?

[16] **Dr Goodall:** The escalation level that we have used here is the one that is part of the tripartite arrangements that we take forward with HIW and the Wales Audit Office. That gives us three levels that we can particularly pursue for them, which is in agreement with our external regulators. The first level there is enhanced monitoring; the second level is about the targeted intervention; and the third level is about special measures. So, it is actually the intermediate one of those three at this stage. Again, I think that everyone's view would be not to be at the top level of escalation level at this moment, because it is about putting in a support mechanism around the board's arrangements.

[17] **Darren Millar:** So, the previous escalation levels in terms of the NHS delivery framework, of 0 to 4, are obsolete given the new arrangements that you have and have agreed with the regulators. Is that right?

[18] **Mr Dean:** We will continue with enhanced monitoring, so we are already working much more closely with Betsi than we are with other health organisations, so we are continuing with that enhanced monitoring. The targeted intervention, as Dr Goodall said, allows us to provide support. I will quote from the statement that is in framework, which says that part of the point of targeted intervention is to:

[19] 'consider whether to take and co-ordinate action in liaison with the NHS body to consider where the NHS body needs to strengthen its capability and capacity in order to drive improvement'.

[20] That is the territory that we are in. So, it is working with the team to understand what it needs to put in place to deliver and drive improvement. It is not special measures; it is a supportive mechanism that we will want to understand quite clearly how they intend to act quickly.

[21] **Darren Millar:** How many other health boards in Wales or NHS organisations are at level 2? What levels are NHS organisations at currently?

[22] **Mr Dean:** Most NHS organisations are in routine monitoring. We have two others that are in enhanced monitoring.

[23] **Darren Millar:** Thank you for that. I have a number of Members who want to come in. I will start with Sandy Mewies.

[24] **Sandy Mewies:** So, what you are saying, I think—and forgive me if I have not grasped it all, because it quite a surprise to have this letter tabled this morning, as you can imagine—is that there are other boards that are at this level too. Is that right?

[25] **Mr Dean:** There are two organisations that are in enhanced monitoring.

[26] **Darren Millar:** That would be level 1, would it?

[27] **Mr Dean:** No, that is level 2. So, routine arrangements are business as usual, which is the first of the four levels. Then, the first escalation is into enhanced monitoring, where we determine that we have some concerns about specific aspects of a body's performance.

[28] **Sandy Mewies:** This is what BCUHB is on—level 2—is it?

[29] **Mr Dean:** It was on level 2. It has been on level 2 since July.

[30] **Sandy Mewies:** It is on level 3 now, is it?

[31] **Mr Dean:** It is now on level 3, which is why we are saying that we have been monitoring the organisation, we are not satisfied yet with the progress it is making and we want to sit alongside the organisation and make sure that it is putting in place, with our help, the support that it will need to deliver. The aim, of course, is to de-escalate it back to normal arrangements.

[32] **Sandy Mewies:** You had your meeting on Friday.

[33] **Mr Dean:** We did.

[34] **Sandy Mewies:** When did you first realise that this meeting needed—. Who requested the meeting? When did you realise that such a meeting was necessary? I have looked at what you have talked about. On the capital issues, I think I know what they are talking about. They will be looking at, perhaps, Glan Clwyd, will they? On the mental health issue, I think that we know what that is too, as well as the financial issue. However, you say that there are other issues.

[35] What I am a bit concerned about is that there was to be training. One of our recommendations was training for the new board members. Has that been completed? This is very concerning to me. Since the new regime began, I have had some issues raised with me—this covers my constituency—about transparency. The general public is, in fact, left wondering what is going on at BCUHB. While there are communications between BCUHB and various stakeholder groups, members of the public who are directly affected by changes are not being told in any way, shape or form, what is going on.

09:15

[36] I have written several times, and I am hoping soon to have a meeting again with the chief executive. Personally, I am not clear on how BCUHB is attempting to regain the confidence of the public, if it is not telling the public what it is doing. I think that they work against each other. You did mention peripheral issues. For me, transparency is an issue. Is it a peripheral issue or not? What brought this meeting about? That is what I really want to know. Who asked for it? Why was it asked for?

[37] **Dr Goodall:** If I just give an overview, and I will ask Simon to do it, we have ways of calling for these meetings based on our escalation framework, and that has been in place since April. In fact, it was one of the recommendations that came out of the Betsi Cadwaladr governance review. Normally, that is part of our cycle around our mid-year cycle and our end-of-year process—we have joint executive team meetings that take place with every organisation in Wales. However, they do provide an opportunity, either on the Welsh Government side or through the regulators themselves, for a meeting to be requested that is ahead of those. We actually have a joint executive team meeting taking place later this week. Simon, it is probably worth outlining the process for asking for the meeting and how that links in, because it is based on work over recent weeks and the culmination of that.

[38] **Mr Dean:** As Dr Goodall said, we met with WAO and HIW following the last round of joint executive team meetings. So, we met in July. It was the first time that we had used the framework. We reviewed the status of all health bodies in Wales, and at that stage we determined that Betsi Cadwaladr was under enhanced monitoring. So, we have been monitoring the position even more actively than usual since July. Normally, we would have then met again in January of next year for the next round of meetings to consider the status of all health boards. However, because of the position that we sought through our monitoring of the health board, I wrote about 10 days ago to the WAO and HIW to say that we were concerned and proposed to call a special meeting to consider the escalation status of Betsi Cadwaladr. I had a reply back from both WAO and HIW to say that they would welcome such a discussion. That led to the meeting that we held on Friday. So, it was an extraordinary meeting, which is allowed under the framework, to consider the outcome of the enhanced monitoring process that we have been undertaking with Betsi.

[39] **Dr Goodall:** Going back to the broader communication with the public, which is a key issue, obviously we have had expectations that the board would ensure that it was liaising, not just with stakeholders, but with the public more broadly. I know that it is developing plans. Its three-year plan is going to give some opportunity to describe what some of the proposals could be for putting Betsi Cadwaladr on a sustainable basis, which is one of our expectations around the three-year plan. However, of course, we also rely on other mechanisms for that. So, recently, the health board would have produced its annual report, for example. It would have had its annual general meeting, which would have been an opportunity to try to convey some of that. It has recently, at the end of September, also produced its annual quality statements for the organisation, which means that it is able to try to describe these more broadly than just the organisation itself or indeed with stakeholders. The extent to which that is received by the public is something that we need to work through, but there are mechanisms in place to make sure that the boards can discharge that public responsibility. In respect of the need to meet with local stakeholders, and I would include Assembly Members in that, I am very happy to pick that up with the chief executive, because, of course, that would be a normal expectation that there would be liaison with local Assembly Members. I know that the chair specifically had been making sure that he was able to go out and discharge some of those meetings over the tenure of his appointment.

[40] **Sandy Mewies:** Training was the other thing.

[41] **Darren Millar:** Okay, yes, very briefly.

[42] **Dr Goodall:** From the board training perspective, yes, Betsi has had a whole series of actions in place, as was outlined, I think, back in July when you had Professor Purt and Dr Peter Higson reporting to you. There were some concerns that there had been delays, not least around the new chief executive appointment. Although the chair had put in place various mechanisms with the board around the training environment, it was quite important, I think, to have the chief executive stamp on things as well, not least with the new team wrapping around. Yes, we can comment that they have progressed those issues over the interim three

months, that training is being provided for board members and that they have had that facilitated by external support as well. I do believe that they are discharging not just the actions of the original expectation of the PAC, but also the spirit of that. However, I think that, as they reported back in July, some of that was probably slower than they would have intended because it has taken longer to appoint the chief executive.

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

[44] **Darren Millar:** Mr Dean, you shed a little bit further light—. I am going to come to Alun Ffred next and then Aled Roberts. You shed a little bit more light on the meeting—the extraordinary meeting that was held in order to discuss whether there was the need to escalate the intervention further. Obviously, members of this committee will be familiar with the mental health unit Tawel Fan and some of the problems that appear to have occurred there. No doubt that was part of your discussions. However, may I ask what the scale of the forecasted deficit was, at what point that triggered the need for intervention and whether any other boards were in a similar-sized scale of deficit?

[45] **Dr Goodall:** On the financial perspective, one of the triggers for us during this last month was that, after its month 6 position, I had received a letter from the chief executive outlining the fact that it was currently running ahead of its forecast and that it was going to go beyond its projected year-end position. So, I received that as an accountable officer letter and indicated that I had concerns about where the board was heading at this time, that it was right that it should be forecasting accurately its end-of-year position, but, of course, we would still have expectations in the last six months for actions to be taken and for there to be improvement. That in itself had acted as a trigger that we needed to look at the escalation framework anyway. There was a need to clarify, I think, individual responsibilities for the board. We have also, over this last period of time, had the opportunity, through the mid-year performance appraisals of chairs, which have been taking place, to pick up on these issues generally, and there was an opportunity with Betsi also to clarify what the board's expectations were at that time, which were to improve things, but I received a formal letter from Betsi Cadwaladr outlining that its forecast position was now deteriorating—

[46] **Darren Millar:** Should it require a formal letter from the board before you notice these things?

[47] **Dr Goodall:** Its forecast up until that point was that it was running hotter than it would have expected and that there were financial pressures that it was experiencing. I think that it is part of the normal liaison that we have; we have normal mechanisms for meeting with the board. Those meetings happen on a monthly basis in respect of finance, but they also happen in respect of quality and delivery. However, it was the first time that the board was formally indicating to us that it felt that it was going to go beyond its forecast for the end of the year, and that is an accountable officer issue that needs to be flagged to us, otherwise our expectations would be that it would be meeting its year-end financial targets.

[48] **Darren Millar:** So, what is the scale of the projected deficit?

[49] **Dr Goodall:** At the moment, from the board's perspective, it has indicated that it believes that it will be running to a pressure of around £27 million more than it had originally forecast at this stage. That has been set out in its accountable officer letter. The board does not have the expectation that that is a fixed position for this year, so it is expecting to take targeted actions and it will be looking to improve that position. However, I think that, when there are pressures, what is important in terms of transparency is that organisations need to describe some of the financial pressures that they are under, and we would expect that to come through. It is not merely about expecting it, Chair; it is actually an intention that we should see targeted actions and profiles and, in fact, some of the targeted intervention that we

are expecting to provide will be around the financial basis within the organisation and an ability, I hope, to help with some of the actions that can improve the position.

[50] **Darren Millar:** Are there any other health boards in Wales with a similar scale of deficits being projected at present by the end of the current financial year as a share of their overall turnover or income?

[51] **Dr Goodall:** We have not gone through the budget process with sign-off yet, although we have been going through budget scrutiny, and, obviously, through the Minister, we are able to make some announcements about health at this stage, so we have not yet given formal allocations out to organisations on the premise of what that budget may mean for this year. There are some organisations that are still running with pressures, as they would normally do at this time of year, which they look to mitigate and plan for. We always see savings plans progress during the year, as you have seen yourself through some of the evidence that has been given in previous Public Accounts Committee meetings. At this stage, it is Betsi Cadwaladr that has declared that it has gone significantly over its individual forecast. We know that there are other organisations that probably will still have to take some further actions during the course of the year to get back to their financial position, but that is the only accountable officer letter that I have received at the moment from organisations across Wales.

[52] **Alun Ffred Jones:** Byddaf yn gofyn fy nghwestiynau yn Gymraeg. Dylwn ddweud ar y dechrau fy mod i wedi cael nifer o gyfarfodydd gyda'r cadeirydd a'i fod wedi bod yn agored iawn gyda fi ynglŷn â rhai o'r datblygiadau. O ran y sefyllfa gyllidol, cyn yr ad-drefnu diwethaf, roedd Ymddiriedolaeth GIG Gogledd Orllewin Cymru nid yn unig yn perfformio'n dda ond hefyd yn perfformio'n ariannol yn gytbwys ac yn llwyddiannus. Felly, byddwn yn hoffi gwybod a oes rhywbeth systemig yn y gogledd sydd wedi peri bod y sefyllfa ariannol hon wedi dirywio i'r fath raddau—yn benodol yn y gogledd. A oes rhyw amgylchiadau yn y gogledd sy'n wahanol i ardaloedd eraill? Dyna'r cwestiwn cyntaf.

Alun Ffred Jones: I will be asking my questions in Welsh. I should say at the outset that I have had a number of meetings with the chair and that he has been very open with me about some of the developments. In terms of the financial situation, before the last reorganisation, the North West Wales NHS Trust was not only performing well, but it was also financially balanced and successful. So, I would like to know whether there is something systemic in north Wales that has caused this financial situation to deteriorate to such an extent—specifically in north Wales. Are there some specific circumstances in north Wales that are different to other areas? That is the first question.

[53] Yn ail, rydych wedi nodi hefyd, fel rhan o'r pryderon a drafodwyd ddydd Gwener, fod materion cyfalaf, felly a allwch fanylu beth yw'r materion cyfalaf sy'n peri pryderon i chi?

Secondly, you have also said that, as part of the concerns that were discussed on Friday, there were capital issues, so could you say in more detail what those capital issues are that are causing you concern?

[54] **Dr Goodall:** In terms of the scenario and the situation before 2009, obviously, the biggest change that has happened to us is accommodating a very austere environment for public services. I have been a chief executive for 10 years now, and have worked for the NHS for 23 years. It has been a very difficult and challenging period for all public services, and, obviously, the NHS has its component parts. So, the real trigger is the extent to which organisations have been able to respond to some of those underlying pressures. The health service does run with inbuilt inflation around the way in which clinical advances happen in technology. We do try to ensure that, as far as allocations work across Wales, there is an ability to take account of respective population issues. We know that there may be some aspects that feature—obviously, we had the mid Wales review and report that was issued last

week, and we need to review that properly as Welsh Government and distil some of our messages, which may lead to some of the issues in that area. However, in some respects, Betsi Cadwaladr is not in a different or unique situation, as we see it, from other organisations across Wales, because there will always be aspects of deprivation or rurality, or aspects of service change, that need to be taken forward.

[55] Perhaps one area that has not happened as quickly as we would have wished over the last year or two in the Betsi Cadwaladr area is the extent to which service change has been pushed forward in a similar way to some other areas of Wales. That might be one of the underlying features, because we can see that some of the fragile services that they have maintained, some of the pressures around locum medical expenditure, and difficulties with some of the junior doctor vacancies that exist up there have probably created some of the extra financial pressures that they are under, but all the services, across Wales, have actually been experiencing normal growth, expectations around quality and investment at this stage. So, I think that part of our wish to put in some of the targeted financial support, in order to support the board and, indeed, the local executive team, will be to understand why we are where we are at this stage and some of the underlying analysis and then, hopefully, to target some of the actions as well. Equally, we will have an expectation that that will become clearer to us as we go forward, but they do have normal pressures.

[56] In respect of the second question, I am sorry; I have just—

[57] **Alun Ffred Jones:** Gwariant cyfalaf. **Alun Ffred Jones:** Capital issues.

[58] **Dr Goodall:** Okay. On the question of capital, I am limited, to some extent, in what I will go into, but colleagues may be aware that there was an investigation that did take place in north Wales to do with a particular capital scheme. It was subject to a criminal investigation. That just raised some broader concerns for us within the organisation, and while I would not want to comment on the individual detail there, one of the areas that we have been going through at the moment is to make sure that, with those triggers that happened in that individual case, we can have confidence and assurance that, as other schemes progress, they can basically meet the criteria that we would expect for capital at this stage. So, I know that the Betsi Cadwaladr university health board has already been doing its own external reviews, with support. We have also provided support from within shared services in Wales to make sure that that can be reviewed as well. Our hope and expectation would be that we can actually have confidence in all the residual schemes that take place at this time. However, at the moment, it was felt that there should be a pause, just to make sure that any individual scheme can actually be pushed forward on its own merits at this stage. However, I would rather leave the criminal investigation issue to the side, if that is okay, because, obviously, that is still a pending issue at this stage.

[59] What we have received to date, however, is a very comprehensive overview from the board itself. It was taken as a very serious issue earlier in the year, during the summer, and I received a very comprehensive response from the chief executive of the organisation. I think that we were very happy with the actions that were taken, but, obviously, they have to work through all of those existing schemes. On the current escalation levels, it was felt that it was one of those areas where we would want to see confidence before we could drop them down, at least on the capital schemes at the moment. Obviously, there are a number of schemes that are proposed for north Wales at this time.

[60] **Alun Ffred Jones:** A gaf i ddod yn ôl at y materion cyllidol? Rydych wedi nodi yn eich ateb fod pryderon ynglŷn â'r defnydd o *locums*, ac rwy'n gwybod bod pryderon ynglŷn â'r defnydd o nyrsys asiantaeth, sy'n **Alun Ffred Jones:** May I come back to the financial issues? You said in your answer that there were concerns about the use of locums, and I know that there are concerns about the use of agency nurses, which increases costs

cynyddu'r costau'n sylweddol, a bod hynny wedi'i ganoli'n arbennig ar un ysbyty. Byddem ni fel Aelodau am gael mwy o fanylion am hynny, oherwydd, ar hyn o bryd, mae digon o sibrydion am broblemau, ond nid ydym ni, ar ran y cyhoedd, yn cael y wybodaeth angenrheidiol. Os oes problemau penodol, boed hynny mewn un ysbyty neu ar draws yr ysbytai, neu ar unrhyw agwedd, rwy'n meddwl ei bod yn bwysig bod y cyhoedd yn cael gwybod a'n bod ni yn cael gwybod. Byddwn yn gofyn felly am y wybodaeth honno i'r pwyllgor hwn pan fydd hynny yn rhesymol.

significantly, and that that is focused mainly in one hospital. What we as Members would want is more detail about that, because, at present, there are lots of rumours about the problems, but we are not, on behalf of the public, getting the necessary information. If there are specific problems in one hospital, or across the hospitals, or elsewhere, I think that it is important that the public find about that and that we know. I would ask that this committee should get that information when that is reasonable.

09:30

[61] **Aled Roberts:** Byddwn yn ategu hynny hefyd. Yn y pen draw, mae cyfarfodydd eithaf rheolaidd rhyngom ni fel Aelodau unigol a'r cadeirydd a'r prif weithredwr, ond i fod yn hollol onest, nid oes unrhyw fath o wybodaeth wedi cael ei rhoi bod achos i bryderu ynglŷn â sefyllfa'r bwrdd. Y neges roeddwn i'n ei chael oedd bod y sefyllfa'n gwella, felly mae'r llythyr hwn y bore yma yn creu cryn bryder i ni. Hwyrach y dylai'r Llywodraeth ystyried briffio Aelodau'r gogledd am fanylion y sefyllfa, achos mae hyn wedi bod yn mynd ymlaen yn rhy hir. A dweud y gwir, nid ydym ni fel Aelodau Cynulliad hyd yn oed yn deall yn union beth yw'r sefyllfa. Mae'n amser i'r bwrdd hwnnw fod yn hollol onest ynglŷn â beth yw'r sefyllfa, yn hytrach na rhoi rhyw fath o *PR spin*, fel yr ymddangosodd yn y *Daily Post* ddydd Sadwrn, er enghraifft, lle roedd yn dweud bod swyddogion newydd wedi cael eu penodi a bod y bwrdd yn troi y rhod.

Aled Roberts: I would endorse that comment. Ultimately, there are fairly frequent meetings between us as individual Members and the chair and chief executive, but to be completely honest with you, no information has been passed on that there was cause for concern in the board's situation. The message that I got was that the situation was improving, so this letter this morning causes a great deal of concern for us. The Government should, perhaps, consider briefing north Wales Members about the details of the situation, because this has been going on for too long. Truth be told, we as Assembly Members even do not understand exactly what the situation is. It is time for that board to be completely honest about the situation, rather than put some sort of PR spin on it, as appeared in the *Daily Post* on Saturday, for example, when it said that new officials had been appointed and that the board was turning a corner.

[62] Ynglŷn â'r monitro dwysach hwn rydych wedi cyfeirio ato y bore yma, beth mae hynny yn ei olygu o ran y bwrdd? Ai ynglŷn â materion cyllidol yn unig rydych yn pryderu? Rydym i gyd yn pryderu ynglŷn â sefyllfa gofal iechyd meddwl, ond i fod yn hollol onest, mae pobl yn y gogledd yn poeni mwy am faint maen nhw'n aros am driniaeth, ac nid yw'r sefyllfa honno yn gwella. Un o'r materion y dylech fod yn cyfeirio ato yw bod y bwrdd iechyd yn y gorffennol wedi bod yn prynu gwasanaethau i mewn o Loegr. Roedd penderfyniad gan y bwrdd yn flaenorol i gwtogi ar y gwasanaethau hynny heb

In relation to this more intense monitoring that you have referred to this morning, what does that mean for the board? Are you only concerned about financial matters? We are all concerned about the situation in terms of mental health care, but to be completely honest, there are people in north Wales who are more concerned about long waiting times for treatment, and that situation is not improving. One of the matters that you should be referring to is that the health board in the past has been buying services in from England. A decision was previously made by the board to cut back on those services

fuddsoddi mewn gwasanaethau newydd yn y gogledd. Felly, o lle mae rhai ohonom yn sefyll, mae polisi bwriadol yn y gogledd lle mae pobl wedi gorfod aros am fwy o amser nag mewn mannau eraill yng Nghymru.

without investing in new services based in north Wales. So, from where some us are standing, there has been a deliberate policy in north Wales where people have had to wait longer than in other parts of Wales.

[63] O feddwl ein bod yn y fath stâd, mae gennyf fanylion yn fy swyddfa ynglŷn â chwestiynau rwyf wedi gofyn am gost yr holl gefnogaeth sydd wedi cael ei rhoi gan Lywodraeth Cymru i'r bwrdd iechyd yn ystod y 18 mis diwethaf. A ydych mewn sefyllfa y bore yma i ddweud yn union faint mae Llywodraeth Cymru wedi ei wario yn ystod y 18 mis diwethaf ar gefnogaeth ychwanegol? O ystyried bod rhai o'r uwch swyddogion hyn yn cael cyflogau eithaf sylweddol, byddech yn disgwyl wrth iddynt dderbyn y cyflogau eithaf sylweddol hynny bod ganddynt fodd i reoli'r sefyllfa yn well nag y maent.

To think that we are in such a state, I have details in my office of questions that I have asked about the cost of all the support that has been given by the Welsh Government to the health board over the last 18 months. Are you in a situation this morning to say exactly how much the Welsh Government has spent over the last 18 months on additional support? Given that some of these senior officials are in receipt of fairly substantial salaries, you would expect as they receive those salaries that they would have the means to manage the situation better than they are currently doing.

[64] Mae fy nghwestiwn olaf yn ymwneud â'r cynllun monitro. Mae lefel 3 yn dweud bod y Llywodraeth yn cytuno ar raglen welliant gyda'r bwrdd iechyd. Beth yw'r amserlen o ran cytuno ar y rhaglen welliant, ac a fyddech yn fodlon rhannu'r rhaglen welliant honno gyda thargedau ynglŷn â beth rydych yn gofyn i'r bwrdd ei gyflawni cyn iddo fynd yn ôl i lefel 2 o ran y cynllun?

My final question is on the monitoring scheme. Level 3 states that the Government agrees on an improvement programme with the health board. What is the timetable for agreeing that improvement programme, and would you be willing to share the details of that programme with targets as to what you are requiring the board to achieve before it goes back to level 2 in terms of the scheme?

[65] **Darren Millar:** There were lots of questions there. Andrew, do you want to start?

[66] **Dr Goodall:** Perhaps if I start, Simon will pick up on the enhanced monitoring and the timetable, if that is okay. In respect of where we are at this stage of the year, we do have expectations that performance must improve and, where there are concerns, they must be addressed. That includes the financial performance of the organisation. I said in my introductory comments that it is a new team in place and I think that we need to respect that. Some of the individuals have only been in post for a number of weeks or so. I know that there will be a focus around getting a three-year plan in place, and I think that that is a positive focus for the organisation. However, we do require progress to be made sooner rather than later. The whole intention here is not to undermine the local team; the point of the targeted intervention is to support it to get some of the pace and urgency in place with immediate actions. Normally, it will take time to work through a new team environment. In my own experience, you cannot expect those changes to happen overnight; it can often be a number of months into the organisation. We have to have higher expectations than that for the organisation to make sure of it. So, the targeted intervention is intended as a support mechanism for a new team coming in. Our hope would be that we can step away from those arrangements reasonably speedily, but at least we have the assurance about the pace and urgency of those actions that are taking place. Simon, do you want to pick up on the in-house monitoring and the detail?

[67] **Mr Dean:** Thank you. You mentioned concerns about waiting times. As I said

earlier, we placed the health board under enhanced monitoring when we considered its position in July. The main concerns at that stage were things such as waiting times and unscheduled care performance. As I also said, the targeted intervention is in addition to the enhanced monitoring, so we will continue to work closely with the health board.

[68] **Aled Roberts:** Do you get any indication from the health board regarding what it expects to achieve? We get letters saying that the waiting time has gone up from 40 weeks to 55 or 60 weeks. It is as if that is what people have to accept.

[69] **Mr Dean:** We do have information from the health board as to its current plans. I have three meetings with the health board tomorrow to discuss in detail aspects of its performance plans. That includes a joint executive team meeting that Dr Goodall will chair, which is our executive team meeting with its team. We will be discussing its plan for the remainder of this year. We need to do that within the context of its current performance and the expectations that it has of itself and that we have of it, and the financial position that was touched upon earlier. One of the things that we are concerned about is to make sure that there is clear understanding within the health board as to what appears to have caused the financial position to change so dramatically. We then need to work with the health board to make sure that, for the rest of this financial year, there is a clear plan that the board is prepared to commit to deliver, and that we are prepared to commit to, and which is the best plan that can be developed in the circumstances, which combines a focus on quality, performance and on living within its financial means. We need to work with the new team. As Dr Goodall said, many of them have only been in place a matter of weeks. We need to work with them and discuss with them the support that they believe they need. We will have a view on what that support should be, so we will be discussing that with them, starting tomorrow, and designing a package of intervention that is designed to enable them to succeed. Part of that will be a clear timetable for delivery of milestones and we will performance manage them closely against that.

[70] In addition, we need the health board to be producing a three-year strategic plan to map out the way forward so that we do not find ourselves in a similar position in the coming year. So, we would expect that plan to be discussed through the full board, in public, and to be a commitment to the public of north Wales. So, I would certainly expect it to be transparent in its intentions, both for the remainder of this year and as its three-year plan develops.

[71] **Aled Roberts:** A gaf i awgrymu eich bod yn edrych ar gofnodion bwrdd rheoli Betsi Cadwaladr? Os ydych yn Aelod Cynulliad, heb sôn am fod yn aelod o'r cyhoedd, nid yw'n bosib i chi weld sut yn union mae ei berfformiad o ran targedau, ac, o lle rwy'n sefyll, nid oes gennyf ffydd y byddai unrhyw un yn gweld yn union beth yw'r rhaglen welliant o ddarllen cofnodion y bwrdd. Nid yw cofnodion y bwrdd ar gael tan gyfarfod y bwrdd nesaf, lle mae'r cyfarfod wedi cytuno ar y cofnodion beth bynnag. Felly, mae rhyw ddeufis rhwng y naill achos a'r llall.

Aled Roberts: May I suggest that you look at the minutes of the Betsi Cadwaladr management board? If you are an Assembly Member, let alone being a member of the public, it is not possible for you to see exactly the performance of the board in terms of targets, and, from where I stand, I do not have any faith that anyone could see exactly what the improvement programme is from reading the minutes of the board. The board's minutes are not available until the next meeting of the board, where that meeting agrees the minutes regardless. So, there is around two months between the two.

[72] **Dr Goodall:** I would expect there to be a more immediate overview of the performance issues, because that is discharged through all of the boards in here. However, certainly in terms of awareness of the baseline position and how we are monitoring and measuring the expectation for the different boards, our starting point for Betsi is the one-year

plan that it had in place. So, from the beginning of this financial year, that has set out the targets and expectations and the improvement trajectory, and we do monitor it against those profiles on a monthly basis. I would expect that to be coming through the performance papers of the board as well. I am also mindful, Chair, that the English services were raised as well and the opportunities there. Again, I would expect that the three-year plan that is a focus of attention in Betsi should be able to work through those areas, but, in the context of broader service change for north Wales and what is best for the population so that that can be worked through, obviously, there has been a traditional reliance on services from across the border in north Wales. It has been a feature of the mechanisms up there for some time, and, of course, there are often opportunities to be able to repatriate some of those services where it is appropriate and so that they can be developed on a more local basis. That has been done in many of the health boards in Wales at various stages, but sometimes it is about accessing the specialist services that can only be provided over the border as well. So, where it is possible and it can be discharged in a local environment, then I think the board should be able to set out those plans within its three-year proposals, but, of course, there will be some residual services that continue to be provided across the border in England, and have been for many years.

[73] **Darren Millar:** Sorry, may I just go back to this issue of monitoring, because I think it is really important? How do members of the public, community health councils and Assembly Members know what arrangements are in place and at what point on the escalation levels their own health boards are? You have heard from all of the north Wales Assembly Members this morning—and we are going to come to other members of the committee in a few moments—that, really, we feel a little bit in the dark about these things. You say that you have been monitoring the waiting times in north Wales and that there have been some enhanced monitoring arrangements in respect of that, but we are not aware of these. So, how on earth are members of the public and how on earth are community health councils supposed to be aware of these things? If it were not for this letter, frankly, and the fact that we are having an evidence session this morning, would we ever have known about these new arrangements and their being in place?

[74] **Mr Dean:** Our expectation would be that each health board would report its escalation status in open sessions of its board, that it would develop plans to address performance concerns, should there be any, that it would be publishing its own—

[75] **Darren Millar:** Should there not be some expectation that the Welsh Government would say, ‘Here is some information for you as an interested stakeholder. Your board is at escalation level 3 for these reasons, and this is what we are monitoring and expecting in return’?

[76] **Mr Dean:** We will be expecting the health organisations and trusts, as well as health boards, to be open and transparent in the way in which they conduct their business. It should be for them to be placing this information in the public domain. It is their public that they are serving.

[77] **Darren Millar:** Forgive me, but they are accountable to you, are they not, and you are accountable to us as Assembly Members, so why do you not publish this information in one place that is easily accessible to the public, Assembly Members, community health councils and everybody else who has an interest in the health service in their area?

[78] **Dr Goodall:** We have a range of information available that is made transparent through My Local Health Service. I am happy to see that as part of the local reporting mechanisms; that we can use some of those mechanisms to see whether the escalation level can be included as well. That is one of the mechanisms to make sure that this information is made very transparent on a local basis and can be accessed in that manner. So, that could be

an opportunity for us to look at that.

[79] **Darren Millar:** So, the My Local Health Service website is something on which you would consider making this information available in terms of enhanced monitoring and escalation levels.

[80] **Dr Goodall:** Yes, and this escalation framework, the enhanced one, has been in place since April. We have been using it for the first time in liaison with Healthcare Inspectorate Wales and the Wales Audit Office. We are very happy to review the progress and the reporting aspects around that as well. However, it would be important to make sure that that is set in the local context, Chair.

[81] **Darren Millar:** Okay, thank you for that. I call on Jenny Rathbone and then Mike Hedges.

[82] **Jenny Rathbone:** So, the board tells us that it is turning a corner, according to the *Daily Post*, we have a new chair and a new vice-chair, and there is a clear letter from the vice-chair on her role in infection control, and that is fine. Alun Ffred said that the chair has been very clear with him as a local Assembly Member, but what about all the other board members? They are being paid to do a job as well, and I am not convinced that they are earning their keep here. On their watch, things like Tawel Fan have happened, which is a serious failing not just of management, but of governance. The board should be across whether or not relatives are being excluded in order to hide poor practice, which is apparently what was happening. It was a huge wake-up call when we looked at this last year—the excoriating exposure of the inadequacies of the board. What are these other board members doing to raise their game? Are they visiting each of the three units, as well as primary care? How often are they doing it and what are they doing to inform the way in which they carry out their duties? If they are not, why do we not replace them?

[83] **Dr Goodall:** Chair, if I may, I will speak generally. I think that, for some of the specifics of what the board members are up to, Betsi Cadwaladr would need to describe that. Obviously, we can look to pursue that information if it helps to discharge some of this.

[84] In respect of Tawel Fan, if it is okay, because of the criminal investigation that is going on, I will put that to the side. However, the board did take action on that and, obviously, has taken some necessary steps over recent months to make sure that there was a focus on those particular services.

09:45

[85] We know that, as part of the board development approaches, the chair in particular had taken some different mechanisms forward that he felt were important to rebalance the board. He introduced the proper individual appraisal mechanisms for individuals to understand their skills and experience that could be brought to the table. Yes, through some of the facilitated board development sessions, they have had a chance to work through some of the shared experiences of the board. I know that they are doing some work around values and behaviours collectively to make sure that there is common understanding, but I also know that a profile of service visits to make sure that the ward-to-the-board philosophy was actually delivered has also been undertaken at this stage. I cannot quote which individual units they have gone to, or which sites, but I know that that has been a feature over the last number of months in terms of having an expectation that the board is more visible. I am happy to liaise with the chair and the chief executive about the nature of those particular visits that have taken place, but we have had assurance that that is part of the individual board member approach that happens.

[86] I think that individual board members need to be supported in two ways: first, as an individual, because they might well have their own development needs as they discharge their rights; and, secondly, a collective approach that is about the way in which the board works together on these issues, be that on scrutiny or assurance, on shared decision making being taken forward.

[87] From the Betsi Cadwaladr health board, we have had reassurance that it has taken that very seriously, and more so over this recent period, and that it has increased some of that development and training. I know that sessions have taken place through July, with a couple in August and through September and October as well, again with the new team in place and the new executives. However, it is very difficult for me to comment on some of the individuals; that would seem to be more the responsibility of the local chair in terms of his oversight responsibility.

[88] **Jenny Rathbone:** Okay, but, at the end of the day, it is the Welsh Government that has to intervene if the board is incapable of doing the very difficult task that it has. My other question is this: what is the board doing to ensure that we have consistent clinical governance in each of the three units? I recall that we had people doing their own little things based on what they thought was good practice, as opposed to what was evidence-based practice. So, could you just give us some general hint of what it is actually doing about that?

[89] **Dr Goodall:** Perhaps if I could just draw in some of the quality components around that on the units, certainly, the board has had to take a new approach around its structures and has been going through some very significant consultation to change the way in which the management structures are discharged. Clearly, with clinical leadership needing to be in place, some of that has led to some changes, but, as Professor Purt outlined in July, the intention was to secure that, irrespective of being a large health board in its own rights, covering the whole of north Wales, he wished to make sure that there was still a local identity that could be created within the new structures that would allow the sites to be dealt with for some of their own issues.

[90] One of the challenges for boards is that although you might need to have a locality approach, you still need to have some consistency on the standards. That is where the board comes in; it has a responsibility to oversee these types of arrangements. I wonder, Ruth, whether it might be worth drawing in some of the quality expectations, but also how clinicians have been involved in some of those new structures at this stage.

[91] **Dr Hussey:** It is fair to say that the quality and safety committee has been very active in looking across the whole organisation, in discussion with the medical director, who has established new arrangements for working. They have developed a new approach to complaints, looking at how they investigate serious incidents; he has introduced the mortality case note review process and has very actively tried to make it consistent, and he is seen to be doing a good job in getting a consistent approach. He has only been in post this year, but the early signs are that he is really trying to bring a systematic approach and doing a lot to ensure clinical engagement, but, obviously, it takes time to develop that.

[92] **Darren Millar:** In terms of the abilities and capabilities of board members, obviously, the board felt it necessary to co-opt additional people; the chair felt it necessary to bring additional resource in, effectively, in terms of support for independent members, with others who are not ministerial appointees but are supporting in their capacities on the board. What is the Welsh Government's reaction to that? Surely, that shows and clearly demonstrates that there is a deficient skillset around the table on the board, does it not?

[93] **Dr Goodall:** I have a different view. I see that if there is an opportunity to offer support or to request it, or if there is a particular discussion that is taking place within a board

environment and there is expertise that is necessary to access, you should pursue that. I think that that is part of good governance sometimes, if there are some potential gaps. Indeed, as I was saying earlier, it is about having to introduce perhaps a more urgent pace in terms of the change that is necessary. I think that that is actually a more rounded view of the boards. I am probably thinking more of my own experience as a chief executive. I have been on four boards myself over the last 10 years or so, and when there have been problems or concerns, I have always tried to access support where it is available, whether that comes from regulators or through external bodies.

[94] **Darren Millar:** But, these are effectively co-opted members who are there permanently; it is not just about bringing them in for a one-off meeting in order to give some expert advice on a particular situation, is it? I mean, that, to me, suggests that the capacity of existing board members is insufficient to meet the demands of the organisation.

[95] **Dr Goodall:** I think that becomes the judgment of the chair as he works through the individual appraisals with individual members.

[96] **Darren Millar:** So, why are we not seeing this elsewhere across Wales? Why is it only Betsi Cadwaladr doing this?

[97] **Mr Dean:** I think that we do, Chair. In Velindre NHS Trust, which is my substantive chief executive post, we have had co-opted members. We had an additional member, an associate member, on our board for a year. That was a development opportunity for that individual who wanted to become a full board member. It was a great opportunity—

[98] **Darren Millar:** Okay. If that is the case, can we have the names of all of these additional co-opted board members? They are not on websites. There is no information out there for the public to be able to digest. I certainly would find it interesting to know whether they are paid, et cetera, and what their skillset is, to know the unique skills are that they are bringing to the table, as it were, in order to compensate for the lack of ability of others.

[99] **Mike Hedges:** Why do we never see the full-year effect of final quarter savings? The traditional way is that big savings are made in the final quarter and then it is as if the balloon is then released and there is a big overspend in the first quarter that comes through after. That has happened for the best part of a decade right across the health service. Why are we not seeing these savings in the final quarter actually making their way through into a full-year effect?

[100] Do you think that the size and complexity of Betsi Cadwaladr is part of its problem? Is there also a problem, and perhaps in lots of other places as well, that people have not fully accepted the merger of the hospitals?

[101] The final question is this. You talked about medicine costs. Has there not been a reduction in a large number of medicines because they have now become available as generic medicines rather than being covered by a patent?

[102] **Dr Goodall:** There were three questions there. In respect of the savings perspective, the point that I would make, as I have done in other committees in the Assembly, is that we start every year with a new series of pressures coming into the NHS rather than the pressures that we handled the last year. So, every year will start differently in the sense that it will be a new 4% to 5% inflationary pressure that comes through, because of developments. We should have an expectation that organisations start from the very beginning of the year, but, inevitably, as we go through discussions, consultation and changes, there will always be some schemes that take some time to build up. Through our three-year planning framework and the flexibility that we are trying to do there, we are trying to break through some of that. I feel

that we have had some success with some of the organisations that have managed to get into that perspective to look for sustainability. It is always a new and fresh set of savings rather than just repeating the savings from the previous year.

[103] I would not wish to comment particularly on size and complexity, and I certainly cannot comment on local perspectives on it. I would indicate that, in terms of structures in Wales, but actually across the UK, there are very large health organisations. They are able to get oversight of their performance. They are able to deal within their financial arrangements. They are able to discharge issues on behalf of their communities. There are some much larger than we have in Wales. In Scotland, there are some organisations with budgets twice the size of some of our Welsh organisations. Equally, there are other organisations in Wales of similar size and budget terms to Betsi Cadwaladr, with some of the complexity. I was formerly a chief executive of an organisation with five unitary authority areas, so that would take a particular approach around size and complexity. I think that you can work through these issues, but it is really important that the organisations find the right mechanisms to communicate properly, publicly and with stakeholders as well.

[104] In respect of medicines, you are quite right to say that as you go into every year, there are always some medicines that change into generics and move away from some of their branded labels at this stage, but the reverse is true as new drugs are also developed. I think that we have actually made some really good progress across the whole of Wales over recent years: about our medicines management approach, about doing more within our resources, about showing particular savings plans and also demonstrating that the quality measures can improve at the same time. So, I think that your point is right and valid, but there will equally be some new drugs and developments that come in, and there will be an expectation that people want to do that—subject to their approval, of course.

[105] **Mike Hedges:** Can I return to the first question that I asked, because I am a bit confused by your answers? Say that you saved £5 million in the final quarter, if that had a full-year effect, that would be £20 million in the full year. You talk about inflation as if it is a 1 April problem. Surely, inflation occurs throughout the year. Everything from, say, 1 April is going to go up. The point that I was trying to make is that if you save £5 million or £10 million in the final quarter, if you can multiply that by four and have the full-year effect, it would more than equate to the inflationary pressure that may or may not be occurring.

[106] **Dr Goodall:** I think that good levels of financial savings have been made across the whole of Wales, not least over the last four of five years or so, as we have had to deal with public service pressures more generally. I agree with your point that when we were promoting the financial flexibility arrangements and the new three-year plan mechanisms, one of the intentions there was to try to ensure that this end of financial year was just an artificial break, and that we had an ability to put in some smoothing of that across the years, with some of the flexibility and the regulations that have been put in place. I think that that is starting to come through with some of the proposals that we have developed, that people are able to make it more sustainable. So, I do not disagree with your point. I do feel that there are new pressures, but I also think that we have tried to harness that through the three-year planning process and the financial flexibility that has been put in place. So, we should have that expectation for organisations.

[107] **Julie Morgan:** You mentioned earlier that one of the key roles for board members is scrutiny, and I think the auditor general's memorandum says that this is often not robust enough. I think that we have seen that in evidence that we have had before us in this committee, where board members have not had access to all the information they should have had, or they have not challenged it enough. I mean, it is quite a lot to ask of board members to have the capacity to do that. I wonder whether you could comment on how that can be achieved.

[108] **Dr Goodall:** I think that we have to be mindful of the wealth of information that is available for boards to work through. Again, speaking as a former chief executive of a health board, it is a judgment call and a balance about the level of information, and when you provide the broader picture and when you provide the level of detail that is necessary. Certainly, where there are problems and concerns, you do need to be able to explore the level of detail. We acknowledge as well that, in respect of the way that boards operate, there will be some concerns, perhaps, about the time that is available from independent members to actually discharge this. We have had some discussions with chairs across Wales over these recent weeks and months about their views on that as they have gone through the individual board members' appraisals. Certainly, we are prepared to look at that in terms of what it means to be able to discharge that. So, we will be taking some of that work forward at this stage to just adjust what is there.

[109] However, I think that your point is right. There is a lot of scrutiny of health boards, which starts within their local services in terms of the structures that they have in place, their clinical divisions, for example, and an expectation that people should be delivering to quality, to targets and actually within financial arrangements. The board has its own role to discharge also, and there is a level of scrutiny, yes, at the board level through the public board meetings that take place, but actually there is a lot of serving of issues at a more detailed level below the board level, with the various committees that are taken forward, whether it is discharging quality and safety oversight or not. Also, then, there is a level of scrutiny that happens over and above that, and of course that includes Welsh Government itself, our escalation frameworks and the way we have our regular performance meetings at this stage, and the board has to look down through the organisation but, of course, it also has to look upwards in terms of those arrangements.

[110] My own view is that, for scrutiny to work, board members need to use the support that is around and available to them. If there is a Welsh Government report that has been received or there has been a recent joint executive team meeting, for example, it is important that boards receive that kind of information. They have access to regulators, they can ask for judgments and views, whether that is done in development sessions or, indeed, through public formal meetings as well. So, I think that they do have an opportunity to access information that helps them to triangulate some of the pressures and concerns.

[111] The final bit I would raise is how they use stakeholders also. I think that the best boards that we have are often triangulating with stakeholders, speaking to community health councils and having public meetings with the public where these things can be expressed and worked through. I think the board members also have a duty and a responsibility to listen through those mechanisms, as well. It may not feel as though that is in place everywhere, and I think that even the review that was done by the committee highlighted some of these issues. However, where we are seeing effective boards in place, this is often a feature and part of their characteristics.

[112] **Julie Morgan:** Do you think that the model of the boards is the right model?

[113] **Dr Goodall:** I think that the stakeholder board model that we established, not least with the size of the organisations, was a particular decision when we introduced the local health boards. I am actually a proponent of it in the sense that, having been a previous LHB chief executive, there is that need to work through individuals sitting around the boards who sat there with a stakeholder hat on, who could help to participate and give us some views on behalf of communities, whether through the local government representation or through their community stakeholder representation. I think that the size of organisations that we are requires board members to have the time available to work through all of the issues we have, because, with the broad range of services that we have—from GPs right through to specialist

hospital services or mental health through to community—it takes an awful lot of time to make sure that they happen. The one thing that they do need, however, is a clear filter to make sure that the problems and concerns are always raised appropriately, whether externally or through the executive team itself and the organisation.

[114] **Darren Millar:** One very final question. Be very brief, please, Alun Ffred, and please give a very brief response, as well.

[115] **Alun Ffred Jones:** Mr Goodall, mewn sylwadau cynharach, dywedasoch nad oedd bwrdd Betsi Cadwaladr wedi mynd i'r afael â newid trawsffurfiannol, sydd yn digwydd, neu wedi digwydd, mewn ardaloedd eraill. Beth oeddech chi'n ei feddwl?

Alun Ffred Jones: Mr Goodall, in your earlier comments, you said that Betsi Cadwaladr board had not tackled transformational change that is happening or has happened in other areas. What did you mean by that?

10:00

[116] **Dr Goodall:** I think that, as we look at all health services across Wales, we know that there are services that are under pressure: we see it with some of the vacancies that exist around medical staff and some of the changes that we have seen around junior doctors. We have an expectation in Welsh Government that, for any board to produce a sustainable range of services, within the resources and within the workforce, they have to have a clear three-year plan in place to discharge it. I know that there have been some local changes that have been made within Betsi Cadwaladr, and it has been possible to take them forward, but from talking to the new team, I know that it wishes to make sure that it can give a clear sense of direction for the population of north Wales that takes them over the next three years, but also into the future as well. What my expectation is is that we will receive a clear three-year plan in January that actually allows the new team to outline what those issues should be, and it is, as always, about providing safe local services, but also handling and dealing with some of the concerns that are there. We do recognise that, within Betsi Cadwaladr as an area, some of the triggers, like high nursing expenditure on agency staff or high locum expenditure on junior doctors, show that there are some inherent problems with services that we do need to look to address for the future.

[117] **Darren Millar:** Okay, thank you. On that note, unfortunately, the clock has beaten us. We are going to have to draw this evidence session to a close. We would appreciate it if you could send a note through to the committee as a follow-up for some of the issues that we have discussed and, in addition, if you could just give us some information and a bit more detail on the NHS governance and quality Green Paper and the timeline on that that the Minister announced earlier this year. Thank you, Andrew Goodall, for your help in today's committee, and Simon Dean and Ruth Hussey for your attendance. You will get a copy of the transcript of proceedings. If there are any inaccuracies in that, then we will make the necessary amendments. Thank you very much indeed.

[118] We will just wait for the witnesses to be shown in for the next item.

10:03

Llywodraethiant Byrddau Iechyd GIG Cymru
NHS Wales Health Boards' Governance

[119] **Darren Millar:** We will continue with our consideration of NHS Wales health boards' governance arrangements. I am very pleased to be able to welcome to the table Professor Andrew Davies, chair of Abertawe Bro Morgannwg University Local Health Board,

Paul Roberts, the chief executive of ABMU, Rory Farrelly, director of nursing—welcome to you, Rory—and Hamish Laing, medical director, ABMU. Welcome to you all. We are very grateful for your attendance today. You are probably aware that the committee has been considering NHS governance arrangements for a number of years, now. We were prompted to do so as a result of joint reports in relation to the Betsi Cadwaladr health board that were presented to the committee by the Wales Audit Office and Healthcare Inspectorate Wales, and we felt very strongly that there were lessons that needed to be learned across the whole of the country and NHS Wales rather than just in north Wales as a result of that.

[120] Your own board, of course, has faced some challenges itself in recent times. Many of those have been highlighted and documented in the 'Trusted to Care' report, which of course is sometimes referred to as the Andrews report. We may well touch on some of those issues as well this morning, but I wanted to give you the opportunity to make a few opening remarks, if any of you want to do so, before we go into Members' questions.

[121] **Professor Davies:** May I, first of all, thank the committee for giving us the opportunity to appear before you. Obviously, governance has been a key issue for us. You have outlined some of the challenges that we have faced. However, Paul, the senior management team and I have created, or are creating, as I think the Wales Audit Office has acknowledged, a culture of openness and honesty, and tackling problems wherever we have dealt with them, be it in the case of difficulties that are highlighted in the Andrews report, or in other areas, such as the cardiac surgery service at Morriston. So, I think that we are on that journey. We are not the finished article by any means, but I think that the direction of travel is extremely clear.

[122] **Darren Millar:** We have heard this morning that there are clear levels of intervention, and it would be helpful, I think, for the committee to know exactly where you are on that scale, as a board, in terms of Welsh Government intervention.

[123] **Mr Roberts:** I am certainly happy to pick that up. As you know, we have the escalation intervention arrangements, which we put in place just earlier this year. We are in one that requires us to have enhanced monitoring, which is called 'level 3'. We had a letter setting that out, and that was to do with the monitoring that the Welsh Government wanted to do around 'Trusted to Care', the Andrews report. So, that was the clear context for that.

[124] **Darren Millar:** Okay. Just touching on the Andrews report, just to give us a steer—

[125] **Mr Roberts:** I should also say, Chair, that that is set out in our public meetings, in our board meetings and on our performance reports, too. So, that is publicly available information.

[126] **Darren Millar:** Okay. Thank you for that. Just touching on the Andrews report, obviously, it made for shocking reading—there were some appalling findings in that report that none of us welcomed, really, in terms of what was found. It was horrific reading indeed. When did you as a board first become aware of the problems referred to in that report?

[127] **Professor Davies:** It was in around February 2013. I had been in post for about a month, and there had been a series of ombudsman reports detailing activity that went back, depending on the case, to 2010-11. There were allegations of falsification of blood glucometry tests at the Princess of Wales Hospital, and there were also the risk adjusted mortality index, which indicated that the PoW hospital was an outlier. Paul and I, and the executive team, discussed it, and I said to Paul, 'As chair, I want assurance that these are not systemic problems'. Clearly, when we took firm action, we introduced a taskforce to look at some of the problems, and it was clear that there were deep-seated problems. From that arose all the interventions that we made, introducing, for example, earlier this year, direct

management—drafting one of our executive team into the direct management of the hospital. So, there was a whole range of actions that we took as a result of that coming to light in February 2013.

[128] **Mr Roberts:** I might just add a little bit of detail to that. I would argue that it was a sort of constellation of issues that were particularly focused on the Princess of Wales Hospital. I think that with any one of those things that you might see, from time to time, with a part of your service, you may have a critical ombudsman report—there have been others, and throughout the service. However, bringing those things together, we had two ombudsman reports published within a few months of each other, and we became aware of the draft conclusions of those before they were published. So, they were actually published a little bit later in the year, but we knew that they were coming, because the ombudsman had shared the drafts.

[129] The RAMI results for the Princess of Wales Hospital were not the worst in Wales, but it was among the worst-performing of the hospitals. I would just add that there were also several complaints that caused me and other colleagues concern as well, which were not ombudsman's complaints, but they did point to issues to do with the care of particularly vulnerable elderly people. So, we thought that, because these issues came together, we needed to take some very specific action around the Princess of Wales Hospital, which is what we did.

[130] **Darren Millar:** You commissioned a review of your own, did you not?

[131] **Mr Roberts:** We did.

[132] **Darren Millar:** Can you tell us a little bit more about that?

[133] **Mr Roberts:** Do you want me to touch on it? Hamish may then want to say little bit more about it.

[134] **Darren Millar:** Yes, please.

[135] **Mr Roberts:** As the chairman said right at the start, I think that the regime that we have tried to have within our governance is one of being open and accountable, and we decided to get in external expertise. The Advancing Quality Alliance is an NHS organisation. It is actually hosted by the Salford Royal, which you probably know has an international reputation for the quality of its health services. Therefore, it is an organisation that has a very good track record of looking at and doing reviews of hospitals around England, mainly in the north-west of England. We felt that its international reputation meant that it would be a good organisation to bring in to help us with the review. Its methodology is to dig deeply into the organisation and talk a lot to front-line clinicians and front-line staff. We felt that that was a good way of responding to the concerns that we had raised, so we got it in during 2013.

[136] **Darren Millar:** When did it complete that work and report to you?

[137] **Mr Roberts:** The final report was presented to our May board meeting the next year. We had a draft of that report earlier, but the final report—

[138] **Darren Millar:** So, it was May 2014?

[139] **Mr Roberts:** Yes.

[140] **Darren Millar:** I see. That is a long time, is it not?

[141] **Mr Laing:** There was a lot of fieldwork and then there was a lot of data analysis. One of the challenges, I think, was being able to accurately benchmark our data and the data of the other health boards in Wales against English peers or UK peers. Its methodology was to do that, and we felt that it was very important that we were being benchmarked against the very best. There are real challenges in that, and it took quite a lot of time for some of those measures to be worked through so that they were able to be compared on a UK-wide or on an England-and-Wales basis.

[142] **Darren Millar:** But, even though that work was ongoing, Professor Andrews was asked to come in and to do a piece of work in the meantime, was she not? Why was it necessary? Was there not duplication there?

[143] **Mr Roberts:** Well, the decision to bring in Professor Andrews was obviously the Minister deciding that, with escalated concerns, he wanted to commission his own review. Obviously, that is a matter for the Minister. Our view is that working with organisations such as AQuA—and, on a smaller scale, we have done other work with other external people as well—is a part of the business of making sure that we are transparent and open about quality. So, we were quite happy that the AQuA work would continue while the Andrews review was going on. They were overlapping reviews, but they were looking at slightly different things. AQuA has perhaps a more technical approach to looking at safety and quality systems.

[144] **Professor Davies:** The AQuA system is very much data-driven whereas the Andrews review was experiential, interviewing patients and families as well as staff. They were complementary methodologies but different.

[145] **Darren Millar:** I thought, Mr Roberts, that you had just suggested that the AQuA review also spoke to staff and front-line clinicians.

[146] **Mr Roberts:** Yes.

[147] **Darren Millar:** It sounds very similar to the Andrews approach.

[148] **Mr Roberts:** I think that what the chairman says is right. What AQuA prides itself in doing is having a really good, thorough review of all the data on safety and quality as well, but it would argue—and I think, probably, that it is obviously correct—that you cannot just look at the data and all the information, particularly when it is so challenging to have good comparables, because the data are very complex data. Therefore, it also does a lot of work, in its case, with staff—clinicians and front-line staff. Professor Andrews obviously spoke to staff too, but she did a lot of work with relatives and communities as well.

[149] **Darren Millar:** The Welsh Government was aware that you had commissioned the AQuA review, was it?

[150] **Mr Roberts:** Correct.

[151] **Darren Millar:** It was also aware of the terms of reference for that review. Its report was published in May 2014. Was that put into the public domain?

[152] **Mr Roberts:** Yes, it was.

[153] **Darren Millar:** At that time, in May?

[154] **Mr Roberts:** I should say, with regard to what Mr Laing was saying about the data issues, we actually published the recommendations at an earlier board meeting. What we agreed with AQuA was that its recommendations were not likely to change, even though it

was looking at and reviewing the accuracy of the comparabilities of the data. So, we published the recommendations at an earlier board meeting, but the full report was put in the public domain at our May board meeting.

[155] **Darren Millar:** When were the recommendations discussed by the board?

[156] **Mr Roberts:** I would probably have to get back to you on the exact date, but it was a couple of months before.

[157] **Darren Millar:** Okay. I have a number of Members that want to come in here, so I am going to bring in Jenny Rathbone, then Sandy Mewies and Mike Hedges.

[158] **Jenny Rathbone:** The Andrews report said that

[159] 'the volume of undigested data at Board and sub-Board level means Board members are denied the ability to understand and act on symptomatic complaints'.

[160] I just wondered how you got yourself into that situation, because that is obviously extremely serious and a failure of governance?

10:15

[161] **Professor Davies:** When I was appointed, I said that one of my first priorities was to undertake a governance review, which I did in the first year. It was clear from discussing with not just the executive team but also members of the board—for example, the chair of equality and safety—that there was a huge amount of information and data but, almost, you could not see the wood for the trees. One of the things that we decided, as a board, was that we needed to be much clearer; we needed fewer metrics by which we could assess quality and safety and patient experience. As an aside, by the way, we were gathering very little data on patient experience. It was only about 1% of the total patient experience that we were able to actually capture, let alone analyse. So, we realised that we had to, basically, get our act together in terms of being much clearer about what were going to be the important measures by which we measure quality and safety and patient experience. However, by the time that Professor Andrews and Mark Butler came to do the review, those new systems were not in place.

[162] **Jenny Rathbone:** Okay, but I would just like to understand a little bit more from the chief executive, and, indeed, the medical director, how you got yourselves into this situation where you were just burying yourselves in information.

[163] **Mr Roberts:** Indeed. I am happy for both the medical director and the nurse director to come in on this. I think that there was a strong culture in healthcare, and in the Welsh NHS and in our board, of over-measuring process measures and access measures, which are important things, and not putting enough emphasis on outcome. Outcome can sometimes be quantitative outcomes taken from national audits and things such as that, but I think that the dimension that we were trying to develop—and, as the chairman says, we have a lot more of our systems up and running now, and we were in the process of developing these when Professor Andrews came to look at it—was actually the experiential outcome measures, so, the findings and feedback that you get from complaints, from incidents, but also, more importantly, from asking patients or relatives and families what their view is on the outcome of their care. So, we have done a lot of work on that. We had started that work well before Professor Andrews came into place, but I think that her criticism is reasonable in the sense that those systems were not fully developed when she came along. For instance, we put in something that we call 'the friends and families test', which we were piloting in the Princess of Wales Hospital, which is a really simple feedback process that allows patients themselves or families to give an indication of their confidence in the hospital for use by a relative or a

friend. Professor Andrews actually tested that system and found that it was working and being responded to. So, that was an early pilot on actually getting outcomes directly from patients. That, to me, is the most important element of what we are trying to do now. We are trying to move away from having hundreds and thousands of process measures, which are often burdensome for front-line staff to gather that information, and trying to concentrate on fewer indicators, but many of them being directed at outcome.

[164] **Jenny Rathbone:** That sounds entirely sensible, but would you not agree that it must have been a failure of governance by non-executives whose job it is not to drown in detail but to look at the overview and to say, 'All of this stuff is not sufficient to enable me to understand what is going on from the patient perspective'?

[165] **Professor Davies:** It is a fair point. As I said, as part of my governance review, in discussions individually and collectively with the non-exec directors, they were making it very clear that they felt that they were unable to do their job because of just the sheer amount of information that they were having to deal with. That was part of it: how we can clear the undergrowth and have a much clearer system. It is a system that we inherited and, I think, as I said in my introductory remarks, Paul and I are very clear about creating a very different culture—one that is based on openness and transparency. That is openness and transparency not just for the board to be able to scrutinise, but also for the public and patients to be able to review how we perform.

[166] **Jenny Rathbone:** So, to what extent now are non-executives getting their jackets off and visiting wards and GP surgeries just to be able to understand what the reality looks like on the ground?

[167] **Professor Davies:** There is a very extensive programme. I and all of my colleagues undertake that. Obviously, I am, effectively, full-time but most of my non-executive colleagues are not. Nevertheless, getting that balance between ward and board is a difficult one. Obviously, you do not want them in committee meetings all of the time. However, for example, my vice-chair, who leads on primary care, has organised a series of visits to GP practices across the whole of the health board, and that is just one example of how the non-execs are carrying out their functions and duties. The chair of quality and safety is now rotating, his committee meets in different locations across the health board and, as part of that, there is now a 15-step programme that he and his colleagues undertake in terms of scrutinising. Rory, may want to say a bit more on that.

[168] **Mr Farrelly:** Yes, the chair of the quality and safety committee made a decision that was crucial from a leadership and accountability perspective that the quality and safety committee of executive directors and non-officers actually tested out what was coming to quality and safety. Certainly, since I have come into post, at every meeting there is a patient experience paper on where we are with updates. It is the same with complaints. It is about testing that out through unannounced inspections via the 15-steps methodology, which is about improvement, identification, talking to staff, patients and relatives in the clinical arena, capturing that and feeding that back through the teams in relation to what we have found that needs to improve and what we have found is good practice because we are also picking up on good practice as part of the 15-steps challenge. That is a structured process. Again, it is important that it is one part of a triangulation of how we look at patient experience because, as the chief executive has described, we have the friends and family test, which we have rolled out across the Princess of Wales site. We are the only board in Wales that is doing it on this level. So, we have done a piece of work since I have come into post on how we benchmark with friends and family in England. In July of this year, we hit the top 20% of hospitals in the UK on the friends and family test, which I think is really important. We have currently just stepped down the friends and family test at the Princess of Wales because we are piloting a new system called iWantGreatCare. That went live two weeks ago. We have

had, so far, 215 responses on that website and we are hitting five stars on it. The five stars is the top level that you can hit. So, again, there are two other pieces of information that need to be triangulated into the visits and papers that go to the quality and safety committee.

[169] **Jenny Rathbone:** Thank you very much. Those sound like very positive moves. Could you just tell us how many unannounced visits the quality and safety committee has done since it started?

[170] **Mr Farrelly:** We have done 10 unannounced through quality and safety, but in total we have done 100 unannounced spot checks in the last three months, both in hours and out of hours, at weekends and at night. They have not always been on the back of quality and safety because, on the back of the Andrews report, we had set up our own internal unannounced spot checks and we have done 100 across the board. We have also done these in mental health and primary care facilities. They have not just been around secondary care.

[171] **Mr Roberts:** As well as the Minister's spot checks, the HIW have done two unannounced visits just in the last couple of months.

[172] **Darren Millar:** Health boards have to measure the same things and report back to Welsh Government in all sorts of different ways on different performance measures. Do you not get any guidance from the Welsh Government as to what board members should be looking at?

[173] **Professor Davies:** Obviously, there are the agreed performance indicators that have developed over time. Those are part of the programme that we, through the committees or indeed through visits, will be looking at and exploring.

[174] **Darren Millar:** It seems to me that you are having to reinvent the wheel in terms of looking at the things that you think are important to you as a board. Should not the same things be important to all boards in Wales?

[175] **Professor Davies:** There is always a balance between being very prescriptive and allowing each board to decide its priority and this is trying to get the mix. In many cases a lot of what we do is very prescriptive. It has grown over time and, as we have indicated, a lot of what we measure and assess our performance against is very prescriptive. We feel that there should be more autonomy, but maybe Hamish will talk more on that.

[176] **Mr Laing:** I would just give you an example in that we have had Stephen Palmer's report about risk-adjusted mortality indices and how they might best be used and where they are applicable. That is an approach that has been adopted across Wales. We are still awaiting a final decision from Welsh Government about that and that will be, I am sure, in the form of guidance. There is a very clear view of health boards working together to develop the mortality reviews of every person who dies in hospital. We are looking to extend that more widely, but at the moment it is of every person who dies in hospital. Every case note is reviewed, looking for triggers that warrant deeper and further investigation. Of course, for most people who die in hospital, there is not much to learn, but there is always something to learn. So, we now have a process that allows for in-depth review of cases that trigger further investigation and then learning. That is a mechanism that has been developed by medical directors across Wales to get right, and people have adopted different approaches. We now have a set of guidance, if you like, for NHS Wales about how we should do that.

[177] **Darren Millar:** Okay. I understand that in terms of mortality reviews—

[178] **Mr Roberts:** May I make a comment, briefly?

[179] **Darren Millar:** —but the point that I am making is this: is there consistency across Wales in terms of the information that the Welsh Government feels that board members ought to be paying attention to? What guidance and support do you get from the Welsh Government? We are trying to look at this interaction between your governance arrangements, the accountability of the Welsh Government and what support it is giving you.

[180] **Mr Roberts:** May I make a comment? In the light of that second question, it might not be quite so helpful, but I suppose that I would argue slightly with the premise as well. I actually think that a lot of best practice, whether that be working out ways of measuring good care and finding out what patient experience is and what quality is, is developed locally. I think that you have to develop a permissive environment even within huge health boards like ours for people to find out how to do these things and run with them, and then, if they are good, things like the mortality reviews that Mr Laing was talking about, we can then actually adopt more widely within the NHS in Wales. So, I think that those things are really helpful. If you look at the 1000 Lives programme that has been running for many years, that is really the methodology that it uses as well. It goes and does very concentrated pieces of work in a few places and then, when it finds that there is a good product to roll out, that is rolled out across the NHS more widely. Of course, Welsh Government supports that approach and encourages us, and indeed asks for assurance from us that we are adopting it.

[181] **Darren Millar:** But, board members still have to hack away at this undergrowth in order to pay attention to the right things. That is what you said earlier on, Andrew Davies.

[182] **Professor Davies:** In many cases, yes.

[183] **Darren Millar:** May I just touch on this issue of—.

[184] **Mr Roberts:** I mean I do—

[185] **Darren Millar:** I am going to bring Sandy Mewies in, in a second, and I will allow you to respond, but can I just touch on this issue of the RAMI figures? You suggested earlier on, Mr Davies, that the RAMI figures were part of the information that you triangulated in order to determine that there needed to be a focus on some of the problems on these elderly wards. How does that match up with the Welsh Government's recent statements following the Palmer review?

[186] **Mr Laing:** I think that RAMI, or versions of it, have been used and are used across the UK. I think, increasingly, people were concerned about how well it was reflecting what it was supposed to be reflecting. Indeed, in a way, and really coming back to Ms Rathbone's question about why people were not taking notice, the problem with RAMI is that although it was elevated in the Princess of Wales, and we were taking note of it and people were looking into why that was, there was an underlying suspicion that it may not be accurately reflecting reality, and in a way that has been confirmed by Professor Palmer. So, there are many variables that will alter the RAMI. For example, if a patient is deemed to be on an end-of-life care pathway, they are excluded from RAMI. So, the percentage of patients that are considered to be in that position will quite significantly cause variants in the RAMI and there were different approaches to how that was done. So, you have a situation where you have a measure, it is the measure that we were asked and are asked to use, but it is not really always very helpful. You cannot ignore it, and we were not ignoring it, but, equally, there was an underlying suspicion that some of the numbers may not be right. It was only when there were other bits of evidence that triangulated to say, 'Actually, there are several things here that suggest that there might be a problem,' that really the board became aware.

[187] **Darren Millar:** But it was one of those things that helped to shine a light on the particular situation.

[188] **Mr Laing:** It was.

[189] **Darren Millar:** Okay. Mr Roberts, I will allow you to briefly respond to my earlier point and then I am going to bring in Sandy Mewies.

[190] **Mr Roberts:** All that I was going to say is that I think that there needs to be, certainly for our board, a change in emphasis between a myriad of process measures into fewer, but much more focused, outcome measures. I think that that is a journey that we are on. I would like to think that our health board, perhaps because we have had the Andrews report—and that has really focused our minds, although we had started doing some of this work beforehand—is leading the way on a lot of that. If you look at the recommendations in the Advancing Quality Alliance report, they talk about how you use things like mortality indices to improve, rather than use it as a sort of league table-type system.

10:30

[191] **Sandy Mewies:** Forgive me if I am going to go on a bit about the data. I was struck by the comment in 'Trusted to Care' that ABMU was awash with data, but that people did not know what to do with them. They did not know whether they were the right data. I think there was a concern that they did not inform outcomes and the patient experience. I think that is true of a lot of data that are collected. They are just numbers and they do not inform boards of what patients are experiencing. So, I suppose what I would like to know is whether you are now confident that the data you collect are the correct data and how are they being used to ensure that outcomes for patients are improved in the short, medium and long term. That is the first area.

[192] The second area I would like to talk to you about is the fact that the Betsi Cadwaladr report brought to people's minds this phrase: communication between ward and board. I am concerned about communication between ward, board and the general public, who are, in actual fact, your constituents. When reports like 'Trusted to Care' and the governance report for BCUHB come into the public domain, there are people—your clients—and I know it has happened in my area, who say things like, 'I'm frightened to go into hospital'. So, you have to ensure that those people, not just your patients or the people who are in there, have confidence in the service that you provide.

[193] Now, the family and friends service sounds like a good one. How many people are replying to that, though? How many do you ask and how many respond? In my experience, when I have complaints from people, one of the things I ask them is whether they have been to the board and they say, 'I didn't want to do that. I wanted to leave a bit of space between us'. So, how many people are responding to that? You have changed that now to a different methodology, and I think the Chair has touched on this. If it is not imposed, this consistency, how are you sharing that good practice with other boards? If you think it is good practice—and I agree totally that you have got to come up with systems that suit the huge areas that you have—how are you sharing it?

[194] **Professor Davies:** I will start. As I said, as part of the governance review, we were looking at not just the way the board behaved but also the committees. It was clear that—. You are quite right about it being awash with data; we were not able to understand them. Obviously, part of what we have done now is to create a new performance committee that gives a greater focus to analysing our performance according to relatively few metrics, largely around the integrated medium-term plan. However, at the same time as changing the way the board operates, we have also changed substantially the executive team. As of this week, half of our senior management team has changed. We have a new director of nursing and patient experience; the job title was very deliberately 'director of nursing and patient experience',

and Rory leads on that. We have obviously a new medical director, a new HR director and a new director of strategy. So, it was not just in terms of the board and its committees, but also in terms of the executive leads.

[195] In terms of the details, maybe I could ask Rory to give an example of how we are operating in terms of scrutiny.

[196] **Mr Farrelly:** In relation to the numbers around the friends and family test, to stick to the July example, we had 672 people completing our friends and family test in July and we had a response rate of 82%. Now, one of the things in relation to the friends and family test is that it just asks two questions in relation to whether you would recommend a clinical area or not. One of the things I have commissioned is a piece of work on how we link that with discharges, so as to see whether in that month we had 672 discharges, for example, so that we are capturing everyone. However, at the moment, we are seeing a high number of people completing it. As I say, we have just currently stepped that down, because we are piloting iWantGreatCare. We have had 215 responses to iWantGreatCare so far, in two weeks.

[197] **Mr Laing:** To add to that, the questions on the iWantGreatCare website are the same as those in the friends and family test, but it just does it in a slightly different way. The thing that is really different about it is that it is published on the web for everyone to see, as people submit their responses, both their personal comments and the star ratings they give. I think the website is iwantgreatcare.org, if you want to look at it.

[198] You just need to put in 'Princess of Wales', and you will see what is happening today and how people are responding. It is very open and transparent, and we are really pleased to see actually just how positively people are scoring their care in that hospital. It is a pilot. We will evaluate it at four months, and at the end, to see whether it is the way that we want to go forward. However, it is a real commitment to openness and transparency.

[199] You asked a question about using information—or 'data' I think that you said—for improvement. It is true to say, I think, that all health boards—and certainly in our health board—have a lot of data, and it is not always very well converted into information. Part of that is because a lot of it is collected in a secondary way. It is not collected as part of the primary delivery of care, and that makes it into a bit of an industry to collect, and it means that it is collected in different ways and is often quite hard to compare. I am very keen. I have not been medical director for very long, but I have also been the lead director for informatics and innovation, for even less long than that. However, bringing those two roles together is very important, because I am very committed to seeing us using information to improve clinical care and patient outcomes. In fact, we took our informatics team to visit University Hospitals Birmingham NHS Foundation Trust 10 days ago. It is probably the leading organisation in the UK for using information to drive up and improve quality of care and outcomes. It is extraordinarily impressive. It is able to do it because it is collecting this information as part of the delivery of care. It essentially has electronic records, electronic prescribing and so on. The way that it uses that is really impressive. We would love to emulate that, and we will be setting out plans on how we will do so in our integrated medium-term plan in coming years.

[200] We are trying to focus on what we think are the really important bits of information that we get. One of them, in terms of clinical care, is the programme of national audits. Clinical audit is a thing that has been in the NHS for a very long time, but there are now—and this, again, is perhaps a national approach—a set of agreed audits, which are often UK-wide, that are mandatory for health boards and clinicians to take part in. These include, for example, the cardiac surgery audit, which is much regarded, but there are others for other specialty areas, with something like 52, I think, national audits that we are mandated to be part of. They have real power because they are collecting information that is considered to be clinically

important. They are published openly and nationally, and you are again being benchmarked against large numbers of people across the UK rather than just within Wales. We receive those reports in the health board, and we have a committee within the board that specifically receives them, looks at them, and brings in the clinicians from those areas to challenge and understand how we can improve and address any concerns or non-excellent performance that we see from that.

[201] I have touched on mortality review. That, again, is about not just counting the number of people who die, or even risk-assessing why they die, but it is learning from the case note if we could have done things better, and then sharing that across the organisation. We do that both back to the original clinicians and more widely. We also discuss those themes with the Welsh Government as part of our joint executive team meetings—what we are learning from mortality reviews—and in conversations that I have with the chief medical officer, for example.

[202] **Professor Davies:** May I just say a bit more on the engagement? Again, we have a commitment to openness and transparency. Obviously, we have talked about friends and family and other ways that we can capture patient experience but, more widely, how we engage with the community and citizens. I think that we have a proud record of engagement, whether it is in terms of service transformation, for example, a closure of a community hospital, working very closely with the community, with the community health council and other stakeholders, or generally in how we engage. For example, through the first stage of the south Wales programme, 70% of the responses across the whole of the south Wales programme were from within ABMU. Again, I think that that is an area where we feel that we have made considerable progress. However, we realise again that we are not the finished article and that there is a lot more that we need to do.

[203] **Sandy Mewies:** May I just add to that? I presume, because every board says that everything is on the website, that this is in jargon-free language, which ordinary people, if they have a computer, access to websites and know how to use them, can translate.

[204] **Mr Roberts:** Yes, we make use of the website but we do a couple of other things that I think are important. We know nowadays that lots of people engage with public services through web-based methodology, so we do a lot on the internet. We also do a lot on social media. I am amazed to see how many people are on social media in our patch. It is not only the younger generation, although, of course, it is skewed. So, we do a lot on Facebook and Twitter and we get a lot of conversations and debate going on those areas as well. Within the health board, we have a very interactive intranet, so, as a member of staff, I regularly blog. I talk about issues of importance that we are facing in hopefully easy-to-understand language. As a member of staff you can comment on my blog anonymously or by leaving your name, and we can get good debates about the issues that are being raised. We have a rumour line so that people can say, 'I have heard a rumour that such and such is taking place'. People can anonymously place that on the intranet and they will get an answer from us within a short period of time. We are promoting a lot of interaction. Some of it is physical and getting information and some of it is using web-based approaches, too.

[205] **Professor Davies:** It is also about the language we use. As our board secretary knows, I have said very clearly that all our board papers must be understandable by anybody who is a non-technical person. There is major new investment at Morriston Hospital with the new out-patients entrance, and we are incorporating everyday language. So, for example, you will not go to 'phlebotomy'; you will go to have a 'blood test'. You will not go to 'radiology'; you will go to 'x-ray'. So, again, we are looking at the use of language, which we hope will be much more understandable.

[206] **Sandy Mewies:** That is very useful, thank you.

[207] **Darren Millar:** Thank you for that. Mike Hedges is next.

[208] **Mike Hedges:** I have two very brief questions. We have talked for the best part of an hour and 40 minutes now about health. Health boards have almost become synonymous with hospitals. Is primary care getting the attention it deserves, either in ABMU or generally across Wales? The second question is: with ABMU, you have a major hospital in Morriston and its health community and the areas it deals with are substantially different to your board boundaries. For example, all of west Carmarthenshire and large parts of southern Powys, certainly the Swansea valley part of it, see it as their main hospital, yet they belong to different boards. Does that create any problems?

[209] **Professor Davies:** On your first question, I think that you are right. There has been traditionally a focus in the health service on secondary and acute care. Most of the targets we are required to reach by the Welsh Government are related to secondary or acute care. However, as a board, we know that 90% of people's contact with the health service is through primary care and community services, and we need to shift focus. It is the underlying rationale behind 'Changing for the Better', which is our change programme. We acknowledge as a board that we need to will the means to shift focus and resource from secondary and tertiary care towards primary care and community services. As a board, we have now made an in-principle decision to establish a more robust form of community networks, which are clusters of GP practices, and we are looking now at how we do that—the models and the governance around that. We might even look at not-for-profit or mutual models for delivering that, for example. It is a huge amount of work that we are in the middle of doing, but we realise that if we are to have an enhanced role for community networks, then something will have to give in terms of the existing structure. We are moving towards an enhanced role for community networks both in the delivery but also in the commissioning of services, and a reduced role for localities, if not elimination of localities altogether. Part of that complementary move is more direct management of hospitals. I do not know whether Paul wants to come in here.

[210] **Mr Roberts:** Perhaps I will pick up the second question. We have a principle where we are treating a lot of patients from outside the health board both through primary care catchments and in secondary care. My own view is that the patient should be able to move relatively freely between health boards. Our job as health boards is to make sure that we have the financial systems and planning in place.

10:45

[211] I think that health boards in the past have been too hermetically sealed to allow that to happen as it should do, but I think that the changes that we are making as a result of doing things such as the south Wales programme—in our case, the Changing for the Better programme—and the acute care network that we have set up with Hywel Dda Local Health Board, means that we are trying to free-up those movements, so that where they are in the interests of a community or a particular patient, they happen better, but making that happen is not without its problems.

[212] **Professor Davies:** I believe that the relationship with Hywel Dda in particular is in a much better place than it was when I took over. Paul and I saw this as a priority because, as you have pointed out, a lot of patients come from the Hywel Dda area, and we need to work much more closely. There are now joint executive team meetings between the two health boards, and we are looking at the governance arrangements in the future. I always said that it was anomalous as part of the south Wales programme that Hywel Dda was not a part of it, and I argued forcefully in the programme board that it should be. In the future, Hywel Dda will be part of the south Wales collaborative and it will obviously be part of the south-west

network.

[213] **Aled Roberts:** Pan ddaethoch yn gadeirydd efo tîm rheoli newydd, roeddech yn dweud eich bod yn awyddus i edrych ar bob peth. Fodd bynnag, os oedd problemau ynglŷn â faint o ddata a oedd yn cael ei gasglu a bod y negeseuon cywir ddim yn cael eu trafod gan y bwrdd, a oedd unrhyw awgrym gan reoleiddwyr neu Lywodraeth Cymru eu bod nhw'n anfodlon efo'r sefyllfa cyn i chi edrych ar y mater a chyn i'r holl bryderon hyn gael eu codi? Yr hyn rydym ni'n edrych arno yw a yw'r system llywodraethu yn y gwasanaeth iechyd yn ddigonol, ac rydym hefyd yn edrych ar y berthynas rhwng Llywodraeth Cymru â'r NHS. A oedden nhw neu'r rheoleiddwyr wedi codi unrhyw bryderon cyn i chi benderfynu bod angen edrych ar y sefyllfa?

Aled Roberts: When you became chair, and with a new management team, you say that you were eager to look at all aspects. However, if there were problems in relation to the amount of data being collected and that the correct messages were not being discussed within the board, was there any suggestion from regulators or Welsh Government that they were not content with the situation before you looked at the issue and before all of these concerns were raised? What we are looking at is to see whether the governance system within the health service is sufficient, and we are also looking at the relationship between the Welsh Government and the NHS. Did they or the regulators raise any concerns before you decided that there was a need to look at the situation?

[214] **Professor Davies:** Obviously, I cannot speak for what happened before January 2013 when I took over as chairman. Certainly, in all the discussions that I had with Government and the regulators—we have a very good relationship with the Wales Audit Office—and through the work that we do with the WAO, we were making these points that we wanted to move towards a system that is much more outcome-focused rather than process-driven.

[215] **Mr Roberts:** I do not think that any very specific concerns were raised by the regulators, but there is always an ongoing dialogue with regulators and Welsh Government about performance issues. The standards for health services are something that we regularly discuss with Health Inspectorate Wales and Wales Audit Office as to our ability to demonstrate compliance with those standards, which are relatively outcome-focused.

[216] **Aled Roberts:** Felly, o fewn mis i'r cadeirydd newydd fod yn ei swydd, roedd yn dweud ei fod wedi edrych ar y data RAMI ac wedi gweld y cwynion yn dod i law. Onid oedd pryder wedi cael ei amlygu gan Lywodraeth Cymru ar unrhyw adeg cyn hynny?

Aled Roberts: So, within a month of the new chair taking up his role, he said that he had looked at the RAMI data and had seen the complaints coming in. Had no concerns been raised by Welsh Government at any time before that?

[217] **Mr Roberts:** Some of the timescales associated with these things being raised were because these things actually happened within those timescales, and that was a lucky or unlucky coincidence for the chair arriving. The ombudsman's reports arrived when they arrived, which was in the early months of the new chairman's tenure. Although we had had access to RAMI results before, they were published first in Wales a few months after the chairman arrived. As to the protection of vulnerable adults investigation, which led to the concerns being raised about blood glucometry, it happened in January 2013, which is the month that the chairman started. As the chairman has indicated, although he has held me and my team to account and tackled these issues as chair of the board with rigour, there was a degree of time coincidence in terms of the chairman arriving at that point in time.

[218] **Aled Roberts:** Jest er mwyn i mi ddeall beth yn union yw'r sefyllfa ar hyn o bryd, rydych wedi sôn am y prawf *families*

Aled Roberts: Just so that I can understand exactly what the situation is at present, you have talked about the families and friends

and friends. Nid oeddwn yn glir ai cynllun o fewn Ysbyty Tywysoges Cymru oedd hwnnw, neu a ydyw o fewn pob un o'ch ysbytai. Hefyd, o ran iWantGreatCare, eto, roeddech yn dweud mai cynllun peilot oedd hwn o fewn yr un ysbyty. Beth yw'r amserlen ynglŷn ag ehangu hynny ar draws y bwrdd os yw'n llwyddiant?

test. I was not clear whether that was a scheme within the Princess of Wales hospital or whether it is a scheme across all of your hospitals. Also, in terms of iWantGreatCare, once again, you said that this is a pilot scheme within one hospital. What is the timetable in terms of rolling that out across the board if it is successful?

[219] Credaf fod Sandy Mewies wedi gwneud pwynt gwerthfawr; wrth ystyried bod pob bwrdd yn gallu creu ei strwythur ei hun o ran gwelliant, faint o fyrddau Cymru sydd wedi dod atoch er mwyn ichi rannu gwybodaeth ynglŷn â *friends and family*, y gwersi rydych wedi eu dysgu o Ysbyty Tywysoges Cymru, ac wedi trafod yn fanwl efo chi pa wersi mae hynny'n dysgu iddynt?

I believe that Sandy Mewies made a valuable point; given that every board can create its own structure in terms of improvement, how many boards in Wales have come to you so that you can share information with them with regard to friends and family, the lessons that you have learned from the Princess of Wales Hospital, and have discussed in detail with you the lessons that this might teach them?

[220] **Mr Roberts:** I will, perhaps, ask Rory to answer the first part of your question; I am happy to come back to the second part if that is helpful.

[221] **Mr Farrelly:** In relation to friends and family, as a board, we have a roll-out plan to put it everywhere. We were starting with the Princess of Wales and Neath Port Talbot hospitals. We have a plan in that we were buying a system called Snap 11, which was going to enable us to collect it all electronically and then link it back with outcomes. That plan is on time, and we will have it fully rolled out everywhere by March 2015.

[222] In relation to iWantGreatCare, we are piloting it for four months. We are only doing it on the Princess of Wales Hospital site, because it has been commissioned by the Welsh Government to happen on the Princess of Wales Hospital site and in Wrexham as another hospital site. So, the plan is to pilot it for four months and then evaluate the pilot project, linked with an outcome, and we will contribute as part of that process.

[223] **Aled Roberts:** All of these procurements are separate, are they, for each health board? We heard before about shared services et cetera and the roll-out of all of these software programmes that they have; they are not actually looking at that across NHS Wales, then.

[224] **Mr Laing:** The purpose of the Welsh Government commissioning iWantGreatCare is to see whether it would wish to see it across Wales. It is a commercial product. There are others and, quite properly, it thinks that we should evaluate it. However, it does give the opportunity to industrialise the collection of patient experiences. iWantGreatCare has told us that, in the hospitals it works with—I think that it now works across 18 countries, but predominantly in England—it gets at least 40% of all patients who are discharged providing feedback. It is called 'the Trip Advisor for health' by some. In its best performing hospital, it is 70% of all patients who are being discharged. That is a hospital focus, because it is predominantly being used in England in hospitals, but it has the opportunity to be used in primary care as well, and that is another opportunity that we might want to look at.

[225] **Mr Roberts:** Perhaps I could make a brief comment on the second part of the question. One of the first things that we did at the invitation of Andrew Goodall was to lead a session at Team Wales with all of the executive teams of the health boards about the things that we were doing, our response to the Andrews report and the practice that we were

developing. Therefore, through that session, quite a lot of links were made between the people at that meeting, and I think that was very helpful.

[226] The chief executives, as a group, are encouraging the director groups to be much more strategic about sharing good practice. So, the medical directors' group will be talking about many of the things that Hamish has raised, and the nursing directors' group will be doing the same thing and sharing good practice that way. I feel that that is being done in a more structured way than it was done before.

[227] The final thing is that one of the recommendations in the Andrews report is that we as a health board develop a dashboard for the care of frail older people in Wales. That is something that Rory Farrelly is leading on, and it is a piece of good practice that will be spread throughout Wales.

[228] **Mr Laing:** Chair, may I add something?

[229] **Darren Millar:** Very briefly, as we are up against the clock.

[230] **Mr Laing:** I will just pre-empt a question by saying that, although iWantGreatCare is a web-based tool, it is possible to collect the responses on paper. In fact, the majority of patients are responding on paper at the moment, which is why you will see the number of respondents go up in big batches, because we collect them and post them off to iWantGreatCare, which then enters the data. So, that is just to reassure people.

[231] **Darren Millar:** Thank you for that.

[232] **Julie Morgan:** Do you individually give them to patients?

[233] **Mr Laing:** Yes.

[234] **Julie Morgan:** So that does encourage a response.

[235] **Mr Laing:** Every ward and department has a poster with a QR code, a two-dimensional barcode, if people wish to use their mobile phone—we have free Wi-Fi in our hospitals, so they can do so. However, they are offered a paper form if they would prefer. They put it in a box, we collect it and then send it to iWantGreatCare, which then enters it manually.

[236] **Julie Morgan:** Following on from Mike Hedges's question about shifting from hospital acute care, with more emphasis being put on primary care, how much work are you able to do on preventative care?

[237] **Professor Davies:** I think that the short answer is: not as much as we would want. Public health, for example, is a crucial part of our operation, and we are looking at this now as to how we can put a greater focus on preventative health, particularly through our commissioning processes, which is a very new development for the health board—as it is for all health boards—and how that feeds in to the integrated medium-term plan. We recognise that it is an area where there is a considerable amount of work yet to do, and we can only do that in collaboration, particularly with local authorities and the third sector in terms of that preventative agenda. Paul may want to sum up.

[238] **Mr Roberts:** Just again to summarise, we have six strategic aims in our plan that are very clear throughout the organisations. The first one is excellent population health, and we have particular milestones that we want to meet in order to meet our planning. So, we put it right up at the front as our first strategic aim as a health board. As the chairman says, we feel

that there is a lot more that we need to do, but we have put a very great emphasis on it in the organisation.

[239] **Darren Millar:** The clock has just about beaten us, but we have time for one more question, I think. It is in relation to the peer support, Mr Roberts, that you provided to the Betsi Cadwaladr board in the wake of the joint HIW/Wales Audit Office review. Do you think that your absence from your own board, at a time when it was facing particular challenges in the care of elderly, frail people in its hospitals, was—I do not know—contributory to some of those problems? Do you think that it meant that the eye was taken off the ball in terms of some of its problems? How do you think it impacted on the outcome of the 'Trusted to Care' review and, indeed, the AQuA report, given that they were ongoing at the same time?

[240] **Mr Roberts:** It is only fair that I let the chair comment first, because he is my boss, but I would like to comment second, if I may.

[241] **Professor Davies:** I think that, inevitably, when your chief executive is away for three days, if not longer, during the week—. I do not think that it meant that we dropped the ball; I just think that a lot of the work that Paul and I started early last year was inevitably put on hold. As I said, one of the first things that I undertook to do was a governance review, and that was something that I said to the Minister. Paul, at the same time, was doing a review of management and organisational structures. Inevitably, that work had to be put on hold until his return in the autumn of last year.

[242] **Darren Millar:** So, it was a factor in impeding the progress that you wanted to make.

[243] **Professor Davies:** Yes. I think that I would be less than honest if I were to say anything else.

[244] **Mr Roberts:** I think that that is very fair. The balancing point is that I also learned a lot going into Betsi, because I think that you learn from these situations. Some of the learning that I took from Betsi I have brought into our programme and our plan within the health board. So, I think that there is a balancing factor, but I agree with the chair's comments.

[245] **Darren Millar:** Okay. I am afraid that that is going to have to draw this evidence session to a close, but thank you very much indeed for your attendance. We will send you a copy of the transcript of today's proceedings. If there are any inaccuracies, please let us know. However, we appreciate your coming in to help us with our inquiry. Thank you, Andrew Davies, Paul Roberts, Rory Farrelly and Hamish Laing. Good to see you again, Hamish.

10:58

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting

[246] **Darren Millar:** I will now move, under Standing Order 17.42, to resolve to move into private session for the final item of today's meeting and for the first two items of our next meeting on 11 November. I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order 17.42(vi).

[247] I see that there are no objections, so we will move into private session. Thank you.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10:59.
The public part of the meeting ended at 10:59.